

The Limitations of Legislatively Imposed Damages Caps: Proposing a Better Way to Control the Costs of Medical Malpractice

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I. INTRODUCTION

Health care providers believe their liability insurance premiums are too high because the judicial system is out of control. “The largely indiscriminate nature of the system—where anyone can file a lawsuit for any reason regardless of whether there is evidence that negligence occurred—has engendered a fear of liability in physicians that is harmful to individual patients and to the health care system as a whole.”¹ Providers claim that because of high insurance premiums, physicians are retiring early, relocating to states with lower insurance rates, avoiding high-risk practice areas, and practicing defensive medicine by ordering unnecessary tests and limiting high-risk, perhaps necessary, procedures.² This situation has led both doctors and lawyers to declare that there is a “malpractice insurance crisis in the United States today.”³

This crisis, or the claim that one exists, is not new. “Physicians have contended that since the early- to mid-nineteenth century there has been a medical malpractice crisis pitting physicians against injured patients and their attorneys.”⁴ The debate over how to respond to this crisis

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1. Donald J. Palmisano, Case Study, *Health Care in Crisis: The Need for Medical Liability Reform*, 5 YALE J. HEALTH POL’Y L. & ETHICS 371, 374 (2005).

2. Juan Carlos B. Gomez, Commentary, *Silencing The Hired Guns: Ensuring Honesty in Medical Expert Testimony Through State Legislation*, 26 J. LEGAL MED. 385, 385 (2005); see also Katherine Baicker & Amitabh Chandra, *Defensive Medicine and Disappearing Doctors?*, REGULATION, Fall 2005, at 24.

3. Richard E. Anderson, Case Study, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 YALE J. HEALTH POL’Y L. & ETHICS 341, 343 (2005); see also Gomez, *supra* note 2, at 385.

4. *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440, 447 (Wis. 2005).

is not limited to physicians, their patients, and the attorneys representing them, however. Rather, it is a national debate among doctors, lawyers, Congress, state legislatures, and our judiciary about how to respond to calls for change.⁵

Health care providers and insurance companies are asking legislatures to limit damages awards to victims of medical negligence. As one court recently observed: “In the case of medical malpractice, interest groups representing every aspect of the delivery of health care are heavily involved in lobbying the legislature.”⁶ These lobbyists are seeking statutory control of jury verdicts in the form of damages caps.⁷

The argument for damages caps is premised upon an assumption that legislative limits will lead to lower insurance premiums, which will in turn ensure “quality health care by creating an environment that health care providers are likely to move into, or less likely to move out of.”⁸ Proponents also argue that caps will prevent the practice of defensive medicine.⁹ The “underlying assertion” of the call for legislation, how-

5. See Kimberly J. Frazier, Note, *Arkansas's Civil Justice Reform Act of 2003: Who's Cheating Who*, 57 ARK. L. REV. 651, 696 (2004); see also *Ferdon*, 701 N.W.2d at 447; Robert F. Williams, *Foreword: Tort Reform and State Constitutional Law*, 32 RUTGERS L.J. 897, 900 (2001) (observing that the “conflict over tort reform pits the plaintiffs’ bar . . . against the defense bar”).

6. *Ferdon*, 701 N.W.2d at 448.

7. Most states with damages caps limit “noneconomic” damages, although some states limit both economic and noneconomic damages. See, e.g., OKLA. STAT. ANN. tit. 63 § 1-1708.1F (West Supp. 2006) (capping noneconomic damages); S.C. CODE ANN. § 15-32-220(A) (West Supp. 2005) (capping noneconomic damages); VA. CODE ANN. § 8.01-581.15 (West Supp. 2005) (capping economic and noneconomic damages). A typical definition of noneconomic damages is as follows:

[M]oneys intended to compensate for pain and suffering; humiliation; embarrassment; worry; mental distress; noneconomic effects of disability including loss of enjoyment of the normal activities, benefits and pleasures of life and loss of mental or physical health, well-being or bodily functions; loss of consortium, society and companionship; or loss of love and affection.

WIS. STAT. ANN. § 893.55(4)(a) (West Supp. 2005). The definition in a proposed congressional bill is similar, defining noneconomic damages as “physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.” Help Efficient, Accessible, Low-cost, Timely Healthcare Act, H.R. 534, 109th Cong. § 9(15) (2005). In contrast, a typical definition of economic damages is as follows:

[O]bjectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

Id. § 9(6).

8. *Ferdon*, 701 N.W.2d at 487.

9. See *id.* at 465. “Defensive medicine” is defined as occurring “when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily . . . to reduce their exposure to malpractice liability.” *Id.* at 487 n.230 (internal quotation omitted).

ever, is “that the tort system is ‘broke’ or at least badly in need of repair.”¹⁰

While this may be the call of some physicians and insurance companies looking for ways to reduce the high costs of medical malpractice insurance,¹¹ there is no agreement as to the best way to control these costs. Some commentators claim that it is “clear” that the “current problems are the result of a dramatic increase in the cost of litigation,”¹² but others are not so sure.¹³ As discussed below, other explanations for the high cost of malpractice insurance include insurers’ poor investment decisions and insurers’ business decisions, such as offering low premiums to attract new customers.¹⁴ At the very least, the evidence is anything but “clear,” and, as one observer has stated: “The possible causes of the medical malpractice insurance increases are always subject to debate.”¹⁵ Despite compelling evidence that the current approach of limiting damages has not lowered malpractice premiums, however,¹⁶ health care providers and their insurers continue to call for legislatively-imposed damages caps, and our state and federal legislatures are responding.¹⁷

Since 1986, more than forty-one states have passed legislation “to limit the liability of wrongdoers, restrict the amount of monetary damages injured consumers [can] receive in court, or make it more difficult for the injured to obtain attorneys to represent them against insurance companies.”¹⁸ Limitations include damages caps for both noneconomic and economic losses, shortened limitations periods for filing suit, and

10. *Id.* at 467.

11. See Anderson, *supra* note 3, at 352; Melissa C. Gregory, Note, *Capping Noneconomic Damages in Medical Malpractice Suits is Not the Panacea of the “Medical Liability Crisis,”* 31 WM. MITCHELL L. REV. 1031, 1033 (2005).

12. See, e.g., Anderson, *supra* note 3, at 343.

13. See, e.g., *Ferdon*, 701 N.W.2d at 472; Baicker & Chandra, *supra* note 2, at 24; Gregory, *supra* note 11, at 1034.

14. See *infra* Part IV.

15. Gregory, *supra* note 11, at 1035. A review of the current literature makes clear that the debate is raging. Compare Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417, 467 (2004) (arguing that prevailing market forces in the property/casualty insurance industry are driving premiums up and that damage caps address only one of several factors causing the increased premiums), and Gregory, *supra* note 11, at 1034–35 (questioning whether legislatively mandated caps will cure any of the problems facing health care providers), with Palmisano, *supra* note 1, at 382–83 (calling for legislatures to enact medical liability reform).

16. See *infra* Part IV.

17. See Palmisano, *supra* note 1; see also W. Kip Viscusi & Patricia Born, *Medical Malpractice Insurance in the Wake of Liability Reform*, 24 J. LEGAL STUD. 463, 463 (1995).

18. J. ROBERT HUNTER & JOANNE DOROSHOW, CTR. FOR JUSTICE & DEMOCRACY, PREMIUM DECEIT: THE FAILURE OF “TORT REFORM” TO CUT INSURANCE PRICES 3 (2002), <http://insurance-reform.org/PremiumDeceit.pdf>.

restrictions on where a suit may be brought.¹⁹ Some of these statutes have been invalidated on constitutional grounds, but “[f]or the most part, these new ‘tort limits’ have remained on the books.”²⁰

Oliver Wendell Holmes once said: “The life of the law has not been logic: it has been experience.”²¹ Logic may not, however, be so easily separated from experience. Indeed, it is defined by experience, and judges “apply logic *and* experience” when reviewing the cases before them.²² Based on logic and experience, it is now time to revisit the issue of how best to control medical malpractice premiums and preserve the health of the health care industry.

This Article considers whether state damages caps are constitutional and examines recent studies suggesting that damages caps are not achieving their intended goals. Given the mounting evidence against the effectiveness of damages caps and the questions about their constitutional validity, this Article proposes moving away from legislative caps on damages. Instead, this Article argues for a modified market model based on a combination of improved care, which would include improvements in service; better peer review; and, if necessary, legislation which would be designed to protect the confidentiality of peer review, reduce frivolous lawsuits, and regulate insurance rate increases.

Part II examines federal and state legislative responses to the call for damages caps. Part III addresses the constitutional issues raised by legislatively imposed limitations on damages awards. Part IV goes beyond these issues to ask whether, even if damages caps pass constitutional muster, these legislative limits offer any real solution to the issue that is really at the heart of the debate: premium rate increases. Part V proposes a solution that combines market forces and legislative controls to regulate insurance rate increases, enhance peer review, and reduce frivolous lawsuits.

II. THE LEGISLATIVE RESPONSE

Health care providers and insurers have turned to the legislative branch of our federal and state governments for a solution to increasing liability premiums, and the legislatures have responded. The U.S. House of Representatives has passed, and several state legislatures have en-

19. *See id.* at app. A.

20. *Id.* at 3.

21. O.W. HOLMES, THE COMMON LAW 1 (1881).

22. *Dickinson v. Zurko*, 527 U.S. 150, 163 (1999) (emphasis added).

acted, various limitations on medical malpractice claims and the recovery of damages for such claims.²³

A. Federal Legislation

In January 2005, President Bush challenged Congress to limit the manner in which a plaintiff injured by a negligent doctor can recover damages.²⁴ In response, the U.S. House of Representatives passed the Help Efficient, Accessible, Low-cost, Timely Healthcare Act (HEALTH Act).²⁵ The Act would limit noneconomic damages awards to \$250,000, restrict where plaintiffs may file medical malpractice suits, shorten the limitations period in which such suits may be brought, restrict attorneys' contingency fees, and allow the introduction of collateral-source benefits.²⁶ The stated purpose of the HEALTH Act is "to implement reasonable, comprehensive, and effective health care liability reforms," which are designed to:

- (1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;
- (2) reduce the incidence of "defensive medicine" and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;
- (3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;
- (4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and
- (5) provide an increased sharing of information in the

23. See, e.g., Help Efficient, Accessible, Low-cost, Timely Healthcare Act, H.R. 534, 109th Cong. (2005) (containing venue restrictions, contingent fee limitations, collateral source rule modifications, limitations on joint and several liability, shortened statute of limitations); OKLA. STAT. ANN. tit. 63, § 1-1708.1D(B) (West 2004) (modifying the collateral source rule); VA. CODE ANN. § 8.01-1 (West 2000) (shortening the statute of limitations); Virginia Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. § 38.2-5002 (West Supp. 2005) (establishing a no-fault approach for obstetricians); *Id.* § 8.01-581.15 (limiting economic and noneconomic damages); MO. ANN. STAT. § 538.210 (West Supp. 2006) (limiting noneconomic damages); OKLA. STAT. ANN. tit. 63, § 1-1708.1F (West Supp. 2006) (limiting noneconomic damages).

24. President George W. Bush, Address at the Gateway Center in Collinsville, Illinois, 41 WEEKLY COMP. PRES. DOC. 9 (Jan. 5, 2005), available at <http://www.whitehouse.gov/news/releases/2005/01/20050105-4.html>.

