

MEDICAL MALPRACTICE AND TORT REFORM IN THE SOUTHEAST: IT APPEARS TO HAVE WORKED

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I. BACKGROUND

The mid 1980's played host to the second wave of tort reform efforts in state legislatures across the country. While the first wave of change in the 1970's was driven by the medical establishment, the reform effort of the 1980's was broad-based, addressing all facets of the tort system. Among the interest groups calling for more reform were representatives of property and casualty insurers (and their business insureds) as well as the health care industry.

Many of the early tort reform efforts of the 1970's were voided by the courts because of the special protections afforded the health care profession. The 70's reform efforts were ready targets of "equal protection challenges". In general terms, a legislative enactment which applies only to a narrow group of persons will not survive a constitutional challenge of "equal protection" unless the courts find a rational basis for the discriminatory treatment afforded that group. By contrast, most of the reform efforts of the mid 80's were broadly drafted to apply to all classes of tort actions. While the recent reforms have been received with more favor by the state courts, not all of the legislative efforts of the 80's have withstood constitutional scrutiny.

In addition to the general tort reform efforts of the 80's, many state legislatures also enacted tort reform provisions applicable only to medical (or "professional") malpractice claims. As would be expected, the reform statutes which have taken a more specialized approach to calls for help from the health care industry have not fared as well in the courts as the system wide tort changes.

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The purpose of this article is to outline tort reform efforts of the 80's in the southeast and to report which efforts have survived court challenges. In addition, the paper will provide a preliminary report on the effect of reforms on the cost of malpractice insurance. In that the cost of medical malpractice insurance is pegged to the payment and defense of claims, insurance cost is a strong indicator of the effectiveness of the reform efforts. Particular emphasis will be placed on the reform efforts of the states of Georgia and Florida, in that those two states expended considerable legislative energy in addressing medical malpractice issues. In that appellate cases are reaching the stage of decision on critical elements of tort reform throughout the southeast, the jury is still out on the efficacy of the recent tort reform efforts. Enough time has elapsed, however, to permit cautious generalizations of what works and what doesn't.

A. Inherent Constitutional Tension

Before analyzing the respective southeastern states reform efforts, a brief review of constitutional restraints is in order. The three main challenges faced by tort reform proponents are: (1) due process of law; (2) equal protection of law; and (3) right to jury trial. These protections are contained in the Bill of Rights of the U.S. Constitution, and have been routinely interpreted to apply in both federal and state actions (via the Fourteenth Amendment).¹ In addition, the constitutions of most states have been modeled after the U.S. Constitution, and contain similarly worded provisions. To complicate matters, courts often use the terms "equal protection" and "due process" interchangeably, without differentiating the constitutional subtleties involved.

It is the impression of this writer that reform advocates have a tendency to dismiss, or merely pay lip service to, the constitutional protections outlined above. For tort reform to be truly effective, proponents must recognize the significant protection provided by the state and federal constitutions, as well as the strong commitment of the judiciary to upholding the principles of due process and equal protection. Whether one agrees with this as "fair" in the broad sense, the depth of the judiciary's commitment to due process and equal protection should not be underestimated.

II. SUBSTANTIVE TORT REFORM CATEGORIES

The tort reform legislation of the mid 80's focused on two broad categories: (1) damage restrictions; (2) alternative dispute resolution (ADR)

¹ U.S. Const. amend. V, VII, XIV. *See generally* R. ROTUNDA, J. NOWAK, AND J. YOUNG, TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE AND PROCEDURE (1986).

mechanisms. While specifics of the reform measures were naturally framed in the context of each state's tort law, some generalizations can be made.

A. *Damages Restrictions*

1. Damage Caps

Perhaps the most significant reform measure enacted by the various state legislative bodies has been the placing of upper limits, or "caps", on the damages awarded injured parties. Caps have been applied variously to compensatory damage claims (Louisiana, \$500,000 cap on total damages recoverable for any injury of death or a patient); to non-economic damages (Alabama, \$400,000 cap on non-economic loss, and \$1,000,000 cap on wrongful death of patient); and to punitive damages (Georgia, \$250,000 punitive cap.) Constitutional challenges to the cap provisions have been undertaken in all states where enacted. The judicial response to these challenges has been varied, as will be noted in the state by state analysis.

2. Periodic Payment of Future Damages

Another damage limitation mechanism adopted with some frequency in the 80's was the requirement that the payment of damages for future projected medical costs be made on a periodic basis. The payment provisions were enacted to reflect both the time value of money and to avoid unintended windfalls for the families of injured parties. In the southeast, the states of Alabama, Florida, Louisiana, and South Carolina provide for periodic payment of damages. As of this writing, none of the southeastern states periodic payment statutes have been successfully challenged, although cases in Kansas, New Hampshire, and North Dakota have held their states' respective statutes to violate constitutional provisions of due process and/or equal protection.

3. Collateral Source Rule

The "collateral source" rule of evidence traditionally prohibited defendants from introducing any evidence that a patient had been reimbursed by other sources for the costs associated with the injury claim. A popular tort reform measure of the 1980's was the repeal of the collateral source rule, thereby permitting evidence of other payment sources to be admissible. Some states mandate an offset for collateral payments, while others merely permit the jury to hear the evidence as one of the factors to consider in determining damages. In the southeast, the states of Alabama, Georgia, Florida and Tennessee have adopted collateral source reform.

