Approved 4/12/85
Date

MINUTES OF THE House COMMITTEE ON Judiciary.

The meeting was called to order by Representative Joe Knopp at
Chairperson

3:30 ~~a.m.~~/p.m. on March 26, 1985 in room 526-S of the Capitol.

All members were present except:

Representatives Duncan, Harper and Luzzati were excused.

Committee staff present:
Jerry Donaldson, Legislative Research Department
Mike Heim, Legislative Research Department
Mary Ann Torrence, Revisor of Statutes Office
Mary Hack, Revisor of Statutes Office
Becca Conrad, Secretary

Conferees appearing before the committee:

Jerry Slaughter, Kansas Medical Society
Linda Warren, M.D. from Hanover, Kansas
Sister Elizabeth Stover, Administrator of St. Joseph's Hospital in Concordia, Kansas
Harold Riehm, Kansas Association of Osteopathic Medicine
James Rider, D.O., Valley Falls, Kansas
Homer Cowan, Western Casualty Insurance Company, Ft. Scott, Kansas
Bill Sneed, Legislative Counsel for the Kansas Association of Defense Counsel
Wayne Probasco, Kansas Podiatry Association
Sherman Parks, Executive Director of the Kansas Chiropractic Association
Ken Schafermeyer, Executive Director of the Kansas Pharmacists Association
Paul Klotz, Kansas Association of Community Mental Health Centers
Don Snyder, Chairman of the Sedgwick County Health Care Cost Containment Roundtable
Dr. Calvin Bigler, President of Kansas Medical Society

SB 110 - An act concerning medical malpractice liability actions; relating to procedures for assessment of exemplary or punitive damages, and consideration of collateral source of indemnification in certain actions; limiting recovery of certain damages.

Jerry Slaughter, Kansas Medical Society, spoke in favor of this bill as shown in Attachment No. 1. He also referred to a paper written by Banks McDowell on the Collateral Source Rule, Attachment No. 2, and an Opinion of the California Supreme Court in Fein v. Permanente, Attachment No. 3.

Linda Warren, M.D. from Hanover, Kansas, spoke in favor of this bill. She said because of the high malpractice insurance rates she and her colleagues had to pay, she was considering stopping providing high risk services. If the rural doctors discontinue their practices, those people will have to travel maybe 60 - 100 miles for this type of service. She also said that many physicians will not locate in Kansas -- they wil look for states that have lower premiums because they cannot afford this.

Sister Elizabeth Stover, Administrator of St. Joseph's Hospital in Concordia, Kansas, said the Kansas Hospital Association strongly supports the provisions of Substitute for SB 110. See Attachment No. 4.

Harold Riehm, Kansas Association of Osteopathic Medicine, said that this organization strongly supports the passage of SB 110. He said many of their members are in rural areas and small towns in Kansas. For that reason, the malpractice premium problem is particularly acute.

James Rider, D.O. in Valley Falls, Kansas, urged the committee's support of SB 110. Attachment No. 5 is his testimony.

There was further discussion between the conferees and the committee members concerning threats of physicians leaving rural areas, the Collateral Source Rule, overhead expense of a doctor's office, the number of actual cases against the fund in Kansas, if the standard of care will be affected and the threat of lawsuits held over doctors and how it affects their performance.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Judiciary,

room 526-S, Statehouse, at 3:30 ~~a.m.~~/p.m. on March 26, 1985.

Homer Cowan, Western Casualty Insurance Company, Fort Scott, Kansas, spoke in support of this bill. He addressed some concerns such as the Collateral Source Rule and the stabilization fund. He said their ratio presently is a little over 200 percent -- they pay out $2.00 for every $1.00 they take in.

Bill Sneed, Legislative Counsel for the Kansas Association of Defense Counsel, spoke in favor of SB 110 as shown in Attachment No. 6.

Wayne Probasco, Kansas Podiatry Association said this association strongly supports SB 110.

Sherman Parks, Executive Director of the Kansas Chiropractic Association, also supports this bill. See Attachment No. 7.

Ken Schafermeyer, Executive Director of the Kansas Pharmacists Association, urged the committee's support of SB 110. See Attachment No. 8.

Paul Klotz, Kansas Association of Community Mental Health Centers, was not able to appear in person, but wanted it announced that they support this bill.

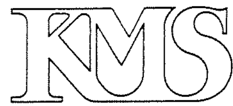
Don Snyder, Chairman of the Sedgwick County Health Care Cost Containment Roundtable, expressed support for this bill as shown in Attachment No. 9.

The committee further discussed "defensive" medicine, what percentage of fees goes where, the control of the quality of care, and the rapid development of medical technology and that doctors cannot keep up with it.

Dr. Calvin Bigler, President of Kansas Medical Society, said that a tremendous amount is done in the ongoing education of physicians. He said the Kansas Medical Society is in charge of Kansas Medicine which is the longest, continuously produced journal in the State of Kansas. It is devoted to education of members of the medical profession. Kansas Medical Society is also responsible for surveying and accrediting educational programs throughout the state to certify that they are actually proper and give appropriate education to the physicians. He said another thing the public is not aware of is peer review.

There was further discussion on the stabilization fund.

The meeting adjourned at 5:40 p.m.



KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

HOUSE JUDICIARY COMMITTEE

March 26, 1985

Substitute for SB 110; Concerning Medical Malpractice

By

Jerry Slaughter
Executive Director

Attachment No. 1
House Judiciary
March 26, 1985

Substitute for SB 110; Concerning Medical Malpractice

The Kansas Medical Society appreciates the opportunity to comment on Substitute for SB 110. During the next couple of days you are going to be asked to absorb a tremendous amount of information about medical malpractice. We are here because the legislature plays an important role in this debate. Much of the solution to the problem is within your ability to change.

The frustrating thing about this issue is that there really aren't any culprits in the system we can blame for causing the problem. It is not a problem of bad medical practice, which can be solved through disciplinary action against doctors. It is not just a controversy between physicians and trial attorneys, although it is convenient to portray it as such. It is not primarily a problem of the insurance industry, manifested by rising premiums, although it is certainly involved.

It is a problem of personal injury to patients in an environment of high technology, modern health care, multiple treatment modalities, an astronomical number of decisions and individual judgments for delivery of care, and the occurrence of bad results, negligence or treatment failures, sometimes in patients who a few years ago might not have survived. The fact is, that doctors, lawyers, hospitals, insurance companies, and patients, all want the same thing: good results, good medical practice, and fair compensation if someone is injured through negligence. Nothing in the bill before you will limit a person's ability to sue for and recover actual economic loss. Nor will the bill deny an injured person the right to competent legal counsel. We don't want to get negligent doctors off the hook. We do want to see that the injured patient gets the bulk of the award, and that the spiraling cost of the malpractice system is brought under control.

The facts are that the number of lawsuits filed grows every year -- seven times as many in 1984 as in 1979. Million dollar-plus awards are common now, whereas in 1976 we hadn't had any. Premiums for insurance coverage have increased tenfold since 1975.

Opponents of reform will tell you that the problem is simply one of lots of malpractice committed by negligent doctors. The data, however, doesn't support that. Physicians in this country are better trained and more closely regulated and reviewed than anywhere else in the world. The medicine practiced here is second to none, yet we have more lawsuits per capita than anybody. Last year we sponsored legislation which beefed up our Healing Arts Board. We hired a full-time disciplinary lawyer who does nothing but investigate and help prosecute physicians who aren't up to standard. If there are "bad doctors" out there, we will deal with them, through better peer review and a stronger disciplinary system.

But it's not just bad doctors getting sued. Data shows that it is often the most highly trained doctors, doing the most difficult cases, who get sued. Our surveys show that there are only a handful of physicians who have multiple claims against them (Attachment A). Almost 2/3 (63.5%) of Kansas doctors have never been sued, and another 24% have been sued just once. However, as the number of suits grows, it is unlikely that any physician will make it through his or her career without being hit.

In the next fiscal year there will probably be over 235 malpractice suits filed (Attachment B) and the number is increasing rapidly. That's about 8 per 100 doctors. When you consider that there are about 7 million separate physician-patient encounters a year in this state, that's a pretty good success rate. However, that relatively small number of suits is causing huge problems.

The problem is two-fold. As the number of suits (frequency) has increased, so have awards and settlements (severity). The only way you can lower malpractice system costs is to reduce the frequency of suits, or reduce the severity of awards. Compounding the problem is the fact that the injured patient only receives about one-third of the premium dollars which are paid into the system. The courts, lawyers and insurance companies -- the system -- consumes about two-thirds of every dollar paid in.

This expensive system, and the increasing frequency and severity of claims have had a devastating effect on premiums (Attachment C). Many doctors in Kansas are paying $20,000 or more for liability insurance. Within two years the cost will double again, and for those doing obstetrics it may double again this year. The trends indicate that premiums of $75,000 to $100,000 may not be far away. These premiums have been exploding while doctors' fees have been frozen. About three-fourths of Kansas physicians voluntarily froze their fees last year in recognition of a tough economy. Medicare has frozen fees at 1982 levels. Medicaid fees are essentially frozen at 1975 levels. Blue Shield has frozen fees since last year. It's been interesting to watch the plaintiffs' lawyers protest our proposal to place a reasonable limitation on contingent fees, when physicians have been living with government-set fee limits for years.

Opponents of change will tell you tomorrow that rising premiums aren't a burden because doctors and hospitals are rich -- they can afford it. It's that "deep pocket" mentality that is driving our malpractice system to such excess. At what point does it become unreasonable and unaffordable? The lawyers tomorrow will say that malpractice insurance costs represent a small portion of doctors' overhead expenses. Our data shows that it averages about 9.5% for all physicians, while the trial lawyers say it is 4%. Whatever the figure, it is

irrelevant to the issue. If your property taxes doubled or tripled in two years, wouldn't you be concerned, even if they represented only 5-10% of your expenses? As a rural family practice doctor, is it worth doubling your premium to deliver 15 to 20 babies a year, and live under the constant threat of suit? Unquestionably, doctors earn good incomes. But they average 55 to 65 hours a week at their practice. The work is difficult and demanding. Doesn't it ignore the problem to simply say that "doctors can afford it?" Ultimately, the patient pays the bill. When premiums double and triple, health costs go up.

Studies indicate that "defensive medicine" adds significantly to the cost of care. We've enclosed a graphic from a survey (Attachments D1, & D2) we did this year which illustrates this point. National estimates on the effect of defensive medicine range from $15-40 billion annually. Our survey showed that about a third of the doctors who do obstetrics are going to stop delivering babies if the liability situation doesn't improve. In fact, the liability environment is forcing physicians into early retirement. You can't wind down your practice, and work half time anymore. With liability costs doubling, you have to carry a full patient load to be able to pay your liability premium.

You will also hear tomorrow that insurance companies are just profit-takers, ripping doctors off with higher premiums. The data doesn't support that, either. We've attached a chart which shows that physician owned malpractice insurance companies have had losses exceeding premiums since 1980 (Attachment E,1). Another graphic from the Medical Protective Company (Attachment E,2) shows that their losses have been exceeding premiums for the last five years. That can't continue indefinitely. A fundamental problem is that there are so few doctors over which the risk can be spread. There are only about 400,000 doctors in the United States, and about 3,000 in Kansas. It doesn't take too

many multimillion dollar awards to trigger incredible premium increases if a company only has 15,000 to 20,000 doctors insured. An auto insurance company, on the other hand, which may insure 3 to 4 million people, can absorb a multimillion dollar loss with an insignificant effect on premiums. Insurance companies have to collect sufficient premiums to meet expenses, make a profit, and build adequate reserves for claims that average 4-6 years from injury to award. Don't be misled by the argument that this is an insurance problem. That is a diversion, and shows the complete unwillingness of the KTLA to acknowledge that a problem exists with the system. A system which is slow, expensive, and which returns to the injured patient only a small part of the money collected in the form of premiums.

I would like to briefly highlight the major provisions of Substitute for SB 110. Although our original proposal contained several other provisions, we will confine our consideration to the present form of the bill which passed the Senate on a 33-7 vote. It deals with four issues: punitive damages, awards for pain and suffering, the collateral source rule, and informing juries of the non-taxability of awards.

The punitive damage provision sets up a two-phased trial for determining and assessing punitive damages. It also sets a limit on such awards, based on income of the defendant, up to a specified maximum. In recent years, a disturbing trend towards seeking punitive damages in medical malpractice cases has developed. Punitive damage claims used to be very rare, but they are fast becoming a frequent allegation of the plaintiff's attorney. In the vast majority of cases however, they are completely unjustified. Nevertheless, the threat of a punitive damage award, which is not covered by insurance, has a devastating effect on physicians. In recent cases, plaintiffs' attorneys have

filed punitive damage claims, and then offered to dismiss the claim if the physician would pressure his or her insurance company to settle the suit. In these cases, punitive damages are being used as a hammer or threat to achieve settlement. That is completely inappropriate, but illustrates how plaintiffs' attorneys use the system to their advantage.

Although the punitive damage limit is helpful, we feel some amendments are necessary. Attachment F contains amendments to this section which codify the definitions of willful conduct, fraud, and malice, and establish a standard for the awarding of punitive damages. We believe these amendments are necessary to make the awarding of punitive damages more uniform, meaningful, and less subject to misinterpretation.

The recovery limit on awards for pain and suffering is an important part of this bill. Most of us can sympathize with the desire of juries to do everything they can for the injured patient in a malpractice case. However, juries sometimes award millions of dollars for pain and suffering damages, intended solely to alleviate emotional losses, and not compensate actual or economic losses. These awards are highly subjective, and though well motivated, they have little to do with the actual needs of the patient and a lot to do with the astronomical growth of malpractice costs in recent years. Some compensation for the trauma of malpractice is justified in many cases, but a reasonable limitation on pain and suffering awards will help control malpractice costs. Other states have enacted such limits, and the California Supreme Court just recently upheld their $250,000 limitation on the recovery of noneconomic damages. The California court stated, "Thoughtful jurists and legal scholars have for some time raised serious questions as to the wisdom of awarding damages for pain and suffering in any negligence case, noting, inter alia, the inherent difficulties in placing a

monetary value on such losses, the fact that money damages are at best only imperfect compensation for such intangible injuries and that such damages are generally passed on to, and borne by, innocent consumers." The court went on to note that, "It appears obvious that this section -- by placing a ceiling of $250,000 on the recovery of noneconomic damages -- is rationally related to the objective of reducing the costs of malpractice defendants and their insurers."

The collateral source rule is the other significant provision in Substitute for SB 110, a discussion of which you heard yesterday from Professor Canconnon. Often in malpractice suits the plaintiff's own insurance company will have already paid his or her medical bills, for example, but attorneys aren't allowed to tell the jury that damages have been covered from such "collateral sources." As a consequence, juries end up awarding thousands of dollars to cover bills that are already paid,and the plaintiff recovers double. Substitute for SB 110 contains a provision that would allow juries to be informed when damages have been paid from collateral sources. Presumably, juries would lower the award to take into account collateral benefits, if appropriate in each particular case.

Sixteen states have eliminated the use of the collateral source rule in medical malpractice actions. It is an outdated rule of common law which, according to most contemporary analysts, should be abolished. The abolition of the collateral source rule lets the jury have reliable evidence on matters where otherwise they are likely to be speculating, and doing so inaccurately. The California Supreme Court also upheld that state's abolition of the collateral source rule.