25. Help Efficient, Accessible, Low-cost, Timely Healthcare Act, H.R. 534, 109th Cong. (2005).

26. *Id.* "Under the collateral source rule, benefits received by the plaintiff from a source wholly independent of and collateral to the wrongdoer will not diminish the damages otherwise recoverable from the wrongdoer." *Hayes Sight & Sound, Inc. v. Oneok, Inc.*, 136 P.3d 428, 440 (Kan. 2006).

health care system which will reduce unintended injury and improve patient care.²⁷

The Senate is currently considering similar legislation, but has not yet passed a bill.²⁸ In President Bush's 2006 State of the Union address, he renewed his request for Congress "to pass medical liability reform this year."²⁹

B. State Legislation

Many states have also enacted limitations on medical malpractice damages awards. "In 2003 alone, forty-one states introduced legislation that either proposed or changed caps on noneconomic damages for medical malpractice awards."³⁰ By late 2005, approximately twenty states had enacted caps on noneconomic damages.³¹ Legislation from a few representative states is presented below by way of example only and is not intended to be an exhaustive list of what each state has done.

Typical statutory language can be found in South Carolina's recent enactment of a cap on noneconomic damages awarded against health care providers.³² Noneconomic damages are limited to "an amount not to exceed three hundred fifty thousand dollars for each claimant."³³ If judgment is rendered against more than one health care provider, liability for each provider is limited to "an amount not to exceed three hundred fifty thousand dollars for each claimant, and the limit of civil liability for noneconomic damages for all health care institutions and health care

27. Help Efficient, Accessible, Low-cost, Timely Healthcare Act, H.R. 534, 109th Cong. § 2(b) (2005).

28. See Healthy Mothers and Healthy Babies Access to Care Act, S. 366, 109th Cong. (2005); Pregnancy and Trauma Care Access Protection Act, S. 367, 109th Cong. (2005); Help Efficient, Accessible, Low-cost, Timely Healthcare Act, S. 354, 109th Cong. (2005).

29. President George W. Bush, State of the Union Address, 42 WEEKLY COMP. PRES. DOC. 145 (Jan. 31, 2006), available at <http://www.whitehouse.gov/news/releases/2006/01/20060131-10.html>.

30. Gregory, *supra* note 11, at 1033.

31. See Kevin McManus, Comment, *Finding a Cure for High Medical Malpractice Premiums: The Limits of Missouri's Damage Cap and the Need for Regulation*, 49 ST. LOUIS U. L.J. 895, 896, 896 n.8 (2005) (referencing Alaska, California, Colorado, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Montana, New Mexico, North Dakota, Utah, Virginia, West Virginia, and Wisconsin statutes). Since that survey was completed, South Carolina has also enacted a cap on noneconomic damages. See S. C. CODE ANN. §§ 15-32-200-240 (West Supp. 2005). Wisconsin's cap, however, has been invalidated on constitutional grounds. See *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440, 447 (Wis. 2005).

32. See S. C. CODE ANN. § 15-32-210(5) (West Supp. 2005). Health care provider is defined as "a physician, surgeon, osteopath, nurse, oral surgeon, dentist, pharmacist, chiropractor, optometrist, podiatrist, or similar category of licensed health care provider." *Id.*

33. *Id.* § 15-32-220(A).

providers is limited to an amount not to exceed one million fifty thousand dollars for each claimant."³⁴ The limitations

do not apply if the jury or court determines that the defendant was grossly negligent, willful, wanton, or reckless, and such conduct was the proximate cause of the claimant's noneconomic damages, or if the defendant has engaged in fraud or misrepresentation related to the claim, or if the defendant altered or destroyed medical records with the purpose of avoiding a claim or liability to the claimant.³⁵

While South Carolina's cap limits each individual claimant's recovery, other state statutes limit the total recovery for each negligent act, regardless of how many claims are filed.³⁶ Oklahoma refers to this type of limit on total recovery as a "hard cap" because it applies "regardless of the number of actions brought with respect to the personal injury."³⁷ Oklahoma has a hard cap of \$300,000, which applies only if the defendant has made an offer of judgment.³⁸ The jury may lift the cap in certain circumstances.³⁹

To account for inflation, state damages cap statutes may provide for increases in the total amount of recoverable damages in a variety of ways. For example, Oklahoma's cap may be adjusted annually "based upon any positive increase in the Consumer Price Index that measures the average changes in prices of goods and services purchased by urban wage earners and clerical workers' families and single workers living alone (CPI-W) for the preceding calendar year."⁴⁰ Virginia, which caps

34. *Id.* § 15-32-220(C). Missouri has a similar cap on noneconomic damages. See MO. ANN. STAT. § 538.210 (West Supp. 2006).

35. S. C. CODE ANN. § 15-32-220(E) (West Supp. 2005).

36. See, e.g., OKLA. STAT. ANN. tit. 63, § 1-1708.1F-1(A) (West Supp. 2006); TEX. CIV. PRAC. & REM. CODE ANN. § 74.301(a) (Vernon 2005).

37. See OKLA. STAT. ANN. tit. 63, § 1-1708.1F-1(A) (West Supp. 2006).

38. If an ultimate judgment is less than the amount of an offer of judgment previously made by a litigant, that offer of judgment protects the litigant from having to pay certain costs incurred after the offer is made. See OKLA. STAT. ANN. tit. 12, § 1101.1 (West Supp. 2006); accord FED. R. CIV. P. 68 ("If the judgment finally obtained by the offeree is not more favorable than the offer, the offeree shall pay all costs accruing after the making of the offer.").

39. OKLA. STAT. ANN. tit. 12, § 1-1708.1F-1(A), (D) (West Supp. 2006). The statute provides, in part:

If nine or more members of the jury find by clear and convincing evidence that the defendant committed negligence or if nine or more members of the jury find by a preponderance of the evidence that the conduct of the defendant was willful or wanton, the limits on noneconomic damages provided for in subsection A of this section shall not apply; provided, however, the judge must, before submitting such determination to the jury, make a threshold determination that there is evidence from which the jury could reasonably make the findings set forth in the case.

Id. § 1-1708.1F-1(D).

40. *Id.* § 1-1708.1F-1(B); see also MICH. COMP. LAWS ANN. § 600.1483(4) (West 2006) (allowing the state treasurer to "adjust the limitation on damages for noneconomic loss set forth in

economic and noneconomic damages at \$1.5 million regardless of the number of claims,⁴¹ accounts for inflation as follows:

The maximum recovery limit of \$1.5 million shall increase on July 1, 2000, and each July 1 thereafter by \$50,000 per year; however, the annual increase on July 1, 2007, and the annual increase on July 1, 2008, shall be \$75,000 per year. Each annual increase shall apply to the act or acts of malpractice occurring on or after the effective date of the increase. The July 1, 2008, increase shall be the final annual increase.⁴²

Texas caps noneconomic damages at \$250,000 for each individual claimant

where final judgment is rendered against a physician or health care provider other than a health care institution . . . regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.⁴³

Texas limits claims against a single health care institution to \$250,000 for each claimant.⁴⁴ When more than one institution is sued, liability is capped at “\$250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$500,000 for each claimant.”⁴⁵

subsection (1) by an amount determined by the state treasurer at the end of each calendar year to reflect the cumulative annual percentage change in the consumer price index. As used in this subsection, ‘consumer price index’ means the most comprehensive index of consumer prices available for this state from the bureau of labor statistics of the United States department of labor.”)

41. See VA. CODE ANN. § 8.01-581.15 (West Supp. 2005).

42. *Id.*

43. TEX. CIV. PRAC. & REM. CODE ANN. § 74.301(a) (Vernon 2005).

44. *Id.* § 74.301(b).

45. *Id.* § 74.301(c). The Texas statute is silent on whether these caps will be adjusted for inflation. See *id.* In contrast, Texas’s statutory cap on damages in a wrongful death case does provide for adjustments for inflation:

[T]he liability limit . . . shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index, as published by the Bureau of Labor Statistics of the United States Department of Labor, that measures the average changes in prices of goods and services purchased by urban wage earners and clerical workers’ families and single workers living alone (CPI-W: Seasonally Adjusted U.S. City Average—All Items), between August 29, 1977, and the time at which damages subject to such limits are awarded by final judgment or settlement.

Id. § 74.303(b).

It should be noted that Texas is different than most states because it amended its constitution to allow the legislature to enact these damages caps.⁴⁶ As discussed below, in states without such constitutional authorization, courts are divided over whether these types of statutory limitations are constitutional.

III. CAN LEGISLATURES CONSTITUTIONALLY SAVE THE MEDICAL PROFESSION?

State damages caps are constitutionally suspect under both the federal and state constitutions. They have been challenged on various constitutional grounds, and state courts are divided over whether the limits are constitutional.⁴⁷ A review of these state court decisions suggests that states' legislative power to enact damages caps is anything but clear. The differences in the outcomes can be explained, in part, by variations in state constitutions. For example, as discussed above, Texas amended its constitution to specifically allow its legislature to impose caps on damages.⁴⁸ In contrast, Arizona has amended its constitution to prohibit its legislature from abrogating tort remedies.⁴⁹ These differences, however, do not account for the inconsistent state court decisions regarding whether damages caps are constitutional.⁵⁰

The constitutional challenges discussed below fall into two categories: (1) individual rights, including the right to equal protection under

46. See TEX. CONST. art. III, § 66. To protect its statutory cap from constitutional challenge, the Texas legislature passed House Joint Resolution 3, commonly referred to as "Proposition 12," which was approved by the voters. See H.R.J. Res. 3, 78th Leg., Reg. Sess. (Tex. 2003). It authorized the legislature to set limits on noneconomic damages, and it applies to limitations in medical malpractice liability cases as well as all other tort actions. Ruben James Reyes, *Capping Your Rights: The Texas Statute of Non-Economic Damage Caps in Medical Malpractice Cases and its Assault on the Rights of the Injured and the Power of the Courts*, 6 SCHOLAR 347, 353 (2004).

47. See *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440, 448 (Wis. 2005).

48. See TEX. CONST. art. III, § 66; see also discussion *supra* note 46.

49. The Arizona constitution provides: "No law shall be enacted in this state limiting the amount of damages to be recovered for causing the death or injury of any person." ARIZ. CONST. art. II, § 31. It further provides: "The right of action to recover damages for injuries shall never be abrogated, and the amount recovered shall not be subject to any statutory limitation." *Id.* art. XVIII, § 6.

Legislation imposing caps has been struck down. See, e.g., *Duncan v. Scottsdale Med. Imaging, Ltd.*, 70 P.3d 435, 443 (Ariz. 2003) (statute abolishing right to bring action in battery against licensed health care provider violated anti-abrogation clause of Arizona constitution); *Hunter Contracting Co., Inc., v. Super. Ct.*, 947 P.2d 892, 899 (Ariz. 1997) (statutory requirement of an affidavit from an expert when filing a lawsuit unconstitutionally violated fundamental right to pursue damages under Arizona constitution); *Smith v. Myers*, 887 P.2d 541, 548 (Ariz. 1994) (statutory periodic payment scheme for medical malpractice actions violated plaintiffs' right to recover damages for personal injuries or wrongful death as guaranteed by Declaration of Rights in Arizona constitution).

