New York's Medical Malpractice Insurance Crises--A New Direction for Reform

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NEW YORK'S MEDICAL MALPRACTICE INSURANCE CRISIS—A NEW DIRECTION FOR REFORM

I. Introduction

Beginning in the early 1970's, insurance companies nationwide began dropping out of the medical malpractice market. Medical malpractice had become an unprofitable field for investment, partly because of a sharp and continuing increase both in the number of malpractice suits being brought against health-care providers and in the size of damage awards and settlements in medical malpractice cases. In response to increasing pressure from the medical profession and the insurance industry, many states in the mid-1970's began to experiment with ways of limiting the number of claims being entered against physicians and hospitals, and reducing the size of malpractice awards and settlements. New York passed its first medical malpractice reforms in 1974. Despite these initial efforts, malpractice


2. In 1975, Andrew Kalmykow, counsel for the American Insurance Association, stated:

The most recent figures issued by the Insurance Services Office, the national statistical and rating agency for the insurance industry, indicate that losses, that is, payouts to claimants and defense costs, alone will exceed 150 percent of the total premiums received. In other words, companies writing this business will have to pay out 50 percent more in losses than they received in premiums.


Americans are filing more than three times as many medical malpractice claims as they did ten years ago, and are winning record settlements . . . . After a marked decline in the late 1970's, A.M.A. and insurance industry statistics show, 16 malpractice claims were filed for every 100 doctors in 1983, about 20 percent more than the year before. In 1975, at the height of what was then called a medical malpractice crisis, fewer than five claims were filed for every 100 doctors.

Id.

4. For a discussion of these statutes and their similarities to certain provisions of Program Bill No. 75 ("the Bill"), see infra notes 22-29 and accompanying text.

5. For a discussion of New York's first attempt to reform the medical malpractice tort claims system, see infra notes 77-94 and accompanying text.
insurance premiums, the number of suits being brought against physicians, and the size of damage awards all continued to increase. New York then attempted to address this continuing problem through Program Bill No. 75 [hereinafter "the Bill"] which Governor Cuomo signed into law on July 2, 1985. Thus, New York launched its second attempt to reform its medical malpractice tort claims systems.

Present and past reform efforts both in New York and in other states have concentrated on reducing malpractice insurance premiums by limiting awards and hindering access to litigation, but have failed to address the most important flaws in the medical malpractice tort

6. From 1975 to 1983, insurance premiums had been increasing at the rate of twenty percent per year. Sullivan, Doctors' Insurers Win 52% Rate Rise, N.Y. Times, Jan. 15, 1985, at A1, col. 2 [hereinafter cited as 52 Percent Rate Rise]. In 1985, rate increases in excess of fifty percent were approved for the Medical Malpractice Mutual Insurance Association and the Medical Liability Mutual Insurance Company, the major insurers of physicians in New York State. Id. A 52 percent increase applied to 900 doctors insured by one of the smallest insurers in the state, the Medical Liability Insurance Association. The increase granted to the association was for 41 percent retroactive to July 1983, and eight percent retroactive to July 1984. Id. at B4, col. 3. Retroactively, the two increases equaled a 52 percent rate increase. Id. A 55 percent increase in medical malpractice insurance rates was awarded to the Medical Liability Mutual Insurance Company, which provides most of the medical malpractice insurance in New York. Sullivan, 55 Percent Rise in Medical Malpractice Rates Granted, N.Y. Times, April 5, 1985, at B2, col. 2. Thus, the amount a Long Island obstetrician paid for malpractice insurance rose from $54,282 to $82,500 a year. See 52 Percent Rate Rise, supra at A1, col. 2.

7. See supra note 3.


9. 1985 N.Y. Laws ch. 294. For a complete text of the Bill see N.Y.L.J., July 3, 1985, at 17, col. 1. Although all provisions of the Bill apply to both medical and dental malpractice, the scope of this article will be limited to a discussion of the Bill's repercussions on medical malpractice.

10. Critics of the present tort claims system state that the current explosion of malpractice litigation is primarily responsible for a steady rise in malpractice insurance premiums. See Taylor, Medical Malpractice Costs Debated at Hearing, N.Y. Times, July 15, 1984, at A23, col. 1. Witnesses at a Senate hearing, held on July 10, 1984, called for federal legislation to limit malpractice lawsuits and head off what they called a potential "crisis of affordability" for malpractice insurance. Id. Supporters of the tort claims system look to other causes to account for increasing malpractice insurance premiums. For example, Thomas Bendorf, director of the Association of Trial Lawyers of America, stated that "insurance companies had made large profits by charging excessive premiums." Id. Others claim that the malpractice insurance crisis simply does not exist. Republican Senator Dan Quayle of Indiana noted "that malpractice insurance remained relatively constant as a percentage of physicians' income since 1970, averaging about 3 percent." Id.
claims system. These flaws include a failure to compensate most victims of medical accidents, a failure to compensate promptly, and a failure to compensate without undue expense. Furthermore, the tort claims system has had a number of deleterious side-effects on the medical profession, including the proliferation of defensive medicine. In contrast, a no-fault system of compensation would provide immediate compensation to a larger number of those injured as the result of medical accidents. In addition, such a system would eliminate the physician’s need to protect himself in ways that are ultimately costly or otherwise harmful to the health care consumer. Experts have not yet determined whether a no-fault system of recovery would, in the long run, be more successful in reducing malpractice insurance premiums than past and current reforms. Such an innovation, however, would address the most glaring flaws in our current system of malpractice compensation.

This Note will first examine the courts’ response to malpractice reform legislation, focusing on other states’ counterparts to the Bill’s major provisions. This Note will then examine the history of the malpractice crisis in New York State, including a discussion of the first reform efforts. Furthermore, this Note will discuss the Bill’s major provisions in terms of their stated purpose and their relation to prior law. Finally, this Note will examine the Bill’s probable impact on the malpractice problem, the Bill’s major shortcomings, and an alternative direction for future reform efforts.

II. State Response to the Malpractice Insurance Crisis

All fifty states responded to the malpractice insurance crisis by enacting a wide variety of reforms, many of which were aimed at

11. See generally Comment, Medical Malpractice Damage Awards: The Need For a Dual Approach, 11 FORDHAM URB. L.J. 973 (1983) (contending that, rather than concentrating on stop gap measures to reduce insurance premiums, reform efforts should be directed toward creating inexpensive recovery and providing immediate compensation for a greater percentage of those injured by medical accidents) [hereinafter cited as Malpractice Damage Awards].
12. See infra notes 224-35 and accompanying text.
13. See infra note 242 and accompanying text.
14. See infra note 245 and accompanying text.
15. See infra note 256 and accompanying text.
16. See infra note 257 and accompanying text.
17. See infra notes 244-47 and accompanying text.
18. See infra notes 33-76 and accompanying text.
19. See infra notes 77-94 and accompanying text.
20. See infra notes 95-198 and accompanying text.
21. See infra notes 199-269 and accompanying text.
22. MEDICAL MALPRACTICE INSURANCE, supra note 1, at 118-19.
reducing malpractice insurance premiums by (1) limiting the size of damage awards; (2) reducing the number of malpractice cases proceeding to trial; and (3) reducing the incidence of malpractice.\textsuperscript{23} These reforms included (1) requiring that malpractice awards in excess of some "ceiling" amount be paid in periodic installments throughout the patient's incapacity;\textsuperscript{24} (2) limiting the size of awards for non-economic damages;\textsuperscript{25} (3) limiting contingency fees;\textsuperscript{26} (4) requiring the losing party to pay all attorney's fees;\textsuperscript{27} (5) limiting the admission of expert testimony;\textsuperscript{28} and (6) requiring malpractice plaintiffs to submit their claims to some alternative forum before proceeding to trial.\textsuperscript{29}

Attacks on medical malpractice legislation were brought primarily under state and federal equal protection and due process clauses.\textsuperscript{30}

\textsuperscript{23} Comment, Recent Malpractice Legislation—A First Check-Up, 50 Tul. L. Rev. 655, 667-88 (1976) [hereinafter cited as Malpractice Legislation].


\textsuperscript{26} Idaho Code § 39-4213 (Supp. 1975) (repealed 1975); Ind. Code Ann. § 16-9.5-5-1 (Burns 1983).


\textsuperscript{30} For a discussion of the reasoning employed by courts entertaining challenges
Opponents of the legislation charged that plaintiffs in medical malpractice actions were being forced to bear the burdens imposed by such legislation when no similar burdens were being imposed on plaintiffs in other negligence suits. They further charged that these statutes curtailed plaintiffs' rights to judicial resolution of their claims and, therefore, were in violation of constitutional guarantees of substantive due process.

A. Standards of Constitutional Analysis

Whether courts sustained the new provisions depended upon which standard of constitutional scrutiny each court chose. Courts which have examined medical malpractice legislation have done so under three standards: strict scrutiny, reasonable relationship, and fair and substantial relationship.

To survive analysis under the strict scrutiny standard the challenged provision had to be a necessary means of achieving a compelling state interest. In the past, courts have applied the strict scrutiny standard only when the challenged legislation authorized differential to medical malpractice legislation on these grounds, see infra notes 33-76 and accompanying text.


32. Comiskey v. Arlen, 55 A.D.2d 304, 306, 390 N.Y.S.2d 122, 124 (2d Dep't 1976), aff'd 43 N.Y.2d 696, 372 N.E.2d 34, 401 N.Y.S.2d 200 (1977). The New York Supreme Court, Appellate Division, Second Department upheld JUD. LAW § 148-a(8), which made unanimous panel findings admissible as evidence, against a due process challenge that interpreted the provision as an unconstitutional burden on a malpractice litigant's right to a trial by jury. 55 A.D.2d at 305, 390 N.Y.S. 2d at 123. It was the trial court's view that "to anticipate anything less than a full and complete adoption by the jury of the Panel's recommendation as to liability is unrealistic and strains credulity." 55 A.D.2d at 306, 390 N.Y.S.2d at 124 (citation omitted).

33. See supra notes 41-76 and accompanying text.

34. Shapiro v. Thompson, 394 U.S. 618 (1969). The Court stated that "any classification which serves to penalize the exercise of [a constitutional right] unless shown to be necessary to promote a compelling governmental interest, is unconstitutional." Id. at 634 (emphasis in original) (citations omitted).
treatment of a "suspect" class of people, or when it burdened some fundamental right.\textsuperscript{35}

Under the reasonable relationship standard, the provision need only be a reasonable means of achieving some end within the state's police power.\textsuperscript{36} New York courts employed this standard in analyzing medical malpractice legislation.\textsuperscript{37}

Finally, in recent years, a few courts have elected to analyze medical malpractice legislation under the "fair and substantial relationship" test,\textsuperscript{38} which has been used in federal courts exclusively in sex-bias and illegitimacy cases.\textsuperscript{39} Some provisions examined under this third test have been upheld, while others have been struck down.\textsuperscript{40}

B. The Ohio Challenge

\textit{Simon v. St. Elizabeth Medical Center,}\textsuperscript{41} a case involving one of the earliest challenges to medical malpractice legislation, was decided

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\item 35. Vance v. Bradley, 440 U.S. 93, 96 (1979). The Court stated:
\begin{quote}
Appellees have not suggested that the statutory distinction between Foreign Service personnel over age 60 and other federal employees over that age burdens a suspect group or fundamental interest; and in cases where these considerations are absent, courts are quite reluctant to overturn governmental actions on the ground that it denies equal protection of
\end{quote}
\begin{footnotes}
Id. (footnotes omitted).
\end{footnotes}


\item 39. See, e.g., Lalli v. Lalli, 439 U.S. 259, 265 (1978) ("[a]lthough ... classifications based on illegitimacy are not subject to 'strict scrutiny,' they nevertheless are invalid under the Fourteenth Amendment if they are not substantially related to permissible state interests"); Reed v. Reed, 404 U.S. 71, 76 (1971) ("a classification [based on the sex of competing applicants for letters of administration] 'must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike.'") (quoting Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920)).

\item 40. For a discussion of the cases utilizing the "fair and substantial relationship" test, see \textit{supra} notes 61-76 and accompanying text.