The key parts of the bill are the award limitation and the collateral source rule change. Will these changes help stabilize premiums? The answer is yes. In a comprehensive analysis of the effects of the 1970s tort reforms, the

Rand Corporation Institute for Civil Justice (1982) found that states which enacted award limits and a mandatory offset of compensation from collateral sources had lower awards by roughly 20% and 50% respectively. In its February, 1985 actuarial analysis of The Health Care Stabilization Fund, the Fred S. James Company, a national, independent actuary, noted that, "specific scheduling of plaintiff attorneys' fees, recognition of collateral sources of recovery, or limitation of non-pecuniary losses are, in order, increasingly likely to reduce the Fund's liabilities ..." We have concluded from the experience of other states and the available literature, that these two reforms, in conjunction with stringent peer review and disciplinary activity, will stabilize premiums and significantly improve the malpractice environment.

Interestingly, in another study by the Rand Coporation (1984) of personal injury cases in Cook County, Illinois, the researchers found that for similar injuries, plaintiffs in medical malpractice cases received four times the compensation that their counterparts in automobile accidents received. The findings suggest that juries may be applying two tiers of justice, and imposing larger awards against "deep pocket" defendants like doctors and hospitals.

In Indiana, a state which enacted an absolute $500,000 limit on awards in 1975, the cost of insurance is considerably less than in Kansas. We've attached graphs from the Medical Protective Company (Attachment G) which compares Indiana rates with other states, including Kansas. The number of lawsuits filed in Indiana is comparable to Kansas when you adjust for physician density and population, but premiums are significantly lower because of the cap on awards. To the extent malpractice premiums are passed on to patients, the Indiana experience

has shown that costs can be contained. In fact, of the 30 physician-owned insurance companies affiliated with medical societies, only one, Indiana's, is not increasing premiums this year. The rest are raising rates as much as 52%, with the average around 30%. The stable liability environment in Indiana, even accounting for many different factors, shows that tort reform can make a difference.

Without question, the reforms we are suggesting are a big step. However, unless we restore balance to the malpractice environment, the fabric of medical services will unravel in Kansas. If our surveys are accurate reflections of physician attitudes, we will see access to high risk services such as obstetrics become less available. In a state that is trying hard to get young physicians to come to our rural areas, the unresolved malpractice problem presents a real barrier.

A final comment about the liability environment in Kansas. In December, 1984, we also surveyed the public about the malpractice problem (Attachment H). We found that Kansans were aware of the problem, and ready for reform. The public knows who pays the freight for our expensive and excessive system. Eight out of ten Kansans said their health care bills were higher because of the effect large malpractice awards have on insurance premiums. Sixty-three percent favored a limit on awards. Almost nine out of ten thought there should be a limit on contingent fees in malpractice suits. In short, the public, we believe, is willing to accept change.

I urge you to give serious consideration to Substitute for SB 110. It is controversial and will be opposed by lawyers who want to maintain the status quo. However, we can't tinker around the margins of reform and hope to solve the problem. It takes direct action. Lawyer groups will tell you to delay,

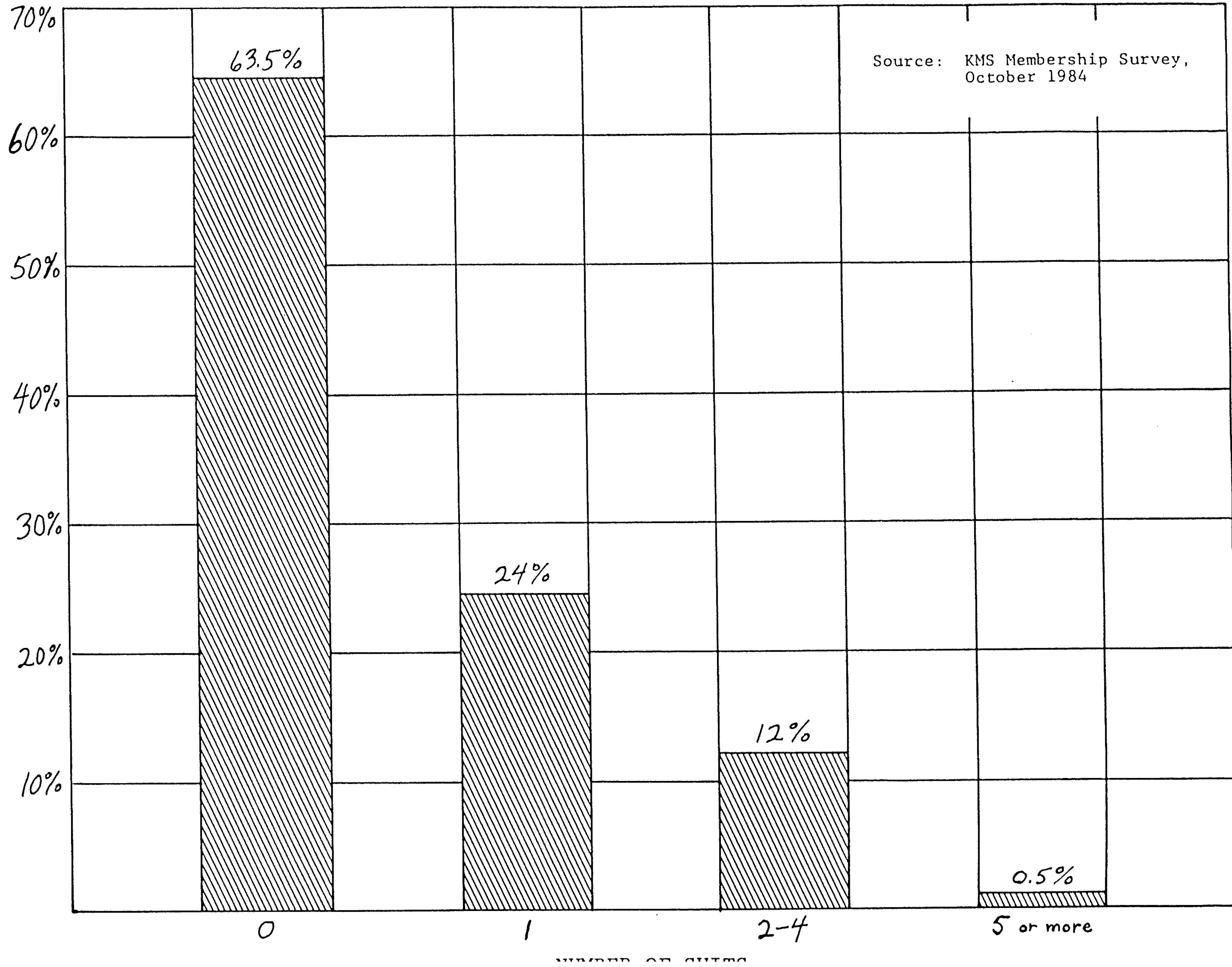
to study the issue. But in the meantime the situation will continue to worsen at a faster pace. And after a couple of years of study don't expect the KTLA to support any reforms that will really make a difference. You can't blame them. They are just responding to the economic incentives in the system. These incentives are all wrong. The system encourages expensive, time consuming litigation, instead of quick and inexpensive resolution of claims. Because medicine is not a perfect science, and possibly because the traditional tort system encourages the notion that a remedy exists for every misfortune, liability claims will continue to rise under the current system. The only question is how fast and how far. It's time to make a first step to change the incentives. I urge you to join your colleagues in the Senate and act favorably on Substitute for SB 110. Thank you for your consideration of our comments.