4. Joint and Several Liability

A separate category of damage reform in the 80's was designed to change the common-law rule of joint and several liability. Under the doctrine of joint and several liability, a plaintiff could recover the entire amount of his damages from any of the defendants, regardless of the degree of culpability of a particular defendant. The reform legislation requires the fact finder to apportion liability among the various defendants. This reform was designed to address the perceived tendency of juries to focus on "deep pocket" defendants without regard to finding of relative fault. In the southeast, the states of Florida, Georgia, and Mississippi have all modified joint and several liability rules. Joint and several liability is one of the least controversial elements of tort reform, and no reported cases have been found in which changes of the rule have been successfully challenged.

It is premature to state with certainty the net economic consequences of damage restriction efforts, but the initial results indicate that they have played a significant role in stabilizing malpractice insurance rates.

B. *Alternative Dispute Resolution (ADR) Mechanisms*

One of the more controversial elements of tort reform is the attempt by health care professionals to take the fault finding mechanism away from juries. ADR efforts have fallen into two general categories: (1) pre-trial screening panels; and (2) binding arbitration.

1. Pre-trial Screening

Pre-trial screening panels, in which medical malpractice claims are reviewed by a panel of medical experts as a precondition to filing suit, enjoyed favor in the late 70's and 80's. Approximately one-half of our states have adopted some form of pre-trial screening mechanisms. Typically, the panel's authority extends to findings of fault as well as recommendations of damages. In none of the states is the panel decision binding on the parties, but is merely a condition precedent to initiating litigation. In some states, the panel's findings are admissible at a subsequent trial.

There is little empirical evidence that the screening panel is cost effective in either reducing litigation or serving as an efficient filter of non-meritorious claims. A leading health care economist concluded after rigorous study that the screening panels were not effective in achieving either objective.² The

southeastern states of Florida and Louisiana have legislatively mandated pretrial panels. Florida's statute did not survive a constitutional challenge.

A new type of screening device has recently been employed by the states of Georgia and Florida. In those states, a plaintiff must secure an expert's affidavit as a precondition to suit. The affidavit must reflect the expert's opinion that facts exist to support the claim of professional negligence. The "affidavit" model seems to achieve much of the screening objective at a low cost to the system.

2. Binding Arbitration

By contrast to the pre-trial screening panels, the binding arbitration model of ADR is designed as an alternative to the jury trial system. To date, no state has attempted to impose binding involuntary arbitration on a party. The constitutional right to jury trials in tort actions is a cornerstone of our system of jurisprudence. Creative advocates have attempted to create a model of binding involuntary arbitration that would withstand a constitutional challenge.

a. Involuntary Binding Arbitration: The AMA Model

The American Medical Association (AMA) has developed and is promoting an administrative panel model to be used in lieu of jury trials for resolving medical malpractice disputes.³ The AMA model adapts its framework from state workers compensation statutes. There is, however, one important difference. Under the AMA model, the administrative panel would first determine "fault", and then assess damages. By contrast, the workers compensation model is not concerned with whether the employer or employee was negligent, but merely whether the employee was injured in connection with employment activities.

No state has adopted the AMA model to date, but significant efforts are continuing on behalf of the medical association. The Georgia General Assembly has seriously debated the AMA model in the past two sessions, and it remains a top legislative priority of both the Medical Association of Georgia and its OB/GYN Section.⁴ On the national level, an industry

³American Medical Association Specialty Society Medical Liability Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based Administrative System*, Chicago (January, 1988) (hereinafter AMA Plan).

⁴In the 1990 session of the Georgia General Assembly, Senate Bill 553 passed the Senate, but was stalled in the House. Senate Bill 553 was modeled after the AMA Plan. During the 1991 Session, the Georgia OB/GYN Society prepared and circulated for discussion a proposed Code for Obstetrical Medical Malpractice Adjudication.⁵ The OB model is essentially the AMA Plan, but would only be available to OB physicians who certified that they extended significant services to the undeserved (L⁵, Medicaid) obstetrical patients. The OB plan was not formally proposed.

funded study was recently conducted by the Program for Health Science and Law of Georgetown University, which urged its adoption on a pilot basis.⁵

b. No-fault Model

A no-fault model for addressing severe neurologically impaired infants has recently been adopted by legislatures in both Virginia and Florida.⁶ The Florida version of no-fault will be discussed below. While it is too early to assess the effectiveness of the no-fault plans, medical experts have expressed the opinion that because of the narrow definition of "neurologically impaired infant" contained in both the Virginia and Florida statutes, only a few individual claimants will be eligible annually. Regardless of its limited scope, the no-fault model of those states presents an excellent opportunity for reform advocates to study its effectiveness in practice.

C. Voluntary Contractual Model

The more traditional binding arbitration model provides for a voluntary contractual agreement between the health care provider and patient. The contract provides that the parties will submit all disputes arising from the treatment of the patient to binding arbitration. The effect of a contract of this nature is to waive the patient's constitutional rights to a jury trial.