\item 41. 3 Ohio Op. 3d 164, 355 N.E.2d 903 (1976).
\end{itemize}
by the Ohio Court of Common Pleas. In that case, laws providing for compulsory arbitration of medical malpractice claims and a damage limitation of $200,000 were struck down under a strict scrutiny analysis.\textsuperscript{42}

In its analysis, the court in \textit{Simon} adopted, in its entirety, the reasoning of the earlier Ohio case of \textit{Graley v. Satayatham}.\textsuperscript{43} The \textit{Graley} court invalidated the sections of Ohio's Medical Malpractice Act limiting general damages, forbidding the reduction of damages by collateral recovery, and requiring the listing of collateral sources of recovery in the plaintiff's pleadings. The \textit{Graley} court stated that because the challenged statutes confer benefits on the medical malpractice defendant unavailable to other defendants in tort cases, as well as deprive plaintiffs in these cases of benefits available to others, "'an appropriate governmental interest [must be] suitably furthered by the differential treatment.'"\textsuperscript{44} The court went on to state that

\begin{quote}
\textbf{[t]here obviously is 'no compelling governmental interest' unless it be [sic] argued that any segment of the public in financial distress [can] be at least partly relieved of financial accountability for its negligence. To articulate the requirement is to demonstrate its absurdity, for at one time or another every type of profession or business undergoes difficult times, and it is not the business of government to manipulate the laws so as to provide succor to one class, the medical, by depriving another, the malpracticed patients, of equal protection mandated by the constitution.}\textsuperscript{45}
\end{quote}

The court further acknowledged that the legislation was aimed at protecting public health by assuring the availability of medical care through the reduction of malpractice premiums. Even so, the court stated that the legislation could prove counterproductive "'[t]o the extent that in tort actions of the malpractice type if the medical profession is less accountable than formerly, relaxation of medical standards may occur with the public the victim.'"\textsuperscript{46}

Other cases have upheld malpractice legislation as a reasonable exercise of the state's police power to protect the health and welfare of the community.\textsuperscript{47} These courts have held that in enacting legislation

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\item \textsuperscript{42} \textit{Id.} at 167, 355 N.E.2d at 906.
\item \textsuperscript{43} 74 Ohio Op. 2d 316, 343 N.E.2d 832 (1976).
\item \textsuperscript{44} \textit{Graley}, 74 Ohio Op. 2d at 320, 343 N.E.2d at 837 (citing Police Dep't of Chicago v. Mosley, 408 U.S. 92, 95 (1972)).
\item \textsuperscript{45} 74 Ohio Op. 2d at 320, 343 N.E.2d at 837.
\item \textsuperscript{46} \textit{Id.} at 320, 343 N.E.2d at 838.
\item \textsuperscript{47} \textit{See e.g.}, Woods v. Holy Cross Hosp., 591 F.2d 1164, 1173-75 (5th Cir.
\end{itemize}
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aimed at reducing malpractice premiums, the state took reasonable steps toward ensuring the continued availability of high quality health care.\textsuperscript{48}

C. The New York and California Responses

Two New York cases, \textit{Comiskey v. Arlen}\textsuperscript{49} and \textit{Halpern v. Gozan,}\textsuperscript{50} were among the earliest cases upholding Judiciary Law Section 148-a\textsuperscript{51} under the rational relationship test. Relying on \textit{Montgomery v. Daniels},\textsuperscript{52} the courts in \textit{Comiskey} and \textit{Halpern} pointed out that the strict scrutiny test "could only be applied only where the challenged law created classifications which impaired some fundamental constitutional rights."\textsuperscript{53} Such rights did not include the right of uninhibited access to the court for the purpose of suing for damages in a negligence action.\textsuperscript{54} Thus, the courts in \textit{Comiskey} and \textit{Halpern} chose to examine the New York panel system under a less stringent rational relationship test which stated:

In the area of economic and social welfare, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some "reasonable basis," it does not offend the Constitution simply because the classification "is not made with mathematical nicety or because in practice it results in some inequality."\textsuperscript{55}

The court in \textit{Comiskey} then observed that the panels were created "due to the urgent necessity to find a reasonable procedure for

\textsuperscript{48} See infra notes 56-60 and accompanying text.


\textsuperscript{50} 85 Misc. 2d 753, 381 N.Y.S.2d 744 (Sup. Ct. Queens County 1976).

\textsuperscript{51} This statute created medical malpractice screening panels. N.Y. JUD. LAW § 148-a (McKinney 1983). For the complete text of § 148-a, see infra note 144.

\textsuperscript{52} 38 N.Y.2d 41, 340 N.E.2d 444, 378 N.Y.S.2d 1 (1975). In \textit{Montgomery}, the court of appeals upheld the legislature's no-fault auto insurance statute against due process and equal protection challenges brought under the fourteenth amendment. \textit{Id.}

\textsuperscript{53} \textit{Comiskey}, 55 A.D.2d at 313, 390 N.Y.S.2d at 129; \textit{Halpern}, 85 Misc. 2d at 757, 381 N.Y.S.2d at 747.

\textsuperscript{54} \textit{Comiskey}, 55 A.D.2d at 313, 390 N.Y.S.2d at 129; \textit{Halpern}, 85 Misc. 2d at 757, 381 N.Y.S.2d at 747.
dealing with the crisis situation of increasing medical malpractice insurance rates.” The court upheld panels on the grounds that they bore a rational relationship “to deal[ing] comprehensively with the critical threat to the health and welfare of the State as a result of the lack of adequate medical malpractice insurance coverage at reasonable rates.”

A similar analysis was applied in a recent California case to statutes authorizing periodic payment of malpractice damage awards and limiting damage recoveries. In *Fein v. Permenate Medical Group,* the Supreme Court of California began its analysis by recognizing the existence of a crisis in the health care industry, caused by the “increasing number of suits against health care providers, . . . increasing settlements and awards in those suits, . . . a decrease in the number of companies willing to provide malpractice insurance, and skyrocketing costs of such insurance.” The court went on to state:

The Legislature could reasonably determine that . . . limitation of awards for non-pecuniary damages and the payment of damages by periodic installments over the period during which the damages would be incurred would have the effect of reducing the costs of insuring health care providers without depriving the injured party of provision for his needs.

**D. Innovations in New Hampshire and Indiana**

Departing somewhat from traditional analysis, two recent cases evaluated similar malpractice legislation under the “fair and substantial relationship” test. In *Carson v. Maurer,* the Supreme Court of New Hampshire invalidated provisions which limited awards for

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56. 55 A.D.2d at 314, 390 N.Y.S.2d at 129-30.
57. 55 A.D.2d at 314, 390 N.Y.S.2d at 130 (citing Memorandum of State Executive Dep’t, N.Y. LEGIS. ANN. 419 (1975)).
59. 121 Cal. App. 3d at (opinion omitted), 175 Cal. Rptr. at 186.
60. *Id.*
non-economic losses to $250,000,\textsuperscript{62} empowered the court to order periodic payment of future damages in excess of $50,000,\textsuperscript{63} and imposed a contingent fee scale for attorneys representing parties in medical injury actions.\textsuperscript{64} The court recognized that the United States Supreme Court had restricted the use of the substantial relationship test under the federal constitution to cases involving classifications based on gender and illegitimacy.\textsuperscript{65} The court went on to note, however, that the application of this standard was not so limited under its state constitution.\textsuperscript{66}

Utilizing this test, the court found that the challenged classification was not sufficiently based "upon some ground of difference having a fair and substantial relation to the object of the legislation."\textsuperscript{67} The court further decided that the two damage provisions invidiously discriminated against medical malpractice victims, as op-

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\item \textsuperscript{62} N.H. REV. STAT. ANN § 507-C:7 II (Supp. 1979). The court stated that the purpose of this statute was to stabilize insurance risks and reduce malpractice insurance rates by guaranteeing that insurers will not have to pay out damages for "pain and suffering or other non-economic loss" in excess of $250,000. \textit{Carson}, 120 N.H. at 941, 424 A.2d at 836.
\item \textsuperscript{63} N.H. REV. STAT. ANN. § 507-C:7 IV (Supp. 1979). The court deemed this provision to ensure that claimants with substantial injuries requiring long-term treatment would have money available to pay for future medical care. \textit{Carson}, 120 N.H. at 943-44, 424 A.2d at 838.
\item \textsuperscript{64} N.H. REV. STAT. ANN. § 507-C:8 (Supp. 1979). The court stated that this provision ensures that plaintiff rather than his attorney, receives the bulk of any award. \textit{Carson}, 120 N.H. at 944, 424 A.2d at 838-39.
\item \textsuperscript{65} Id. at 831 (citing Lalli v. Lalli, 439 U.S. 259, 265 (1979) (illegitimacy); Reed v. Reed, 404 U.S. 71, 76-77 (1971) (gender)).
\item \textsuperscript{66} The court stated:
In interpreting our State constitution, however, we are not confined to federal constitutional standards and are free to grant individuals more rights than the Federal Constitution requires . . . . Indeed, we have applied the "fair and substantial relation" test not only in scrutinizing gender-based classifications . . . but also in examining economic and social legislation and ordinances which did not involve distinctions based upon gender or illegitimacy.
120 N.H. at 932, 424 A.2d at 831 (citations omitted).
\item \textsuperscript{67} Id. (quoting State v. Scoville, 113 N.H. 161, 163, 304 A.2d 366, 369 (1973) quoting F. S. Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920)). In discussing the limitation on damage awards, the court pointed out that because paid out damage awards constituted but a small portion of the total insurance premium costs, and because few individuals suffer non-economic damages in excess of $250,000, the necessary relationship between the goal of rate reduction and the means chosen to attain it was lacking. 120 N.H. at 941, 424 A.2d 836. In discussing periodic payments, the court stated that the purpose of the applicable provision was to eliminate a "bonus element," namely, the payment of portions of the award no longer needed to compensate the malpractice victim. 120 N.H. at 944, 424 A.2d at 838. The court was referring to that portion of the provision that allowed courts
posed to other tort claimants and, at the same time, discriminated against those medical malpractice victims suffering the most serious injuries. As the court stated, "[i]t is simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation." In invalidating the contingent fee schedule, the court emphasized the tenuous relationship between limiting attorney's fees and reducing insurance premiums, stating that "[t]here is no 'direct evidence that juries consider attorney's fees in coming to a verdict . . . .'"

In *Johnson v. St. Vincent Hospital, Inc.*, the Supreme Court of Indiana used the same "fair and substantial relationship" test to uphold provisions placing a ceiling of $500,000 on malpractice damage awards, limiting contingency fees in malpractice cases, and requiring pre-trial submission of malpractice claims to a malpractice panel. Examining the provision under both the state and federal constitutions, the court held that such measures were reasonably related to preserving the availability of medical malpractice to terminate periodic payments for non-economic damages, such as pain and suffering, after the plaintiff's death. The court went on to state that regardless of whether the provision furthered the purpose of reducing premiums, by denying plaintiff's right to dispose of his property as he pleased, and by limiting periodic payments to damages in excess of $50,000, the provision discriminated against health care plaintiffs and unduly burdened the most seriously injured malpractice victims. *Id.* For the court's discussion of the provision limiting attorney's contingency fees, see *infra* note 70 and accompanying text.

68. 120 N.H. at 941, 424 A.2d at 836-37. The court stated that it is unfair to limit recoveries for medical malpractice plaintiffs while leaving recoveries for other tort victims unimpaired. "It is also clear that the cap on damage recovery distinguishes . . . between malpractice victims and victims of other torts . . . ." *Id.*

69. *Id.* The court found that the provision denied equal protection of the law to the more seriously injured medical malpractice plaintiffs as opposed to those plaintiffs suffering relatively minor injuries because it precluded "only the most seriously injured victims of medical negligence from receiving full compensation for their injuries." 120 N.H. at 941, 424 A.2d at 836.

70. *Id.* at 941, 424 A.2d at 837.