50. See *Ferdon*, 701 N.W.2d at 448, 448 n.12.

the law, the right to due process of law, and the right to trial by jury,⁵¹ and (2) separation of powers.⁵²

A. Individual Rights

1. Equal Protection: A Case Study

Many state courts have addressed the issue of whether damages caps violate the guarantees of equal protection, due process, and the right to a jury trial.⁵³ In *Ferdon ex rel. Petrucelli v. Wisconsin Patients Compensation Fund*,⁵⁴ the Wisconsin Supreme Court considered a medical malpractice victim's constitutional challenge to damages caps and provided a thorough analysis of the issues surrounding the debate. The court's decision rested on equal protection grounds.⁵⁵ However, the court's thorough review of the practice of medicine and the empirical data related to the impact of damages caps is instructive and may be applicable to the resolution of any individual rights constitutional challenge to damages caps. The court relied upon empirical data spanning a period of over ten years, including non-partisan state and federal governmental studies, as well as studies done by private interests groups, such as the American Trial Lawyers Association and the American Medical Association (AMA).⁵⁶ A discussion of this case will provide a guide for analyzing the issues that are at the heart of the debate. Other cases that are consistent and inconsistent with *Ferdon's* holding will be briefly discussed or briefly mentioned to illustrate different courts' approaches to the issues.

In *Ferdon*, plaintiff Matthew Ferdon suffered injuries as a result of a physician's negligence during his birth.⁵⁷ According to evidence produced at trial and accepted by the jury, the doctor delivering Matthew pulled on his head and caused an injury called obstetric brachial plexus

51. See *infra* Part III.A.

52. See *infra* Part III.B. Other constitutional provisions, such as open courts provisions and uniform operation of laws provisions, have also been relied on to challenge damages caps. See, e.g., *Judd v. Drezga*, 103 P.3d 135, 138 (Utah 2004). The standard for determining whether these provisions have been violated is similar to, or less stringent than, the standard applied in an equal protection analysis, see *id.* at 140–42, and thus will not be separately considered here. Similarly, due process challenges will not be separately analyzed because, as one court has noted, “the tests for whether legislation violates the Due Process and Equal Protection Clauses . . . are essentially the same.” *Zdrojewski v. Murphy*, 657 N.W.2d 721, 737 n.12 (Mich. Ct. App. 2002).

53. See, e.g., *infra* notes 112 & 113.

54. 701 N.W.2d 440 (Wis. 2005).

55. See *id.* at 447.

56. See *id.* at 470 nn.136–50, 488 n.232.

57. *Id.* at 449.

palsy.⁵⁸ This injury resulted in paralysis and deformity in Matthew's right arm.⁵⁹ By the time of trial, he had already undergone repeated surgeries and occupational therapy and would require more surgery and therapy in the future; his arm would never function normally.⁶⁰ Based on these facts, the jury awarded him \$403,000 for future medical and hospital expenses.⁶¹ In addition, the jury awarded him \$700,000 in noneconomic damages for past and future personal injuries, but made no award for loss of future earning capacity.⁶² The jury awarded Matthew's parents \$87,600 as compensation for the personal care they would provide to Matthew until the age of 18.⁶³ After the verdict, the court reduced the \$700,000 personal injury award to \$410,322, as required by the state's cap on noneconomic damages.⁶⁴ According to the court's computation, the statutory cap "mean[t] that Matthew Ferdon will have an award of approximately \$5,900 a year as the reasonable amount necessary to compensate him for living with a partially functioning, deformed right arm."⁶⁵

On appeal, Matthew challenged the noneconomic damages cap on several grounds. He claimed that it violated several provisions of the Wisconsin Constitution, including the equal protection guarantees,⁶⁶ the right to a trial by jury,⁶⁷ the right to a remedy,⁶⁸ the due process clause,⁶⁹ and the separation of powers doctrine.⁷⁰ Concluding that the cap violated the equal protection guarantees of the state constitution, the court did not address the other constitutional challenges.⁷¹

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.* The cap was \$350,000, which was adjusted for inflation, as required by WIS. STAT. §§ 655.017 and 893.55(4)(d) (2001–2002). *Id.* According to the statute:

The limit on total noneconomic damages for each occurrence . . . shall be \$350,000 and shall be adjusted by the director of state courts to reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, at least annually thereafter, with the adjustment limit to apply to awards subsequent to such adjustments.

WIS. STAT. § 893.55(4)(d) (2001–2002).

65. *Ferdon*, 701 N.W.2d at 446.

66. WIS. CONST. art. I, § 1.

67. *Id.* art. I, § 5.

68. *Id.* art. I, § 9.

69. *Id.* art. I, § 1.

70. *Id.* art. VII, § 2.

71. *Ferdon*, 701 N.W.2d. at 447.

The court first had to decide what level of scrutiny to apply in the equal protection analysis.⁷² Matthew argued that the court should apply strict scrutiny.⁷³ According to the court, strict scrutiny would require the defendant to prove

that the \$350,000 cap on noneconomic damages caused by medical malpractice tortfeasors promotes a compelling governmental interest and that the \$350,000 cap is the least restrictive means for doing so. That is, the [defendant] would have to show that the cap is precisely tailored to serve a compelling state interest.⁷⁴

The defendant, on the other hand, argued that rational basis, not strict scrutiny, was the appropriate level of scrutiny.⁷⁵

The court agreed with the defendant, noting that the damages cap “does not deny any fundamental right and does not involve a suspect classification.”⁷⁶ This conclusion placed a heavy burden on Matthew to prove that the statute was unconstitutional: “A person challenging a statute on equal protection grounds under the rational basis level of scrutiny bears a heavy burden in overcoming the presumption of constitutionality afforded statutes.”⁷⁷ Respecting the role of the legislature, the court noted that “the judiciary is not positioned to make the economic, social, and political decisions that fall within the province of the legislature.”⁷⁸ Accordingly, the court held that Matthew had to “demonstrate that [the] statute [was] unconstitutional beyond a reasonable doubt.”⁷⁹ To meet this

72. Both the U.S. Constitution and state constitutions guarantee equal protection of the law. *Frame v. Nehls*, 550 N.W.2d 739, 741 (Mich. 1996). To determine whether a legislative classification violates equal protection, the reviewing court applies one of three tests. *Crego v. Coleman*, 615 N.W.2d 218, 223 (Mich. 2000). Strict scrutiny applies if the legislation “impermissibly interferes with the exercise of a fundamental right or operates to the peculiar disadvantage of a suspect class.” *Vargo v. Sauer*, 576 N.W.2d 656, 661 (Mich.1998) (citing *Mass. Bd. of Retirement v. Murgia*, 427 U.S. 307, 312 (1976)). See also *State v. Anala*, 484 N.W.2d 138, 144 (Wis. 1992) (citing *Murgia*, 427 U.S. at 312). An “intermediate level” of scrutiny will be applied where the classification “must serve important governmental objectives and must be substantially related to achievement of those objectives.” *Ferdon*, 701 N.W.2d at 456 (quoting *Craig v. Boren*, 429 U.S. 190, 197 (1976) (applying intermediate scrutiny to a gender-based classification)); accord *Neal v. Oakwood Hosp. Corp.*, 575 N.W.2d 68, 77 (Mich. Ct. App. 1997). As stated by the Michigan Court of Appeals, “social and economic legislation is generally examined under the traditional rational basis test.” *Zdrojewski v. Murphy*, 657 N.W.2d 721, 738 (Mich. Ct. App. 2002) (internal quotations omitted).

73. *Ferdon*, 701 N.W.2d at 456.

74. *Id.*

75. *Id.* at 457.

76. *Id.*

77. *Id.*

78. *Id.* at n.69 (quoting *Aicher ex rel. LaBarge v. Wis. Patients Comp. Fund*, 613 N.W.2d 849, 857 (Wis. 2000)).

79. *Id.* at 457–58.

burden, the challenger must show that the statute is “patently arbitrary” with “no rational relationship to a legitimate government interest.”⁸⁰

To determine the constitutionality of the damages cap under the rational basis standard, the court undertook a “thoughtful examination of not only the legislative purpose, but also the relationship between the legislation and the purpose.”⁸¹ Examining the legislative concerns, the court noted that

the legislature found that malpractice lawsuits raise the cost of medical malpractice insurance for providers. According to the legislature, higher medical malpractice insurance costs, in turn, harm the public because they result in increased medical costs for the public and because health care providers might leave Wisconsin. The legislature also found that health care providers were practicing defensive medicine because of the rising number of claims and that they might refuse to enter the Wisconsin health care market.⁸²

As observed by the court, the legislature sought to remedy these concerns and enacted the damages cap in order to: (1) “Ensure adequate compensation for victims of medical malpractice with meritorious injury claims;” (2) “Enable health care insurers to charge lower malpractice insurance premiums by reducing the size of medical malpractice awards;” (3) “Reduce overall health care costs (by lowering malpractice insurance premiums) for consumers of health care;” and (4) “Encourage health care providers to practice in Wisconsin.”⁸³ The court addressed each of these objectives individually, as set forth below.

a. Ensuring Adequate Compensation for Victims

The court first considered “whether a rational relationship exists between the legislative objective of compensating victims fairly and the classification of medical malpractice victims into two groups—those who suffer noneconomic damages under \$350,000 and those who suffer noneconomic damages over \$350,000.”⁸⁴ Analyzing this classification, the court acknowledged that “the burden of the cap falls entirely on the most seriously injured victims of medical malpractice. Those who suffer the most severe injuries will not be fully compensated for their non-

80. *Id.* at 459 (quoting *Maurin v. Hall*, 682 N.W.2d 866, 890 (Wis. 2004)).

81. *Id.* at 460.

82. *Id.* at 463–64.

83. *Id.* at 464–65. A fifth objective, not relevant here, was the legislature’s intent to protect the state’s Injured Patients and Families Compensation Fund, *id.*, which is supported by all health care providers and was “created to pay medical malpractice claims that exceed primary insurance thresholds established by statute.” *Id.* at 451 (citing WIS. STAT. § 655.23(4)(b)(2) (2001–2002)).

84. *Id.* at 465.

economic damages, while those who suffer relatively minor injuries with lower noneconomic damages will be fully compensated.”⁸⁵ The court also pointed out that “[y]oung people are most affected by the \$350,000 cap on noneconomic damages, not only because they suffer a disproportionate share of serious injuries from medical malpractice, but also because many can expect to be affected by their injuries over a 60- or 70-year life expectancy.”⁸⁶

Starting with the presumption of constitutionality,⁸⁷ and acknowledging that the “legislature enjoys wide latitude in economic regulation,”⁸⁸ the court nevertheless concluded that “the legislative classification created by a \$350,000 cap on noneconomic damages is arbitrary and creates an undue hardship on a small unfortunate group of plaintiffs.”⁸⁹ Accordingly, the court held that:

If the legislature’s objective was to ensure that Wisconsin people injured as a result of medical malpractice are compensated fairly, no rational basis exists for treating the most seriously injured patients of medical malpractice less favorably than those less seriously injured. No rational basis exists for forcing the most severely injured patients to provide monetary relief to health care providers and their insurers We therefore conclude that a rational relationship does not exist between the classifications of victims in the \$350,000 cap on noneconomic damages and the legislative objective of compensating victims of medical malpractice fairly.⁹⁰

b. Lowering Malpractice Insurance Premiums

The court then considered whether the damages cap was rationally related to the legislative objective of lowering malpractice insurance premiums, noting that Wisconsin “has a legitimate interest in reasonably priced premiums for medical malpractice insurance if the cost or delivery of health care is threatened by escalating premiums.”⁹¹ Acknowledging that the \$350,000 cap “intuitively appears to be rationally related to the legislative objective of lowering medical malpractice insurance costs to ensure quality health care for the people of the state,”⁹² the court reviewed empirical evidence from several studies examining the impact of

85. *Id.*

86. *Id.* at 466.