Jerry Slaughter
Executive Director

JS:arb

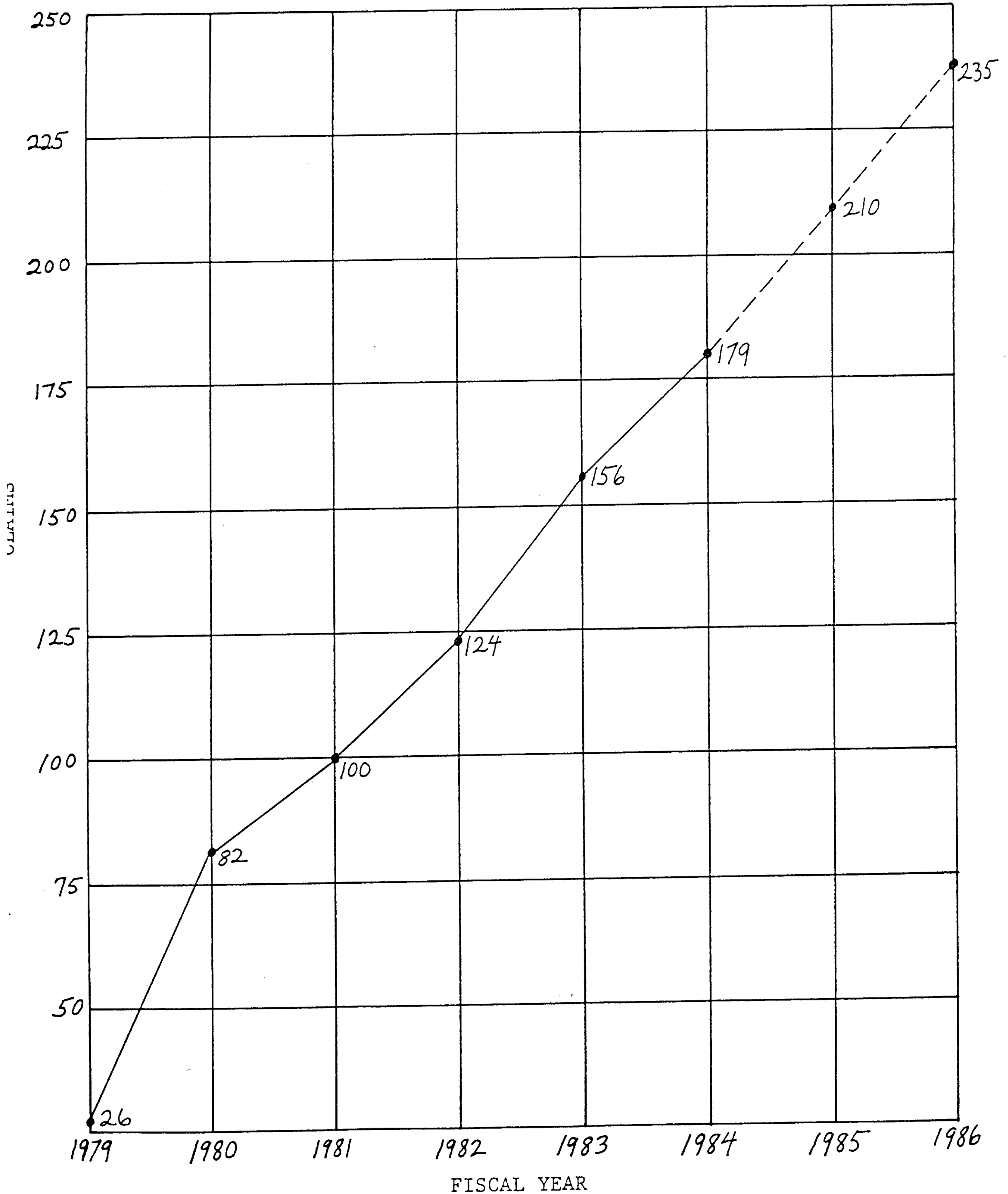
ATTACHMENT A

FREQUENCY OF MALPRACTICE SUITS AGAINST KANSAS PHYSICIANS



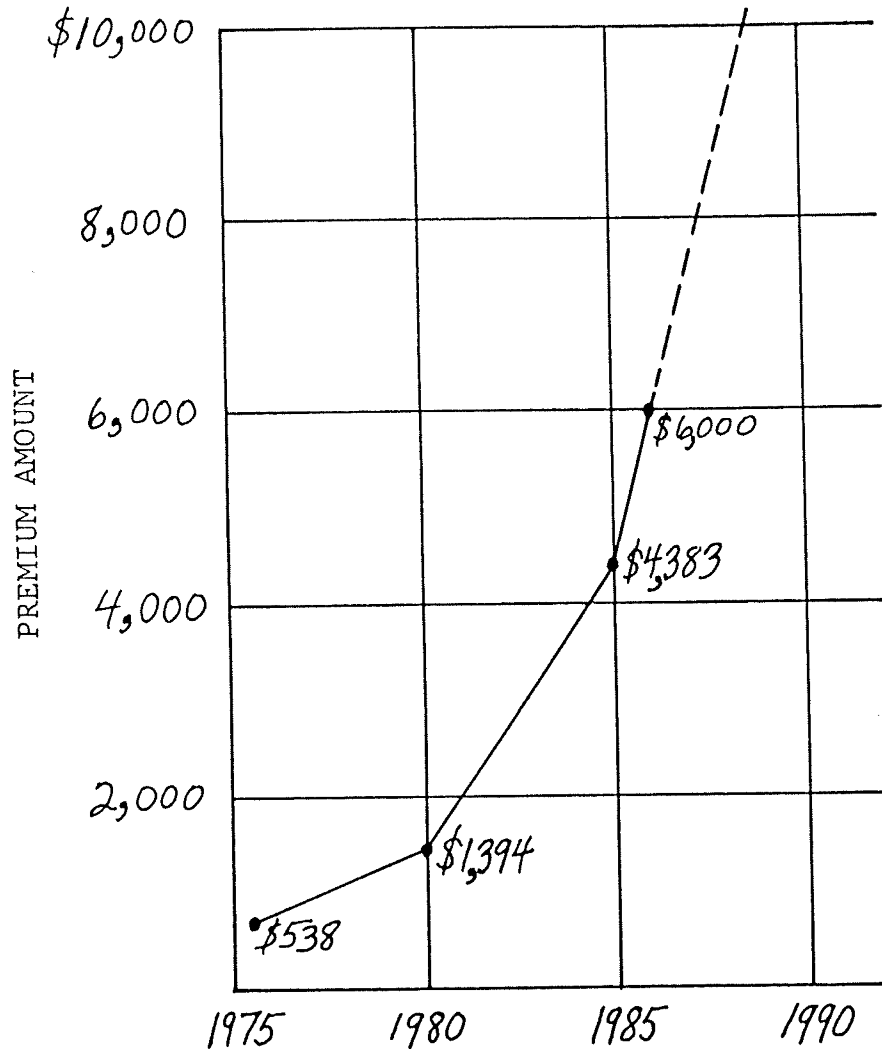
ATTACHMENT B

CLAIMS FILED AGAINST HCSF, FY 1980 -- FY 1986

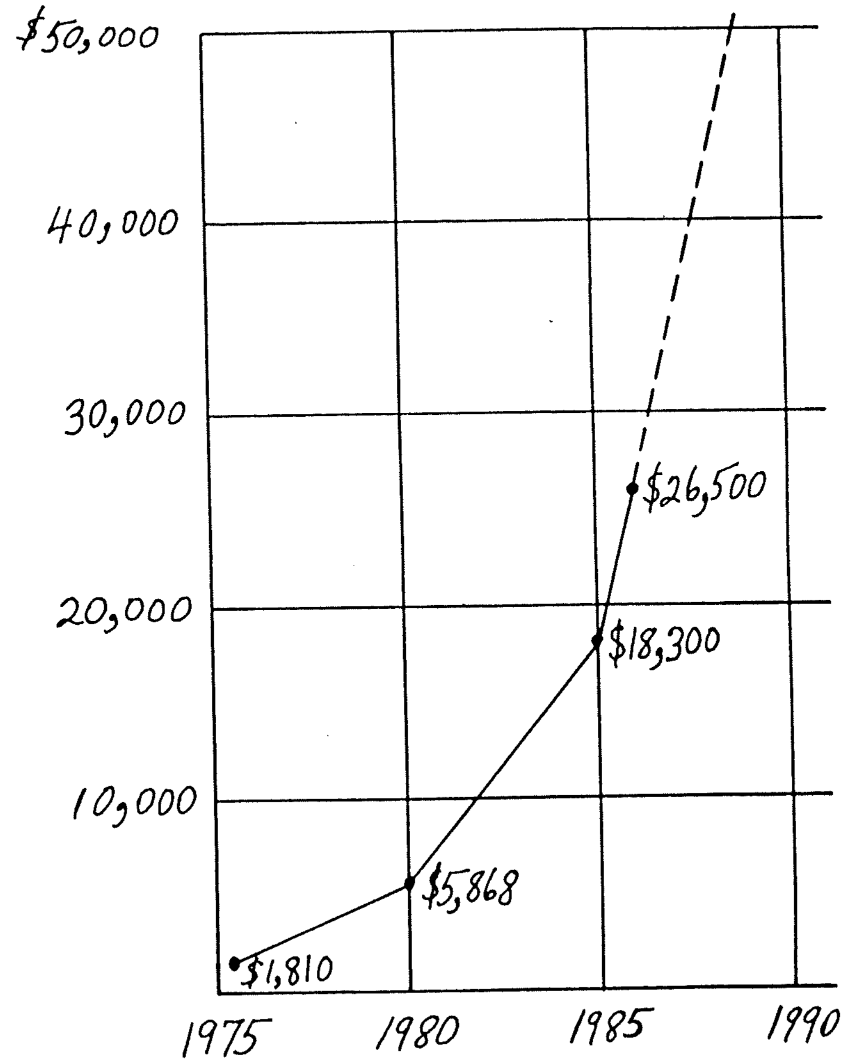


ATTACHMENT C

PHYSICIAN MALPRACTICE PREMIUMS FOR REQUIRED COVERAGE

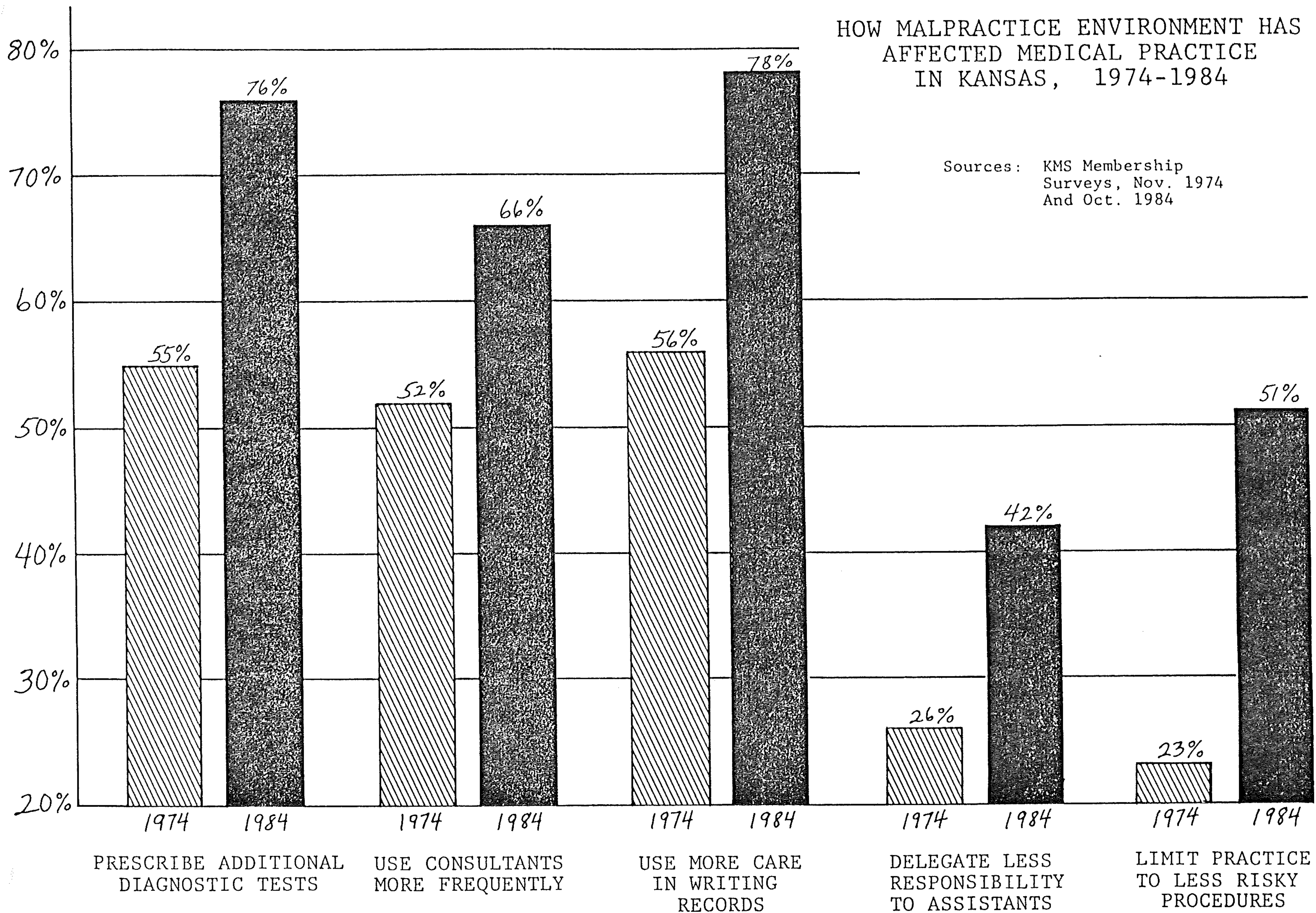


FAMILY PRACTICE AND
INTERNAL MEDICINE SPECIALTIES



SURGICAL SPECIALTIES
INCLUDING OBSTETRICS

ATTACHMENT D



Professional Liability Survey

Kansas Medical Society, October 1984

In October 1984, the Kansas Medical Society surveyed its member physicians for data and opinions on the medical professional liability environment in Kansas. In all, 1,261 responses were received, which represents about one-half of the active, practicing membership. The responses were classified by specialty area of practice.

Results of the survey showed a considerable degree of concern among Kansas physicians about the professional liability situation. Nearly nine of ten physicians (86%) said problems associated with medical malpractice have affected their practices. Many felt the physician-patient relationship had suffered because of medical malpractice problems. Physicians apparently are delegating less responsibility to assistants (42%), and more than one-half (51%) are limiting their practices to less risky procedures.

The phenomenon of defensive medicine is very much an outcome of professional liability pressure. More than three-fourths (76%) of physicians who responded to the survey are prescribing additional diagnostic tests; and two-thirds (66%) use consultants more frequently.

Data on frequency of claims in Kansas seem to parallel national trends. Almost 40 per cent of Kansas physicians have been sued during their careers. Of those who have been sued, two-thirds (66%) have been sued once, one-third had two to four suits, and fewer than 1 per cent had five or more claims. These data dispel the myth that it is only the "bad doctor" who gets sued. Frequency of suits varies by specialty, with physicians in higher risk practices having greater claim activity.

Respondents whose practices have included obstetrics were asked to answer a specific set of questions to determine if the professional liability situation might be creating problems of access to obstetrical care. The results provide a bleak picture of what lies ahead in this high risk field of practice. About three of ten physicians (28%) who had practiced obstetrics had stopped altogether. Another one-third indicated they planned to discontinue obstetrics practice in the near future if the liability situation didn't improve. Taken together, 61 per cent of the respondents had either quit obstetrics practice or were planning to quit in the near future. Significantly, a large number of those who plan to discontinue obstetrics practice are family practitioners, presumably many in rural areas. The responses to this particular question clearly indicate potential access problems for obstetrical patients in many Kansas communities.

The respondents were also asked for the names of their insurance carriers. Medical Protective insured the most physicians at 40 per cent of the market. St. Paul Fire and Marine was close at 35 per cent of the market. Two relative newcomers to the state — Pennsylvania Casualty and Medical Defense — had 9 and 6 per cent of the market, respectively.

About 3 per cent of respondents were insured through the state insurance availability plan administered by Western Casualty of Fort Scott. The remaining 7 per cent were spread among several smaller insurers, mostly specialty-related carriers.

In summary, the 1984 survey showed serious concerns among Kansas physicians about problems associated with medical professional liability. A significant number of physicians surveyed indicated the professional liability situation is adversely affecting their practices and contributing to early retirement decisions. Physicians who practice obstetrics are especially concerned about the future, and problems of access to care may not be far away. Widespread defensive medicine and a more conservative practice approach are significant trends among Kansas physicians. Overall, the survey indicates that problems associated with professional liability are escalating rapidly, and that physicians are extremely concerned about the future of patient care in such an environment.

YOUR listing could be in our Physician Directory section — see page 61.

Professional liability premiums and losses: 1977-1983

2 billion
1.9 billion
1.8 billion
1.7 billion
1.6 billion
1.5 billion
1.4 billion
1.3 billion
1.2 billion
1.1 billion
1 billion
750 million
500 million

Losses
Premiums

1977 1978 1979 1980 1981 1982 1983

	Premiums Written	Losses (Losses and loss expenses incurred)
1977	$1.20 billion	$817 million
1980	1.27 billion	1.5 billion
1982	1.48 billion	1.6 billion
1983	1.57 billion	2.0 billion

(selected years)

——— Premiums Written
------- Losses

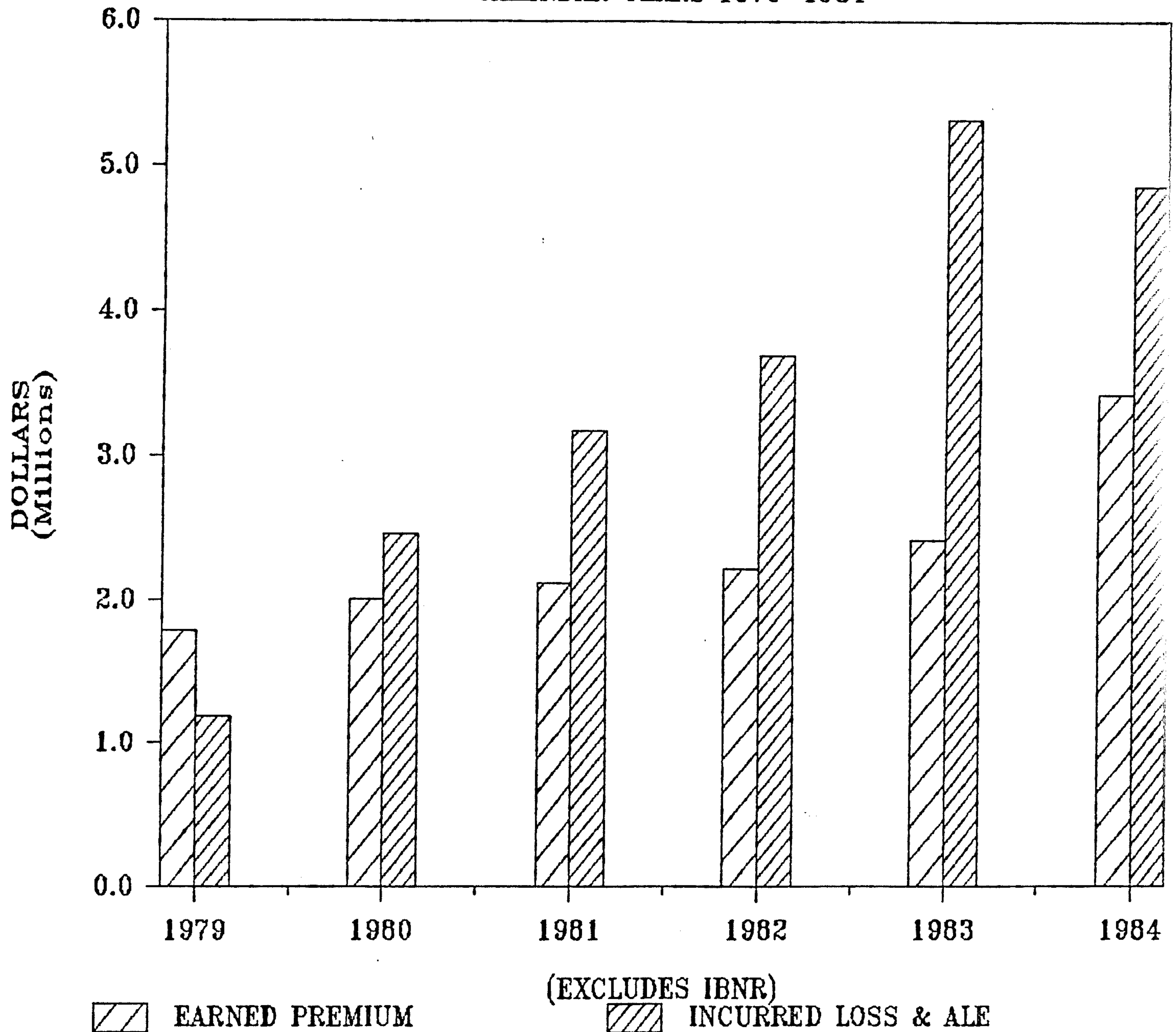
Data source: *Best's Insurance Management Reports*, 1983-1984

By the late 1970s losses and loss adjustment expenses exceeded premiums written for professional liability insurance. From 1982 the losses sharply increased compared to the increase in premiums written.