71. *Id.* at 945, 424 A.2d at 839 (quoting Jenkins & Schweinfurth, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. Cal. L. Rev. 829, 943 (1979)) [hereinafter cited as Jenkins & Schweinfurth]. The court is meant that if attorneys receive a smaller portion of each malpractice award, juries will feel less compelled to grant malpractice plaintiffs such large recoveries. The court went on to state that "at least one study shows that juries do not include an assessment of the lawyer's contingency fee in their allotment of damages . . . ." *Id.* (citations omitted) (quoting Jenkins & Schweinfurth, *supra* at 943).

72. 273 Ind. 374, 404 N.E.2d 585 (1980).

73. *Id.* at 397-400, 404 N.E.2d at 600-01.

74. *Id.* at 401-02, 404 N.E.2d at 602-03.

75. *Id.* at 386-91, 404 N.E.2d at 596-97.
insurance and, thus, "to protect[ing] the public interest adversely being affected by a curtailment of malpractice insurance for health care providers." 76

III. New York's First Medical Malpractice Reform Effort

In the early 1970's, New York began to experience the effects of the increase in medical malpractice litigation that was affecting much of the country. 77 By 1975, private insurers had completely abandoned the medical malpractice market. 78 Since that time, two non-profit organizations, the Medical Malpractice Insurance Association 79 and the Medical Liability Mutual Insurance Company 80 have been the principal insurers of physicians in New York. 81

In response to pressure from physicians, businessmen, and insurers, Governor Hugh Carey created a special advisory panel to explore the fundamental causes of the medical malpractice problem. 82 The

76. Id. at 402, 404 N.E.2d at 603. In addition to examining these provisions under the equal protection clause of the fourteenth amendment, the court also looked at their validity under the Indiana constitution's privileges and immunities clause and that constitution's prohibition against special legislation. The standard the court applied under its own constitution was "whether the legislative classification is based upon substantial distinctions with reference to the subject-matter, or is manifestly unjust or unreasonable." Id. at 392, 404 N.E.2d at 597 (citing Steup v. Indiana Hous. Fin. Auth., 273 Ind. 72, 402 N.E.2d 1215 (1980); Phillips v. Officials of Valparaiso, 233 Ind. 414, 120 N.E.2d 398 (1954)). The court further stated that under both the federal and state constitutions "the burden was on the appellants below to negative every conceivable basis which might have supported the classification." 273 Ind. at 392, 404 N.E.2d at 597, (citing Madden v. Commonwealth of Kentucky, 309 U.S. 83, 93 (1940), Lehnhausen v. Lake Shore Auto Parts Co., 410 U.S. 356 (1973)). The court found that appellants failed to satisfy this burden. 273 Ind. at 393, 404 N.E.2d at 597.

77. Malpractice Damage Awards, supra note 11, at 973 n.2. One insurer paid the following totals, which include damage awards and attorney's costs for prior claims, for the years 1971-75: 1971, $7.1 million; 1972, $11.2 million; 1973, $17.4 million; 1974, $21.7 million; 1975, $27.6 million. Id.

78. New York Medical Liability Reform Coalition, New York's Continuing Medical Liability Crisis: Why It Still Exists and Proposed Solutions to the Problem, A Background Memorandum 6 (1983) [hereinafter cited as Background Memorandum].

79. The association, also called MMIA, was established by the legislature. See N.Y. Ins. Law §§ 5501-515 (McKinney 1985).

80. The Medical Liability Mutual Insurance Company, otherwise known as MLMIC, is physician-owned. Malpractice Damage Awards, supra, note 11, at 984.

81. Background Memorandum, supra note 78, at 6.

82. T. Lombardi, Medical Malpractice Insurance 100 (1978). In addition to its chairman, William McGill, then president of Columbia University, the panel was composed of four legislators, two physicians, an attorney, and a hospital administrator. Id. The panel conducted hearings in the fall of 1975 in Albany,
panel issued its report in January of 1976, in which it stated: "Inasmuch as the present tort law liability insurance system for medical malpractice will eventually break down, and costs will and have continued to rise to unacceptable levels, fundamental reform of the present tort law liability insurance system should be undertaken."\(^3\)

In anticipation of the panel’s recommendation, the New York Legislature began its first attempts to check escalating premiums in 1974.\(^8\)\(^4\) This first attempt at reform included: (1) creation of medical malpractice screening panels;\(^8\)\(^5\) (2) limitation of malpractice actions based on informed consent to non-emergency situations or to cases in which a diagnostic procedure invades or disrupts the integrity of the body;\(^8\)\(^6\) (3) reduction of the statute of limitations in malpractice actions to two and one-half years after accrual of the action\(^8\)\(^7\) and to ten years for indigent minors and others acting under a disability;\(^8\)\(^8\) and based its report on testimony it received from a cross-section of individuals interested in and affected by the malpractice crisis. \(^Id.\)

83. BACKGROUND MEMORANDUM, supra note 78, at 6.
84. Malpractice Damage Awards, supra note 11, at 982.
85. N.Y. Jud. Law § 148-a (McKinney 1983). For the complete text of this provision, see supra note 145.
86. N.Y. Pub. Health Law § 2805-d (McKinney 1983). This provision defines lack of informed consent as:

[T]he failure of the person providing the professional treatment or diagnoses to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.

\(^Id.\)

87. N.Y. Civ. Prac. Law § 214-a (McKinney Supp. 1986). This provision states:

An action for medical or dental malpractice must be commenced within two years and six months of the act, omission or failure complained of or last treatment where there is "continuous treatment" for the same illness, injury or condition which gave rise to the said act, omission or failure; provided, however, that where the action is based upon the discovery of a foreign object in the body of the patient, the action may be commenced within one year of the date of such discovery or of the date of such discovery of facts which would reasonably lead to such discovery, whichever is earlier. For the purpose of this section the term "continuous treatment" shall not include examinations undertaken at the request of the patient for the sole purpose of ascertaining the state of the patient's condition. For the purpose of this section, the term "foreign object" shall not include a chemical compound or prosthetic aid or device.

\(^Id.\)

88. N.Y. Civ. Prac. Law § 208 (McKinney Supp. 1986). This provision states:

If a person entitled to commence an action is under a disability because of infancy or insanity at the time the cause of action accrues, and the
(4) allowing consideration by the court of payments from collateral sources of recovery in setting awards; and (5) providing an insurance pool through the establishment of the aforementioned Medical Malpractice Insurance Association. Many physicians felt that the above reforms would have no substantial effect on rising premiums. Their dissatisfaction resulted in the doctors’ strike of 1975. Furthermore, the special advisory panel appointed by the governor to study the malpractice problem

time otherwise limited for commencing the action is three years or more and expires no later than three years after the disability ceases, or the person under the disability dies, the time within which the action must be commenced shall be extended to three years after the disability ceases or the person under disability dies, whichever event first occurs; if the time otherwise limited is less than three years, the time shall be extended by the period of disability. The time within which the action must be commenced shall not be extended by this provision beyond ten years after the cause of action accrues, except, in any action other than for medical or dental malpractice, where the person was under a disability due to infancy. This section shall not apply to an action to recover a penalty or forfeiture, or against a sheriff or other officer for an escape.

Id.

89. N.Y. Civ. Prac. Law § 545 (McKinney Supp. 1986). This provision states:

In any action for medical malpractice where the plaintiff seeks to recover for the cost of medical care, custodial care or rehabilitation services, loss of earnings or other economic loss, evidence shall be admissible for consideration by the court to establish that any such cost or expense was replaced or indemnified, in whole or in part from any collateral source such as insurance, (except for life insurance), social security (except those benefits provided under title XVII of the Social Security Act) workers’ compensation or employee benefit programs, (except such collateral sources entitled by law to liens against any recovery of the plaintiff).

If the court finds that any such cost or expense was replaced or indemnified from any collateral source, it shall reduce the amount of the award by such finding, minus an amount equal to the premiums paid by the plaintiff for such benefits for the two-year period immediately preceding the accrual of such action.

Id.

90. N.Y. Ins. Law §§ 5501-15 (McKinney 1985). The statute defines medical malpractice insurance as “insurance against legal liability of the insured, and against loss, damage, or expense incident to a claim of such liability arising out of the death or injury of any person due to medical or hospital malpractice by any licensed physician or hospital.” Id.

91. Halpern v. Gozan, 85 Misc. 2d 753, 755, 381 N.Y.S.2d 744, 746 (Sup. Ct. Queens County 1976). Though traditionally opposed to strikes by physicians, the American Medical Association issued the following statement in support of a strike by interns and residents at twenty-three New York City hospitals, which took place in March of 1975: “The malpractice problem is so critical that if the legislatures do not respond to remedial legislation we are absolutely going to have utter chaos in this country because for the first time in history you are going to see massive walkouts and withholding of services by American doctors.” Medical Malpractice Insurance, supra note 1 at 36 (quoting Altman, Malpractice Crises Overshadow Agenda as A.M.A. Session Opens, N.Y. Times, June 15, 1975, at 44, col. 2).
implied its dissatisfaction with these reforms by stating as its first recommendation that "the overriding concern should be to create a system of compensation for adverse medical outcomes resulting from medical treatment, whether or not caused by negligence." 92

Consistent with the most pessimistic predictions, the number of suits against health care providers, and the size of the malpractice insurance premiums continued to rise. 93 As a result, Albany launched its second attempt to deal with the medical malpractice problem. 94

IV. The Cuomo Bill

The Bill's stated purpose is to promote "the continued availability and affordability of quality health services in New York state" 95 by reducing the cost of malpractice insurance, which "discourage[s] physicians . . . from initiating and continuing their practice in New York and contribute[s] to the rising cost of health care as premium costs are passed along to the health care consumer." 96 Like its predecessors in other states, the Bill purports to achieve this goal in three ways: (1) by adjusting malpractice awards; 97 (2) by reducing the number of cases that proceed to trial; 98 and (3) by reducing the incidence of malpractice. 99

A. Adjusting Awards

The Bill makes two major changes in the laws governing malpractice awards. First, section 9 provides for periodic payment of future damages. 100 Second, section 15 sets out a new schedule for determining attorney's contingency fees. 101

1. Periodic Payment of Awards

Section 9 of the Bill provides that awards be divided into two...

92. SPECIAL ADVISORY PANEL ON MEDICAL MALPRACTICE, NEW YORK STATE LEGISLATURE, RECOMMENDATION NO. 1 (1976).
93. For statistics on the increase in the number of suits brought against physicians for 1975-1985, see supra note 3. For statistics on the rise in insurance premiums for this same period, see supra note 6.
94. For a discussion of the major legislative changes that comprised this second wave of reform, see infra notes 95-197 and accompanying text.
95. 1985 N.Y. LAWS ch. 294 § 1.
96. Id.
97. For a discussion of these provisions, see infra notes 102-15.
98. For a discussion of these provisions see infra notes 116-88 and accompanying text.
99. For a discussion of these provisions see infra notes 189-98 and accompanying text.
100. N.Y. CIV. PRACT. LAW art. 50-a (McKinney Supp. 1986).
parts. The first, or "lump sum" part, is available to the plaintiff immediately after the entry of judgment. It includes compensation for damages incurred before the amount of the award is determined—past damages—as well as for damages, up to $250,000, incurred after the award is announced—future damages. It also includes litigation expenses and "that portion of the attorney's fees related to future damages for which, pursuant to N.Y. Civ. Prac. Law art. 50-a, the claimant is entitled to a lump sum payment." The second part of the award, or all future damages in excess of $250,000, is paid over that period of time "determined by the trier of fact" with the added proviso that that portion of the award attributable to pain and suffering will be paid over ten years or some other period of time "determined by the trier of fact, whichever is less."  