Somewhat surprisingly, the courts generally approve of these contractual waivers, so long as sufficient safeguards are present to ensure that the waivers are knowingly and freely made. For example, the Michigan medical malpractice arbitration statute requires that the waiver clause be explained to the patient; that an agreement to arbitrate not be required as a condition of treatment; that the agreement may be rescinded by the patient within 30 days of completion of treatment; and that the patient must have had the capacity to understand the consequences of the waiver.⁷ The Michigan statute was upheld by that state's Supreme Court.* A similar contractual based arbitration statute has passed constitutional muster in California.⁹

In the southeast, only Louisiana has a statute permitting pre-dispute arbitration contracts to be entered into. Both Alabama and Georgia permit arbitration after disputes arise, if all parties are willing to submit the claims

in 1991, but will probably be introduced in 1992.

⁵Va. Code Ann. § 38.2-5000 et. seq. (1988); Fla. Stat. § 766.303 (Supp. 1988).

⁶Medical Malpractice Alternatives Evaluation Project of the Program for Science and Law, Georgetown University Medical and Law Centers. The report, "An Assessment of Organized Medicine's Administrative Alternative for Resolving Medical Liability Disputes", was released in March of 1991.

⁷Mich. Comp. Laws Ann. § } 500.3053-3061 (1983) and } } 600*041.5044 (Supp. 1985). *Melnsty v. Valley OB-GYN Clinic, 405 N.W.2d 88 (Mich. 1987).

⁹Doyle v. Guiliucd, 401 P.2d 1 (Cal. 1965)

to arbitration. Needless to say, the Alabama and Georgia statutes are rarely, if ever, used.

Florida has recently adopted a unique and creative model which deserves study. While the ADR Florida model is voluntary, it provides economic incentives for both parties to utilize arbitration, and economic disincentives if one party wishes to arbitrate and the other party refuses. The Florida statute will be discussed more fully under the state section below.

III. STATE BY STATE REPORT

This section of this paper will catalog recent reform legislation in the southeast and judicial response to the reform.

A. ALABAMA

The State of Alabama has been in the forefront of tort reform in our region. Both the legislature and the courts of Alabama have been active over the past decade.

1. Damage caps

Alabama adopted a three part damage cap scheme in 1987.¹⁰ The caps are as follows:

- (1) non-economic loss \$400,000;
- (2) punitive damage caps (excluding wrongful death cases) \$250,000;
and
- (3) medical malpractice wrongful death cap: \$1,000,000 dollars.

The recent United States Supreme Court decision of *Pacific Mutual Life Insurance Company v. Haslip*¹¹ approved Alabama's regime for imposing punitive damages. Two recent cases from the Alabama Supreme Court have also addressed the validity of damage caps. The case of *Killough v. Jahandarfarid*,¹² decided in February of 1991, held that excluding wrongful death actions from caps did not violate the equal protection clause of the Alabama constitution. In *Killough*, the Court approved the legislative determination that a monetary cap should not be placed on the value of human life, as contrasted with other causes of action. In a decision the following month, *Armstrong v. Roger's Outdoor Sports*¹³ the Alabama

¹⁰Ala. Code § 6-5-544 et. seq.

¹¹59 LW. 4157 (March 4, 1991)

¹²Ala. Sup. Q. No. 89-925, 59 LW 2539, March 12, 1991.

¹³Ala. Sup. CL No. 88-1190, 59 LW. 2571 (March 26, 1991).

Supreme Court held that the provision of the punitive damage statute directing state trial and appellate courts to accord no presumption of correctness to jury awards in its post-trial review violated the separation of powers clause of the Alabama Constitution. The dissent in *Armstrong* pointed out that this very provision had been expressly approved by the U.S. Supreme Court in *Pacific Mutual*. The U.S. Supreme Court had relied on Alabama's post-trial judicial review process to ensure "meaningful and adequate review by the trial court whenever a jury has fixed the punitive damages".¹⁴

It can be argued that *Armstrong* undercuts the rationale of the U.S. Supreme Court's decision in *Pacific Mutual*. The realities of the discretionary Supreme Court review practice suggests that the U.S. Supreme Court is not likely to re-open the Pandora's box of punitive damages in the near future. The implication of the *Armstrong* decision for tort reform in Alabama is that judicial review of punitive damage awards must be conducted under a presumption that the jury award is valid. As a result of the *Armstrong* decision, the judiciary in Alabama will be less likely to reduce large punitive damage awards in the future.

2. Periodic Payment of Damages

The 1987 Alabama tort reform statute mandated periodic payment of future damages in excess of \$150,000; and provided for discretionary payment of future awards over \$100,000.¹⁵ The statute is only applicable to medical malpractice cases. In that the statute protects only a narrow class of defendants, it will likely be challenged under an "equal protection" argument. No appellate decisions have addressed this issue to date.

3. Collateral Source Rule

The 1987 Alabama reform efforts included a modification in the common law collateral source rule.¹⁶ Under the reform legislation, evidence of collateral source payments is admissible, but it is within the discretion of the fact finder as to whether to offset the payments against damages.

4. Alternative Dispute Resolution

Alabama law has permitted voluntary arbitration of malpractice disputes since 1975.¹⁷ Like many of the other first generation reform statutes, the arbitration applies only to agreements to submit claims to arbitration after a

¹⁴59 LW. 4157, at 4162.

¹⁵Ala. Code § 6-5-486, 543.

¹⁶Ala. Code § 6-5-545.

¹⁷Ala. Code § 6-5-485.

dispute arises. If the Alabama experience is anything like that of her neighboring state of Georgia, this provision is rarely used.