ATTACHMENT

KANSAS CLAIMS MADE EXPERIENCE

CALENDAR YEARS 1979-1984



Source: Medical Protective Company

March 1985

ATTACHMENT I

[As Amended by Senate Committee of the Whole]

Session of 1985

Substitute for SENATE BILL No. 110

By Committee on Judiciary

3-7

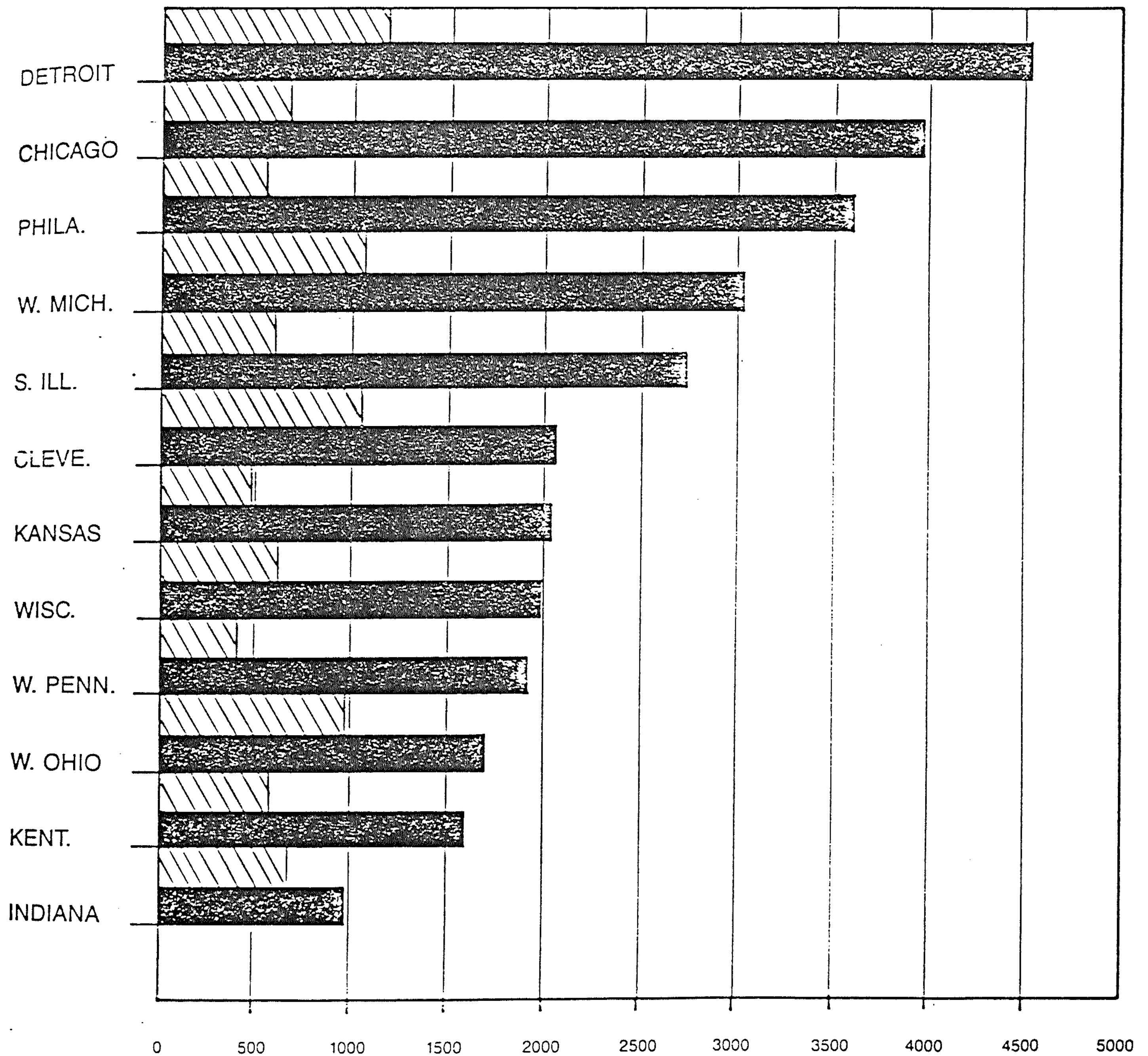
0018 AN ACT concerning ~~civil procedure~~ *[medical malpractice lia-*
0019 *bility actions]*; relating to procedures for assessment of exem-
0020 plary or punitive damages~~; concerning procedures for~~ *[and]*
0021 consideration of collateral sources of indemnification in cer-
0022 tain actions; limiting recovery of certain damages ~~in certain~~
0023 ~~actions~~; repealing K.S.A. 60-471.

0024 *Be it enacted by the Legislature of the State of Kansas:*
0025 Section 1. (a) In any *[medical malpractice liability]* action in
0026 which exemplary or punitive damages are recoverable, the trier
0027 of fact shall determine, concurrent with all other issues pre-
0028 sented, whether such damages shall be allowed. If such damages
0029 are allowed, a separate proceeding shall be conducted to the
0030 court to determine the amount of such damages to be awarded.
0031 (b) At a proceeding to determine the amount of exemplary or
0032 punitive damages to be awarded *[under this section]*, the court
0033 shall hear evidence of the financial condition of any party against
0034 whom such damages have been allowed. Such evidence may
0035 include the party's gross income earned from ~~the activity from~~
0036 ~~which liability for exemplary or punitive damages arises~~ *[pro-*
0037 *fessional services as a health care provider]* but shall not include
0038 any such income for more than five years immediately before the
0039 act for which such damages are awarded. At the conclusion of the
0040 proceeding, the court shall determine the amount of exemplary
0041 or punitive damages to be awarded, but not exceeding the
0042 amount provided by subsection (~~c~~) (d), and shall enter judgment for
0043 that amount.

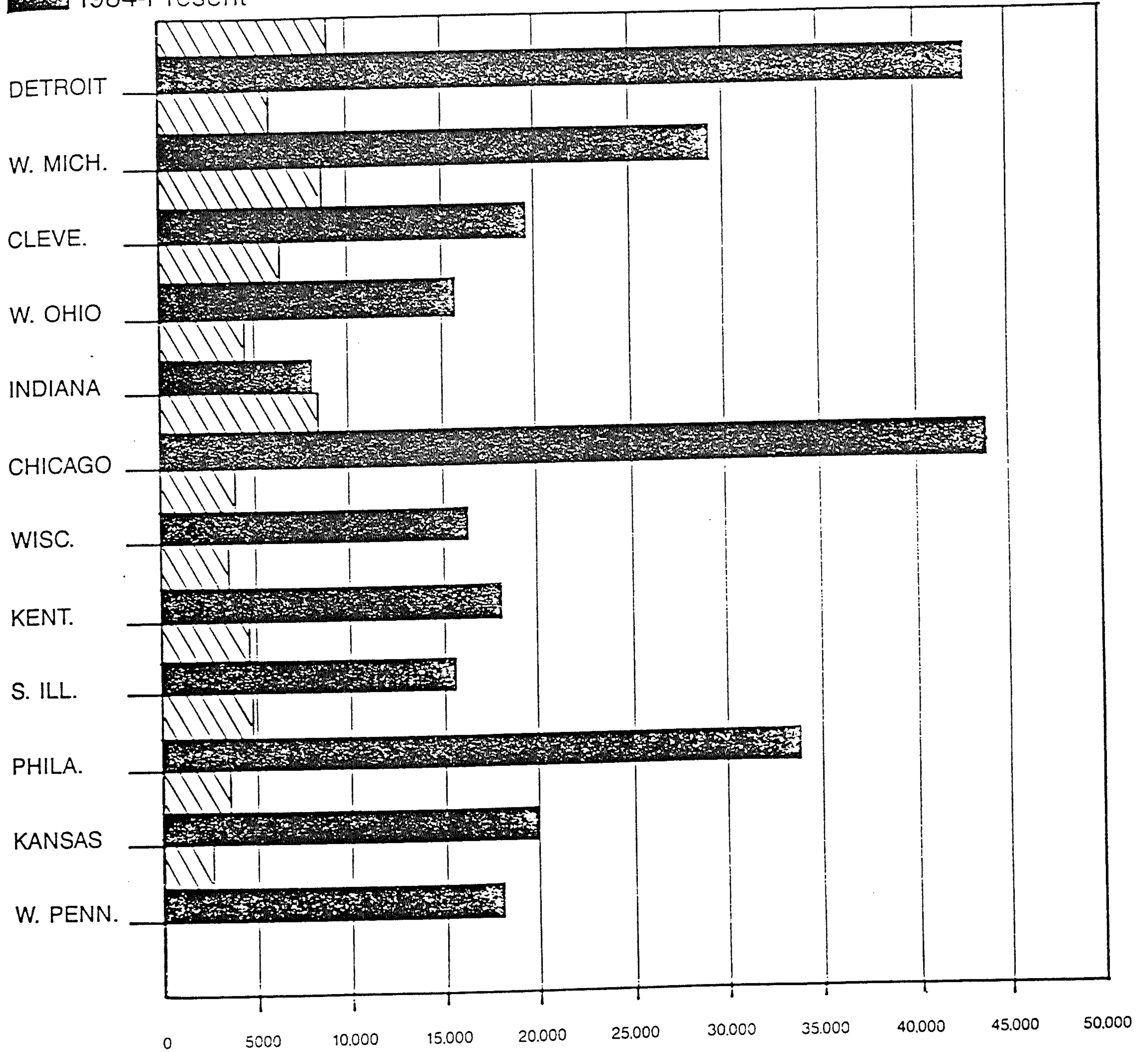
(c) In any medical malpractice liability action where claims for punitive damages are included the plaintiff shall have the burden of proving the defendant's culpability as defined in section (g) by clear and convincing evidence in the initial phase of the trial. Presumptions shall not be used to shift the burden of proof to the defendant.

0044 (~~c~~) (d) No award of exemplary or punitive damages *[under this*
0045 *section]* shall exceed the lesser of: (1) Twenty-five percent of the
0046 annual gross income earned by the party against whom the

ATTACHMENT G



ATTACHMENT G



A Study of Attitudes
Toward Medical Malpractice Issues
in the State of Kansas

January 8, 1985

Marketing and Research Consultants, Wichita, Kansas

SUMMARY OF RESPONSES

"Do you think the amount of money awarded in malpractice suits is usually too much, not enough, or about right?"

Too Much	33.9%
Not enough	5.5
About Right	18.1
Don't Know	42.5
	100.0%

"Lawyers who represent patients in malpractice suits usually charge from 1/3 to 1/2 of any award for their fee, which is the so-called contingent fee. Do you think there should be a limit on lawyers' fees in malpractice suits?"

Yes	86.6%
No	6.4
Dont' Know	7.0
	100.0%

"The number of multimillion dollar malpractice awards has been increasing. Do you think there should be a limit on the amount of money that can be awarded to someone in a malpractice suit?"

Yes	62.7%
No	20.3
Don't Know	17.0
	100.0%

"Currently, patients who file malpractice lawsuits don't have to disclose whether their medical insurance will cover any care they need resulting from their medical injury. Do you think that information should be disclosed?"

Yes	59.6%
No	28.2
Don't Know	12.2
	100.0%

"Do you think that consumers pay higher health care costs because of the effect large malpractice awards have on malpractice insurance premiums?"

Yes	82.0%
No	8.9
Don't Know	9.1
	100.0%

(e) (1) In no case shall punitive damages be assessed against a principal or employer for the acts of an agent or employee unless such principal or employer authorized or ratified the questioned conduct. The ratification or authorization must have been made by a person expressly empowered to do so.

(2) In no case shall punitive damages be assessed against a professional corporation for the acts of a member of that corporation unless such professional corporation authorized or ratified the questioned conduct.

(g) In determining the culpability of a defendant in the first phase of the trial, it must be proven that the defendant acted toward the plaintiff with willful conduct, fraud or malice. These terms, as used in this act, are defined as follows:

(1) "Willful conduct" means an act performed with a designed purpose or intent on the part of a person to do wrong or to cause an injury to another.

(2) "Fraud" means an intentional misrepresentation, deceipt or concealment of material fact known to the defendant with the intention on the part of the defendant to deprive a person of property or legal rights or otherwise causing injury.

(3) "Malice" means a state of mind characterized by an intent to do a harmful act without a reasonable justification or excuse.

(4) In no case shall punitive damages be awarded for any harm if the defendant has acted in good faith, on the advice of an attorney or on the advice of any government official. No punitive damages shall be awarded if the defendant has relied upon a statute or a judicial decision.

0047 damages are awarded from ~~the activity from which liability for~~
0048 ~~such damages arises~~ *[professional services as a health care pro-*
0049 *vider]*, as determined by the court based upon the party's highest
0050 gross annual income earned from such ~~activity~~ *[services]* for any
0051 one of the five years immediately before the act for which such
0052 damages are awarded; or (2) three million dollars.

(f)
0053 *[(d) As used in this section:*
0054 *[(1) "Health care provider" has the meaning provided by*
0055 *K.S.A. 40-3401 and amendments thereto.*
0056 *[(2) "Medical malpractice liability action" means any action*
0057 *for damages for personal injury or death arising out of the*
0058 *rendering of or failure to render professional services by a health*
0059 *care provider.]*

(h)
0060 ~~(d)~~ ~~*[(e)]*~~ This section shall be part of and supplemental to the
0061 code of civil procedure.
0062 Sec. 2. (a) In determining damages in a medical malpractice
0063 liability action, evidence shall be admitted for consideration by
0064 the trier of fact to establish that any damages or expenses in-
0065 curred or reasonably expected to be incurred by the claimant
0066 were indemnified or replaced, or may be indemnified or re-
0067 placed, in part or whole, from any collateral source.
0068 (b) When evidence of a claimant's entitlement to collateral
0069 source benefits is introduced, the claimant may present evidence
0070 of any amounts paid to secure a right to such benefits, or that the
0071 right to recovery is subject to a lien or subrogation.
0072 (c) As used in this section, "medical malpractice liability
0073 action" means any action for damages for personal injury or
0074 death arising out of the rendering of or failure to render profes-
0075 sional services by a health care provider as defined in K.S.A.
0076 40-3401 and amendments thereto.
0077 (d) This section shall be part of and supplemental to the code
0078 of civil procedure.
0079 Sec. 3. (a) The total amount of damages recoverable for pain
0080 and suffering by a claimant for personal injury in a medical
0081 malpractice liability action shall not exceed $250,000.
0082 (b) As used in this section, "medical malpractice liability
0083 action" means any action for damages for personal injury or

0084 death arising out of the rendering of or failure to render profes-
0085 sional services by a health care provider as defined in K.S.A.
0086 40-3401 and amendments thereto.
0087 (c) This section shall be part of and supplemental to the code
0088 of civil procedure.
0089 *[Sec. 4. (a) In any medical malpractice liability action, the*
0090 *court, if requested by either party and if the tax laws so provide,*
0091 *shall instruct the jury that any damage award is not subject to*
0092 *state or federal income taxation.*
0093 *[(b) As used in this section, "medical malpractice liability*
0094 *action" means any action for damages for personal injury or*
0095 *death arising out of the rendering of or failure to render profes-*
0096 *sional services by a health care provider as defined in K.S.A.*
0097 *40-3401 and amendments thereto.*
0098 *[(c) This section shall be part of and supplemental to the*
0099 *code of civil procedure.]*
0100 Sec. 4 *[5].* K.S.A. 60-471 is hereby repealed.
0101 Sec. ~~5~~ *[6].* This act shall take effect and be in force from and
0102 after its publication in the statute book.

24 Wash L.J. ___ (1985)

THE COLLATERAL SOURCE RULE - THE AMERICAN MEDICAL ASSOCIATION, AND TORT REFORM*

Banks McDowell**

1. Introduction

The Collateral Source Rule is a common law rule created by the courts in the nineteenth century. It has been defined by the reporters of the Second Restatement of Torts as follows:

> Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability although they cover all or a part of the harm for which the tortfeasor is liable.[1]

This may be merely a rule of evidence preventing admission of proof of collateral benefits, or it may be viewed as a rule of substantive law specifying that collateral benefits are not to be deducted as an element under the appropriate damage formula.

Scholarly analysis over the last two decades has generally concluded that the rule should be abolished.[2] This common law rule could be abrogated by the courts who created it if they felt that the reasons justifying the rule no longer existed. It has, however, been adopted for so long a period and relied on to such an extent that courts should feel reluctant to reverse the precedents. It is more appropriate to seek repeal by statute.[3] Eighteen states have passed statutes eliminating

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the operation of the Collateral Source Rule in medical malpractice actions.[4] Colorado has abolished the Rule as to first-party insurance benefits payable under its automobile accidents no-fault scheme.[5] A more general statute abolishing the Collateral Source Rule in all tort actions has been introduced in the Kansas legislature.[6]

This article will consider a number of problems. (1) Why a rule developed under nineteenth century fault concepts of tort law may not work well under twentieth century compensatory concepts? (2) What is the impact of the lobbying efforts by the medical profession to repeal the rule in malpractice actions? (3) Is it advisable as a matter of legislative policy to generalize this reform to all tort litigation?[7] (4) If the Collateral Source Rule is abolished by statute, what form should the statutes take in order to minimize the problems and achieve the purposes of such reform?