87. *See id.* at 457.

88. *Id.* at 466.

89. *Id.*

90. *Id.* at 466–67.

91. *Id.* at 467.

92. *Id.*

damages caps, including those of the Officer of the Wisconsin Commissioner of Insurance.⁹³ In each of its reports, the Office of the Commissioner of Insurance found “[n]o direct correlation” between the damages cap and medical malpractice premium insurance rates.⁹⁴ The court noted that “[o]ther studies support the Commissioner’s finding that medical malpractice insurance premiums are not affected by caps on noneconomic damages.”⁹⁵ A review of “the available evidence from nearly 10 years of experience with caps on noneconomic damages in medical malpractice cases in Wisconsin and other states”⁹⁶ led the court to hold that “it is not reasonable to conclude that the \$350,000 cap has its intended effect of reducing medical malpractice insurance premiums.”⁹⁷ Thus, “the \$350,000 cap on noneconomic damages in medical malpractice cases [was] not rationally related to the legislative objective of lowering medical malpractice insurance premiums.”⁹⁸

c. Reducing Overall Health Care Costs

Next, the court questioned “whether there is a conceivable set of facts from which the legislature could conclude that a \$350,000 cap on noneconomic damages furthers the state’s interest in controlling medical malpractice insurance costs for health care providers, thereby controlling health care costs for the people of the state.”⁹⁹ Although the court noted that the damages cap appeared “at first blush, to be related to the legisla-

93. *Id.* at 470. The Office of the Wisconsin Commissioner of Insurance is required by law to report on the impact of Wisconsin’s damages cap every two years. *Id.* (citing WIS. STAT. § 601.427(9) (2001–2002)).

94. *Id.* at 471 (quoting WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE, REPORT ON THE IMPACT OF 1995 WISCONSIN ACT 10 (May 12, 2005)).

95. *Id.* These studies included those done by the U.S. General Accounting Office (GAO), “a non-partisan federal government entity that is the audit, evaluation, and investigative arm of Congress,” and the Wisconsin Academy of Trial Lawyers. *Id.* at 471, 471 n.141. According to the court, the results of several GAO studies indicated “that a number of factors go into whether medical malpractice premiums increase or decrease and that there is no definitive correlation between caps on noneconomic damages and lower medical malpractice premium rates.” *Id.* at 471. See also *id.* at 471 nn.141–58 for citations to other studies. The court discounted the value of the Wisconsin Academy of Trial Lawyers’ study, which discussed “the effects of noneconomic damage caps on premiums, payouts and the availability of insurance coverage,” because it used “only ‘median’ figures in drawing its conclusions without providing the reader with the underlying data, averages, or even the range that gave rise to the median figures used.” *Id.* at 471 n.141. Because of this, the court reasoned, “a state that shows a median decrease in premiums may have actually had an average increase in premiums, or vice versa. It is impossible to draw any conclusions from the data and figures . . . [in the Wisconsin Academy of Trial Lawyer’s study].” *Id.*

96. *Id.* at 474.

97. *Id.*

98. *Id.*

99. *Id.* at 483.

tive objective of keeping overall health care costs down,”¹⁰⁰ the court ultimately concluded that “the correlation between caps on noneconomic damages and the reduction of medical malpractice premiums or overall health care costs is at best indirect, weak, and remote.”¹⁰¹ Thus, the court held, “there is no objectively reasonable basis to conclude that the \$350,000 cap justifies placing such a harsh burden on the most severely injured medical malpractice victims, many of whom are children.”¹⁰²

d. Encouraging Health Care Providers to Practice in Wisconsin

Finally, the court examined the legislature’s interest in attracting and retaining health care providers. Citing the legislature’s declaration that “[t]he cost and the difficulty in obtaining insurance for health care providers discourages and has discouraged young physicians from entering into the practice of medicine in this state,”¹⁰³ the court proceeded to examine the empirical data to determine if there was any support for this assertion. After reviewing a number of studies,¹⁰⁴ the court decided that it could not

conclude that a \$350,000 cap on noneconomic damages is rationally related to the objective of ensuring quality health care by creating an environment that health care providers are likely to move into, or less likely to move out of, in Wisconsin. The available evidence indicates that health care providers do not decide to practice in a particular state based on the state’s cap on noneconomic damages.¹⁰⁵

In connection with the state’s interest in encouraging health care providers to practice in Wisconsin, the court considered whether providers were practicing defensive medicine, thereby increasing the cost of patient care.¹⁰⁶ Although the court acknowledged “anecdotal support for the assertion that doctors practice defensive medicine,”¹⁰⁷ the court noted that “[t]hree independent, non-partisan governmental agencies have found that defensive medicine cannot be measured accurately and does not contribute significantly to the cost of health care.”¹⁰⁸ Other studies

100. *Id.*

101. *Id.* at 485. In reaching this conclusion, the court noted that “medical malpractice insurance premiums are an exceedingly small portion of overall health care costs,” *id.* at 483, and that “even if the \$350,000 cap on noneconomic damages would reduce medical malpractice insurance premiums, this reduction would have no effect on a consumer’s health care costs.” *Id.* at 485.

102. *Id.*

103. *Id.* at 485 n.101 (quoting *Maurin v. Hall*, 682 N.W.2d 886, 892 app. (Wis. 2004)).

104. *See id.* at 485 nn.224–29.

105. *Id.* at 487.

106. *Id.* at 488.

107. *Id.* at 487.

108. *Id.* at 488 & nn. 235–37 (citing GAO studies).

supported this conclusion as well.¹⁰⁹ Thus, the court concluded, the overall “evidence [did] not suggest that a \$350,000 cap on noneconomic damages is rationally related to the objective of ensuring quality health care by preventing doctors from practicing defensive medicine [E]vidence of the effects of defensive medicine was ‘weak or inconclusive.’”¹¹⁰

e. Ferdon’s Conclusion

Based on all of these grounds, the court declared: “To hold that a rational basis exists for the \$350,000 statutory cap on noneconomic damages in medical malpractice cases would amount to applying a judicial rubber stamp to an unconstitutional statute.”¹¹¹ While adhering “to the concept of judicial restraint that cautions against substituting judicial opinion for the will of the legislature,” the court nevertheless concluded “that the challengers have met their burden and have demonstrated that the \$350,000 cap . . . is unconstitutional beyond a reasonable doubt.”¹¹²

f. A Contrasting View

In contrast, a number of states have upheld the constitutionality of damages caps when faced with equal protection or other constitutional challenges.¹¹³ For example, in *Zdrojewski*, the Michigan Court of Ap-

109. *See id.* at 489 nn.238–40.

110. *Id.* at 489 (citing CONGRESSIONAL BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 1 (Jan. 8, 2004)).

111. *Id.* at 491.

112. *Id.* Other state courts have similarly struck down damages caps. *See, e.g.*, *Moore v. Mobile Infirmary Ass’n*, 592 So. 2d 156, 171 (Ala. 1991) (holding that limitation on noneconomic damages in medical malpractice action violated the equal protection and right to jury trial guarantees of the Alabama State Constitution); *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1089 (Ill. 1997) (holding that damages cap violated Illinois’s constitutional prohibition on special legislation that arbitrarily discriminates in favor of a select group and also violated the separation of powers doctrine); *Brannigan v. Usitalo*, 587 A.2d 1232, 1236 (N.H. 1991) (holding that noneconomic damages cap violated equal protection guarantee of the New Hampshire constitution); *Arneson v. Olson*, 270 N.W.2d 125, 136 (N.D. 1978) (holding that limitation on all medical malpractice damages violated equal protection); *Lakin v. Senco Prods., Inc.*, 987 P.2d 463, 475 (Or. 1999) (holding that jury determination of damages is a necessary part of the right to a jury trial).

113. *See, e.g.*, *Univ. of Miami v. Echarte*, 618 So. 2d 189, 191 (Fla. 1993) (holding that noneconomic damages cap in medical malpractice arbitration statute did not violate due process, equal protection, the right to trial by jury, the takings clause, or nondelegation doctrines); *Zdrojewski v. Murphy*, 657 N.W.2d 721, 735–39 (Mich. Ct. App. 2002) (holding that a noneconomic damages cap did not deny patient equal protection or the right to have damages determined by a jury and did not violate separation of powers doctrine of the state constitution); *Adams v. Children’s Mercy Hosp.*, 832 S.W.2d 898, 901, 908 (Mo. 1992) (holding that damages caps did not infringe on plaintiff’s access to the courts, right to a jury trial, or right to equal protection and due process under the state and federal constitutions); *Robinson v. Charleston Area Med. Ctr.*, 414 S.E.2d 877, 887–88 (W. Va. 1991) (holding that statutory \$1 million noneconomic damages cap did not violate plaintiffs’ equal protection or substantive due process rights or the right to certain remedy guaranteed by West Vir-

peals determined that Michigan's damages cap did not violate the state constitution's individual guarantees of equal protection and due process of law.¹¹⁴ Applying rational basis review to the equal protection question, the court held that the "statute at issue here is rationally related to a legitimate governmental purpose."¹¹⁵ The court noted that the "purpose of the damages limitation was to control increases in health care costs by reducing the liability of medical care providers, thereby reducing malpractice insurance premiums, a large component of health care costs."¹¹⁶ Without analyzing the empirical data or considering whether the damages cap actually responded to the legislative concerns, the court concluded: "Controlling health care costs is a legitimate governmental purpose. By limiting at least one component of health care costs, the non-economic damages limitation is rationally related to its intended purpose."¹¹⁷

2. The Right to Trial by Jury

State constitutions guarantee plaintiffs in civil suits the right to trial by jury, which "includes the right to have damages determined by a jury."¹¹⁸ Thus, challenges to damages caps may rest in part on the argument that statutory damages caps violate the right to trial by jury.¹¹⁹ The *Zdrojewski* court also held that Michigan's damages cap did not violate

ginia's constitution); *Judd v. Drezga*, 103 P.3d 135, 145 (Utah 2004) (holding that statutory cap on quality-of-life damages did not violate open courts clause in state constitution, uniform operation of laws provision in state constitution, plaintiff's right to due process and jury trial, or separation of powers doctrine).

114. 657 N.W.2d at 737, 739. The statute limiting noneconomic damages provides, in part: (1) In an action for damages alleging medical malpractice by or against a person or party, the total amount of damages for noneconomic loss recoverable by all plaintiffs, resulting from the negligence of 1 or more of the defendants, 1 or more of the following exceptions apply as determined by the court pursuant to section 6304, in which case damages for noneconomic loss shall not exceed \$500,000.00: (a) The plaintiff is hemiplegic, paraplegic, or quadriplegic resulting in a total permanent functional loss of 1 or more limbs caused by 1 or more of the following: (i) Injury to the brain. (ii) Injury to the spinal cord. (b) The plaintiff has permanently impaired cognitive capacity rendering him or her incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal, daily living. (c) There has been permanent loss of or damage to a reproductive organ resulting in the inability to procreate.