Section 9 provides a number of advantages. The first of these is that periodic payments of future damages will prevent successful plaintiffs from squandering their awards. In addition, plaintiffs will receive the entire amount of damages in periodic tax-free installments. This section also benefits defendants in that the plaintiff's death will relieve the defendant from having to make any further payments towards plaintiff's future health care and his non-economic expenses. Finally, the provision will reduce the overall cost of judgment by allowing the insurer to retain and invest future damages before installments come due.
2. **Contingency Fees**

Section 15 of the Bill sets out the following mandatory schedule for payment of contingency fees:

- 30\% of the first $250,000 of the sum recovered;
- 25\% of the next $250,000 of the sum recovered;
- 20\% of the next $500,000 of the sum recovered;
- 15\% of the next $250,000 of the sum recovered;
- 10\% of any amount over $1,250,000 of the sum recovered.\(^{109}\)

Furthermore, plaintiff's attorney can make application to the court for greater compensation than that provided in the schedule if he believes in good faith that because of extraordinary circumstances, the schedule will not compensate him sufficiently.\(^{110}\)

Previously, the law allowed plaintiff and his attorney to choose between a graduated schedule like the above and a straight one-third of any recovery.\(^{111}\) The old schedule was labelled "inadequate and outdated" by Governor Cuomo\(^{112}\) while physicians complained that it unduly enriched attorneys at the expense of injured plaintiffs.\(^{113}\)

Section 15 of the Bill also ensures that a larger percentage of the award will compensate the plaintiff rather than his attorney.\(^{114}\) Theoretically at least, it should also encourage juries to lower the amounts of awards because the jury will know that a larger percentage


\(^{111}\) Former N.Y. Jud. Law § 474-a(2) created the following contingent fee schedule for medical malpractice actions: 50\% of the first $1,000 of the sum recovered; 25\% of the next $2,000 of the sum recovered; 20\% of the next $22,000 of the sum recovered; 15\% of the next $250,000 of the sum recovered; 10\% of any amount over $1,250,000 of the sum recovered; or '[a] percentage not exceeding thirty-three and one third percent of the sum recovered, if the initial contractual arrangement between the client and the attorney so provides, in which event the procedure hereinafter provided for making application for additional compensation because of extraordinary circumstances shall not apply.' N.Y. Jud. Law § 474-a(2) (McKinney 1983).

\(^{112}\) Program Bill Memorandum, supra note 106 at 5.

\(^{113}\) See, e.g., Strausz, How to Drive Doctors Out, N.Y. Times, Apr. 8, 1985, A2, col. 2. (Although "the malpractice lawyer's view that 'doctors must pay for their mistakes' may have a touch of altruism, mostly this stance reflects legally sanctioned greed for the vast profits earned under the contingent fee system." Id. at col. 3).

\(^{114}\) See Program Bill Memorandum, supra note 106, at 5 (stating that the Bill will "establish maximum levels for contingency fees in medical malpractice actions to assure that the injured party will receive a sufficient share of the judgment and to target insurance premium dollars primarily to the plaintiff's compensation") Id.
of the award will go to the plaintiff than would have before the Bill became law. 115

B. Reducing the Number of Cases Proceeding to Trial

Besides making changes in the laws governing malpractice awards, the Bill seeks to reduce the number of cases proceeding to trial by eliminating "frivolous" suits. 116 It attempts to do this by authorizing the court to award attorney's fees to the prevailing party in an action which the court later determines to be frivolous, 117 by subjecting the qualifications of each side's expert witnesses to discovery; 118 and by providing for a new study of the panel system. 119

1. Awarding Attorney's Fees in the Event of a Frivolous Claim

Section 10 of the Bill provides that the successful party in a medical malpractice action may recover attorney's fees if his opponent commences or continues a frivolous claim, defense, or counterclaim. 120 Such fees will be awarded at the discretion of the court if it finds that

(i) the action, claim, counterclaim, defense or cross claim was commenced, used or continued in bad faith, solely to delay or prolong the resolution of the litigation or to harrass or maliciously injure another; (ii) the action, claim, counterclaim, defense or
cross claim was commenced or continued in bad faith without any reasonable basis in law or fact and could not be supported by a good faith argument for an extension, modification or reversal of existing law. 121

While the "American rule" states that, absent extraordinary circumstances, litigants should pay their own attorney's fees, 122 both courts and legislatures have created numerous exceptions to this doctrine. 123

The New York Court of Appeals has held that New York courts have no power to award attorney's fees unless they are permitted by contract or statute. 124 Several New York statutes contain such a provision. For example, attorney's fees are available in New York in landlord/tenant disputes, 125 debtor/creditor disputes, 126 domestic disputes, 127 and class actions. 128 A recognized objective of such statutes is the elimination of "frivolous" litigation. 129 Thus, a provision allowing courts to award attorney's fees in medical malpractice cases would be consistent with prevailing legal trends.

2. Expert Witnesses

Section 4(d)(1) of the Bill requires that prior to trial, each party shall identify for his opponent, upon request, the subject matter as

121. N.Y. CIV. PRAC. LAW § 8303-a(c)(i)(ii) (McKinney 1986).
122. Alyeska Pipeline Serv. Co. v. Wilderness Soc'y, 421 U.S. 240, 247 (1975) ("In the United States, the prevailing litigant is ordinarily not entitled to collect a reasonable attorney's fee from the loser").
126. N.Y. DEBT. & CRED. LAW § 276-a (McKinney 1945).
129. For example, a taxpayer who is adjudged to have brought a frivolous suit can be fined up to $5,000. I.R.C. § 6673. Furthermore, the Code of Professional Responsibility provides for disciplinary sanctions against attorneys who
well as the substance of the facts and opinions on which his expert witnesses shall testify, the expert’s qualifications and a summary of the grounds for the expert’s opinion. The provision seeks to weed out frivolous claims and defenses by improving each party’s ability to expose, through cross examination, incompetent or dishonest “experts.”

Unlike expert witnesses in most tort cases, the expert witness in medical malpractice litigation has assumed a pre-eminent position. Traditionally, New York courts regard experts with suspicion as an unfair influence on the finder of fact. Indeed, in contrast to the Federal Rules of Evidence, New York courts will admit expert testimony only when it is necessary to enable the jury to render a verdict. In medical malpractice cases, however, courts are generally in agreement that unless the plaintiff can produce expert testimony to demonstrate both what the appropriate standard of care would be and that the doctor’s negligence caused the patient’s injury, a verdict of nonsuit must be rendered. Furthermore, in cases in

“[k]nowingly advance a claim or defense that is unwarranted under existing law . . . [or cannot] be supported by good faith argument for an extension, modification or reversal of existing law.” Code of Professional Responsibility DR 7-102(2) (McKinney 1975).

131. See Program Bill Memorandum, supra note 106, at 8(b).
132. For a discussion of the status of the expert witness in medical malpractice cases, see infra notes 135-37.
133. See, e.g., Kulak v. Nationwide Mut. Ins. Co., 40 N.Y.2d 140, 148, 351 N.E.2d 735, 740, 386 N.Y.S.2d 87, 92 (1976) (“[a]bsent such inability or incompetence [of juries to comprehend the issues, evaluate the evidence, and to estimate the likely outcome of a specific action] the opinions of experts, which intrude on the province of the jury to draw inferences and conclusions, are both unnecessary and improper”).

134. See Kulak, 40 N.Y.2d at 148, 351 N.E.2d at 740, 386 N.Y.S.2d at 92. Federal Rule of Evidence 702 provides: “If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.” Fed. R. Evid. 702.

135. See, e.g., Fileccia v. Massapequa Gen. Hosp., 99 A.D.2d 796, 472 N.Y.S.2d 127, 128 (2d Dep’t) (defendant’s motion for summary judgment granted in absence of expert evidence that he negligently read and interpreted plaintiff’s x-ray), aff’d, 63 N.Y.2d 639, 468 N.E.2d 702, 479 N.Y.S.2d 520 (1984); Gibson v. D’Amico, 97 A.D.2d 905, 906, 470 N.Y.S.2d 739, 741 (3d Dep’t 1983) (complaint dismissed for plaintiff’s failure to present expert evidence of standard of care in the area or that defendant negligently examined plaintiff’s knee following auto accident); Pan v. Coburn, 95 A.D.2d 670, 463 N.Y.S.2d 223 (1st Dep’t 1983) (complaint dismissed for plaintiff’s failure to present any medical evidence that standard of care was departed from in defendant’s performance of plastic surgery on plaintiff).
which the plaintiff bases his action solely on the lack of informed consent, New York law requires that he support his charge with expert testimony. The only exceptions to the requirement of expert opinion in medical malpractice cases occur when the case presents no issues that are beyond a juror’s understanding or when it does not involve matters of science or art requiring a degree of knowledge or skill not ordinarily possessed by the average person.

Although there are no set standards governing the admissibility of his testimony, an expert witness in a medical malpractice case must overcome two hurdles before he can influence, in any way, the outcome of a trial. First, his credentials must convince the judge, who has almost unlimited discretion in deciding who will be admitted as an expert witness, that he is qualified to testify. Second, he must convince the jury that his testimony merits some weight in their deliberations.

136. Civil Practice Rule 4401 provides that “[a] motion for judgment at the end of the plaintiff’s case must be granted as to any cause of action for medical malpractice based solely on lack of informed consent if the plaintiff has failed to adduce expert testimony in support of the alleged qualitative insufficiency of the consent.” N.Y. Civ. Prac. R. 4401 (McKinney Supp. 1986).


138. Despite the absence of standards, a number of criteria have been established to guide the attorney in finding the most effective way to establish the expert’s credibility. See 9 Am. Jur. P.O.F. Physicians and Surgeons 247 (1961), which states that a party introducing expert medical testimony should use the following checklist to qualify the witness as a medical expert: (1) is the witness licensed to practice; (2) date license was obtained; (3) educational qualifications, that is, does the witness have a medical degree from an accredited medical school, internship or residency program; (4) is the witness certified by any specialty boards; (5) does the witness belong to any professional organizations; (6) is the witness a recipient of any honors or awards; (7) teaching experience; (8) authorships and years of experience; (9) hospital affiliations; (10) number of patients treated concerning the problem giving rise to the litigation; (11) is the witness familiar with the injury complained of. Id.

139. “The prevailing rule is that the question of the qualification of a witness to testify as an expert is for determination, in his reasonable discretion, by the trial court, which discretion, when exercised, is not open to review unless in deciding the question the trial court has made a serious mistake or committed an error of law or has abused his discretion.” Meiselman v. Crown Heights Hospital, 285 N.Y. 389, 398-99, 34 N.E.2d 367, 372 (1941).

140. See Comment, Medical Malpractice—The Necessity of Expert Testimony and the Use of a General Physician as an Expert Witness in a Malpractice Action Against a Specialist, 10 Ohio N.U.L. Rev. 37, 53 (1983) (“a party attempting to introduce an expert witness who lacks certain basic educational requirements will find it difficult to persuade the jury in his direction”) [hereinafter cited as Expert Witness].
Specifying definite standards which the expert must meet before the court will admit his testimony could prevent meritorious claims from reaching the courtroom. The standards could make it too difficult for plaintiffs to obtain the expert witnesses that are almost always necessary. Indeed, the Supreme Court of New Hampshire invalidated a statute stating that a witness is not competent to give expert testimony in a medical malpractice action unless "the court finds that the witness was competent and duly qualified to render or supervise equivalent care to that which is alleged to have caused the injury at the time that such care was rendered." This provision was invalidated by New Hampshire's highest court on the grounds that it "places too burdensome a restriction on medical malpractice claimants who require expert testimony to prove their cause of action." Thus, the Bill's "experts" provision attempts to strike a balance between weeding out frivolous suits and keeping the courts open to meritorious claims by facilitating effective cross examination, thus limiting the influence of the unqualified or dishonest expert.

3. Malpractice Screening Panels

Before passage of the Bill, Section 148-a of the Judiciary Law

141. See Dolan v. Galluzzo, 77 Ill. 2d 279, 285, 396 N.E.2d 13, 16 (1979) (court stated "in order to testify as an expert on the standard of care in a given school of medicine, the witness must be licensed therein"). See Expert Witness, supra note 140, at 54. This Comment concluded that the stringent standard set forth in the Galluzzo court's holding "could prevent parties from using an otherwise qualified physician, such as an unlicensed medical school professor, from testifying as a medical expert." Id.