2. Operation of the Rule

The scope of the Collateral Source Rule is described in Comment c to Restatement of Torts (Second) § 920A:

> c. The rule that collateral benefits are not subtracted from the plaintiff's recovery applies to the following types of benefits:
>
> (1) Insurance policies, whether maintained by the plaintiff or a third party. Sometimes, as in fire insurance or collision automobile insurance, the insurance company is subrogated to the rights of the third party. This additional reason for keeping the

tortfeasor's liability alive is not necessary, however, as the rule applies to insurance not involving subrogation, such as life or health policies.

(2) Employment benefits. These may be gratuitous, as in the case in which the employer, although not legally required to do so, continues to pay the employee's wages during his incapacity. They may also be benefits arising out of the employment contract or a union contract. They may be benefits arising by statute, as in worker's compensation acts or the Federal Employers' Liability Act. Statutes may subrogate the employer to the right of the employee, or create a cause of action other than subrogation.

(3) Gratuitous. This applies to cash gratuities and to the rendering of services. Thus the fact that the doctor did not charge for his services or the plaintiff was treated in a veterans hospital does not prevent his recovery for the reasonable value of the services.

(4) Social legislation benefits. Social security benefits, welfare payments, pensions under special retirement acts, all are subject to the collateral-source rule.[8]

While the scope and form of the collateral source rule has not changed in the past eighty years, the context in which it most commonly operates has changed markedly. This can be illustrated by comparing the kind of fact situation and the type of collateral source which was first before the courts with a more modern context and modern sources of benefits.

An example of a typical early collateral source problem faced by nineteenth century courts is the following.[9] The plaintiff, an elderly woman of modest means, was injured by the clear negligence of defendant's servant. It is probable that the defendant did not carry liability insurance, although that would not be known.[10] The plaintiff needed medical and nursing

care as a result of her injuries, so her two sons came from out of state to care for her. Their services were performed gratuitously. At the trial, the tortfeasor asked the court to not allow the jury to award the plaintiff "reasonable compensation for nurse hire and attendance" since she had received these services free from her sons. The court refused this request.

In deciding whether to credit the defendant with the value of gratuitous benefits received by plaintiff, the court had to select between two important principles, each of which covers the case and each of which clashes with the other. The first principle is the underlying fault concept in tort which says that a defendant should be responsible for all damages flowing naturally and probably from his wrongful act. Such damages would include the reasonable cost of all medical and nursing care the plaintiff needed, whether she could afford to purchase them prior to judgment or not. The second principle is that while plaintiff is entitled to full compensation for her injuries, she is not entitled to double up her recovery or to receive a windfall. When gratuitous benefits have been conferred on the plaintiff, one or the other of the consequences which these principles are designed to avoid must occur. Either the party at fault must pay less than the damages he caused, or the plaintiff receives a windfall, the amount assessed for services which she received gratuitously. The choice is an easy one. One party is innocent; the other at fault. When one must suffer a disadvantageous consequence and

the other receive a benefit, the benefit should go to the innocent party and the penalty be suffered by the wrongdoer. The Collateral Source Rule reaches that result.[11]

The modern context in which the collateral source rule operates is very different. Once again, an illustrative example will be used.[12] The plaintiff owned a building in which he operated a business. The business used natural gas. Due to the negligence of the gas company, there was a gas leakage causing an explosion. There was substantial damage to the building and substantial personal injuries to the plaintiff. The plaintiff carried fire insurance and paid the premiums as a business expense. The fire insurer settled plaintiff's property damage claim for $15,800, which was the appraised value of the loss, $16,100, less a $300 deductible. The plaintiff, a veteran, was hospitalized for three days in a veteran's hospital and was treated by the staff there. His medical expenses, if obtained in a private hospital, would have cost $642. When he returned home, his wife nursed him for two weeks. If those services had been performed by a professional nurse, they would have cost $420. While at home he was also treated by his brother-in-law, a physician. His brother-in-law sent him no bill, but his normal charges for these services would have been $428.00. Plaintiff then sued the gas company for negligence and sought damages of $68,990, consisting of property damage of $16,100, medical expenses of $1,070, nursing expense of $420, loss of earnings of $1,400, and pain and suffering of $50,000. At the trial, the defendant gas company

offered evidence of the plaintiff's settlement from his property insurer and the value of the medical and nursing services. The Collateral Source Rule compelled the judge to reject this evidence and to permit the plaintiff to recover his full damages. The equities produced by this result are very different in the tort system of the nineteen-eighties, when compared with the way the rule operated at the turn of the century.

In discussing this modern context, I assume that the real defendant in interest was not the gas company, but a liability insurer who defended the action and who must pay the judgment rendered against the gas company.[13] Another real party in interest, although not appearing on the record, was plaintiff's fire insurer, the subrogee of plaintiff's claim to the extent that it has paid the loss.[14]

To analyze the impact of the Collateral Source Rule in this modern context and to contrast that with the consequences of abolishing the Rule, it is necessary to separate the damages sought by plaintiff into three categories (a) those for which no collateral source benefits have been received, i.e. the claim for pain and suffering, the claim for loss of earnings, and the claim for the $300 deductible under the fire insurance policy, (b) those for which collateral benefits were obtained, but where there is no right of subrogation in the provider of those services - in this case, the reasonable fee for the services of his brother-in-law as doctor and the reasonable value of the nursing services of his wife, and (c) those

collateral benefits furnished by a party who is entitled under the doctrine of subrogation to recover the value of those benefits from the defendant tortfeasor - here, the fire insurance settlement and the medical care from the veteran's hospital.[15]

In the first category, where there has been no collateral contribution of any kind toward these items of damages, it is clear that the presence or absence of the Collateral Source Rule will have no impact. The plaintiff is entitled to those damages from the defendant (or his liability insurance carrier) in order to be fully compensated.

The abolition of the Collateral Source Rule would change the outcomes in classes (b) and (c). I would like to analyze first the equities involved in class (c), the situation where the collateral benefit has been furnished by an insurer entitled to subrogation. Here the previous analysis made about the appropriateness of the Collateral Source Rule in the typical earlier case does not fit at all. The party who must pay the damages to a plaintiff already compensated by collateral benefits is not a wrongdoing tortfeasor, but his liability insurer. This additional cost must be borne by all insureds of this class. The additional liability under the Collateral Source Rule would increase the defendant's insurance premium only very slightly, but also would increase at the same rate the premiums of this entire class of insureds, whether they be careful or careless. The element of wrongdoing which

justifies leaving this cost on the defendant's side is not nearly so clear once liability insurance is introduced. On the plaintiff's side, we are not dealing with what could be described as a windfall, but more accurately as double recovery. Here, plaintiff purchased the right to indemnification from his fire insurer and, in addition, has the right to full compensation given him by the law of torts. Both these rights cover the same injury. The doctrine of subrogation solves the double recovery problem. The plaintiff only gets to keep one recovery, the amount paid by his insurer. That portion of the tort judgment meant to compensate for the property damage belongs to his insurer. In summary, we are not penalizing a wrongdoing defendant, but defendant's compensated liability insurer, and not leaving a benefit with an innocent and poor plaintiff, but with plaintiff's compensated fire insurer.[16] The problem is to determine which insurance is primary. The Collateral Source Rule makes the liability insurance primary; its abolition would make the first party fire insurance primary.

Tort litigation to establish defendant's fault is an expensive and clumsy way to answer the question of whether the first party insurer is entitled to transfer its loss payment to a liability insurer. If we assume a case where the only item of plaintiff's damage was one for which he had been fully compensated by settlement with his insurer, then the only function of the tort action would be to charge defendant's insurer with that amount. In this limited case, the Collateral

Source Rule encourages litigation and the attendant legal costs, such as attorney's fees, use of court resources, and time of witnesses, litigants, and jurors. That is necessary because the issue of which insurer is primary turns on the determination of fault and this can only be finally answered by litigation. The abolition of the Collateral Source Rule would eliminate this litigation since the first party insurer would not be able to transfer its liability to pay the loss.

In the middle category, where the provider of collateral benefits is not entitled to subrogation either because the benefits were furnished gratuitously or because subrogation is not a right extended to this provider, the equities are closer to the original collateral source context. The Collateral Source Rule permits the plaintiff to be overcompensated for his loss, since he would recover a full tort judgment for all his injuries and could retain the value of the collateral benefits as well. Abolition of the rule would save the liability insurer costs which ought to be passed on in the form of reduced premiums to the wrongdoing defendants as well as to prudent actors carrying liability insurance. The choice between these two consequences is more evenly balanced than the choice in the original collateral source context. Which choice is preferable turns on how far our tort system has moved away from being a fault system designed to punish wrongdoing and has become a compensatory system intended to provide victims with full compensation for their losses.[17] If our main purpose is to

guarantee compensation for tortious injuries, that end is fully accomplished without the Collateral Source Rule.

A large majority of the scholarly writing about the Collateral Source Rule in the last two decades has been critical.[18] The most thorough and scholarly analysis was made by John Fleming,[19] who after surveying the operation of the rule in England, the Commonwealth countries, and the United States, concluded that the Rule should be abolished. As he states in the conclusion:

> In increasing measure, a person who has met with an accident may nowadays look for compensation not only to the law of torts but to other collateral sources. The coexistence of several such regimes of compensation in any individual case calls for important decisions as to their relation one to another. Three solutions are open: first, to let the accident victim cumulate the various benefits; second, to shift the ultimate burden of the accident loss to the tortfeasor; relieving as far as possible other compensation funds; third, to credit the tortfeasor with any benefits received from another source.
>
> The first alternative associated with the "collateral source rule", condones multiple recovery to avoid giving the tortfeasor a "windfall" . . . in contrast to most other countries which are categorically committed to the compensatory and opposed to the punitive theory of tort damages, American courts continue to entertain an ambiguous and uneasy tolerance of double recovery ...
>
> Turning from double recovery to a consideration of other alternatives, we note that these differ from the former in posing a decision as to which of two sources of compensation to treat as the primary and which as the secondary. In contrast to cumulation of benefits, they force a confrontation with the basic policy orientation whether accident losses generally, or any particular accident loss, should be absorbed by the tortfeasor or by a collateral source, whether in accordance with the regime of tort law or the regime of private or social insurance ...

> [The] primarily moralistic postulates [underlying the collateral source rule] are gradually yielding in their appeal to an economic value system which places in the forefront the high collection costs of reshifting the loss from a collateral source to the tortfeasor, the attendant wastefulness of multiple insurance and, most important of all perhaps, an awareness that in these days, when tort liability qualifies as a significant source of compensation only in case of defendants who can pass on the loss through liability insurance or pricing of their goods or services, the question is not so much whether a wrongdoer deserves to be relieved as which of several competing "risk communities" should bear the loss ...[20]

Once the fault justication for the Collateral Source Rule has been abandoned, the only modern justification advanced for the rule is that it helps prevent undercompensation for the victim.[21] The plaintiff will usually receive only one-half to two-thirds of the amount awarded by the jury as full compensation.[22] The fee for his attorney and other legal costs must be paid out of the proceeds. Since most plaintiffs' attorneys work on a contigency basis and the usual fee for litigating a case averages one-third of the judgment but may go as high as one-half,[23] the plaintiff's actual recovery will be diminished by that amount. To the extent that collateral benefits received by plaintiff approach one-third to one-half of the verdict, they would seem to compensate plaintiff for his legal costs and thus correct that unfortunate principle adopted in the American common law that each party must bear the full cost of his own legal expenses, however free of fault he is compared to the other.

The operation of the Collateral Source Rule does not improve the position of the plaintiff. First, it should be

clear that only those collateral benefits for which there is no right of subrogation could improve the plaintiff's position. All other collateral benefits for which a corresponding sum was included in the general verdict belong to the subrogee, not the plaintiff.[24] Beyond this, the Collateral Source Rule actually worsens the position of the plaintiff because the base on which the contingency fee is figured is the verdict and this is larger under the Collateral Source Rule than it would be if the rule were abolished.

This result can be illustrated by considering the fact situation discussed above under the modern context for operation of the Collateral Source Rule.[25] There I posited a case where the plaintiff sued to recover damages of $68,990.00 for personal injuries and property damage which were caused by the negligence of the gas company. Included in this were items for which plaintiff had received collateral benefits of $17,290.00. Of this amount, $16,442.00 was supplied by a collateral source entitled to subrogation. Now I would like to assume that the jury determines that the full amount prayed for is what plaintiff is entitled to as full compensation. Secondly, I assume that the plaintiff's attorney has a contingency contract under which he receives as his fee one-third of any recovery after litigation begins. Based on these assumptions, it is possible to compare the operation of the Collateral Source Rule and of its abolition.

Collateral Source Rule		No Collateral Source Rule	
Verdict	$68,990	$51,700	($68,900 less collateral benefits of $17,290)
less attorney's fees of 1/3 of recovery	$22,993	$17,233	
	$45,997	$34,467	
less subrogated benefits	$16,442	642.[26]	
Plaintiff actually receives	$29,555	$33,825	

Abolition of the Collateral Source Rule would permit plaintiff to recover $4,270 more. At the same time, his attorney would recover $5,760 less. Thus, the Collateral Source Rule favors not only first party insurers over third party insurers, but plaintiffs' attorneys over plaintiffs.

This is not to suggest that there is anything improper about the contingency fee concept. It has always been a guarantee that those persons unable to hire a lawyer will have the benefit of counsel when pressing civil claims for injury.[27] But there is nothing in that salutary option that demands it be measured on anything more than the net loss suffered by the plaintiff, that is, the sum which is owed by the defendant after collateral benefits have been credited.

One further point should be made about the operation of the Collateral Source Rule. It is one of a series of legal rules designed to keep the decision of jurors untainted by intrusion of the issue of insurance. Other rules aimed at this result are: (1) that a plaintiff only partly compensated from

collateral sources is the real party in interest so that his first party insurer subrogated to a part of that tort recovery need not appear as the plaintiff of record,[28] and (2) the introduction of the fact that defendant has liability insurance is so prejudicial to the interests of the defendant that he would normally be entitled to a new trial.[29] Abolition of the Collateral Source Rule would not conflict with this basic policy because no insurer appears as a party to be affected by the jury's verdict, either as claimant or as the party who must ultimately pay the judgment. All the jury will learn is that some insurance money has already been paid. A question ought, however, to be raised about the underlying policy. When these rules were first developed, insurance was not common, so it was safe to assume that the average juror would suspect there were no insurers behind either the plaintiff or the defendant unless insurance were in the open. Today, all persons of means carry insurance and are moderately sophisticated about the general facts of insurance. Any automobile driver knows about automobile insurance, which he or she is required to carry. Almost every homeowner carries homeowner's comprehensive insurance. Most adults are covered by some form of medical and health insurance. Jurors may well speculate about the availability of insurance and such speculation could influence their decision one way or another. The completely uninsured person may be damaged by the operation of rules designed to protect an insured person and insurers as a class, because the

jury might assume the presence of typical insurance protections when they do not in fact exist. The abolition of the Collateral Source Rule which would permit evidence to be admitted on actual insurance protection owned by plaintiff lets the jury have reliable evidence on matters where otherwise they are likely to be speculating and doing so inaccurately.