Id. at 736 n.7 (citing MICH. COMP. LAWS § 600.1483 (2000)).

115. *Id.* at 739.

116. *Id.*

117. *Id.* Although the plaintiff had not briefed the due process challenge to the damages cap, the court noted that it would not invalidate the cap on that basis either, stating: "the tests for whether legislation violates the Due Process and Equal Protection Clauses of the Michigan Constitution are essentially the same." *Id.* at 737 n.12.

118. *Id.* at 736.

119. *See id.*

the plaintiff's right to a jury trial.¹²⁰ Because the plaintiff was "able to try this case in front of a jury that rendered a verdict," and because the Michigan statute "prohibits the trial court from informing the jury of the noneconomic damages limitation,"¹²¹ the court concluded that "the jury rendered its damages award on the basis of the facts of the case, unaware of the limitation of the statute."¹²²

Similarly, in *Kirkland v. Blaine County Medical Center*,¹²³ the Idaho Supreme Court held that Idaho's cap on noneconomic damages¹²⁴ did not violate the right to a jury trial as defined by the Idaho constitution.¹²⁵ The court reasoned that "the statute does not infringe upon the jury's right to decide cases. The jury is still allowed to act as the fact finder in personal injury cases. The statute simply limits the legal consequences of the jury's finding."¹²⁶ As in *Zdrojewski*, the court relied on the fact that "the jury is not instructed about the cap, and is free to make all factual determinations relevant to the case. Once those factual determinations have been made, it is then up to the judge to apply the law to the facts as found by the jury."¹²⁷ The court did acknowledge that other courts have concluded that this procedure "plays lip service to the form of the jury but robs the institution of its function."¹²⁸ However, the court was not persuaded, concluding:

[T]he [plaintiffs] had a jury trial during which they were entitled to present all of their claims and evidence to the jury and have the jury render a verdict based on that evidence. That is all to which the right to jury entitles them. The legal consequences and effect of a jury's verdict are a matter for the legislature (by passing laws) and the courts (by applying those laws to the facts as found by the jury).¹²⁹

120. *Id.* at 737.

121. *Id.*; MICH. COMP. LAWS ANN. § 600.6304(5) (West 2000) ("In an action alleging medical malpractice, the court shall reduce an award of damages in excess of 1 of the limitations set forth in section 1483 to the amount of the appropriate limitation set forth in section 1483. The jury shall not be advised by the court or by counsel for either party of the limitations set forth in section 1483 or any other provision of section 1483.").

122. *Zdrojewski*, 657 N.W.2d at 737.

123. 4 P.3d 1115, 1120 (Idaho 2000).

124. IDAHO CODE ANN. § 6-1603 (1998).

125. IDAHO CONST. art. I, § 7.

126. *Kirkland*, 4 P.3d at 1120 (citing *Etheridge v. Med. Ctr. Hosps.*, 376 S.E.2d 525, 529 (Va. 1989) (holding that a statute limiting damages awarded in medical malpractice actions did not violate the plaintiff's right to a jury trial because, "although a party has the right to have a jury assess his damages, he has no right to have a jury dictate through an award the legal consequences of its assessment.")).

127. *Id.*

128. *Id.* (quoting *Lakin v. Senco Prods., Inc.*, 987 P.2d 463, 473 (Or. 1999)).

129. *Id.*

B. Separation of Powers

The separation of powers doctrine mandates that each of the three branches of government—legislative, executive, and judicial—remain “entirely free from the control or coercive influence, direct or indirect, of either of the others.”¹³⁰ Just as the U.S. Constitution protects the “three coequal but separate branches of government, each with the ability to exercise checks and balances on the two others,”¹³¹ state constitutions also require that “[e]ach branch of government ha[ve] its own unique sphere of authority that cannot be exercised by another branch.”¹³²

Legislatively-imposed damages caps implicate the separation of powers doctrine because caps arguably “contravene[] the traditional authority of the courts to assess, on a case-by-case basis, whether a jury’s damages award is excessive.”¹³³ “For over a century it has been a traditional and inherent power of the judicial branch of government to apply the doctrine of remittitur, in appropriate and limited circumstances, to correct excessive jury verdicts.”¹³⁴ In *Best v. Taylor Machine Works*, the Illinois Supreme Court considered the constitutionality of Illinois’s \$500,000 damages cap “in all common law, statutory or other actions that seek damages on account of death, bodily injury, or physical damage to property based on negligence.”¹³⁵ The court held that the statutory cap violated the state constitution’s separation of powers doctrine, reasoning that the legislative limit “undercut[] the power, and obligation, of the judiciary to reduce excessive verdicts.”¹³⁶ In the court’s view, a legislatively-imposed damages cap “functions as a ‘legislative remittitur’ . . . [that] disregards the jury’s careful deliberative process in determining damages that will fairly compensate injured plaintiffs who have proven their causes of action. The cap on damages is mandatory and operates

130. *Mistretta v. United States*, 488 U.S. 361, 380 (1989) (quoting *Humphrey’s Ex’r v. United States*, 295 U.S. 602, 629 (1935)).

131. *Schindler ex rel. Schiavo v. Schiavo*, 404 F.3d 1270, 1273 (Birch, J., concurring) (11th Cir. 2005).

132. *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1078 (Ill. 1997) (citing ILL. CONST. art. II, § 1).

133. *Id.*

134. *Id.* at 1079.

135. *Id.* at 1064, 1066 (quoting 735 ILL. COMP. STAT. ANN. 5/2-1115.1 (West 1996)).

136. *Id.* at 1080. In addition to concluding that the legislatively-imposed damages cap violated the separation of powers doctrine, the court held that the cap violated the special legislation clause of the state constitution, *id.* at 1069, which provides: “The General Assembly shall pass no special or local law when a general law is or can be made applicable. Whether a general law is or can be made applicable shall be a matter for *judicial* determination.” ILL. CONST. art. IV, § 13 (emphasis added). Because a “special legislation challenge generally is judged under the same standards applicable to an equal protection challenge,” *Best*, 689 N.E.2d at 1070, the court’s analysis of the special legislation challenge was similar to *Ferdon*’s equal protection analysis. *See id.* at 1069–78. The *Best* court did not consider the plaintiffs’ other claims. *See id.* at 1081.

wholly apart from the specific circumstances of a particular plaintiff's noneconomic injuries."¹³⁷ Based on these conclusions, the court held that the legislative cap "unduly encroache[d] upon the fundamentally judicial prerogative of determining whether a jury's assessment of damages is excessive within the meaning of the law."¹³⁸

The *Best* court relied on a discussion of legislative remittitur contained in *Sofie v. Fibreboard Corp.*¹³⁹ In that case, the Washington Supreme Court held that Washington's statutory limit on noneconomic damages, which limited damages recoverable in personal injury or wrongful death actions, was unconstitutional.¹⁴⁰ Although the *Sofie* court's holding was ultimately based on the violation of the plaintiffs' right to a trial by jury, the court also noted that the statutory damages cap might violate the separation of powers doctrine.¹⁴¹ The court reasoned that the damages cap might unconstitutionally operate as a "legislative remittitur" because it "directly change[d] the outcome of a jury determination . . . by taking a jury's finding of fact and altering it to conform to a predetermined formula."¹⁴²

In *Best*, the court agreed with the Washington Supreme Court's observation that:

[R]emittitur is wholly within the power of the trial judge, and it is the judge who is empowered to make the legal conclusion, on a case-by-case basis, that the jury's damage award is excessive in light of the evidence. Consequently, because the '[l]egislature cannot make such case-by-case determinations,' separation of powers concerns would be violated by the 'legislative attempt to mandate legal conclusions.'¹⁴³

Accordingly, the *Best* court noted that "courts are constitutionally empowered, and indeed obligated, to reduce excessive verdicts where appropriate in light of the evidence adduced in a particular case."¹⁴⁴ Because the statutory cap "invade[d] the power of the judiciary to limit excessive awards of damages," the court held that the cap violated the separation of powers doctrine.¹⁴⁵

137. *Id.* at 1080.

138. *Id.*

139. 112 Wash. 2d 636, 771 P.2d 711 (1989).

140. *Id.* at 638, 77 P.2d at 713.

141. *Id.* at 654, 77 P.2d at 721.

142. *See id.* at 653, 77 P.2d 720.

143. *Best*, 689 N.E.2d at 1080-81 (quoting *Sofie*, 112 Wash. 2d at 654, 771 P.2d at 721).

144. *Id.* at 1081.

145. *Id.*

Other courts have reached the opposite conclusion, however.¹⁴⁶ In *Judd v. Drezga*, for example, the Utah Supreme Court upheld Utah's \$250,000 limit on noneconomic damages.¹⁴⁷ In that case, the plaintiff suffered severe brain damage at birth due to a physician's "incompetence in his failed attempt to deliver [the plaintiff] with the use of forceps."¹⁴⁸ The jury awarded the plaintiff damages for past expenses and \$1,000,000 as "the amount necessary to maintain his life during his expected—although shortened—life span."¹⁴⁹ The jury also awarded \$1,250,000 in noneconomic damages, which the court described as "damages in recognition of the difference between a life as a normal, healthy boy, and a life as he must now live it: severely brain damaged, with drastically reduced life experiences and expectations."¹⁵⁰ The measure for these damages, according to the court, is "the difference between what life would have been like without the harm done by the medical professional, and what it is like with that additional burden. In [the plaintiff's] case, the difference [was] dramatic in terms of his abilities, his joys, his opportunities, and his life expectancy."¹⁵¹

Analyzing the plaintiff's constitutional challenges, including the argument that the damages cap violated the separation of powers doctrine,¹⁵² the court considered the legislature's purpose in enacting the cap:

The legislature imposed this cap because it was convinced that doing so would limit malpractice insurance costs for medical professionals, thereby helping to control excessively high medical care costs and health insurance premiums paid by most citi-

146. See, e.g., *Zdrojewski v. Murphy*, 657 N.W.2d 721, 735–39 (Mich. Ct. App. 2002) (holding that cap on noneconomic damages did not violate equal protection or the right to have damages determined by a jury, and did not violate separation of powers doctrine of state constitution); *Judd v. Drezga*, 103 P.3d 135, 145 (Utah 2004) (holding that statutory cap on quality-of-life damages did not violate open courts clause, uniform operation of laws provision, due process, right to a jury trial, or separation of powers doctrine under the state constitution).

147. *Judd*, 103 P.3d at 141 (upholding UTAH CODE ANN. § 78-14-7.1 (2002)). The statute provides that "an injured plaintiff may recover noneconomic losses to compensate for pain, suffering, and inconvenience," UTAH CODE ANN. § 78-14-7.1(1), and the limit may be adjusted for inflation. *Id.* § 78-14-7.1(1)(a)–(c).

148. *Judd*, 103 P.3d at 137.

149. *Id.*

150. *Id.*

151. *Id.* at 138.