143. Carson v. Maurer, 120 N.H. at 934-35, 424 A.2d at 832. The Carson court had no objection to requiring that an expert witness be qualified to render or supervise equivalent care to that alleged to have caused the injury. Id. The court did object, however, to requiring that the witness be so qualified at the time such care was rendered. Id. (The section of the statute that the court objected to has yet to be amended by the New Hampshire legislature). See N.H. REV. STAT. ANN. § 507-C:3 1 (1983 & Supp. 1985).

144. See Expert Witness, supra note 140, at 71-72.

145. § 148-a of the Judiciary Law provides:

2. (a) A list of doctors regularly admitted to practice medicine in the state of New York shall be prepared by each presiding justice of the appellate division with the assistance of the Medical Society of the State of New York, a county medical society and/or the New York Academy of Medicine. Said list shall be divided into lists of doctors according to the particular specialty of each. (b) The presiding justice shall prepare a list of attorneys with trial experience, not confined, however, to the field of medical malpractice. (c) Names of doctors and attorneys may
required each Appellate Division of the New York State Supreme Court to establish, within its judicial department, medical malpractice

be added to or taken off the list at any time by the presiding justice in his discretion. (d) Any party prior to the date set for the hearing may file a written objection to the designation of a doctor or attorney which objection shall be decided by the justice presiding as a member of the panel. 3. (a) The rules of the appellate division shall provide that prior to the date set for hearing the parties shall submit to the court all written material, including pleadings, bill of particulars, medical and hospital reports (or authorization to obtain the same), said written material to be submitted in triplicate except as to hospital records and X-rays, and that these materials shall be made available to any panel member desiring to see the same in advance of the hearing. (b) The rules of the appellate division shall provide that the Medical Society of the State of New York, a county medical society and/or the New York Academy of Medicine shall review the said submitted material and designate the medical specialty involved and notify the court as to such designation. 4. The hearing shall be informal and without a stenographic record. Except as otherwise provided in this section, no statement or expression of opinion made in the course of the hearing shall be admissible in evidence either as an admission or otherwise in any trial of the action. The justice presiding at the hearing shall not preside at the trial. No other panel member shall participate in the trial either as counsel or witness except as otherwise provided herein. 5. All parties shall be represented at the hearing by counsel authorized to act for their respective clients. If authority is not conferred, the plaintiff and a representative of the carrier so authorized must attend. Failing an appearance, the justice presiding may order an inquest, strike the case from the calendar, or make such direction as justice requires. 6. The panel may request an additional doctor having particular expertise in the specialty involved to assist it in the determination of the claim. Such doctor shall make a report to the panel. The panel shall determine the fee and expenses to be paid to such doctor and the parties to the hearing shall share equally in such fee and expense. The doctor may be called at a subsequent trial as a witness by any of the parties. The party calling such witness shall pay all reasonable fees and expenses of the doctor. 7. Following presentation and discussion between the panel and counsel, if any disposition is arrived at, either as to the whole case or any part thereof, an appropriate order shall be entered. If the justice presiding deems a further hearing necessary or desirable, he shall fix a date for the same. If no disposition is arrived at the case shall be remanded to its regular place on the calendar. 8. If the three members of the panel concur as to the question of liability, a formal written recommendation concerning such question of liability shall be signed by the panel members and forwarded to all parties. In such event, the recommendation shall be admissible in evidence at any subsequent trial upon the request of any party to the action. The recommendation shall not be binding upon the jury or, in a case tried without a jury, upon the trial court, but shall be accorded such weight as the jury or the trial court chooses to ascribe to it. If the recommendation is read to the jury or by the trial court, the doctor member or the attorney member of the panel, or both of them, may be called as a witness by any party with reference to the recommendation of the panel
screening panels consisting of a doctor, a lawyer, and a judge. The panel, after reviewing a medical malpractice case, either rendered a unanimous opinion of malpractice, no malpractice, or, in the event of disagreement, no opinion. If the panel rendered a unanimous opinion, the party in whose favor the panel decided could use the opinion as evidence if the case went to trial. In such cases, the opposing party was entitled to cross-examine either the doctor or the attorney on the panel as to the basis of the panel’s decision.

The legislature’s purpose in creating panels was to reduce the number of cases proceeding to trial by: (1) weeding out frivolous suits; and (2) encouraging pre-trial settlement of meritorious claims. The legislature also hoped that panels would help to reduce the size of awards. Panels have had limited success in achieving these goals. There is as yet no evidence that panels have had any success in weeding out frivolous claims. When the legislature created panels, it hoped that they would result in settlement at or immediately after the panel hearing. Only 4.3 percent of the cases that go to panel are settled in this manner. Sixty-eight percent of the cases receiving a unanimous panel verdict are eventually settled, but there is no evidence that settlement resulted because of a panel hearing. However, panels do successfully serve to apprise the parties of the strengths and weaknesses of their claims.

only. The party calling such witness or witnesses shall pay their reasonable fees and expenses.

146. N.Y. JUD. LAW § 148-a(1), (2) (McKinney 1983).
150. Report of the Ad Hoc Committee on Medical Malpractice Panels to the Chief Administrative Judge on the Operation of Medical Malpractice Panels in New York State 1 (June 1979) (Preliminary Analysis) [hereinafter cited as Malpractice Panels Committee (Preliminary Analysis)].
151. In its final report, the committee stated that in the years studied, 68 percent of the cases going to panel were eventually settled. Report of the Ad Hoc Committee on Medical Malpractice Panels to the Chief Administrative Judge of the State of New York on the Operation of Medical Malpractice Panels 161 (March 1980) [hereinafter cited as Malpractice Panels Committee (Final Report)]. However, the committee made no attempt, in either its preliminary or final report, to isolate the number of meritless cases abandoned because of an adverse panel verdict.
152. Malpractice Panel Committee (Final Report), supra note 151, at 163-64.
153. Id. at 161-62.
154. Id. at 164. In its 1980 final report the committee stated that “other tort cases for the period of January 1976—June 1978 were ‘disposed of’ before trial at a rate of 83.5 percent.” Id. at 161. The court concluded from these statistics that “an aggressive pre-trial conference conducted by the court in the ordinary course of its business will produce a greater rate of settlements than will a court encumbered by the additional layer of medical malpractice panel procedure.” Id. at 162.
Unfortunately, unanimous panel opinions of malpractice often strengthen the plaintiff's determination to proceed to trial in hopes of obtaining the largest award possible. Likewise, where a unanimous finding of no malpractice results, defendants are rarely willing to settle. In addition, panel settlements tend to be for higher awards than settlements that are reached subsequent to the court's ordinary pre-trial activity. Thus, overall, panels have done little to reduce either the number of claims proceeding to trial, or the size of malpractice settlements.

Thus far, panels have survived constitutional attack in New York. However, recent judicial decisions, coupled with some unforeseen consequences of the practical operation of panels, have revived doubts about their constitutional validity.

155. Id. at 163.
156. Id.
157. Id. at 165.
158. Id.
159. Comiskey v. Arlen, 55 A.D.2d 304, 390 N.Y.S.2d 122 (2d Dep't 1976), aff'd, 43 N.Y.2d 696, 372 N.E.2d 34, 401 N.Y.S.2d 200 (1977); Halpern v. Gozan, 85 Misc. 2d 753, 381 N.Y.S.2d 744 (Sup. Ct. Queens County 1976). N.Y. JUD. LAW § 148-a (McKinney 1983) provides that if the three members of a panel concur that malpractice does or does not exist, their finding should be admissible at trial, although it shall not be binding on the jury. Id. In Comiskey and Halpern, it was claimed that this section violates due process by denying a right of access to the court. Comiskey, 55 A.D.2d at 312, 390 N.Y.S.2d at 128; Halpern, 85 Misc. 2d at 757, 381 N.Y.S.2d at 747. The courts found that the right to redress a grievance in a court of law merited constitutional protection only where the right sought to be protected was a right recognized as carrying a preferred status in a constitutional sense. Comiskey, 55 A.D.2d at 313, 390 N.Y.S.2d at 129 (citing Montgomery v. Daniels, 38 N.Y.2d 41, 60, 340 N.E.2d 444, 445, 378 N.Y.S.2d 1, 17 (1975)); Halpern, 85 Misc. 2d at 758, 381 N.Y.S.2d at 747. The right to non-negligent medical treatment does not carry such a preferred status. Comiskey, 55 A.D.2d at 314-15, 390 N.Y.S.2d at 130; Halpern, 85 Misc. 2d at 759, 381 N.Y.S.2d at 749. The courts also rejected the equal protection challenge because the provision was reasonably related to "dealing comprehensively with the critical threat to the health and welfare of the State as a result of the lack of adequate medical malpractice insurance coverage at reasonable rates." Memorandum of State Executive Dep't, 1975 N.Y. Legis. Ann., 419; accord Kletnieks v. Brookhaven Memorial Ass'n., 53 A.D.2d 169, 172-73, 385 N.Y.S.2d 575, 579-80 (2d Dep't 1976); Comiskey, 55 A.D.2d at 314, 390 N.Y.S.2d at 130.

160. See generally Comment, Medical Malpractice Screening Panels: A Judicial Analysis of Their Practical Effect, 42 U. PITT. L. REV. 939 (1981) [hereinafter cited as Screening Panels]. This Comment traces the judicial responses to panels in various states. The Comment demonstrates that initially, constitutional challenges to panels often resulted in their being declared invalid under a strict scrutiny analysis. Id. at 950-51. The Comment further states that this trend later reversed itself when courts began employing more lenient constitutional standards. Id. at 951. The Comment concludes that the two-tier analysis of panels—employed by the supreme courts of Pennsylvania and Florida, in which courts examine both
Panels have been constitutionally challenged on five grounds. Opponents of panels have charged that they violate: (1) the equal protection clause of the fourteenth amendment; (2) the due process clause of the fourteenth amendment; (3) the separation of powers doctrine of the applicable state constitution; (4) the right to a trial by jury; and (5) the right of access to the courts as guaranteed

theoretical and practical problems that panels cause—necessitates reform of panels if they are not to become an extinct bureaucratic device. Id. at 959.

161. For a discussion of the various constitutional challenges leveled at panels, see infra notes 166-75 and accompanying text.

162. See, e.g., Eastin v. Broomfield, 116 Ariz. 576, 583, 570 P.2d 744, 751 (1977) ("[p]etitioner asserts the classification is arbitrary and unreasonable in that the treatment accorded to medical malpractice plaintiffs is different from tort plaintiffs generally."); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 167, 355 N.E.2d 903, 906 (1976) ("[The panel provision] confer[s] benefits on the medical malpractice defendant unavailable to other defendants in tort cases."). The court in Simon applied the same equal protection analysis to panels that the court applied to damage limitations in Graley v. Satayatham, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (1976), stating:

Although not presented as an issue in Graley, the compulsory arbitration requirements of R.C. Section 2711.21 discriminate against medical malpractice claimants in the same fashion as do the damages and pleadings limitations and requirements which were addressed by Graley. In this respect, the arbitration provisions suffer from the equal protection infirmities as identified in Graley, with respect to damages and pleadings under the Medical Malpractice Act.

3 Ohio Op. 3d at 167, 355 N.E.2d at 906-07. For a discussion of the Graley court’s equal protection analysis, see supra notes 43-45 and accompanying text.

163. See, e.g., Comisky, 55 A.D.2d at 314, 390 N.Y.S.2d at 128; Halpern, 85 Misc. 2d at 758, 381 N.Y.S.2d at 748. The courts in Comisky and Halpern applied the same due process analysis as the court of appeals did in Montgomery v. Daniels, 38 N.Y.2d 41, 340 N.E.2d 444, 378 N.Y.S.2d 1 (1975). The statute in Montgomery, like the statute in Comisky and Halpern, allegedly denied the substantive right of access to the courts. The standard applied by the Montgomery court, and adopted by the courts in Comisky and Halpern, to determine if a statute meets the requirements of substantive due process is whether the regulation “is reasonable in relation to its subject and is adopted in the interests of the community ....” Montgomery, 38 N.Y.2d at 54, 340 N.E.2d at 451, 378 N.Y.S.2d at 11 (citing West Coast Hotel v. Parrish, 300 U.S. 379, 391 (1937)).