3. The American Medical Association and the Collateral Source Rule

Rarely does scholarly analysis about a legal problem and the need for reform lead directly to change. Some politically active group who stands to gain by the reform has the responsibility of turning a dispassionate analysis into a new and effective legislative program. That impetus came from the perceived crisis in medical costs when medical malpractice litigation mushroomed in the past two decades. Defendant doctors and, behind them, their liability insurers were particularly outraged when asked to pay in malpractice judgments not only very large sums for pain and suffering and for economic losses, but also to pay for the doctor's own services, corrective services, and additional health care for which the patient had been fully compensated by health insurance programs of one sort or another.

In the nineteen-seventies, the American Medical Association organized a nationwide campaign to achieve major reforms in the tort system which they hoped would limit the explosion in malpractice judgments and the cost of malpractice

insurance. Among the reforms were the introduction of screening panels to weed out unmeritorious claims,[30] the provision for arbitration agreements to be executed between patients and health care providers,[31] the grant of power to courts to review attorneys' fees to ensure that they were reasonable,[32] the abolition of the collateral source rule, and the fixing of a maximum dollar limit on recovery in malpractice actions.[33] Having achieved limited success in persuading state legislatures to adopt these reforms, the American Medical Association has turned its attention to supporting a no-fault compensation scheme for malpractice in the federal Congress.[34]

The reform in the collateral source rule is the least radical change in the existing tort system and thus was the most widely adopted.[35] These statutes are in no sense uniform, although they all contain two common elements: (1) they apply only to medical malpractice actions, and (2) they permit the defendant health care provider(s) to introduce evidence of some collateral benefits received by the plaintiff. One of the most elaborate and complete is the Arizona statute, which provides:

> A. In any medical malpractice action against a licensed health care provider, the defendant may introduce evidence of any amount or other benefit which is or will be payable as a benefit to the plaintiff as a result of the injury or death pursuant to the United States Social Security Act, any state or federal workmen's compensation act, any disability, health, sickness, life, income-disability or accident insurance that provides health benefits or income-disability coverage and any other contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of income-disability or medical, hospital, dental or other health care services to establish that any cost, expense, or loss claimed by the

plaintiff as a result of the injury or death is subject to reimbursement or indemnification from such collateral sources. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any such benefits or that recovery from the defendant is subject to a lien or that a provider of such collateral benefits has a statutory right of recovery against the plaintiff as reimbursement for such benefits or that the provider of such benefits has a right of subrogation to the rights of the plaintiff in the medical malpractice action.

B. Evidence introduced pursuant to this section shall be admissible for the purpose of considering the damages claimed by the plaintiff and shall be accorded such weight as the trier of the facts chooses to give it.

C. Unless otherwise expressly permitted to do so by statute, no provider of collateral benefits, as described in subsection A, shall recovery any amount against the plaintiff as reimbursement for such benefits nor shall such provider be subrogated to the rights of the plaintiffs.[36]

The major issues on which the various statutes differ is: (1) whether it lies in the discretion of the jury to make the deduction,[37] or whether the court must make the deduction as a matter of law,[38] (2) whether the statute specifically denies the right of subrogation to the provider(s) of collateral benefits,[39] or whether this is left to implication,[40] and (3) whether the evidence which may be introduced covers all benefits received by the plaintiff,[41] whether such benefits as life and accident insurance are excluded from admissibility,[42] or whether benefits purchased by the plaintiff or his employer are excluded from admissibility.[43]

These medical malpractice statutes abolishing the Collateral Source Rule have been subjected to vigorous constitutional attack.[44] The grounds argued to establish unconstitutionality are varied. It has been contended that the limited abolition of the Collateral Source Rule violates the requirements of due process and equal protection under the federal constitution.[45] It has also been argued that state constitutional guarantees of equal protection or due process are violated by such statutes.[46] In addition, challengers have relied on special provisions of state constitutions, such as a prohibition against special legislation,[47] a prohibition against limiting damages,[48] or a provision guaranteeing open courts and remedies for all wrongs.[49]

The highest courts of two states, New Hampshire[50] and North Dakota[51] have held unconstitutional that part of their medical malpractice act which abolished the collateral source rule. In doing so, each court relied primarily on state constitutional provisions and their local views of appropriate constitutional principles. Both courts used a stricter rule of legislative scrutiny, the so-called "substantial relationship" test, requiring a close correspondence between the stated legislative goals and the classifications and means selected by the legislature to achieve those goals. Applying this stricter standard, the Supreme Court of North Dakota was persuaded that the crises in medical malpractice was not great and thus reform was not essential. The Supreme Court of New Hampshire felt the means chosen by the legislature were not the most effective or

were not constitutionally permissable ways to achieve the goals.[52]

A substantial majority of courts which have considered the constitutionality of these statutes abolishing the collateral source rule have upheld them as valid.[53] These courts use a less strict rule of legislative scrutiny under due process or equal protection analysis, the rational-basis test. This test accords greater tolerance and respect to legislative judgments about what the needs of society are and which are the best means to achieve these goals.

4. The Generalization of the Malpractice Reform To all Civil Actions

The core of the equal protection argument is that there is no rational justification for treating medical malpractice actions differently from all malpractice actions or more generally from all tort actions. In the Florida case testing the constitutionality of their Medical Malpractice Act,[54] Chief Justice Sundberg in his dissent said:

> [The Florida statute in question] essentially abolishes the collateral source rule, but only with reference to the medical profession. This common law rule typically prevents reduction of the plaintiff's tort recovery by any amounts of alternative compensation received from sources such as health insurance or disability benefits. The justifications for the rule are (1) to avoid penalizing the plaintiff who purchases insurance, (2) to avoid discouraging the purchase of insurance, and (3) to increase the deterrent effect of liability. The validity of these rationales has been debated, but

> commentators agree that if the collateral source rule is modified, there is no justification for confining changes to medical malpractice cases.[55]

While Chief Justice Sundberg's arguments were not and should not be persuasive to the Supreme Court of Florida on the constitutional question, they are valid on the issue of sound legislative policy. While the constitutional structure should permit the legislatures the choice to legislate differently for medical malpractice, that discretion should be exercised only if there are justifiable reasons for the differential treatment. The reasons for modifying or abolishing the Collateral Source Rule apply to all tort actions, not just to medical malpractice.

Similar crises or potential crises exist in other parts of our torts-compensation system. The cost and administrative delays in automobile compensation led to a variety of attempts to control costs, the most prominent of which has been no-fault legislation. The cost of products liability litigation and compensation is another tort area approaching crisis dimensions.

As Jeffrey O'Connell, one of the leading proponents of no-fault approaches to tort liability, has written:

> The main intellectual, rather than practical, challenge currently posed by no-fault insurance is the application of the no-fault principle to accidents other than those involving autos, principally to claims arising from medical mistreatment and malfunctioning products. Indeed, the success of no-fault auto insurance has meant that medical malpractice and product liability claims comprise a much greater portion of personal injury

claims generally than before the advent of such no-fault laws.

Furthermore, the undesirable characteristics of the present tort liability system are even more evident in medical malpractice and products liability claims than in claims arising out of auto accidents. In medical malpractice and products liability suits, many more victims are left uncompensated. Payment, even when made, is much more delayed. Finally, much more of the premium dollar is spent on legal fees.[56]

If automobile accidents, medical malpractice, and injuries from defective products all represent areas of serious cost and administrative problems for our tort system, can there be any justification for abolishing the Collateral Source Rule in one case, but not in the others. And if we decide that these three problem areas require similar treatment by abolishing the Collateral Source Rule, is this not one of those cases where the exceptions would swallow up the rule, because the overwhelming bulk of tort litigation occurs in one of these three areas. Deciding that there ought to be uniform treatment, however, does not determine which way to generalize - whether to retain the rule or to abolish it.

The reasons behind the Collateral Source Rule no longer exist. The widespread and increasing use of liability insurance has virtually eliminated the fault aspects and deterrent operation of the law of tort. Anyone with sufficient assets to pay a tort judgment will almost invariably carry liability insurance. If there is no liability insurer, there is in all probability a judgment-proof tortfeasor. The penalties exacted by the Collateral Source Rule are thus hardly

ever paid by wrongdoing tortfeasors, but rather by the entire class of insureds under liability policies. Thus, liability insurance becomes a compensatory scheme for accident victims, no different in quality from other compensation schemes, such as health insurance, accident insurance, disability insurance, wage continuation plans, etc. Once the fault orientation to tort liability has been abandoned, the purpose of the tort system is to insure that accident victims are fully compensated. That end is adequately and fully achieved if the liability insurer behind the defendant is required to pay only the true loss of the plaintiff, which is that amount not covered by the variety of collateral support plans now available to plaintiffs who have been injured.

Ultimately, the really important issue is which systems of compensation are primary, the liability insurer, or the providers of collateral benefits. To the extent that these collateral benefits have not been provided gratuitously by friends and relatives, they have already been funded, either by tax money, by private insurance premiums, or as fringe benefits in exchange for the employee's services. Their coverage is almost always broader than just for those accidental injuries where causal fault of a third party can be proved. The allocated cost of these benefits is usually figured free of the ability of the provider to transfer a portion of those costs to a defendant and his insurance carrier through subrogation or assignment. To the extent that there would be a savings

occruing from subrogating first party providers of collateral benefits to the third party liability insurer, this savings is often wiped out by the costs of obtaining such transfers. If subrogation or transfer costs exceed recoupment from subrogation, there is an added burden on the total injury compensation system.

5. Special Problems in the Drafting of a Reform Statute

The conclusion that the Collateral Source Rule should be abolished does not resolve in and of itself several subsidiary problems: (a) Should the statute be evidentiary only, so that the deduction of collateral benefits is left to the discretion of the jury, or should the judge be required to deduct the collateral receipts as a matter of law? (b) Should the reform apply to all collateral benefits, or only to some? (c) Should the plaintiff recover in the tort action the premiums and other consideration paid to the provider for the collateral benefits? (d) Should the providers' right of subrogation be abolished as well? The medical malpractice statutes which have abolished the Collateral Source Rule[57] often do not cover one or more of these problems and, to the extent they do, the problems are resolved in very diverse ways.

(a) Issue of Fact for the Jury or Matter of Law for the Judge

Whether the judge or the jury should have the power to decide on the impact of collateral benefits is not an issue where there is a clear answer, but there are reasons for leaving the matter to the discretion of the jury. First, there may be fact disputes to be resolved, such as, did the plaintiff actually receive the benefits, and what was its worth in dollars. Gratuitously rendered benefits, particularly the delivery of services or goods, often pose such issues. In order to leave the ultimate decision to the judge, it would be possible to set up a two tier procedure, whereby the jury in a special verdict would make the necessary fact determinations, quantifying the benefit, and then the judge would deduct the liquidated amount from the general verdict.[58] This procedure would not be frequently used because unliquidated and gratuitous goods or services are not the most common or important collateral benefits today. Insurance payments, such as property damage settlements, health insurance refunds, or disability payments under private or governmental plans, as well as salary paid under wage continuance plans, are easy to prove and are liquidated.

A more general reason for leaving the deduction to the discretion of the jury arises from the very nature of the general verdict. In arriving at a single final sum as the award to plaintiff in full compensation for his losses, the jury probably balances a number of factors, such as the strenth

of the liability issue as against the seriousness of the injury, the nature and persuasiveness of the proof on the various items of damage, and the relative fault of the plaintiff as compared with the fault of the defendant. Letting the jury know of and be able to balance the amount of collateral benefits received only adds another factor to be used in arriving at a single just award. Not permitting the jury to know about or to balance these items, but instead requiring the judge to deduct it after the verdict is awarded, gives the element of collateral benefits much greater weight than the other factors because it has been removed from the scales.

Furthermore, the solution to this issue should be related to the answer to the next problem, the types of collateral sources which may reduce the defendant's liability. If the judge is required to deduct them as a matter of law, the collateral benefits should be only those which are clearly liquidated. If the question is one for the jury, a broader range of benefits, including gratuities, could be admissible.

Of those legislatures abolishing the Collateral Source Rule in medical malpractice actions, nine of them chose to leave the issue to the discretion of the jury,[59] and five made it a matter of law for the judge.[60] In addition, New York originally left the matter to the jury, but in 1981 amended its statute to make the issue one of law for the judge.[61]

(b) Types of Collateral Benefits Which Should be Admissible

This is the problem on which the medical malpractice statutes show the greatest divergence. The broadest classification is to cover all collateral benefits of every type and from every source.[62] Another approach is to list quite specifically the collateral benefits for which evidence would be admissible.[63] A good example appears in the Arizona statute quoted above on page 16. A third approach is to specify that all collateral benefits are admissible with specific named exceptions. The most common exceptions are death benefits under life insurance policies[64] and insurance purchased with assets of the claimant or members of the claimant's immediate family or paid for by claimant's employer.[65] Another common provision is to limit the collateral benefits to those which are clearly liquidated special damages, particularly payments or reimbursements for medical care, rehabilitative care, and custodial care, as well as for lost earnings.[66]

This welter of approaches to indentifying collateral benefits admissible under a statute abolishing the common law Collateral Source Rule raises two important problems: first, whether unliquidated gratuitous assistance given a claimant by friends or relatives should be a collateral benefit reducing a tort judgment, and, secondly, whether life insurance and non-medical accident insurance should be excluded from admissibility.

There are policy and administrative grounds why the gratuitious unliquidated services should not be used to reduce

a tortfeasor's judgment. The administrative reason is the difficulty in proving the receipt, the extent, and the value of such services. The policy reason is that we want to encourage or support a dwindling tradition in our society, the willingness of family and friends to help someone in need. If the amount of the help could be used to diminish the recovery of the victim in his legal action, this will certainly have a chilling effect on the willingness of such people to make contributions.

Life insurance and accident insurance except for medical payments pose much the same issue. A potential victim may in planning for himself or beneficiaries in the event of a serious accident or death chose to provide for certain intangible losses not contemplated by any compensatory scheme. If a planner decides he wants to leave his beneficiaries in a better economic position than would be provided by a wrongful death action, should he not have the freedom to purchase such further protection through private insurance? If he wishes himself to be cared for in the event of a disabling accident more generously than either a tort judgment or other compensatory schemes are likely to provide, should he not also have the power to purchase additional accident insurance? If the purchased protection would be used to reduce the judgment he would receive from a wrongdoer, that would be a disincentive to the exercise of this freedom or power.

The analysis of these two problems suggest that the admissible collateral benefits should be those covering the items of special damage in tort, the medical expenses and loss

of earnings. If the impact of the collateral source rule or its abolition is primarily to select which of several compensatory schemes would have primary responsibility for indemnifying the victim, the compensatory schemes which are in competition with the tort system are directed to cover clear economic loss of the victim. The three main types are medical insurance, either governmental or private, wage continuance plans, and private or governmental disability payments. If admissibility is limited to these types, not many collateral benefits of real value will be left out.