152. UTAH CONST. art. V, § 1. In addition to the separation of powers challenge, the plaintiff argued that the cap violated the state constitution's open courts provision, *id.* art. I, § 11, the uniform operation of laws, *id.* art. I, § 24, the guarantee of due process, *id.* art. I, § 7, and the right to a jury trial in civil cases, *id.* art. I, § 10. *Judd*, 103 P.3d at 138.

zens and assuring a continued supply of medical care to all. This was a policy choice made by the legislature, as is its duty.¹⁵³

The court acknowledged that “the empirical truth of these findings is a matter of some dispute,” but did not analyze the empirical data.¹⁵⁴ The court deferred to the legislature and concluded: “The damage cap represents law to be applied, not an improper usurpation of jury prerogatives. Consequently, it does not violate the separation of powers provision of the constitution.”¹⁵⁵

Comparing the above cases reveals that there are “clear disagreements among the states regarding the constitutionality of statutory caps on medical malpractice awards.”¹⁵⁶ Moreover, there is disagreement even within the courts themselves. As the Wisconsin Supreme Court observed in *Ferdon*: “Even in state courts in which caps have been declared constitutional, there is invariably one or more strong dissents.”¹⁵⁷ A new model, based on controls other than damages caps, will alleviate this uncertainty and allow for a more consistent handling of medical malpractice liability concerns.¹⁵⁸

153. *Judd*, 103 P.3d at 138.

154. *Id.* at 140.

155. *Id.* at 145.

156. Michael J. Cetra, Comment, *Damage Control: Statutory Caps on Medical Malpractice Claims, State Constitutional Challenges, and Texas Proposition 12*, 42 DUQ. L. REV. 537, 550 (2004).

157. *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440, 448 (Wis. 2005).

158. This uncertainty may underlie, in part, President Bush’s call for a uniform rule. See President George W. Bush, Address at the Gateway Center in Collinsville, *supra* note 24. While it is true, “given the structure and limitations of federalism,” that states have traditionally regulated health care and are allowed “great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons,” *Gonzales v. Oregon*, 126 S.Ct. 904, 923 (2006), Congress may nonetheless have the power under the Commerce Clause, U.S. CONST. art. 1, § 8, cl. 3, to enact federal regulation imposing damages caps. For a more complete discussion of whether Congress has the power to enact federal damages caps, and whether Congress should do so, see Nim Razook, *A National Medical Malpractice Reform Act (and Why the Supreme Court may Prefer to Avoid It)*, 28 SETON HALL LEGIS. J. 99 (2003). Congress already has noted that “the increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State,” 42 U.S.C. § 11101(1) (West, WESTLAW current through P.L. 109-240 approved 7-11-06). In response to these problems, Congress established a national practitioner reporting system and data bank. See Health Care Quality Improvement Act, 42 U.S.C. §§ 11101–11152 (West, WESTLAW current through P.L. 109-240 approved 7-11-06). The Health Care Quality Improvement Act, addressed below, may be a better way to respond to the concerns regarding medical malpractice and the rising costs of health care. See *infra* Part V.D.

IV. DO DAMAGE CAPS SOLVE THE PROBLEM THEY ARE MEANT TO SOLVE?

Even if state or federal limitations are constitutionally permissible, the important question is whether they achieve their intended goal of keeping malpractice premiums low. As stated by the *Ferdon* court, “we must test whether the legislative hypothesis that a \$350,000 cap on non-economic damages bears a rational relationship to malpractice insurance premiums has a basis in reality.”¹⁵⁹ The empirical data simply does not support this hypothesis. Recent studies suggest that there is “little or no relationship between the level of malpractice insurance premiums and the enactment of tort-reform measures such as damage caps, and state-level tort reform does little to avert local physician shortages.”¹⁶⁰

Although California is often cited as the pioneer of medical malpractice reform because its decision to cap damages supposedly kept liability insurance premiums from rising,¹⁶¹ a close look at exactly what happened in California reveals the fallacy of that supposition. Even as the California Supreme Court held that the legislatively-imposed cap of \$250,000 was “rationally related to the objective of reducing the costs of malpractice defendants and their insurers,”¹⁶² the cap did nothing to control increasing medical malpractice premiums.¹⁶³ Indeed, after the passage of the California statute in 1975, “California’s malpractice insurance premiums continued to increase through 1988 to an ‘all-time high’ that was 450% higher than in 1975.”¹⁶⁴ It was only after California passed insurance reform legislation in 1988 that the rise in insurance premiums ceased.¹⁶⁵

Other states have had similar experiences. For example, as of 2005, insurance rates in Texas had not come down despite the enactment of a

159. 701 N.W.2d at 468.

160. *Tort Reform Has Little Effect on Med-Mal Insurance Rates, Study Finds*, 12 *Andrews Med. Devices Litig. Reporter* (West) No. 26, at 11 (Feb. 20, 2006); see also HUNTER & DOROSHOW, *supra* note 18, at 1–2; Baicker & Chandra, *supra* note 2, at 31. See generally THOMAS O. MCGARITY, DOUGLAS A. KYSAR, & KAREN SOKOL, THE CENTER FOR PROGRESSIVE REFORM, WHITEPAPER NO. 509, THE TRUTH ABOUT TORTS: AN INSURANCE CRISIS, NOT A LAWSUIT CRISIS (2005), available at http://www.progressiveregulation.org/articles/Torts_509.pdf

161. See Gregory, *supra* note 11, at 1036; see Medical Injury Compensation Reform Act of 1975, CAL. CIV. CODE § 3333.2 (West 1975).

162. *Fein v. Permanente Med. Group*, 695 P.2d 665, 680 (Cal. 1985).

163. See Gregory, *supra* note 11, at 1044–46.

164. *Id.* at 1039.

165. See *id.*; see also Chris A. Messerly & Genevieve M. Warwick, *Nowhere to Turn: A Glance at the Facts Behind the Supposed Need for Tort “Reform,”* 28 *HAMLIN L. REV.* 489, 494 (2005) (stating that “Proposition 103 mandated that insurance companies immediately decrease rates by 20 percent and prohibited any insurance company from imposing rate increases of greater than 15 percent without first holding a public hearing to explain the need for the substantial increase.”); MCGARITY, KYSAR, & SOKOL, *supra* note 160, at 8.

noneconomic damages cap in 2003.¹⁶⁶ Similarly, in Missouri, insurance premiums hit “record highs in 2002 and 2003” even though Missouri has had a cap on damages since 1986.¹⁶⁷ Conversely, Minnesota has no damages caps but has had relatively low growth in premium rates and claims payments.¹⁶⁸

The insurance industry itself has admitted that caps on noneconomic damages will not lead to lower premiums because these damages “make up such a small fraction of the amounts actually paid to injured individuals.”¹⁶⁹ An insurance industry study revealed that claims account for a tiny portion of every dollar spent on health care, and malpractice premiums are due to many factors—not just the size of jury awards.¹⁷⁰ Indeed, according to the president and chief executive officer of a leading insurance association, “the industry’s problems were due to price cuts taken ‘to the point of absurdity’ in the early 1980s.”¹⁷¹

Empirical studies have also shown that caps do not affect the availability of physicians or the kind of medicine they practice.¹⁷² For example, one such study, conducted by Katherine Baicker and Amitabh Chandra, professors of economics at Dartmouth College and Harvard University, respectively, examined data from the early 1990s through 2003.¹⁷³ The Baicker study analyzed the claims of tort reform advocates that physicians in states without caps will face increases in their malpractice premiums, which will result in a decrease in a state’s physician population and an increase in the practice of “defensive” medicine by those physicians who remain.¹⁷⁴

166. Messerly & Warwick, *supra* note 165, at 495.

167. McManus, *supra* note 31, at 897 (citing MO. REV. STAT. § 538.210 (2000)).

168. Ferdon *ex rel.* Petrucelli v. Wis. Patients Comp. Fund, 701 N.W.2d 440, 472 (Wis. 2005) (citing U.S. GENERAL ACCOUNTING OFFICE, GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 37 (2003)).

169. Messerly & Warwick, *supra* note 165, at 495. Presumably, the balance of the amounts actually paid to injured individuals reflected their actual economic loss, which, as one court had noted are “subject to careful calculation.” Judd v. Drezga, 103 P.3d 135, 138 (Utah 2004).

170. Ferdon, 701 N.W.2d at 472 n.141 (citing U.S. GENERAL ACCOUNTING OFFICE, GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (2003)).

171. HUNTER & DOROSHOW, *supra* note 18, at 4 (quoting Maurice R. Greenwald, *Insurers Must Share Blame: AIG Head*, BUS. INS., Mar. 31, 1986, at 3). To attract new customers, insurance companies offer coverage at very low premium rates, which then prove to be very costly for the insurers. *See id.* The insurers subsequently raise rates to existing customers that are not tied to their claim history but rather to the insurers’ previous rate decisions. *See id.*; *see also* Alison Lothes, Comment, *Quality, Not Quantity: An Analysis of Confidential Settlements and Litigants’ Economic Incentives*, 154 U. PA. L. REV. 433, 467 n.152 (2005).

172. *See* sources cited *supra* note 165.

173. Baicker & Chandra, *supra* note 2, at 26.

174. *Id.* at 24.

The study found “no relationship between the level of malpractice premiums and the presence of traditional tort reform measures such as damage caps.”¹⁷⁵ Moreover, the researchers saw “very little effect” of increased premiums “on the total number of physicians in each state.”¹⁷⁶ They did acknowledge, however, that older physicians and surgeons in rural areas “may leave practice when premiums rise, but they comprise a small enough subset of the physician population that overall size of the physician workforce per capita does not seem to be affected.”¹⁷⁷

The *Ferdon* decision confirmed this finding.¹⁷⁸ The court noted that between 1970 and 2000, states with caps and states without caps all saw an increase in the number of physicians, and, even though Wisconsin had a cap on noneconomic damages for approximately half of that time, it “had a smaller increase than seven states without [them].”¹⁷⁹ Based on this evidence, the court concluded that “health care providers do not decide to practice in a particular state based on the state’s cap on non-economic damages.”¹⁸⁰

The Baicker study also confirmed that the existence of caps does not protect against the practice of defensive medicine. It compared the level of spending in states with and without caps and found no correlation between spending and caps.¹⁸¹ Although the researchers noted that increasing malpractice liability pressures do seem to increase expenditures on diagnostic procedures, they found “little evidence that malpractice payments are driving the dramatic increase in overall health care expenditures.”¹⁸² Similarly, although the *Ferdon* court acknowledged that “[t]here is anecdotal support for the assertion that doctors practice defensive medicine,” the court concluded that “an ‘accurate measurement of the extent of this phenomenon is virtually impossible.’”¹⁸³

As the empirical evidence indicates, it is not easy to determine the extent to which physicians practice defensive medicine or whether capping their liability would encourage them not to do so. There can be no debate, however, that a myriad of factors affect medical malpractice in-

175. *Id.* at 31.

176. *Id.* at 29.

177. *Id.*

178. See *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440, 485–87 (Wis. 2005).

179. *Id.* at 486 n.227.

180. *Id.* at 487.

181. Baicker & Chandra, *supra* note 2, at 29.

182. *Id.* at 31.