B. GEORGIA

In 1987, the state of Georgia passed a comprehensive tort reform package after prolonged debate in the General Assembly.^{1*} The package included general reform measures as well as medical malpractice specific reform. It is interesting to note that key legislative participants in the debate (including the current Governor and Lieutenant Governor) were quoted in the local press as not expecting the changes to reduce the cost of medical malpractice insurance. In the words of then Lt. Governor Miller, "The best we can hope for is some leveling off [of premiums].¹®

In fact, Georgia experienced a rather sharp decrease (22%) in the cost of malpractice insurance during the years immediately following implementation of the reform legislation, and a subsequent leveling off of premiums.²⁰ Information provided by the MAG Mutual Insurance Company during 1990 hearings of the Governor's Commission on Obstetrics confirmed this report but noted a developing trend of increased claims filings during the first nine months of 1990. Informal conversation with insurance industry representatives reveal that the increased claims have not translated into higher premiums, and that malpractice premium costs are not likely to be increased in 1991.

1. Damage caps

There is no general cap on non-economic damages in Georgia. Punitive damages are, however, capped at \$250,000 with the exception of product liability cases, which have no monetary caps. The Georgia reform statute provides that where there is a finding of specific intent to harm, punitive damage caps do not apply.²¹

As would be expected, the plaintiffs trial bar in Georgia has attacked the constitutionality of the punitive damage caps. In a well publicized decision by a Federal trial Court in the Middle District of Georgia, the punitive damage cap was found to be arbitrary, and violative of the due process and equal

¹For a detailed account of the debate in the Georgia legislature, see Note, *Tort Reform*, 3 GA. ST. L. REV. 519 (1987).

²⁰*Id.* at 536, Note 147, citing Strauss 'Experts Doubt Effects of Tort Bills,' Atlanta J. & Const., Jan. 18, 1987 at 1A, col.4.

²¹Mantius, 'Insurance Firm to Cut Malpractice Rates 22%', Atlanta Const., May 31, 1989, at **Bl.coLi**.

[®]O.CGA § 51-12-5.1 (9) (Supp. 1987).

protection clauses of the State and the Federal Constitutions.²² In September of this year, the Georgia Supreme Court ignored the Federal trial court ruling in upholding the constitutionality of the state cap on punitive damages. See *Bagley v. Shortt*, Sup. Ct. Docket No. S91A0662.²³

2. Collateral Source

The 1987 tort reform effort included a discretionary offset collateral source rule similar in design to the Alabama statute.²⁴ In March of 1991, the Georgia Supreme Court held, in the case of *Denton v. Con-way Express*²⁵ that the reform effort violates the equal protection clause of the Georgia Constitution. The decision focuses on unique language in the Georgia Constitution which provides that

"protection to person and property is the paramount duty of government and shall be impartial and complete. No person shall be denied the equal protection of the laws".²⁶

Focusing on the underlined portion of the state constitutional provision, the Court found that permitting evidence of plaintiffs collateral insurance sources to be considered, but not that of defendants, was not "impartial". The *Denton* case may not be a definitive statement of the law in Georgia, in that it was a 3-2-2 decision, with two justices sitting by special designation. The landmark *Bagley v. Shortt* decision noted in the section above made no attempt to reconcile its reasoning with that of the *Denton* opinion. Until this ambiguity is resolved, the status of tort reform in Georgia will remain unclear.

3. Joint and Several Liability

The Georgia reform also included a modification of the traditional joint and several liability rule. Under the new standard, where a plaintiff is to some degree responsible for the injury, the trier of fact may apportion damages among the several defendants.²⁷ Where the plaintiff is totally "fault

²²McBride v. General Motors Corp. D.G.M.D. Ga. No. 89-II0-COL, April 10,1990,58 LW. 2647 (1990).

²³Bagley v. Shortt, No. S91A0662, September 5,1991. Fulton Co. Daily Report, Sept. 9,1991, at 3B. The 5-1 decision, authored by Justice Weltner, stated succinctly that "If punitive damages lawfully may be eliminated... then they may be circumscribed, as in this code section. OCGA § 51-12-5.1(g) is not unconstitutional."

²⁴O.CGA § 51-12-10) (SUPP- 1987).

²⁵Denton v. Con-Way Express, Inc., No. 590A1101 & S90A1245, March 15,1991 Fulton Co. Daily Report, March 20, 1991 at 9 (B), Col.1.

²⁶Ga. Const. Art. 1, Sec.1, Par. II (1983)

²⁷O.CGA § 51-12-33 (Supp. 1987).

free", the old rule is not changed. This distinction appears to be the product of a legislative compromise. No judicial challenges to this section of the tort reform package have reached the appellate level. In that the provision is less controversial than other elements of the tort reform package, it has received little attention by either the legal community or general press. In the context of medical malpractice, it is common for plaintiffs to name both physicians and hospitals in the Complaint. Since patients are typically "fault free", the reform legislation has no effect in the majority of cases.

4. Alternative Dispute Resolution

Since 1978, Georgia's arbitration statute has permitted a voluntary binding arbitration option, if agreed to by both parties after the claim arises.²⁸ Most attorneys in the state are not even aware of this provision, and it is rarely used. Plaintiffs attorneys typically do not consider it in their client's best interest to waive a jury trial after a claim has arisen. There is no economic incentive built into Georgia's statute to encourage its usage.