(c) Credit for Premiums Paid

One argument made against abolishing the Collateral Source Rule was that it would discourage victims from purchasing insurance protection.[67] This led some Medical Malpractice Acts to exclude all benefits from insurance purchased by the claimant or by his employer.[68] There would still be strong incentives to continue to purchase insurance because the potential victim never knows whether the loss can be transferred to a wrongdoer. Genuine accidents do occur. To go to the other extreme and permit all collateral benefits to be introduced to diminish the tort liability of a tortfeasor would work an unfairness. It would give the tortfeasor a windfall - the benefit of the victim's foresightedness in providing insurance protection without the wrongdoer having to pay for that insurance. A widely adopted compromise is to provide that

if the defendant elects to introduce evidence of collateral benefits, the plaintiff is entitled to introduce evidence of the cost of those benefits.[69] The clear import of this is that the jury should diminish the plaintiff's award by the difference between the two. This difference represents the real economic gain which the plaintiff has recieved from the alternative compensatory schemes and is all the credit the defendant is entitled to.

(d) Abolishing the Provider's Right of Subrogation

The Collateral Source Rule and the Right of Subrogation are closely linked. One cannot be altered without requiring changes in the other. This has been recognized by the Medical Malpractice Acts which define the admissible collateral benefits as those for which the provider does not have a right of subrogation.[70] This lets the law of subrogation control the content of the Collateral Source Rule. This is not necessary because state legislatures have the power to abolish the right of subrogation in providers' of collateral benefits except where those benefits are provided by federal governmental programs and federal legislation gives to the provider the right of subrogation.[71]

The state cannot effect the reforms called for by abolishing the Collateral Source Rule, if it leaves the law of subrogation in place. Some of the Medical Malpractice Acts have specifically abolished the right of subrogation in the

providers.[72] A powerful argument can be made that unless the admissible collateral benefits are defined in such a way as to retain the rights of subrogation in those providers who have them, a statute revoking the Collateral Source Rule carries with it by implication the abolition of the right of subrogation in the provider.[73] This matter is too important to be left to implication or construction by the courts. The statute should forthrightly address the question and if the decision is made to abolish the Collateral Source Rule, the statute should clearly abolish the right of subrogation as widely as it is in the power of the state to do so. The analysis of this article would call strongly for Congress to abolish the right of subrogation in favor of federal programs of accident or injury compensation.

6. Conclusion

The Collateral Source Rule is an anachronism based on nineteenth century fault concepts surviving into a twentieth century legal system where the primary goal is to guarantee that victims of acidents in our society should be adequately compensated for their losses. It has been an acceptable anachronism until the rapidly inflating costs to our society of automobile accidents, malpractice actions, and products liability claims have led to close scrutiny of our torts system to see ways in which it could be administered more efficiently. The Collateral Source Rule creats substantial transfer costs in

shifting the duty to pay from one compensatory scheme to another without any corresponding benefit to the victim. If anything, it costs victims something in larger legal fees and costs. The reform which decreases societal and personal cost with the least harm to our current tort system is to do away with this anachronism.

A carefully drawn statute negating the operation of the Collateral Source Rule in all tort actions should be adopted. Such a statute should leave the question of how much to deduct to the discretion of the jury, should limit the admissibility of collateral benefits to those which are clearly liquidated and cover the items of special damage in torts, should insist that the plaintiff receive credit for all premiums or other consideration paid to the providers of the collateral benefits, and should abolish the right of subrogation in the providers of such collateral benefits to the fullest extent possible.

Footnotes

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**Professor of Law, Washburn University, B.A., LL.B., University of Tulsa, LL.M., S.J.D. University of Michigan.

1. The American Law Institute, Restatement of the Law of Torts (Second), § 920A, p. 513, 1977.

2. Articles critical of the Collateral Source Rule include: Fleming, The Collateral Source Rule and Loss Allocation in Tort Law, 54 Calif. L. Rev. 1478 (1966); Bell, Complete Elimination of the Collateral Source Rule - A Partial Answer to Criticism of the Present Injury Reparations System, 14 N.H.B.J. 20 (1972); Peckinpaugh, An Analysis of the Collateral Source Rule, 32 Ins. Coun. J. 32 (1965); Schwartz, The Collateral-Source Rule, 41 B.U.L. Rev. 348 (1961); Note, Unreason in the Law of Damages: The Collateral Source Rule, 77 Harv. L. Rev. 741 (1964). Articles defending the rule are: Moceri and Messina, The Collateral Source Rule in Personal Injury Litigation, 7 Gonz. L. Rev. 310 (1972); Maxwell, The Collateral Source Rule in the American Law of Damages, 46 Minn. L. Rev. 669 (1962).

3. This is the position of the reporters of the Second Restatement of Torts, stated in Comment d. to § 902A:

> d. The collateral-source rule is of common law origin and can be changed by statute. Changes made are sometimes in statutes providing a different method of compensation such as the first-party insurance involved in certain motor vehicle reparations acts.

4. Alaska: Alaska Statutes, § 09.55-548 (1976).

Arizona: Arizona Revised Statutes Annotated, § 12-565 (1976).

California: California Civil Code, § 3333.1 (1976).

Delaware: Delaware Code Annotated, Title 18, § 6862.

Florida: Florida Statutes Annotated, § 768.50 (1976).

Idaho: Idaho Code, § 39-4210 (1975).

Illinois: Smith-Hurd Illinois Annotated Statutes § 110: 2-1205 (1982).

Iowa: Iowa Code Annotated § 147.136.

Kansas: Kansas Statutes Annotated, § 60-471 (1976).

Nebraska: Revised Statutes of Nebraska, § 44-2819 (1976).

New Hampshire: New Hampshire Revised Statutes Annotated: § 507-C:7(I) (1977).

New York: McKinney's Consolidated Laws of New York, Civil Practice and Rules, § 4010 (1975, amended 1981).

North Dakota: North Dakota Code, § 26-40.1-08 (1977, repealed in 1983).

Ohio: Ohio Revised Code § 2305.27.

Rhode Island: General Laws of Rhode Island, § 9-19-34 (1977).

South Dakota: South Dakota Codified Laws, § 21-3-12 (1977).

Tennessee: Tennessee Code Annotated, § 29-26-119 (1975).

Washington: Revised Code of Washington Ann. § 7.70.080 (1975-76).

5. Colorado Revised Statutes, § 10-4-713.

6. Senate Bill No. 758, By Committee on Judiciary, Feb. 20, 1984, which provides:

> 1. (a) In any action for damages for personal injury, including bodily harm, sickness, disease or death, or for property damage the court shall admit into evidence the total amount of all compensation or benefits received or entitled to be received by the claimant from any collateral source.
>
> (b) If a party elects to introduce evidence of compensation or benefits from any collateral source, the courts shall admit evidence of any amount which the party has paid or contributed to secure the party's right to any compensation or benefits concerning which evidence of collateral source compensation or benefits has been admitted.

7. The collateral benfits problem is not confined to tort litigation. It may be an issue in contract recovery. See Billetter v. Posell, 94 Cal. App. 2d 858, 211 P.2d 621 (1949), where an employer being sued to recover damages for wrongful dismissal was not allowed to set off unemployment compensation benefits against the wages owed. The purpose of expectation damages in contract is to place the plaintiff in as good a position as he would have been

if the contract had been performed at the least cost to defendant, so there is little need to award plaintiff more than his net economic loss after collateral benefits have been subtracted. Warren Co. v. Hanson, 17 Ariz. 252, 150 Pac. 238 (1915); Anderson v. Rexroad, 180 Kan. 505, 306 P.2d 1371 (1957); Georgetown Power Co. v. Neale, 137 Ky. 197, 125 S.W. 293 (1910). It may even become an issue in criminal law if some procedure is provided whereby a victim is authorized to recover restitution for his losses from the criminal. In Maine, the statutory right to restitution does not exist to the extent that the victim has been compensated from a collateral source. Maine Revised Statutes Annotated, Title 17-A, § 1324 (2)(C). In Texas, where victims of crimes may recover from a state compensation fund, the state is subrogated to the insurance benefits of the victim to the amount awarded under the Crime Victim's Compensation Act. Texas Civil Statutes, § 8309-1 (11)(A).

8. The American Law Institute, Restatement of the Law of Torts (Second), § 920A, comment c. pp. 514-515, 1977.

9. The fact situation is patterned after Lewark v. Parkinson, 73 Kan. 553, 85 Pac. 601 (1906). Similar cases are: Pennsylvania Co. etc., v. Marion, 104 Ind. 239, 3 N.E. 874 (1885); Varnham v. City of Council Bluffs, 52 Iowa 698, 3 N.W. 792 (1879); Wells v. Minneapolis Baseball & Athletic Ass'n, 122 Minn. 327, 142 N.W. 706 (1913). Reaching a contrary result by not allowing plaintiff to recover the

reasonable value of gratuitious services as items of damage are: Morris v. Grand Ave. Ry Co., 144 Mo. 500, 46 S.W 170 (1898); and Goodhart v. Pennsylvania R. Co., 177 Pa. 1, 35 Atl. 181, 55 Am. St. Rep.705 (1896).

10. Of course, the record should be silent because the clear rule in most states is that it is prejudicial to defendants to inject in the trial the fact that defendant had liability insurance. Cotter v. McKinney, 309 F.2d 447 (7th Cir., 1962); Robins Engineering, Inc. v. Cockrell; Ala, 354 So.2d 1 (1977); Caylor v. Atchison, T. & S. F. Ry. Co., 189 Kan. 210, 368 P.2d 281 (1962); Miles v. Seigle, Okl. App., 571 P.2d 866 (1977). My assumption in the text is based on the likelihood of a small businessman, a livery stable operator, carrying liability insurance in the period before 1906.

11. This is a more detailed analysis of the justification behind the Collateral Source Rule than courts usually give. A typical articulation of the justification appears in Rexroad v. Kansas Power and Light Company, 192 Kan. 343, 388 P.2d 832 (1964), where the Court said:

> "It is well settled that the damages recoverable for a wrong are not diminished by the fact that the party injured has been wholly or partly indemnified for his loss by insurance effected by him; and to the procurement of which the wrongdoer did not contribute. This rule is not affected by the fact that the insurer is entitled to be subrogated to the rights of the insured, as against the tortfeasor, or to recover back from him the amount he recovers. The question of the right to the proceeds of the recovery is a matter between the insurer and the insured. It

> constitutes no defense to the action for damages caused by the wrong, which must be brought in the name of the insured, although it might be for the use of the insurer. The reasons generally given for the rule are that the contract of insurance and the subsequent conduct of the insurer and the insured in relation thereto are matters with which the wrongdoer has no concern and which do not affect the measure of his liabilty ..."

12. This is an elaboration of the fact situations in cases like Davis v. Kansas Electric Power Co., 15 Kan. 97, 152 P.2d 806 (1944) and Rexroad v. Kansas Power and Light Company, 192 Kan. 343, 388 P.2d 832 (1964). Some other modern cases where the provider of the collateral benefits is not doing so gratuitously and where the real defendant is probably a compensated liability insurer or a self-insurer who can pass the cost of judgment on to consumers are: Overton v. U.S., 619 F.2d 1299 (8th Cir. 1980); Aydlett v. Haynes, 511 P.2d 1311 (Alaska, 1973); Taylor v. Jennison, 335 S.W.2d 902 (Ky., 1960); and Iseminger v. Holden, 544 S.W.2d 550 (Mo., 1976).

13. The gas company might choose to be a self-insurer. What this means is that it administers an insurance plan by charging its customers a small fee to build a fund from which tort losses are to be paid. Thus it would be the innocent consumers that must bear the punitive impact of the collateral source rule rather than the wrongdoing company or its agents.

14. The right of the fire insurer to be subrogated to the claim of the insured whose loss it has paid is well

established. Hume v. McGinnis, 156 Kan. 300, 133 P.2d 162 (1943); New Hampshire Ins. Co. v. Kansas, Power & Light Co., 212 Kan. 456, 510 P.2d 1194 (1973). If the action is brought in the name of the insured who has been partially paid by his own insurer, he holds that part of the recovery received from the tortfeasor for which he has been paid by his insurer in trust for the insurer. Deemer v. Reichart, 195 Kan. 232, 404 P.2d 174 (1965). If the insured has been fully compensated for his loss, then the insured is not the real party in interest and the action must be prosecuted by and in the name of the subrogated insurer. Hill v. Leichliter, 168 Kan. 85, 211 P.2d 433 (1949).

15. Hudson v. Lazarus, 217 F.2d 344 (D.C. Cir., 1954). While not entitled to subrogation before 1962, the Veteran's Administration had a practice of taking express assignments from veterans admitted to free treatment in a veteran's hospital who may have a cause of action against a tortfeasor. See 38 C.F.R. 17.48(d)(3). If the state has a policy permitting assignments of personal tort claims, this may have the same effect as subrogration. Since 1962, federal law has provided a right of subrogation in the United States for the reasonable value of any medical care which the United States is required or authorized to provide. 42 U.S.C.A. 2651.

16. Whether there is in fact any windfall to the plaintiff's insurer depends on whether premiums charged to plaintiff

and like insureds are discounted by the amount of subrogation recovery. If so, there is no serious benefit or windfall to the first party insurer. See W. Young, Insurance, Cases and Materials, The Foundation Press, 1971, pp. 342-343, where the editor says:

> Insurance subrogation would have more friends than it does if it could be shown that recoveries enter into premium-rate calculations in an equitable way .... A survey in the early 60's revealed that a number of insurers do not record their subrogation experience by class of insurance. Rating bureaus, it was found, had no information on the volume of subrogation recoveries.
>
> Professor Patterson wrote: "Subrogation is a windfall to the insurer. It plays no part in rate schedules (or only a minor one), and no reduction is made in insuring interest, such as that of the secured creditor, where the subrogation right will obviously be worth something. Hence, in such a case no reason appears for extending it." ...

17. The degree to which our tort system has moved from fault based ends to compensatory ones is evidenced by the adoption of no-fault concepts in automobile injury reparations. See Kansas Automobile Injury Reparations Act, K.S.A. §§ 40-3101 to 40-3121. In Manzanares v. Bell, 214 Kan. 589, 522 P.2d 1291 (1974), where there was a challenge to the constitutionality of this approach, the Supreme Court of Kansas quoted with approval several studies of the operation of fault-based tort approaches to compensation and concluded:

> "All studies concluded that the risk of tort liability based upon negligence is not a significant factor in inducing vehicle

operators to drive more carefully; that the tort system of reparations based on fault is excessively expensive and inefficient as a means of compensating automobile crash victims; that compensation distribution to accident victims under the tort system is inequitable in that it commonly results in overpayment of minor injuries, gross underpayment for those more seriously injured, and long delays in receipt of compensation." (522 P.2d at 1304).

18. See supra note 2.

19. Fleming, The Collateral Source Rule and Loss Allocation in Tort Law, 54 Calif. L. Rev. 1478 (1966).

20. Id. at 1544 - 1547.

21. See Moceri and Missina, The Collateral Source Rule in Personal Injuries Litigation, 7 Gonzaga L. Rev. 310 at 311-312 (1972). See also, the often cited passage from Hudson v. Lazarus, 217 F.2d 344 at 346 (D.C. Cir., 1954), where the court said:

> Legal "compensation" for personal injuries does not actually compensate. Not many people would sell an arm for the average or even the maximum amount that juries award for loss of an arm. Moreover, the injured person seldom gets the compensation he "recovers", for a substantial attorney's fee usually comes out of it. There is a limit to what a negligent wrongdoer can fairly, i.e. consistently with the balance of the individual and social interest, be required to pay. But it is not necessarily reduced by the injured person's getting money or care from a collateral source.