183. *Id.* at 487–88 (quoting U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE 3–4 (1994), available at <http://www.wws.princeton.edu/ota>).

surance premiums, as well as why physicians practice where they do, what specialties they choose, and what tests they order.¹⁸⁴

The empirical evidence suggests that the answer to rising medical malpractice premiums is not simply capping the size of jury verdicts. Premiums are tied to various factors, including “state premium rate regulation, level of competition among insurers, and interest rates and income returns that affect insurers’ investment returns.”¹⁸⁵ Moreover, jury verdicts, in most cases, do not even reach the statutory caps, except in those lawsuits involving “severe injuries, such as quadriplegia or severe brain damage, with terminal diagnosis or the need for lifetime care.”¹⁸⁶ Furthermore, “if it is true, as the legislature has determined, that a health care ‘crisis’ exists, the burden of remedying that crisis should not be placed solely upon the shoulders of malpractice victims. Rather, it more appropriately should fall upon those causing the crisis—the negligent health care providers.”¹⁸⁷

V. A PROPOSED SOLUTION

Market forces should be the starting point for improving health care and reducing claims and liability for those claims. Regulation of insurance rate increases, litigation practices, health care professional peer review procedures, and public access to peer review information will supplement improvements in the quality of care and achieve better health care at lower cost.

A. Regulate Insurance Rates and Litigation Practices

One way to reduce medical malpractice liability premiums is to do what the California legislature did: impose restrictions on insurance companies’ ability to raise rates.¹⁸⁸ Another way to keep costs down is to

184. Elizabeth Stewart Poisson, Comment, *Addressing the Impropriety of Statutory Caps on Pain and Suffering Awards in the Medical Liability System*, 82 N.C. L. REV. 759, 767–70 (2004).

185. Ferdon *ex rel.* Petrucelli v. Wis. Patients Comp. Fund, 701 N.W.2d 440, 472 (Wis. 2005) (quoting U.S. GENERAL ACCOUNTING OFFICE, GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE (2003)); accord James L. Wright & M. Matthew Williams, *Remember the Alamo: The Seventh Amendment of the United States Constitution, the Doctrine of Incorporation, and State Caps on Jury Awards*, 45 S. TEX. L. REV. 449, 461–64 (2004).

186. McManus, *supra* note 31, at 898. In Missouri, for example, only five cases ended with jury verdicts above the state’s \$557,000 cap. *Id.* “[T]he average non-economic damage award was only \$85,140, and the median or typical award was even lower, \$27,872, only five percent of the cap amount.” *Id.*

187. Farley v. Engelken, 740 P.2d 1058, 1067–68 (Kan. 1987).

188. See Medical Injury Compensation Reform Act of 1975, CAL. CIV. CODE § 3333.2 (West 1975); Gregory, *supra* note 11, at 1039. California’s insurance reform legislation is discussed *supra*, note 165.

control the filing of frivolous lawsuits, which some states accomplish by requiring that plaintiffs secure medical expert support for their claims prior to filing suit.¹⁸⁹ For example, South Carolina's recently enacted tort reform legislation requires a plaintiff to file an affidavit of an expert witness along with a notice of intent to file suit before actually filing a medical malpractice complaint.¹⁹⁰ Similarly, Mississippi requires a complaint alleging medical malpractice to be accompanied by an affidavit by the attorney filing the complaint that verifies that the attorney has reviewed the facts of the case, has consulted a qualified expert, and "has concluded on the basis of such review and consultation that there is a reasonable basis for the commencement of such action."¹⁹¹

B. Improve the Quality of Care

Another way to reduce liability costs and premiums is to reduce mistakes and make doctors who commit mistakes pay for them. Currently, all doctors in the same specialty pay the same rates regardless of their performance,¹⁹² which is not consistent with other areas of business. This system could be changed legislatively or perhaps voluntarily by insurers. A less dramatic change, however, would be an improvement in care. As one study concluded, "one of the surest ways to 'deal with the problem of increasing insurance costs' is to eliminate the conditions that result in acts amounting to medical malpractice."¹⁹³ Capping damages will not solve the problem, and it is "counterproductive" to "reduce or eliminate malpractice verdicts" in those cases where mistakes are made and people are injured.¹⁹⁴

A look at the improvements made by anesthesiologists and the impact those improvements have had on liability premiums suggests that the appropriate starting point for controlling costs is to deliver a better

189. See, e.g., MINN. STAT. ANN. § 145.682 (West 2005); MISS. CODE ANN. § 11-1-58 (West Supp. 2005); S.C. CODE ANN. § 15-79-125 (West Supp. 2005).

190. S.C. CODE ANN. § 15-79-125 (West Supp. 2005).

191. MISS. CODE ANN. § 11-1-58 (West Supp. 2005); see also MINN. STAT. ANN. § 145.682 (West 2005) (requiring plaintiff's attorney to file an affidavit with the complaint which declares that: the facts of the case have been reviewed by the plaintiff's attorney with an expert whose qualifications provide a reasonable expectation that the expert's opinions could be admissible at trial and that, in the opinion of this expert, one or more defendants deviated from the applicable standard of care and by that action caused injury to the plaintiff).

192. Lothes, *supra* note 171, at 467 n.152.

193. *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440, 464 n.110 (Wis. 2005) (quoting U.S. GENERAL ACCOUNTING OFFICE, HRD-87-73, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 3 (1987)).

194. *Farley v. Engelken*, 740 P.2d 1058, 1067 (Kan. 1987) (considering Kansas's abrogation of the collateral source rule, KAN. STAT. ANN. § 60-3403 (repealed 1988)).

product.¹⁹⁵ Anesthesiology has undeniable risks; indeed, it is one of the more risk-prone specialties in medicine.¹⁹⁶ After studying their own practices and analyzing the causes of patient deaths, anesthesiologists made great improvements in the way they administer anesthesia and monitor their patients, which has led to a dramatic decrease in the number of patient deaths.¹⁹⁷

In the early 1980s, ABC News aired a program exposing the huge number of deaths caused by anesthesiologists.¹⁹⁸ At around the same time, anesthesiologists were facing the second increase in medical malpractice premiums in ten years.¹⁹⁹ Premium rates for anesthesiologists at that time were two to three times higher than premium rates paid by doctors in other specialties.²⁰⁰ The anesthesiologists were anxious to do something to address this problem.²⁰¹ With \$100,000 of its own money, the American Society of Anesthesiologists created the Anesthesia Patient Safety Foundation to address patient safety.²⁰² The Foundation, comprised of doctors, nurses, insurers, and manufacturers of products used by anesthesiologists, reviewed information obtained from insurers on closed malpractice claims in an effort to understand why anesthesia caused death or injury to so many patients.²⁰³ The information the Foundation collected led to the development of new instruments and procedures that could virtually eliminate death or injury from the most common errors made during the administration of anesthesia.²⁰⁴

195. See Joseph T. Hallinan, *Heal Thyself: Once Seen as Risky, One Group Of Doctors Changes its Ways*, WALL ST. J., June 21, 2005, at A1.

196. *Id.*

197. *Id.* Patient deaths due to anesthesia have declined from one in every 5,000 patients to one death per 200,000 to 300,000 patients. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.* When interviewed by the Wall Street Journal, Ellison C. Pierce Jr., a retired professor of anesthesiology at Harvard Medical School, who is considered by many to be the father of the safety movement within anesthesiology, was quoted as describing the anesthesiologists as "terrified" and anxious to do something. *Id.*

202. *Id.*

203. *Id.* St. Paul Fire & Marine Insurance Company was the first insurer to allow the Foundation to review the claims. *Id.* Other insurers were hesitant to allow the Foundation access to their files because of confidentiality concerns. *Id.* Once St. Paul Fire & Marine Insurance Company allowed access, however, other insurers did the same. *Id.*

204. *Id.* These instruments measured the oxygen level in a patient's blood stream and the carbon dioxide level in a patient's expelled breath to monitor whether the patient was breathing properly. *Id.* The Foundation urged the widespread use of these instruments, despite their cost, which led to the inclusion of the tools as part of basic anesthesia care. *Id.* To keep a patient warm during surgery, which the Foundation's research also identified as a cause of injury and death, anesthesiologists made simple changes such as using heated blankets and blood-and-fluid warmers to keep a patient's body temperature at a safe level. *Id.*

The adoption of these new instruments and procedures led to a dramatic drop in patient injury and death.²⁰⁵ With that drop, the number of malpractice suits against anesthesiologists also dropped.²⁰⁶ The size of payments for malpractice claims declined as well, and claims for serious injuries decreased.²⁰⁷ With the drop in the number of those injured and killed and the decrease in the number of malpractice suits and payouts, there was a corresponding decrease in malpractice insurance rates.²⁰⁸ After adjusting for inflation, malpractice rates for anesthesiologists have fallen thirty-seven percent over the last twenty years.²⁰⁹

Anesthesiologists were the first group of doctors to study patient safety and make real strides in improving patient care,²¹⁰ and the ramifications of these changes and the related decrease in insurance premiums are far-reaching. Other groups of physicians have taken note and are beginning self-studies of their own.²¹¹ For example, the College of Surgeons has begun a closed-claims study, just as the anesthesiologists did, and has begun making changes in surgical procedures.²¹² Already, the College has seen a connection between improving patient safety and

205. *Id.*

206. PUBLIC CITIZEN, ANESTHESIOLOGISTS' EXPERIENCE SHOWS PATIENT SAFETY EFFORTS DO MORE THAN DAMAGE CAPS TO REDUCE LAWSUITS AND INSURANCE PREMIUMS (Feb. 18, 2004), available at <http://www.citizen.org/documents/Anesthesiologists.pdf>. According to the study, after the introduction of these safety procedures and instruments, claims against anesthesiologists accounted for only 3.8% of claims against all doctors, which was consistent with the percentage of anesthesiologists as compared with all other doctors. *Id.* Prior to these improvements, claims against anesthesiologists accounted for 7.9% of all medical malpractice claims, which was double the proportion of anesthesiologists to the rest of the physician population. *Id.*

207. Hallinan, *supra* note 195.

208. *Id.*

209. *Id.* See also Ross Eisenbrey, *Malpractice Made Perfect*, THE AM. PROSPECT ONLINE, Aug. 2, 2005, <http://www.prospect.org/web/view-web.wv?id=10058>, stating:

As the standard of care improved, medical errors, malpractice, and malpractice litigation have all declined. Anesthesiologists have cut their share of all malpractice claims in half, and the share of claims involving serious injury has also fallen. In the 1970s, more than half involved death or permanent brain injury; today, it is less than one-third. The effect on insurance premiums is another cause for celebration. As malpractice premiums for every other specialty have skyrocketed over the last two decades, they have fallen 37 percent for anesthesiologists, to an average of \$22,572 per year.

In 2002, insurance premiums for anesthesiologists were at their lowest since 1985. Since then, even anesthesiologists have seen an increase in their premiums, despite their consistent improvement in care. This supports the claim by many that malpractice premium rates are actually not related to actual payouts in malpractice litigation, but are connected instead to the insurers' overall economic picture. Karen B. Domino, *Another Malpractice Insurance Crisis Brewing for Anesthesiologists?*, ASA NEWSLETTER (Am. Soc'y of Anesthesiologists, Park Ridge, Ill.), June 2002.

210. John A. Ulatowski, *Peter J. Pronovost, M.D., Ph.D.: Recipient of the 2003 Presidential Scholar Award*, 100 ANESTHESIOLOGY, 216–17 (2004).