5. Affidavit of Professional Negligence

The 1987 reform effort produced a little publicized example of tort reform legislation which appears to be achieving its objective. In all claims of professional negligence (including medical malpractice) the plaintiff must include with his complaint an affidavit of an "expert competent to testify" which "shall set forth specifically at least one negligent act or omission claimed to exist and the factual basis for each such claim".²⁹

Although enacted as a section of the Medical Malpractice Act of 1987, the wording has been construed as sufficiently broad to encompass all professionals, including attorneys, accountants, architects and engineers.³⁰ As amended in 1989, the statute provides that failure to file an affidavit with the Complaint will subject the Complaint to dismissal for failure to state a claim. This defect "cannot be cured by amendments" [to the Complaint]³¹

In that the statute is procedural in nature, and took effect in July of 1987, there has already been a significant amount of appellate legislation challenging and interpreting this statute. The Georgia appellate courts have generally been hospitable to this new procedure.³² The courts have

²⁸O.CGA § 9-9-110 et. seq.

²⁹O.CGA § 9-11-9.1 (Supp. 1987).

³⁰Frazier v. Merritt, 380 S.E.2d 495 (Ga. App. 1989) (legal malpractice); Housing Authority v. Gilpen *et al.*, 383 S.E.2d 867 (Ga. 1989) (Architectural malpractice).

³¹O.CGAL j 9-11-9.1(e) (Supp. 1989).

³²Padgett v. Crawford, 376 S.E.2d 724 (Ga. App. 1988); Piedmont Hospital v. Milton, 377 S.E.2d 198 (1988).

interpreted the affidavit requirement as one in which the expert must, at a minimum, have reviewed the medical file of the patient. The affidavit requirement is not as stringent as that needed to survive a Motion for Summary Judgment, but must have some factual basis to support the claim.

Practitioners feel that the affidavit requirement has been quite successful in weeding out claims with little or no merit. If a claimant (or his attorney) incurs the expense and effort to procure an expert affidavit, the claim will generally have been seriously considered. Despite the fact that cynics will point out how easy it is for one to obtain the affidavit of a "professional" affidavit giver, the record reflects that the number of medical malpractice claims filed have been significantly reduced as a result of the affidavit requirement. The MAG Mutual Report to the Governor's Commission on Obstetrics revealed that on an annualized frequency per 100 physicians, claims had declined from 5.5 in 1987 to 4.4 in 1988 and 4.3 in 1989.³³

It appears to this writer that Georgia's expert affidavit requirement is a cost effective alternative to pre-trial screening panels. Practitioners who are forced to prepare a claim for pre-trial screening must undertake essentially the same investigation and file review by an expert as is required by Georgia's affidavit statute. It is submitted that Georgia's affidavit requirement serves the same purpose as a pre-trial screening panel without the costs, delays, and frustrations that many of the states have experienced with the screening panel mechanism. Georgia's experience with the affidavit requirement model gives a framework for ready adaptation by other states interested in controlling the rate of non-meritorious claims in an efficient fashion.

6. Other Reform Measures in Georgia

The 1987 Georgia tort reform efforts incorporated three other changes in the law of this state. The first provided for formal additur and remitter powers of the trial court where inadequate or excessive awards are found to be inconsistent with the preponderance of the evidence.³⁴ Some practitioners feel that this power had always been inherent in trial courts of our state, although many trial judges had been hesitant to invoke that discretionary power. Although the power is still discretionary, courts should be more comfortable exercising their review power when faced with "runaway" jury awards. No empirical evidence has been published which would shed light on the effect of the newly expanded role of the trial judge in jury trials.

A second change provided for charitable immunity of health care practitioners when the provider "without the expectation or receipt of

³³Correspondence from Thomas M. Gose, President of MAG Mutual Insurance Co. to OB Commission Member Andrew Owen, dated September 6, 1990. A copy is on file at Georgia State University.

³⁴O.C.G.A. § 51-12-12(a) (Supp. 1987).

compensation" provides professional health care services." Nothing is known of the extent of use of this provision by the medical community.

A final reform effort in the 1987 medical malpractice package was the provision of a statute of repose for the treatment of minors. Although the two year tort statute of limitations applies to minors and incompetents as well, the statute of limitations is tolled until the minor reaches the age of five. Because of the transition rules applicable to the new limitations, it is premature to attempt to assess the effectiveness of these constraints on reducing malpractice actions.

The "foreign objects" rule was not changed. All patients, including minors and incompetents, may file suit within one year after discovery of a foreign object left in a patients body.⁵⁴

C. FLORIDA

Florida's legislature has been particularly active with tort reform measures in the past decade. Some of the state's earlier tort reform efforts were overruled by the Florida courts as violative of the state's constitution. The recent reforms appear to have been more carefully considered, and are more likely to withstand the constitutional challenges that lie ahead.

1. Damage Caps

Florida passed a general purpose damage cap of \$450,000 in 1986. The legislative act was quickly declared unconstitutional by the Florida Supreme Court.³⁷ Subsequent legislative acts have been more narrowly drawn. Florida's punitive damages statute currently limits punitive damages to an amount three times that of actual damages.³⁴ In view of the recent U.S. Supreme Court's decision in *Pacific Mutual*, Florida's statute would appear to pass constitutional muster.

³⁷O.C.G.A. { 9-3-73(b) (Supp. 1987). *Also* O.C.G.A. { 9-3-71(a) (Supp. 1987).