164. See, e.g., Eastin, 116 Ariz. at 582, 570 P.2d at 750. Petitioners in Eastin asserted that the provision which empowered the medical liability review panel to conduct a hearing and find either for the plaintiff or for the defendant, invaded the judicial function of the Arizona courts as enunciated in the Arizona Constitution. Id.

165. See, e.g., Comisky, 55 A.D.2d at 306, 390 N.Y.S.2d at 124. The party attacking the constitutional validity of panels asserted that to allow the panel’s recommendations to be introduced into evidence would nullify plaintiff’s constitutional right to a meaningful jury trial. Id. The court disagreed with the trial court’s finding that “to anticipate anything less than a full and complete adoption by the jury of the Panel’s recommendation as to liability is unrealistic and strains credulity.” Id. See also Halpern, 85 Misc. 2d at 759, 381 N.Y.S.2d at 748 (court
by the applicable state constitution. 

Challenges to panels as violative of the due process and equal protection clauses of the fourteenth amendment have emphasized the potential burdens that panels place on medical malpractice plaintiffs and their attorneys. Requiring medical malpractice plaintiffs to submit their claims to a panel prior to trial impedes plaintiffs’ substantive right to judicial determination of their claims by imposing additional costs and delays. Furthermore, these burdens are not imposed on any other tort claimants. Panels which have survived these attacks have done so by passing the rational basis test as a reasonable means for achieving a legitimate state end.

In Arizona, the panel concept also survived attack under the separation of powers doctrine embodied in the Arizona state constitution. In *Eastin v. Broomfield*, petitioners alleged that empowering a medical liability review panel to conduct a hearing and find in favor of either plaintiff or defendant invaded the judicial function of the Arizona courts, as defined by the Arizona constitution. The court stated that panels do not enter judgment against either party. Rather, as in New York, “the panel’s finding is intended to encourage settlements and may be introduced into evidence at any subsequent trial.” Thus, the panel’s actions are, at most, advisory. Because the court defined the judicial power as the power to “decide and pronounce a judgment and carry it into effect,” panels did not infringe upon the judicial power of the court.

asked: “Would not the impact of the recommendation be so overpowering as to remove de facto the essential elements of fairness and openmindedness which are so crucial to the total fabric of our jury system, thereby infecting it with prejudicial taint?”

166. *See*, e.g., *State ex. rel. Cardinal Glennon Memorial Hosp. v. Gaertner*, 583 S.W.2d 107, 110 (Mo. 1979), in which the court stated that “[t]he determinative challenge to Chapter 538 is that it imposes a procedure as a precondition to access to the courts. It is contended that it violates Mo. Const. Art. I § 14 which provides that ‘the courts of justice shall be open to every person . . . ’”).


169. *See supra* notes 49-57 and accompanying text.


171. Arizona Constitution, Art. VI, § 1, states: The judicial power shall be in an integrated judicial department consisting of a Supreme Court, such intermediate appellate courts as may be provided by law, a superior court, such courts inferior to the Superior Court as may be provided by law, and justice courts.

*Id.*

172. 116 Ariz. at 582, 570 P.2d at 750.

173. *Id.*

174. *Id.* (citing *Stuart v. Norviel*, 26 Ariz. 493, 501, 226 P. 908, 910 (1926)).

175. 116 Ariz. at 582, 570 P.2d at 750.
Plaintiffs in two New York cases argued that panels restrict the right to a trial by jury, asserting that the decisions of panels unduly influence juries, thus depriving litigants of their right to an unbiased jury determination of their cause. Both courts rejected this argument on the grounds that counsel has the right to cross-examine doctor and attorney panelists as to the basis of their opinion, panel decisions are not binding, and juries are traditionally too jealous of their independence to allow panels to unduly influence their determinations.

Courts have also held that requiring parties to go to panel before going to trial does not by itself impermissibly restrict their right of access to the courts. However, the Supreme Court of Pennsylvania has held that when delays of up to four years occur from the time suit is brought to the time a panel finally convenes, the practical

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176. Comiskey, 55 A.D.2d at 309, 390 N.Y.S.2d at 126; Halpern, 85 Misc. 2d at 759, 381 N.Y.S.2d at 748-49.
177. Comiskey, 55 A.D.2d at 309, 390 N.Y.S.2d at 126; Halpern, 85 Misc. 2d at 759, 381 N.Y.S.2d at 748-49.
178. Comiskey, 55 A.D.2d at 309, 390 N.Y.S.2d at 126; Halpern, 85 Misc. 2d at 759, 381 N.Y.S.2d at 748.
179. Comiskey, 55 A.D.2d at 307, 390 N.Y.S.2d at 125; Halpern, 85 Misc. 2d at 759, 381 N.Y.S.2d at 748-49. The court in Halpern stated:

Historically, jurors for the most part have proven their independence. They guard their roles with a unique jealousy. They accept with obvious pride the admonitions of the trial court that they are the "sole judges of the facts." They show their independence and resentment when the "province that is theirs" is threatened by suggestion, device or artifice. While they sit in judgment of their peers, they rise to heights of great importance during this brief period of their civic lives—a posture brought about by the major determinations they are asked to make and by the continuous deference and solicitous manner of the advocates who seek their favor.

Id.

180. Parker v. Children's Hosp. of Philadelphia, 483 Pa. 106, 120, 394 A.2d 932, 939 (1978). The court was satisfied that any theoretical burden imposed by panel legislation upon a malpractice victim's right to a trial by jury "is counterbalanced by the substantial advantages provided to him or her under the Act."

Id. The court stated: "Rather than imposing a burden, this legislation is designed to afford the plaintiff a swifter adjudication of his claim, at a minimal cost . . . ."

Id. at 119-20, 394 A.2d at 939. In Carter v. Sparkman, 335 So. 2d 802, 807-08 (Fla. 1976) (England, J., concurring), the court stated:

It troubles me that persons who seek to bring malpractice lawsuits must be put to the expense of two full trials on their claim, assuming the medical defendant chooses to put plaintiff to her proof before the panel. Obviously, this procedure favors the medical defendant over a certain category of claimants who have limited resources. The only reciprocal benefit given plaintiffs under the statute is the ability to have the mediation panel's decision admitted into evidence at the later trial, a benefit which
operation of panels does impermissibly restrict the right of access.181 Similar delays are occurring in certain New York counties.182 Thus, panels may be open to renewed constitutional attack.183

Section 14 of the Bill eliminates medical malpractice screening panels in the Fifth Judicial Department and in Suffolk County.184 In addition, section 22 requires the chief administrator of the courts to conduct a study comparing the disposition of medical malpractice actions in these two areas with those in the seventh judicial district and in Nassau County.185 In 1988, the chief administrator must prepare a report of his findings for the governor, the legislature, and the chief judge of the court of appeals.186 The report will compare actions brought in these areas according to numbers of actions brought, speed of disposition, and the impact of panels on the adjudication of each action.187

Sections 14 and 22 of the Bill were enacted to enable the legislature to make an accurate determination of whether, and to what degree, panels are responsible for the unreasonable delays in resolving cases. In addition, these provisions should allow the legislature to compare

is only valuable if the plaintiff prevails before the mediation panel and in any event is fully equated to the reciprocal evidentiary right given to the defendant. While I find the inequity in this procedure harsh to a large and undefined class of litigants, I cannot in good conscience invalidate the statute on that basis. A disparity of resources has always been an imbalance in litigation which the courts are relatively powerless to adjust.

335 So. 2d at 807-08, cert. denied, 429 U.S. 1041 (1977).

181. Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190, 195 (1980). The court found that the panels were incapable of providing the prompt adjudication of medical malpractice claims which was the goal of the act. Id. In support of this finding, the court quoted statistics which revealed that delays of up to four years attended the resolution of some cases filed under the panel system. Id. The court went on to state that: "No extraordinary circumstances have been offered to explain this intolerable delay." Id. The court further found that as of May 31, 1980, thirty-eight percent of the claims filed in 1977, sixty-five percent of the claims filed in 1978, and eighty-five percent of the claims filed in 1979 remained unresolved. Id. The court concluded that "[s]uch delays are unconscionable and irreparably rip the fabric of public confidence in the efficiency and effectiveness of our judicial system." Id.

182. Margolick, Suit Filed to Abolish Medical Malpractice Panels, N.Y. Times, Feb. 27, 1983, at 40, col. 1. The author states that "[i]nstead of speeding up the process . . . the panels have created another time consuming step. Litigants in Manhattan . . . must now wait up to four years to get a panel convened . . . ."

Id. at cols. 4, 5.

183. See Screening Panels, supra note 160, at 959.


186. Id.

187. Id.
the methods used by those counties where panels have been most successful with those used in counties where their success has been more limited. Thus, the legislature hopes that these provisions will enable it to determine whether, and under what conditions, it should allow panels to continue to operate.188

C. Reducing the Incidence of Malpractice

Section 3 of the Bill is directed toward reducing the incidence of medical malpractice.189 This provision attempts to achieve this goal by requiring each hospital in the state to establish a quality assurance committee to review hospital services and to “ensure that information gathered pursuant to the program is utilized to review and revise hospital policies and procedures”190 in order to facilitate the prevention of malpractice. The provision also requires each hospital to periodically review the credentials and competence of all hospital personnel191 and to establish grievance committees to resolve patient complaints that may otherwise result in malpractice claims.192

Maintenance and collection of information “concerning the hospital’s experience with negative health care outcomes and incidents injurious to patients”193 is also mandated. Each hospital is made

188. Id. The section provides:
The chief administrator of the courts shall conduct a study of the impact of section fourteen of this act upon the dispositions of medical malpractice actions in the fifth judicial district and in the county of Suffolk, as compared to medical malpractice actions in the seventh judicial district and in the county of Nassau. On or before January first, nineteen hundred eighty-eight, the chief administrator shall prepare and transmit to the legislature, the governor and the chief judge of the Court of Appeals a report of his findings, including but not limited to numbers of actions brought, speed with which cases reached final disposition, and the impact of the panels on the adjudication of the action, together with any appropriate recommendations.

Id.

189. PROGRAM BILL MEMORANDUM, supra note 106, at 9.
191. N.Y. PUB. HEALTH LAW § 2805-j(1)(c) (McKinney Supp. 1986). This section provides for the “periodic review of the credentials, physical and mental capacity and competence in delivering health care services of all persons who are employed or associated with the hospital.” Id.
192. N.Y. PUB. HEALTH LAW § 2805-j(1)(d) (McKinney Supp. 1986) (section requires each hospital to develop “[a] procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment and other events that may result in claims of medical or dental malpractice”).
193. N.Y. PUB. HEALTH LAW § 2805-j(1)(e) (McKinney Supp. 1986). This information would also include patient grievances, professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention and safety improvement activities. Id.
responsible for creating education programs for hospital staff dealing with patient safety, injury prevention, and the legal aspects of patient care. Each hospital must also maintain continuing education programs for medical staff in their area of specialty.

Furthermore, this section of the Bill requires each hospital, before granting or renewing staff privileges, to obtain from each physician the name of any hospital with which he has had previous association, the reason for his terminating such association, and information concerning any past or pending medical malpractice action against him. The provision requires all hospitals to honor any request for such information coming from another hospital, and absolves the hospital from any civil liability for providing such information.

Any person who "in good faith and without malice" participates on a quality assurance committee or provides information to further the prevention of medical malpractice is also absolved from civil liability.

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194. N.Y. Pub. Health Law § 2805-j(1)(g) (McKinney Supp. 1986). These educational programs would address staff responsibility for reporting professional misconduct. Id. In addition, they would improve communication between staff and patients. Id.


The name of any hospital or facility with or at which the physician or dentist had or has any association, employment, privileges or practice . . . [w]here such association, employment, privilege or practice was discontinued, the reasons for its discontinuation . . . [a]ny pending professional medical or dental misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in such proceedings or actions, and any additional information concerning such proceedings or actions as the physician or dentist may deem appropriate.

Id.