211. Hallinan, *supra* note 195.

212. *Id.*

lowering malpractice premium rates.²¹³ Similarly, Peter J. Pronovost, M.D., Ph.D., has studied medical practices in intensive care units and their relation to patient outcomes.²¹⁴ His research has led to dramatic changes in clinical practice worldwide.²¹⁵

C. Define Standards of Performance

In addition to improving care, the health care profession is focusing on defining standards of performance and holding physicians accountable when those standards are not met. The AMA recently agreed with Congress to develop approximately 140 standards that will measure the performance of physicians across a wide variety of practice areas.²¹⁶ Prompted by a concern over Medicare costs, the Chairman of the AMA and three Republican members of Congress have called for the development of these standards by the end of 2006 to determine “whether doctors follow best practices in treating patients.”²¹⁷ When met, these “best practices” are intended to lead to more efficient care which, according to the supporters of the plan, should be rewarded with Medicare compensation.²¹⁸ As stated by a representative of the American Association of Retired Persons (AARP), “rewarding quality can improve results.”²¹⁹

Many physicians, however, are skeptical of the plan.²²⁰ It was developed and announced with little or no input from the physicians themselves.²²¹ Physicians from many specialties agree that standards of care must be defined, but disagree with the aggressive timetable set for developing those standards and fear that the plan will “become just a smoke screen to cut costs and to reduce the resources devoted to health care.”²²² Emergency room doctors, orthopedic surgeons, neurosurgeons, and gynecologists all agree that standards are necessary and are developing their own standards of performance.²²³ They insist, however, that each specialty area has unique concerns and should develop its own stan-

213. *Id.*

214. Ulatowski, *supra* note 210, at 217.

215. *Id.*

216. Robert Pear, *A.M.A. to Develop Measure of Quality of Medical Care*, N.Y. TIMES, Feb. 20, 2006, at A12.

217. *Id.*

218. *Id.*

219. *Id.* (quoting Thomas Thames, AARP board member).

220. *Id.*

221. *Id.* According to a letter written by seven medical specialty groups to the chair of the AMA, “The A.M.A. acknowledged the existence of this agreement only after we uncovered it.” *Id.*

222. *Id.* (quoting Dr. Frederick C. Blum, President of the American College of Emergency Physicians).

223. *Id.*

dards.²²⁴ However such standards are developed, they will be a helpful tool to improve patient care.

D. Report Mistakes

Another useful tool for improving the quality of care is the reporting system established by Congress pursuant to the Health Care Quality Improvement Act (HCQIA).²²⁵ Acknowledging that “[t]here is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance,”²²⁶ Congress “established a national reporting system which, among other things, requires hospitals to provide information about adverse professional review actions and provides immunity from damages for persons participating in peer review if certain standards are satisfied.”²²⁷ Health care entities are required to report any adverse actions taken against a physician to a national practitioner data bank.²²⁸ This data is available only to health care entities and not to the public.²²⁹

Under the Act, any entity that “makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report [to the Secretary of Health and Human Services] information respecting the payment and circumstances thereof.”²³⁰ In addition, “[e]ach Board of Medical Examiners which revokes or suspends (or otherwise restricts) a physician’s license or censures, reprimands, or places on probation a physician, for reasons relating to the physician’s professional competence or professional conduct, or to which a physician’s license is surrendered, shall report” the information to the Secretary of Health and Human Services or a designated agency.²³¹

The regulations promulgated pursuant to the Act created the National Practitioner Data Bank, which collects and maintains the reported information.²³² Health care entities, including hospitals, health mainte-

224. *Id.*

225. 42 U.S.C. §§ 11101-11152 (West, WESTLAW current through P.L. 109-240 approved 7-11-06).

226. *Id.* §11101(2).

227. *Freilich v. Bd. of Dirs. of Upper Chesapeake Health, Inc.*, 142 F. Supp. 2d 679, 695 (D. Md. 2001) (citing 42 U.S.C. §§ 11133, 11111-11112) (internal citations omitted).

228. 42 U.S.C. § 11133 (West, WESTLAW current through P.L. 109-240 approved 7-11-06).

229. *Id.* § 11137(a); *accord* *Med. Soc’y of N.J. v. Mottola*, 320 F. Supp. 2d 254, 259 (D. N.J. 2004).

230. 42 U.S.C. § 11131(a) (West, WESTLAW current through P.L. 109-240 approved 7-11-06) (referencing *id.* § 11134).

231. *Id.* § 11132(1).

232. The National Practitioner Data Bank, 45 C.F.R. § 60.1 (2006).

nance organizations, and group medical practices are required to report to the National Practitioner Data Bank when they

adversely affect[] the clinical privileges of a physician for a period longer than 30 days; accept[] the surrender of clinical privileges of a physician while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding; or in the case of such an entity which is a professional society, take[] a professional review action which adversely affects the membership of a physician in the society.²³³

HCQIA requires hospitals to request information from the National Practitioner Data Bank whenever “a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital.”²³⁴ With this, Congress intended to “restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance.”²³⁵ Hospitals are also required to obtain information every two years regarding physicians or practitioners who are currently on the medical staff or who have been granted clinical privileges at the hospital.²³⁶

A cornerstone of the statutory scheme, necessary to discover incidents of incompetent treatment and care, is the protection of physicians who reveal the problems. HCQIA provides a broad grant of immunity for those physicians who testify against their peers.²³⁷ The Act presumes that the promise of immunity will encourage physicians to reveal a colleague’s incompetence.²³⁸ Although one factor that discourages doctors from reporting on others may be the perception that it is unprofessional to do so, a more compelling concern for these individuals is that that they may become liable for reporting information, even if it is truthful.²³⁹ By ensuring immunity, Congress intended “to provide incentive and protection for physicians engaging in effective professional peer review.”²⁴⁰

This statutory scheme has been criticized by physicians who have been the subject of performance inquiries. Those physicians who believe their careers have been severely limited and even destroyed in the course

233. 42 U.S.C. § 11133(1) (West, WESTLAW current through P.L. 109-240 approved 7-11-06).

234. *Id.* § 11135(a)(1).

235. *Id.* § 11101(2); *accord id.* § 11135(a)(1).

236. *Id.* § 11135(a)(2).

237. *Id.* § 11111(a)(2).

238. *See id.* § 11101(5).

239. *See id.*

240. *Id.*

of the peer review process believe that, without the fear of being held accountable for their statements, some physicians may report their competitors "to achieve economic or power-driven gains."²⁴¹ Thus, some commentators argue that the peer review laws have the "unanticipated effect" of "promoting bad faith peer review."²⁴² The Act purportedly allows one doctor to ruin another's career regardless of whether the testimony offered is truthful or not.²⁴³ These allegations serve as a reminder that, although members of the medical profession "more so than any other profession, depend on the integrity of . . . members to maintain an exceptionally high level of care and mutual trust with their patients,"²⁴⁴ they may, in some instances, lack integrity and/or trust for one another. HCQIA addresses these concerns, however, by refusing to provide immunity to informers who knowingly provide false testimony.²⁴⁵

While encouraging honest reporting and protecting those whom engage in peer review are important objectives, HCQIA unduly restricts public access to information concerning disciplinary actions against negligent physicians. The Act promises confidentiality to all individuals who participate in the peer review process.²⁴⁶ Information concerning adverse actions may be released to hospitals and other health care facilities when such information is requested as part of a hiring or retention process, but this information cannot be released to the public.²⁴⁷ If the quality of

241. Yann H.H. van Geertruyden, Comment, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. CONTEMP. HEALTH L. & POL'Y 239, 252 (2001).

242. See, e.g., *id.* at 241.

243. See Verner S. Waite, *Sham Peer Review: Napoleonic Law in Medicine*, J. AM. PHYSICIANS & SURGEONS, Fall 2003, at 84.

244. Geertruyden, *supra* note 241, at 240.

245. See 42 U.S.C. § 11111(a)(2) (West, WESTLAW current through P.L. 109-240 approved 7-11-06).

246. See *id.* § 11137(b).

247. *Id.*; see also *Med. Soc'y of N.J. v. Mottola*, 320 F. Supp. 2d 254, 259 (D. N.J. 2004). This may be contrasted with states that require reporting of attorney misconduct. See ALASKA RULES OF PROF'L CONDUCT R. 8.3 (2005); ARK. DISCIPLINARY RULES OF PROF'L CONDUCT R. 8.3 (2005); COLO. DISCIPLINARY RULES OF PROF'L CONDUCT R. 8.3 (2005); DEL. LAWYERS' RULES OF PROF'L CONDUCT R. 8.3 (2005); D.C. RULES OF PROF'L CONDUCT R. 8.3 (2005); FLA. RULES OF PROF'L CONDUCT R. 8.3 (2005); IDAHO RULES OF PROF'L CONDUCT R. 8.3 (2005); IND. RULES OF PROF'L CONDUCT R. 8.3 (2005); MD. LAWYERS' RULES OF PROF'L CONDUCT R. 8.3 (2005); MO. RULES OF PROF'L CONDUCT R. 8.3 (2005); MONT. RULES OF PROF'L CONDUCT R. 8.3 (2005); NEV. RULES OF PROF'L CONDUCT R. 202 (2005); N.J. DISCIPLINARY RULES OF PROF'L CONDUCT R. 8.3 (2005); N.H. RULES OF PROF'L CONDUCT R. 8.3 (2005); N.M. RULES OF PROF'L CONDUCT R. 16-803 (2005); OKLA. RULES OF PROF'L CONDUCT R. 8.3 (2005); PA. DISCIPLINARY RULES OF PROF'L CONDUCT R. 8.3 (2005); R.I. DISCIPLINARY RULES OF PROF'L CONDUCT R. 8.3 (2005); S.C. RULES OF PROF'L CONDUCT R. 8.3 (2005); S.D. RULES OF PROF'L CONDUCT R. 8.3 (2005); UTAH RULES OF PROF'L CONDUCT R. 8.3 (2005); W. VA. RULES OF PROF'L CONDUCT R. 8.3 (2005); WYO. RULES OF PROF'L CONDUCT R. 8.3 (2005). Many states allow public access to attorney disciplinary records, either by

health care is to be fully promoted, however, it is important to provide patients with relevant information about the performance of a physician they may choose. The identities of testifying physicians can be protected from public disclosure, but disciplinary action taken against particular physicians should be available for public review. Only with full disclosure can the public make educated decisions about which health care providers to choose.

VI. CONCLUSION

Logic, experience, and current empirical data suggest that legislatively-imposed damages caps for victims of medical malpractice will not solve the problem of increasing insurance premium rates. A better legislative response would be to restrict insurance rate increases, protect against frivolous lawsuits by requiring pre-filing confirmation of the merits of a claim, and ensure public access to information relevant to choosing a competent physician. Most importantly, however, the health care industry itself should continue improving the quality of care and should be prepared to review and learn from mistakes made by members of the health care profession.

specific request to a state regulatory board or by visiting a website. In Michigan, for example, the public may request information from or access a website maintained by the Michigan Attorney Discipline Board. *See* Attorney Discipline Board, State of Michigan, <http://www.adbmich.org/> (last visited July 30, 2006). *See also* New Jersey Judiciary, [njcourtonline.com, http://www.judiciary.state.nj.us/dae/discipline.htm](http://www.judiciary.state.nj.us/dae/discipline.htm) (last visited July 30, 2006) (public access to disciplinary records of New Jersey attorneys); District of Columbia Bar, http://www.dcbbar.org/for_lawyers/ethics/discipline/discipline01.cfm (last visited July 30, 2006) (public access to disciplinary records of attorneys in the District of Columbia).