³⁴O.C.G.A. { 9-3-72 (Supp. 1987).

³⁴Smith v. Department of Insurance, 507 So.2d 1080 (1987).

⁵⁴Fla. Stat. } } 768.73-74 (Supp. 1986).

2. Periodic Payments of Future Damages

Florida's tort reform statute mandates periodic payments of future damages when the award exceeds \$250,000.³⁹

3. Alternative Dispute Resolution

Florida adopted a mandatory pre-trial screening panel system in 1975. Because of extensive delays in the hearing process, which resulted in more than 50% of the cases being removed from pre-trial screening prior to completion of the process, the Florida Supreme Court found in 1980 that the statute violated due process.⁴⁰ That decision was based on the arbitrary application of the statute in the state; not the mechanism itself.

As a result of its unsuccessful experimentation with pre-trial screening, Florida attempted to take a different approach. In 1986, the legislature created an academic task force, composed of the Presidents of The University of Florida, Florida State University, and the University of Miami, as well as two prominent business persons.⁴¹ The task force assembled a research staff of academic experts in law, insurance and medicine (including Professor Bernard L. Webb of the Insurance Department of Georgia State University). The legislature relied heavily on the academic task force findings and recommendations in formulating the 1988 medical malpractice reforms. At the heart of the task force report was a detailed study of all closed claims between 1975 and 1986.⁴² As a result of the rigorous and unbiased study undertaken by the academic task force, most of the panel recommendations were accepted by the Florida legislature.

4. Affidavit of Professional Negligence

In 1988, Florida adopted its version of the medical expert opinion affidavit requirement.⁴³ It is similar to the one imposed by Georgia the prior year. The Florida statute requires that the expert state there are "reasonable grounds to support the claims of medical negligence". In support of the affidavit requirement, the Florida statute expressly permits pre-suit discovery

³⁹Fla. Stat. § 768.78 (Supp. 1986).

⁴⁰*Aldana v. Holub*, 381 So.2d 231 (Fla. 1980).

⁴¹Tedcaatle and Dewar, *Medical Malpractice: A New Treatment for an Old Illness* FLA. ST U.L. REV. 535, 543 (1988).

⁴²The study methodology and empirical findings are reported in Nye, Gifford, Webb & Dewar, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L. J. 1495 (1988).

⁴³Fla. Stat. § 766.203 (Supp. 1988).

of all medical records, but does not require defendants to submit to interrogatories or depositions prior to institution of litigation.

The Florida statute further requires plaintiff to send a pre-suit notice of intention to file a claim 90 days before filing.⁴⁴ The purpose of this provision is to encourage settlement of claims at an early stage, and thus reduce the transaction costs associated with civil litigation.

As a "quid pro quo" for the plaintiffs affidavit requirement, Florida's reform statute also requires defendants to obtain an expert opinion affidavit prior to denying the claim.⁴⁵ Like the plaintiff's affidavit, the opinion of the defendant must reflect the existence of "reasonable grounds of lack of negligent injury sufficient to support the response". The trial court is authorized to dismiss claims or strike defenses where the expert corroboration requirements have not been complied with.

5. Voluntary Binding Arbitration

After reviewing various voluntary arbitration models, the Florida task force concluded that few plaintiffs will agree to binding arbitration unless there are sufficient incentives to waive trial by jury. Under the Florida plan, where defendants are willing to admit liability and arbitrate the damage issues, the plaintiff is relieved of the burden of proving liability.⁴⁶ If a plaintiff agrees to a defendant's offer of arbitration, attorney's fees (up to 15% of the award) are recoverable from the defendant. Where the plaintiff offers to arbitrate and the defendant refuses, the plaintiff is entitled to attorney's fees (computed as 25% of the trial award), as well as pre-judgment interest.

A primary disincentive for a Florida plaintiff to accept an offer of arbitration is the cap on non-economic damages. In arbitration, the cap is \$250,000.⁴⁷ If the defendant's offer to arbitrate is refused, non-economic damage caps at trial are increased to \$350,000. In effect, the Florida statute provides non-economic damage caps at the \$250,000 or \$350,000 level, under any forum when the defendant offers to arbitrate.

Under the Florida arbitration statute, decisions of all issues are made by a three person panel (composed of a state appointed hearing officer and a representative from the plaintiff and defense side).⁴⁸ Defendant's are responsible for paying the cost of the two public arbitrators. The arbitration procedure calls for a bifurcated panel. The first panel determines damages, including past and future medical expenses (less collateral source payments

⁴⁴Fla. Stat. § 768.57 (1985).

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for which no right of subrogation exists); 80% of lost wages; and noneconomic damages up to \$250,000. If there are multiple defendants, a second arbitration panel is convened to allocate responsibility among the various defendants.⁴⁹

6. No-fault plan for birth related injuries

Florida's 1988 tort reform effort included a cautious dip in the waters of no-fault. Like the pioneering Virginia no-fault plan, Florida provides for full recovery of the economic cost of treating and caring for brain damaged infants, without regard to fault.⁵⁰ The definition of a qualifying injury is, like that of the Virginia statute, very narrow, and extends only to infants weighing at least 2500 grams at birth, and in which the injury was

"caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired...."³¹

The scope of the Florida plan is only slightly less restrictive than the Virginia plan, which applies to injuries

"... which render the infant permanently non-ambulatory, aphasic, incontinent, and in need of assistance of all phases of daily living".³²

Under the Florida plan, it is left to the State Workers Compensation Board to determine whether the injury is within the scope of the statute, as well as the compensation to be awarded for present and future medical expenses. Additionally, periodic or lump-sum payments may be awarded to the parents (not to exceed \$100,000). Expenses, including attorney's fees, also may be recovered.³³

To fund the plan, assessments are made against all physicians and hospitals. Initially, OB's were assessed \$5,000 annually and other physicians \$250 annually. The funding mechanism survived an early court challenge by

⁴⁹Fla. Stat. § 766.206 (Supp. 1988).