197. N.Y. Pub. Health Law § 2805-k(4) (McKinney Supp. 1986). This section provides:

Any hospital which receives a request for information from another hospital pursuant to subdivision one or two of this section shall provide such information concerning the physician or dentist in question to the extent such information is known to the hospital receiving such a request, including the reasons for suspension, termination, curtailment of employment or privileges at the hospital. Any hospital or hospital employee providing such information in good faith shall not be liable in any civil action for the release of such information.

Id.

198. N.Y. Pub. Health Law § 2805-j(2) (McKinney Supp. 1986). This section provides:

Any person who, in good faith and without malice, provides information to further the purposes of the medical and dental malpractice prevention program or who, in good faith and without malice, participates on the
V. Recommendations

A. The Bill’s Expected Impact on Insurance Premiums

Although the Bill’s provisions will provide some measure of benefit to patients, insurance carriers and physicians, they will do little to reduce malpractice insurance premiums. Moreover, like previous reforms, they fail to address the tort claims system’s most glaring inadequacies.

First, section 9 of the Bill, which establishes periodic payment of future damages, provides that only the interest earned by the insurance company on the investment of future installments before they are paid will be deductible from malpractice insurance premiums. The only other possible savings represented by this provision are future damages for non-economic losses, such as pain and suffering, of plaintiffs who die before they can collect the entire award. Thus, additional reductions in premiums would occur only if juries have overestimated plaintiffs’ life-expectancies. Finally, at least a portion of any savings resulting from this provision will be consumed in administering the periodic payment of installments.
Second, while section 15 of the Bill decreases the share of each award going to pay plaintiffs' attorneys, it does nothing on its face to reduce the total amount of damages awardable in a malpractice suit. Furthermore, there is no evidence that decreasing contingency fees in any way affects the jury's determination of an appropriate award. Indeed, the one study that has been done on this subject discovered that such reforms had no effect on damages recovered. Finally, while the legislature has decreased the attorney's share of the malpractice award, it has done nothing to reduce the cost of prosecuting a malpractice claim. These costs may be advanced by plaintiff's attorney.

The final obstacle to any reduction in malpractice insurance premiums resulting from these provisions is posed by section 18 of the Bill. Section 18 provides that physicians insured in the amount of $1,000,000 per claimant and $3,000,000 for all claimants, for any one year, shall be entitled to purchase coverage of an additional $1,000,000 per claimant and an additional $3,000,000 for all claimants for any one year. By requiring insurers to provide double coverage

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upon request, the legislature has enabled potential plaintiffs to recover twice as much as they could have previously.\textsuperscript{211} Although the additional premiums represented by section 18 will, in part, be paid by hospitals, the health care consumer will remain the one who ultimately bears this new burden.\textsuperscript{212}

A number of states have attempted to reduce malpractice premiums by placing arbitrary limits on amounts recoverable for non-economic losses such as pain and suffering.\textsuperscript{213} Of the six such statutes enacted in the United States, two have survived judicial scrutiny.\textsuperscript{214} While such a provision has been proposed in New York, it has yet to be enacted into law.\textsuperscript{215} Even if such a provision were to be enacted, its effect on premiums would be minimal, for damage awards make up only a small part of each premium dollar.\textsuperscript{216}

Sections 10 and 4(d)(1) of the Bill, which seek to reduce premiums by reducing the number of claims proceeding to trial, are steps in the right direction. Section 11, which allows the court to award attorney’s fees to the prevailing party in a “frivolous” action, has received some favorable comment from physicians.\textsuperscript{217} However, the

\textsuperscript{211} See Editorial, \textit{Albany Malpractice}, Syracuse Times, Jan. 29, 1985, Editorial Page (arguing that instead of limiting claims against physicians, the Bill enables malpractice claimants to sue for larger recoveries).

\textsuperscript{212} “The Legislature is telling us that the additional premiums will be paid by hospitals. What the Legislature is not saying is that the hospitals can pass the cost on to patients, putting already astronomical hospital bills really out of sight.” \textit{Id.}

\textsuperscript{213} For a list of statutes placing a ceiling on awards for non-economic damages, see \textit{supra} note 24.


\textsuperscript{215} Gargan, \textit{Doctors and Insurers Press For Limits on Malpractice Awards}, N.Y. Times, Feb. 21, 1983, at B4, col. 1. The Medical Liability Mutual Reform Coalition—an organization of doctors, insurers, and businesspeople—wrote a comprehensive malpractice reform bill that was introduced in the state senate in 1983. \textit{Id.} In addition to many of the provisions contained in the Bill, this proposal also included a provision limiting awards for non-economic damages to $100,000. \textit{Id.}

\textsuperscript{216} For one commentator’s estimate of how each premium dollar is ultimately divided among attorneys, plaintiffs, and insurers, see \textit{supra} note 155.

\textsuperscript{217} See \textit{BACKGROUND MEMORANDUM, supra} note 78, at 12-13. The Medical Liability Mutual Reform Coalition proposed a provision that would require plaintiffs in malpractice actions to post a bond covering costs incurred by defendants, including legal fees, in the event that the plaintiff decided to proceed to trial in the face of an adverse panel determination. \textit{Id.} The bond would be forfeited if the court
discretionary nature of such awards could hinder the statute's deterrent effect.218 This drawback could be eliminated by striking the provision's discretionary aspect—in other words, requiring payment of attorney's fees to the prevailing party in all but extraordinary cases.219 Section 4(d)(1), which subjects to discovery all information relating to expert witnesses, is probably the most effective compromise between weeding out frivolous suits and keeping the courtroom door open to meritorious ones.220

Section 3 of the Bill, which is directed toward reducing the incidence of malpractice, is consistent with the recommendations of the American Bar Association in that it provides immunity from civil liability for certain exchanges of information.221 Indeed, the American Bar Association has recommended the establishment of a national system of information gathering and exchange, through which medical institutions, organizations, and authorized personnel could routinely obtain information concerning disciplinary actions taken in their own and other states.222 However, even if these provisions do help to eliminate incompetent physicians, it is doubtful that they will have an appreciable effect on the incidence of malpractice litigation. Most medical malpractice results not from physician incompetence, but from the mistakes of normally competent physicians, or from the failure of normally reliable procedures.223


219. Florida's spurious claims statute, which requires the losing party in a medical malpractice action to pay all attorney's fees in all but extraordinary cases, has survived constitutional attack on four separate occasions. E.g., Pohlman v. Matthews, 440 So. 2d 681 (Fla. Dist. Ct. App. 1983); Karlin v. Denson, 447 So. 2d 897 (Fla. Dist. Ct. App. 1983); Young v. Altenhaus, 448 So. 2d 1039 (Fla. Dist. Ct. App. 1983), quashed in part, 472 So. 2d 1152 (1985) (holding the statute not applicable to actions accruing before the statute became effective); Davis v. North Shore Hosp., 452 So. 2d 937 (Fla. Dist. Ct. App. 1983). But see Spence v. Roth, Closing the Courthouse Door: Florida's Spurious Claims Statute, 10 Stetson L. Rev. 397 (1981). The authors contend that Florida's attorney's fee statute is unduly restrictive in that it deters all malpractice victims from asserting their claims. Id. at 403.

220. See Expert Witness, supra note 140, at 71-72.


222. Malpractice Legislation, supra note 23 at 687.
B. Alternative Directions for Future Reform Efforts

1. Fundamental Flaws in the Tort Claims System

The Bill’s major flaw is that it fails to provide the fundamental reform that the tort claims system requires. The tort claims system is supposed to compensate the injured and deter potential tortfeasors. Compensation in medical malpractice cases is under-inclusive, expensive, and slow. In addition, the system’s deterrent aspect has done nothing to promote improved health care in New York State. On the contrary, it has done much to increase costs, cripple innovation, and erode the doctor-patient relationship.

According to a consensus of participants in a conference at the Center for Study of Democratic Institutions, most people who sustain medical injuries, either through negligence or unavoidable accident, do not get into the claims system; consequently, they receive no compensation. First, because it is fault-oriented, the present system automatically denies its benefits to those who are injured in the absence of negligence. In addition, many claims will not yield

224. See infra notes 225-243 and accompanying text.
225. “The purpose of the law of torts is to adjust these losses, and to afford compensation for injuries sustained by one person as the result of the conduct of another.” W.L. PROSSER, THE LAW OF TORTS 6 (5th ed. 1984).
226. “[D]amages are given to the plaintiff over and above the full compensation for the injuries, for the purpose of punishing the defendant . . . and of deterring others from following the defendant’s example.” Id. § 2, at 9.
227. See infra notes 230-35 and accompanying text.
228. See infra notes 236-39 and accompanying text. But see Taylor, Medical Malpractice Costs Debated at Hearing, N.Y. Times, July 15, 1985, at A23, cols. 1, 4 (quoting Dr. Patricia Danzon as testifying at a senate hearing in Washington “that the current legal system, under which physicians and hospitals are liable to patients injured by negligent medical care ‘is worth retaining as a system of quality control, a deterrent to malpractice’ ”) [hereinafter cited as Medical Malpractice Hearing].
229. See generally Carlson, A Conceptualization of a No-Fault Compensation System For Medical Injuries, 7 LAW & SOC’Y REV. 329, 335 (1972-73) (The tort claims system is responsible for “higher settlements and verdicts . . . escalating insurance premiums; and the incalculable cost of defensive medicine. . . .”) [hereinafter cited as No-Fault Compensation]. It has been asserted that the fear of litigation causes physicians to opt for more conservative methods of treatment, and to “refuse to apply promising new techniques in favor of tried and true procedures.” Id. at 334. But see Medical Malpractice Hearing, supra note 228.
230. MEDICAL MALPRACTICE 4 (D. McDonald, ed. 1971) (citation omitted); see also C. KRAMER, THE NEGLIGENT DOCTOR 15-18 (1968) (stating that the then current levels of malpractice actions represented only a small portion of those actions which could have been brought).
231. “[M]any patients injured as they pass through the health care system are
recoveries high enough to merit the attention of a competent attorney.\textsuperscript{232}

In addition to being selective in a manner that has only a tenuous relation to the needs of the injured, the tort claims system is often painfully slow in dispensing its largesse. Often, as many as eight years lapse from the time the plaintiff files his claim to the time the jury hands down its verdict.\textsuperscript{233} Even if the plaintiff wins at the trial level, there is often an appeal, or several appeals, which can add another year or two before he is finally paid—assuming, of course, that the final appeal is decided in his favor.\textsuperscript{234}

In addition to the system's inadequacy as a vehicle for providing compensation, it is almost useless as a deterrent. Malpractice insurance protects the potential tortfeasor from damage awards.\textsuperscript{235} Also, premium increases are determined according to the geographic location and specialty of the individual physician, and are rarely influenced by the practitioner's record of claims, settlements, and adverse verdicts.\textsuperscript{236} The vast majority of actual tortfeasors in New York pay almost no surcharge on their premiums.\textsuperscript{237} Thus, the negligent physician ends up paying no more than does the careful one.\textsuperscript{238}

Far from promoting improved health care, the tort claims system may be crippling the medical establishment.\textsuperscript{239} Doctors have responded to the rising incidence of litigation by spending more and more time and money to avoid liability in ways that do not benefit the patient.\textsuperscript{240} In the words of one commentator:

\begin{quote}
not compensated for their injuries. Among the uncompensated are those patients whose injuries were not caused by negligence or who could not prove negligence."
\end{quote}

Medical Malpractice Damage Awards, supra note 11, at 990 (emphasis in original).

\textsuperscript{232} Medical Malpractice 4 (D. McDonald ed. 1971); see also J.B. Spence, Medical Malpractice 279, 283-84 (Practicing Law Instit. No. 68, 1974) (practicing attorney warns colleagues that because of the time and expense of litigating malpractice cases, only the most substantial cases should be accepted).

\textsuperscript{233} What's the Cure For Bad Medicine, N.Y. Times, Apr. 26, 1985, at 30, col. 1.

\textsuperscript{234} O'Connell, An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries, 60 Minn. L. Rev. 501, 512 (1976) [hereinafter cited as Elective No-Fault].