⁵⁰Fla. Stat. § 766.303 (Supp. 1988).

⁵¹Fla. Stat. § 9766.302(2) (Supp. 1988).

general practice physicians claiming the monetary assessment violated their equal protection rights.³⁴

It is too early to determine what effect, if any, Florida's creative reform measures will have on the incidence of claims, the cost of malpractice insurance coverage, and the related transactions costs to the health care system. The Florida reforms appear to represent a balanced well reasoned approach to medical malpractice claims, while not ignoring the constitutional rights of injured parties.

D. LOUISIANA

Louisiana was in the forefront of the first generation of malpractice reforms. Louisiana enacted reform legislation in 1975, and has remained active in the 15 intervening years. Because of the relatively long period that these reforms have been in place, one would have expected economists and academics to have conducted in depth evaluations of Louisiana's efforts. However, no economic or legal studies of the Louisiana experience surfaced in the literature search.

1. Damage Caps

Louisiana's medical malpractice statute was modified in 1975 to place a cap of \$500,000 for all damages except future medical care and benefits.⁵³ The caps were found to be constitutional by the Louisiana Supreme Court in a 1989 challenge.⁵⁴

2. Periodic Payments

In 1984, the Louisiana statute was amended to provide for periodic payments for future medical costs when judgements exceed \$500,000. The source of the periodic payments is the state's payment compensation fund.⁵⁷ No judicial challenge to this part of the Louisiana plan was reported.

3. Pre-trial Screening Panel

Louisiana was one of the first states in the nation to enact pre-trial screening panels, making them mandatory in 1976. The Louisiana statute

⁵³McGibony v. Birth-Related Neurological Injury Compensation Plan, 564 So.2d 177 (Fla.

App. 1 Dist. 1990).

"La. Rev. Sui. Ann. 40:1299.42.

"Williams v. Kushner, 549 So.2d 294 (La. 1989).

"La. Rev. Sut. Ann. 40:1299.43.

permits panel findings to be admissible in evidence at subsequent trials.^{3*} The screening panels survived constitutional challenges in 1978 and 1981.³⁹

4. Arbitration

Since 1975, Louisiana has permitted binding medical malpractice arbitration contracts to be entered into before disputes arise.⁴⁰ The statute provide procedural protections for patients, including giving the patient an option to void the agreement within 30 days of execution. No cases were found interpreting the Louisiana arbitration statute, and it is not known whether health care providers rely upon the contract option with any degree of frequency. The lack of case law suggests it is not routinely used.

E. MISSISSIPPI

No tort reform efforts have been undertaken in Mississippi, with the exception of modification of the common law of joint and several liability in 1989.⁶¹

F. TENNESSEE

The only reform effort reported in Tennessee is a modification of the collateral source rule. Tennessee's version, passed in 1975, provides for mandatory offset of collateral payment in medical injury actions, but exempts privately purchased insurance from the collateral source rule.⁶²

G. NORTH CAROLINA

No tort reform efforts have been undertaken in North Carolina.

H. SOUTH CAROLINA

1. Periodic payments

A 1976 revision to the South Carolina tort statute provides the court with discretion to provide for periodic payment of damages in excess of \$100,000.⁶³

³La. Rev. Stat. Ann. 40:1299-47.

³⁹Everett v. Goldman, 359 So.2d 1256 (La. 1978); Derouen v. Kolb 397 So.2d 791 (La. 1981). ⁴⁰La. Rev. Stat. Ann. 9:4230 et. seq.

⁶¹Mis*. Code Ann. } 85-5-7 (Supp. 1989).

⁶²Tenn. Code Ann. § 29-26-119.

⁶³S.C Code Ann. § 38-79-480.

The chart attached as Appendix "A" reflects, in broad outline, the status of tort reform efforts in the southeast as of fall, 1991. Until the current round of constitutional challenges have run their course, we will not know how many of the reform efforts will survive.

IV. PRELIMINARY ANALYSIS OF EFFECTIVENESS OF TORT REFORM

A rough measure of tort reform effectiveness is found in the claims data released by St. Paul Fire and Marine Insurance Company, the nation's largest malpractice insurer. St. Paul reports that nationally, claims filed peaked at a rate of 17.3 per 100 physicians in 1985, then decreased annually to a level of 13.0 in 1988. This was the lowest rate recorded by St. Paul since 1982.⁶⁴

The American Medical Association reports claims data and insurance costs by census region. In the South Atlantic census region, which includes most of the states included in our report, annual claims per 100 physicians decreased from 7.0 in 1985 to 4.7 in 1988, for an annual average rate of change of -12.4%."