\textsuperscript{236} Id.

\textsuperscript{237} Id. at 981, n.42.

\textsuperscript{238} Id. at 980-81.

\textsuperscript{239} See No-Fault Compensation, supra note 229, at 338.

\textsuperscript{240} Balt. Sun, Nov. 22, 1975, at B1, col. 4. Close to one billion dollars a year was being spent nationally at that time on largely unnecessary x-rays that doctors ordered to protect themselves from potential malpractice claims. Id.
It has become commonplace for physicians to order complete x-ray studies of an injured limb even without the slightest indication of a fracture. Needless to say, the x-rays can add [twenty] to [thirty] dollars to the patient's bill even though they may be unwarranted in ninety-nine out of one hundred cases . . . . In addition to x-rays, physicians now frequently recommend medical consultations even when there are no positive medical grounds for such specialized services . . . . In still other cases, physicians are ordering additional laboratory tests, additional hospitalization, and additional nursing care, both to minimize the chances of being sued for malpractice and to guarantee the successful defense of any suit which might be instituted.241

In addition to promoting such "defensive medicine," the epidemic of malpractice litigation is causing a significant number of physicians to decline to perform services in certain circumstances, or to abandon procedures they are fully qualified to perform, or to retire from practice much earlier than they would under more congenial circumstances.242

2. A No-Fault System of Recovery

Unlike Governor Cuomo's Bill, a no-fault system of recovery would address those problems afflicting the tort claims system that previous reform efforts have left untouched. Such a system would focus on determining the existence of injury and the appropriate compensation and not the existence of fault.243 A no-fault plan would

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241. Testimony of Eli Bernzweig of the Dep't of HEW, Center of Malpractice Claims Prevention to the Ribicoff Subcommittee on Executive Reorganization (1968), reprinted in No-Fault Compensation, supra note 229, at 338. On the other hand, a survey financed by the Committee on Legal Issues in Health Care tentatively concluded that while "[t]he threat of a malpractice suit does induce physicians to overutilize diagnostic tests and procedures in particular cases . . . . the practice is not extensive and probably not a contributing factor to the rising cost of medical care." Project, The Medical Malpractice Threat: A Study of Defensive Medicine, 1971 DUKE L. J. 939, 964. The survey consisted of interviews of 66 physicians at Duke University Medical Center, and questionnaires sent to 100 physicians in California and North Carolina. Id. at 953-55. The survey further concluded that "significant overutilization of our medical resources occurs and can be explained only by factors other than malpractice." Id.

242. Keeton, Compensation for Medical Accidents, 121 U. PA. L. REV. 590, 599 (1973) [hereinafter cited as Keeton]. Indeed, Mr. Keeton goes on to say that "the inducement toward withdrawal from practice is accentuated in some areas of the country by such dramatic increases in malpractice insurance premium rates, and even in unavailability of malpractice insurance, that some physicians find the choice of continuing in practice economically as well as psychologically unattractive." Id.

243. Id. at 601.
thus pay expenses caused by all treatment-related injuries, whether or not the physician is negligent. By eliminating the fault finding mechanism of the trial process, a no-fault system would save both time and money. Finally, such an arrangement would preserve for the patient a greater share of his reimbursible damages because he would not be sharing his award with an attorney.

A no-fault system should survive constitutional scrutiny. The due process right to sue for damages is subject to legislative change. In *New York Central Railroad Co. v. White*, the United States Supreme Court upheld New York's workmen's compensation statute, suggesting but not requiring that the right to sue for damages could be replaced by a legislatively enacted compensation scheme if that scheme was a "reasonable substitute." The Court's later decision in *Duke Power Co. v. Carolina Environmental Study Group, Inc.*, provides additional support for legislative enactments limiting the liability of injured persons in deference to a broader societal goal, so long as the substitution is "reasonably just." In setting this standard of review, the Court stated that the burden is on the one complaining of a due process violation to establish that the legislature has acted in an "arbitrary and irrational way."

A system based on no-fault is, at the very least, a reasonable attempt to remedy the most glaring inadequacies of the tort claims

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245. See Keeton, *supra* note 242, at 603.

246. See *supra* note 113 and accompanying text.

247. Munn v. Illinois, 94 U.S. 113, 134 (1877). The Court stated:

A person has no property, no vested interest, in any rule of the common law .... Rights of property which have been created by the common law cannot be taken away without due process; but the law ... may be changed at the will, or even at the whim, of the legislature, unless prevented by constitutional limitations.

*Id.* at 134.


249. 243 U.S. 188, 201 (1917). The Court noted:

Nor is it necessary ... that a State might, without violence to the constitutional guaranty of "due process of law" suddenly set aside all common law rules respecting liability as between employer and employee, without providing a reasonably just substitute .... No such question is here presented, and we intimate no opinion upon it.

*Id.*


251. *Id.* at 88. *Duke Power* upheld the Price Anderson Act, which imposed a $560 million limitation on liability for nuclear accidents resulting from the operation of federally licensed nuclear power plants. *Id.*

252. *Id.* at 83 (quoting Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 15 (1976)).
In exchange for his right to sue for damages, the medical malpractice plaintiff will receive compensation that is comprehensive, inexpensive, and immediate. In addition, by eliminating the need to assign blame, no-fault should do away with defensive medicine.

Two primary difficulties attend the application of no-fault to medical malpractice. First, the money saved by eliminating the trial process may not balance the money spent answering the additional claims that would be brought under a no-fault system. The second difficulty is defining the compensible event. It is neither fair nor feasible to compensate every patient for the consequences of treatment yielding an unsatisfactory result. Accepting this initial premise, how does one determine whether the patient was injured in the course of treatment, or suffered the natural consequences of the condition that originally sent him to the health care provider?

One possible solution to this problem can be found in the "Medical Adversity Insurance" system ("MAI"). This system would compensate any adverse medical outcome appearing on a pre-determined list. Any injury not appearing on the list, including failure to obtain informed consent, abandonment of the patient, gross negligence, intentional misconduct, and illegal behavior, would be left to the tort claims system. Administrative adjudication or arbitration, with the compulsory cooperation of the health care provider,

253. The Supreme Court's rationale for workmen's compensation is equally applicable to medical malpractice:

[I]n the highly organized and hazardous industries of the present day the causes of accidents are often so obscure and complex that in a material proportion of cases it is impossible by any method correctly to ascertain the facts necessary to form an accurate judgment . . . . New York Cent. R.R. Co. v. White, 243 U.S. 188, 197 (1917). For a discussion of the success of workmen's compensation, see O'Connell, No-Fault Insurance For Injuries Arising From Medical Malpractice: A Proposal For Elective Coverage, 26 EMORY L.J. 21 (1975). But see Ring, The Fault with No-Fault, 49 NOTRE DAME L. REV. 796 (1974); Spangenberg, No-Fault Fact, Fiction & Fallacy, 44 MISS. L.J. 15 (1973).

254. See supra notes 243-46 and accompanying text.

255. See Havighurst & Tancredi, supra note 244, at 69-70.

256. See Elective No-Fault, supra note 234, at 517.

257. In a study conducted by the California Medical Association and the California Hospital Association, researchers found that of the disabilities caused by health care management, 17 percent involved probable liability of the health care provider. Mills, Medical Insurance Feasibility Study, 128 WEST. J. OF MED. 360-65 (Apr. 1978).

258. Havighurst & Tancredi, supra note 244, at 70.

259. Elective No-Fault, supra note 234, at 521.

260. This system is comprehensively described in Havighurst & Tancredi, supra, note 244, and supra notes 259-67 and accompanying text.

261. Havighurst & Tancredi, supra note 244, at 75-89. The list would include the following:
would be employed to determine the cause of the patient's injury.\footnote{262}

Patients would be compensated under MAI for medical and hospital expenses, as well as for loss of earnings incurred as a result of medical injury.\footnote{263} Compensation for "pain and suffering" would be awardable in some cases either in fixed amounts, or according to a specified percentage of medical expenses. Awards for pain and suffering would vary in amount according to whether discomfort was transitory or permanent.\footnote{264}

MAI contains other useful guidelines for a possible no-fault system. Under MAI, health care providers would be required to purchase from a private insurer a policy of "medical adversity insurance" covering their patients.\footnote{265} This policy would provide compensation for all medical and hospital expenses, as well as loss of wages up to a predetermined maximum weekly amount.\footnote{266} The system would also compensate collateral sources of recovery, thereby eliminating patient windfall.\footnote{267} In addition, statutory obligations would be imposed on health care providers to inform patients of the existence of a claim within a prescribed period of time after its recognition, or pay the amount of the claim.\footnote{268}

\begin{itemize}
  \item (1) post-operative infections;
  \item (2) thrombophlebitis and embolism;
  \item (3) catheter infections;
  \item (4) allergic reactions to antibiotics and other drugs;
  \item (5) blood transfusion reactions;
  \item (6) foreign bodies;
  \item (7) hospital accidents;
  \item (8) adverse consequences during experimental treatment;
  \item (9) secondary injuries from surgery.
\end{itemize}

Id. at 76. These events are relatively frequent occurrences and, therefore, their inclusion is meant to be suggestive only. Id. at 76. Greater specification is needed and a complete examination has yet to be undertaken. Id.\footnote{262}

\footnote{262} Id. at 76. Because these behavioral lapses are contrary to special societal expectations regarding professional conduct, their inclusion in a no-fault system would be inappropriate. Id.\footnote{263}

\footnote{263} Id. at 74.\footnote{264} Id. at 72.\footnote{265} Id. at 71.\footnote{266} Id.

\footnote{267} Havighurst & Tancredi, supra note 244, at 71. Loss of wages beyond a specified weekly level would not be compensated because persons in higher income brackets could be expected to insure themselves. The authors would also prescribe a minimum figure limiting recovery for loss of wages by people not "actually or lucratively employed—housewives, children and the poor for example." Id.\footnote{268}

\footnote{268} Id. at 72. Under current New York law, damage recoveries in malpractice actions are reduced by the amounts collected from collateral sources recovery, thus eliminating windfalls to plaintiffs. N.Y. CIV. PRAC. LAW § 4545(a) (McKinney 1963 & Supp. 1986). Under MAI, however, compensating collateral sources of recovery through the malpractice insurance policy would reduce the cost of health care and disability insurance, and employer sick-pay plans. Havighurst & Tancredi, supra note 244, at 72.
VI. Conclusion

The primary problem with Governor Cuomo's medical malpractice reform bill is that it attempts to reduce medical malpractice insurance premiums while ignoring the major flaws in the medical malpractice tort claims system. At the same time, the Bill's provisions will not make significant headway in achieving its stated objective—reducing insurance premiums.

The tort claims system is inherently time consuming, under-inclusive, and expensive. A system based on no-fault, however, will provide prompt compensation to those injured by medical accidents. In addition, it will compensate many who, despite the extent of their injuries, are currently excluded from recovery under the tort claims system. Finally, a no-fault system would eliminate the most expensive component of the tort claims system—the trial process. Unfortunately, there is, as yet, insufficient data to allow analysts to determine whether the money saved by a no-fault system would be balanced by the expense of paying the additional claims that such a system would address.

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269. Id. at 73.
270. See supra notes 224-42 and accompanying text.
271. See supra notes 199-223 and accompanying text.
272. See supra notes 224-34 and accompanying text. An article in the New York Times stated that some opponents of the medical malpractice tort claims system, including Professor Guido Calabresi, Dean of Yale Law School, have stated that malpractice litigation is "expensive, confusing and capricious; failing both to compensate many deserving victims and to punish or deter negligent doctors . . . . " Medical Malpractice: Role of Lawyers, N.Y. Times, Feb. 21, 1985, at A16, col. 4. The article further quoted Professor Calabresi as stating that "[t]he way we handle malpractice cases is quite grotesque . . . . Instead of trying to find solutions for the victim of medical catastrophes, doctors and lawyers are blaming one another and saying each is money grubbing. It's demeaning to both professions." Id.
273. See Havighurst & Tancredi, supra note 244, at 69.
274. See supra note 244 and accompanying text.
275. See supra note 114.