A more accurate gauge of tort reform effectiveness is malpractice insurance cost. The cost of medical malpractice insurance is directly correlated with the payment and defense of tort claims. Two recent rigorous studies of malpractice insurance concluded that insurers' profits on malpractice lines during the past decade have not been excessive; and during some years of the mid-80's produced dramatic losses.⁶⁶ The Nye, et.al. study of over 21,000 claims filed in Florida between 1975 and 1985 concluded that

The primary cause of increased malpractice premiums measured over the last nine years is found to have been the substantial increase in loss payments to claimants."⁶⁷

Accordingly, a comparison of the cost of malpractice insurance during the pre-reform years of 1985-86 with the post reform year of 1989-90 should

"St. Paul Fire and Marine Insurance Company 'Physicians' and Surgeons Update: The St. Paul's 1989 Annual Report to Policyholders." St. Paul, Minnesota. May 1989 as reported in U.S. House of Rep. Comm. on Ways and Means Report, "Medical Malpractice", April 26, 1990, at p.

12.

"GONZALES AND EMMONS, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE: 1969. American Medical Association, Center for Health Policy Research, Chicago 1990, p.4.

"Nye *M-OL*, *supra note* 42.5m also Hansan, *How Profitable Is Medical Malpractice Insurance*, 28 INQUIRY 74, (1991). (INQUIRY is a publication of the Blue Cross and Blue Shield Association).

"Nye *et.al.* 1499.

provide a preliminary basis for testing the effectiveness of tort reform in reducing litigation and claims costs.

The dramatic increase in malpractice premiums in the mid-80's provided much of the impetus for the recent wave of tort reform. Nationally, the average professional liability premiums paid by physicians increased at an 18.3% annual rate from 1982 to 1988, reflecting an inflation adjusted cost to the physician of \$5,800 in 1982 versus \$13,000 in 1988.⁶⁹ This pattern held true in the South Atlantic census region for the years under study.

As the tort reforms of 1987-1988 were put into place, malpractice premium costs tended to stabilize. Nationally, the mean professional liability premiums increased only \$900 from 1987 to 1988.⁶⁹ Unfortunately, the most recently reported cost data from the AMA is 1988.

Current insurance cost data is available for the State of Georgia. In Georgia, the medical malpractice market is divided almost equally between St. Paul Fire and Marine and the physician owned MAG Mutual Insurance Company. Both St. Paul and MAG Mutual produced comprehensive premium cost information to the Governor's Commission on Obstetrics in the fall of 1990. An analysis of the premium data trend, as reflected in the following chart, is illuminating.

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RATE CLASSIFICATION HISTORY LIMITS: \$1,000,000 each loss/\$ 1,000,000 aggregate Annual Mature Claims Made Policy

YEAR	MAG Mutual		St. Paul	
	Amount	% Change	Amount \$	% Change
1982	\$ 1,467	-	-	-
1983	1,739	18.5	1,739	-
1984	2,293	31.9	1,996	14.8
1985	3,012	31.4	2,532	26.9
1986	4380	45.4	3,134	23.8
1987	5,898	34.7	6,473	106.6
1988	7,050	19.5	7382	14.0
1989	6,541	(7-2)	7324	1.9
1990	6,541	(0)	6,636	(11.8)
1991*	6,541	(0)	6,492	(2.2)

YEAR	MAG Mutual		St. Paul	
	Amount	% Change	Amount	% Change
1982	\$ 10,003	-	\$ -	-
1983	12,701	27.0	12,701	-
1984	16371	32.8	14,744	16.1
1985	22389	34.5	18,949	28.5
1986	35306	563	23,781	25.5
1987	46,791	313	53342	123.0
1988	56,157	20.0	60320	14.1
1989	46376	(163)	62,715	3.6
1990	46376	(0)	50,498	(193)
1991*	46376	(0)	43,985	(12.9)

Source: Data provided by H. Andrew Owen, Esq. to Governor's Commiion on Obstetrics, Correspondence of Nov. 8,1990.

- 1991 Rates verified by telephone conference with Mr. Owen on May, 1991. As a practical matter, OB/GYN-Surgery specialists (Class 7) are underinsuredat the above minimum limits. Many choose to purchase limits of \$2,000,000 or \$3,000,000, with premiums being 30% to 50% higher.

This data reveals a direct relationship between the institution of significant tort reform measures in the state of Georgia (1987) and the cost of malpractice insurance. An almost decade long trend of increased premiums was dramatically reversed, and then stabilized. While one can never establish with 100% certainty that the reform measures caused the reversal, no other explanation has been put forward by participants.

It would be helpful to compare data from other states who have taken similar reform measures, and to contrast reform states insurance cost experience with states (such as North Carolina, Tennessee and Mississippi) who did not enact tort reform measures. The premium cost data to allow these comparisons should be available by year end. If the results from Georgia are reflective of the general pattern, we can conclude that the tort reform movement of the mid-80's achieved an important objective, i.e. the stabilization of malpractice insurance premiums.

V. CONCLUSION

In that most of the reform efforts have been in place approximately five years, it is suggested that sufficient time has elapsed for interested persons to begin to evaluate whether tort reform of the mid 80's achieved all, some, or none of the legislative objectives. Insurers, insureds, and regulators are urged to share data with one another and with the academic community. Empirical research depends upon the free flow of claims and cost data. The academic community looks forward to working with the bar, health care providers, and insurers in an effort to craft a tort system that is both fair to all participants and efficient in achieving the goal of social justice.