22. While we are required by the legal theory of fact finding to recognize the general verdict of the jury as the authoritative determination of what constitutes full compensation for plaintiff, that amount may be manipulated

away from the jury's best estimate of true compensation by their corrections for what they assume plaintiff will lose from having to pay attorney's fee, or recoup from having insurance. See discussion infra pp. 13-14.

23. F. MacKinnon, Contingent Fees for Legal Services, particularly Chapter 9, 1964.

24. See supra n. 14.

25. See supra pp. 5-6.

26. This assumes that the abolition of the Collateral Source Rule carries with it explicitly or by implication the denial of the right of subrogation to the suppliers of the collateral benefits as far as it is in the power of the state legislature to do so. See discussion infra n. 40. The subrogation rights of the United States for the medical services furnished by the veteran's hospital under 42 U.S.C.A. 2651 would still exist.

27. For a historical discussion of the contingent fee arrangement and a defense of its utility in protecting the poor who are injured, see J. Auerbach, Unequal Justice, 43-50 (1976).

28. Deemer v. Rechart, supra n. 14; Lines v. Ryan, Minn. 272 N.W.2d 896 (1978). Some courts have decided that real party in interest statutes, such as Fed. R. Civ. Proc. 17(a) require that a subrogated insurer be named as a party plaintiff even if it has paid only a part of the plaintiff-insureds claim. See Pub. Serv. Comm. of

Oklahoma v. Black & Veatch, 467 F.2d 1143 (10th Cir., 1972).

29. See cases cited supra n. 9.

30. e.g., Arizona Revised Statutes, § 12-567; Kansas Statutes Annotated, §§ 65-4901-65-4908.

31. e.g., Smith-Hurd Illinois Annotated Statutes, §§ 110:201-204.

32. e.g., Arizona Revised Statutes, § 21-568; Tennessee Code Ann., § 29-26-120; Revised Code of Washington Ann., § 7.70.070.

33. e.g., California Civil Code, §§ 3333.2 (limits recovery for non-economic losses to $250,000); Ohio Revised Code, § 2307.43 (limits recovery for general damages to $200,000); North Dakota Code, § 26.1-14-11 (limits recovery to amounts provided by malpractice insurance fund and the maximum recovery is $500,00 for each claim and one million dollars for each policy period); South Dakota Codified Laws, § 21-3-11 (total general damages limited to $500,000, but there is no limit on amount of special damages which are recoverable.

34. See House Bill 5400, introduced in the 98th Congress, second session.

35. See Statutes listed, supra n. 4.

36. Arizona Revised Statutes Annotated, § 12-565.

37. e.g., Arizona Revised Statutes Annotated, § 12-565(B); Revised Code of Washington Ann. § 7.70.080.

38. e.g., Florida Statutes Annotated, § 768.50; McMinney's Consolidated Laws of New York, Civil Practice and Rules, § 4010.

39. e.g., Arizona Revised Statutes Annotated, § 12-565(C); California Civil Code, § 3333.1(b).

40. The abolition of the Collateral Source Rule would have to at least impliedly revoke the right of subrogation in the collateral source provider. Otherwise, the plaintiff would receive less than full compensation because there would be a double reduction from his total damages, or else the impact of abolishing the collateral source rule is evaded because the provider in a separate subrogation action would recover from the defendant tortfeasor the amount that was deducted from plaintiff's judgment upon introducing the evidence of the collateral benefit. The courts could avoid this implication only by holding that the evidence of collateral benefits is admissible only if the provider has no right of subrogation. This would mean the abolition would apply only to the category of damages in class (b), but not to class (c) where the equities more strongly justify abolition. See discussion supra pp. 7-10.

41. e.g., Delaware Code Annotated, § 6862; Idaho Code, § 29-4-210.

42. e.g., Florida Statutes Annotated, § 768.50(2)(a)2.; McKinney's Consolidated Laws of New York Ann., Civil Practice Law and Rules, § 4010.

43. South Dakota Codified Laws, § 21-3-12; Tennessee Code Annotated; § 29-26-119; Revised Code of Washington Ann., § 7.70.080.

44. A extended discussion of the constitutional issues may be found in Note, California's Medical Injury Compensation Act: An Equal Protection Challange, 52 S. Cal. L. R. 829 (1979).

45. See: Eastern v. Bromfield, 116 Ariz. 576, 570 P.2d 744 (1977); Pinillos v. Cedars of Lebanon Hospital Corp., Fla., 403 So.2d 365 (1981); Jones v. State Board of Medicine, Idaho, 555 P.2d 399 (1976), cert. denied, 431 U.S. 914; Carson v. Maurer, N.H., 424 A.2d 825 (1980); Arneson v. Olseon, N.D., 270 N.W.2d 125 (1978).

46. See: Pinillos v. Cedars of Lebanon Hospital Corp., supra n. 45, Carson v. Mauer, supra n. 45; Arneson v. Olson supra n. 45.

47. See: Eastin v. Bromfield, supra no. 45; Arnseson v. Olson, supra 45.

48. See Eastin v. Bromfield, supra n. 45.

49. See Prendergast v. Nelson, 199 Neb. 97, 256 N.w.2d 657 (1977).

50. Carson v. Maurer, supra n. 45.

51. Arneson v. Olson, supra n. 45.

52. The Kansas statute was declared unconstitutional by a federal district court in Doran v. Priddy, 534 F. Supp. 30 (D.C. Kan. 1981), on both federal and state constitutional

grounds. The judge found that the distinctions between gratuitous collateral benefits which were admissible and collateral benefits paid for by the plaintiff or his employer which were inadmissible created a discriminatory classification. He also found that abolishing the Collateral Source Rule for only one class of tort defendants, i.e. health providers, was an unfair classification. He felt that these discriminations violated the right to equal protection under the fourteenth amendment to the U.S. Constitution and also violated Sections 1 and 2 of the Bill of Rights of the Kansas Constitution, which are the state equal protection provisions. The court also found the statute violated Article 2, Second 17 of the Kansas Constitution in that it was not a law of general nature having a uniform operation across the state. Whether this constitutional analysis is correct and would be upheld by higher federal courts and by the Kansas courts is open to serious doubt.

The constitutional analysis made by Judge Rogers in the unreported case of Holman v. The Menninger Foundation (NO. 79-40-90, D.C. Kansas, 1982) seems sounder and a better prediction of the judgment that higher federal courts and the Supreme Court of Kansas would come to than the decision in Doran v. Priddy. Judge Rogers reasoned that the validity of K.S.A. 60-471 under equal protection analysis turns on which test is used, the "rational basis"

test or stricter "substantial relationship" test. Those decisions which have held such statutes unconstitutional, including Doran v. Priddy, have used the "substantial relationship" test. Those courts which have used the "rational basis" test have found such statutes constitutional. After surveying the federal authorities, he concluded the appropriate test for federal equal protection was the "rational basis" test. Two Supreme Court of Kansas cases considering the constitutionality of other parts of the medical malpractice act have applied the "rational basis" test and presumably would do so in evaluating K.S.A. 60-471. See Stephens v. Snyder Clinic Association, 230 Kan. 115, 631 P.2d 222 (1981), and State ex rel Schneider v. Liggett, 233 Kan. 610, 576 P.2d 221 (1973).

53. Eastin v. Bromfield, supra no. 45; Pinillos v. Cedars of Lebanon Hospital Corp., supra no. 45; Rudolph v. Iowa Methodist Medical Center, Iowa, 293 N.W.2d 550 (1980); Prendergast v. Nelson, supra no. 49. Cf. Jones v. State Board of Medicine, supra n. 45, where the Supreme Court of Idaho held the appropriate standard was the rational-basis test, but remanded the case to the Civil Court for a finding on whether the national crises in health care insurance was applicable to Idaho.

54. Pinillos v. Cedars of Lebanon Hospital Corp., supra. n. 45.

55. 403 So.2d at 369-370.

56. O'Connell, Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses, 77 Northwestern L. Rev. 589 at 595-6 (1983).

57. Supra, n. 4.

58. Illinois seems the closest to having adopted such a procedure. See Smith-Hurd Illinois Annotated Statutes § 110: 2-1205.

59. See the statutes of Arizona, California, Delaware, Kansas, New Hampshire, Rhode Island, South Dakota, Tennessee, and Washington, cited supra n. 4.

60. See the statutes of Alaska, Florida, Illinois, Nebraska and North Dakota, cited supra no. 4.

61. McKinney's Consolidated Laws of New York, Civil Practice and Rules, § 4010, first adopted in 1975, then amended in 1981.

62. See Idaho Code, § 39-4210.

63. See the statutes from Arizona, California, and Rhode Island, cited supra n. 4.

64. See the statutes from Alaska, Florida, and New York, cited supra n. 4.

65. See the statutes from Iowa, Kansas, Ohio, South Dakota, Tennessee, and Washington, cited supra n. 4.

66. See the statutes from Illinois, New Hampshire, New York, Ohio, and South Dakota, cited supra n. 4.

67. See quote from Chief Justice Sundberg, supra n. 19.

68. See the statutes from Kansas, Tennessee, and Washington, cited _supra_ n. 4.

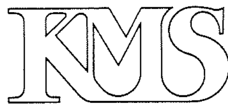
69. See the statutes from Arizona, California, Florida, Kansas, and New Hampshire, cited _supra_ n. 4. The statute in New York limits the credit to two years premiums and that of North Dakota to five years premiums.

70. See the statute from South Dakota, cited _supra_ n. 4. The Alaska statute excludes from the definition of benefits those payments from federal programs which by law must seek subrogation.

71. An example is 42 U.S.C.A. 2651, creating in the United States the right of subrogation against any third person having a tort liability for the reasonable value of the medical care and treatment furnished any victim where the United States is authorized or required by law to furnish such treatment.

72. See the statutes from Arizona, California, Florida, and Ohio, cited _supra_ n. 4.

73. See discussion _supra_ n. 40.



KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

The following items are submitted as addenda to the Kansas Medical Society statement on Substitute for SB 110, in the House Judiciary Committee, March 26, 1985:

"The Collateral Source Rule - The American Medical Association, and Tort Reform," Banks McDowell

Opinion of the California Supreme Court in Fein v. Permanente, February 28, 1985

Attachment No. 3
House Judiciary
March 26, 1985

SUPREME COURT
FILED
FEB 28 1985
LAURENCE P. GILL, Clerk
Deputy

COPY

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

LAWRENCE FEIN,

Plaintiff and Appellant,

v.

PERMANENTE MEDICAL GROUP,

Defendant and Appellant.

S.F. 24336
Super. Ct. 265659

In this medical malpractice action, both parties appeal from a judgment awarding plaintiff about $1 million in damages. Defendant claims that the trial court committed reversible error during the selection of the jury, in instructions on liability as well as damages, and in failing to order that the bulk of plaintiff's award be paid periodically rather than in a lump sum. Plaintiff defends the judgment against defendant's attacks, but maintains that the trial court, in fixing damages, should not have applied two provisions of the Medical Injury Compensation Reform Act of 1975 (MICRA): Civil Code section 3333.2, which limits noneconomic damages in medical malpractice cases to $250,000, and Civil Code section 3333.1, which modifies the traditional "collateral

(SEE DISSENTING OPINIONS)

source" rule in such litigation. Plaintiff's claims are based on a constitutional challenge similar to the challenges to other provisions of MICRA that we recently addressed and rejected in American Bank & Trust Co. v. Community Hospital (1984) 36 Cal.3d 359, Barme v. Wood (1984) 37 Cal.3d 174, and Roa v. Lodi Medical Group, Inc. (1985) ___ Cal.3d ___. We conclude that the judgment should be affirmed in all respects.

I

On Saturday, February 21, 1976, plaintiff Lawrence Fein, a 34-year-old attorney employed by the Legislative Counsel Bureau of the California State Legislature in Sacramento, felt a brief pain in his chest as he was riding his bicycle to work. The pain lasted a minute or two. He noticed a similar brief pain the following day while he was jogging, and then, three days later, experienced another episode while walking after lunch. When the chest pain returned again while he was working at his office that evening, he became concerned for his health and, the following morning, called the office of his regular physician, Dr. Arlene Brandwein, who was employed by defendant Permanente Medical Group, an affiliate of the Kaiser Health Foundation (Kaiser).

Dr. Brandwein had no open appointment available

that day, and her receptionist advised plaintiff to call Kaiser's central appointment desk for a "short appointment." He did so and was given an appointment for 4 p.m. that afternoon, Thursday, February 26. Plaintiff testified that he did not feel that the problem was so severe as to require immediate treatment at Kaiser Hospital's emergency room, and that he worked until the time for his scheduled appointment.

When he appeared for his appointment, plaintiff was examined by a nurse practitioner, Cheryl Welch, who was working under the supervision of a physician-consultant, Dr. Wintrop Frantz; plaintiff was aware that Nurse Welch was a nurse practitioner and he did not ask to see a doctor. After examining plaintiff and taking a history, Nurse Welch left the room to consult with Dr. Frantz. When she returned, she advised plaintiff that she and Dr. Frantz believed his pain was due to muscle spasm and that the doctor had given him a prescription for Valium. Plaintiff went home, took the Valium, and went to sleep.

That night, about 1 a.m., plaintiff awoke with severe chest pains. His wife drove him to the Kaiser emergency room where he was examined by Dr. Lowell Redding about 1:30 a.m. Following an examination that the

doctor felt showed no signs of a heart problem, Dr. Redding ordered a chest X-ray. On the basis of his examination and the X-ray results, Dr. Redding also concluded that plaintiff was experiencing muscle spasms and gave him an injection of Demerol and a prescription for a codeine medication.

Plaintiff went home but continued to experience intermittent chest pain. About noon that same day, the pain became more severe and constant and plaintiff returned to the Kaiser emergency room where he was seen by another physician, Dr. Donald Oliver. From his initial examination of plaintiff Dr. Oliver also believed that plaintiff's problem was of muscular origin, but, after administering some pain medication, he directed that an electrocardiogram (EKG) be performed. The EKG showed that plaintiff was suffering from a heart attack (acute myocardial infarction). Plaintiff was then transferred to the cardiac care unit.

Following a period of hospitalization and medical treatment without surgery, plaintiff returned to his job on a part-time basis in October 1976, and resumed full-time work in September 1977. By the time of trial, he had been permitted to return to virtually all of his prior recreational activities -- e.g., jogging, swimming,

bicycling and skiing.

In February 1977, plaintiff filed the present action, alleging that his heart condition should have been diagnosed earlier and that treatment should have been given either to prevent the heart attack or, at least, to lessen its residual effects. The case went to judgment only against Permanente.

At trial, Dr. Harold Swan, the head of cardiology at the Cedars-Sinai Medical Center in Los Angeles, was the principal witness for plaintiff. Dr. Swan testified that an important signal that a heart attack may be imminent is chest pain which can radiate to other parts of the body. Such pain is not relieved by rest or pain medication. He stated that if the condition is properly diagnosed, a patient can be given Inderal to stabilize his condition, and that continued medication or surgery may relieve the condition.

Dr. Swan further testified that in his opinion any patient who appears with chest pains should be given an EKG to rule out the worst possibility, a heart problem. He stated that the symptoms that plaintiff had described to Nurse Welch at the 4 p.m. examination on Thursday, February 26, should have indicated to her that an EKG was in order. He also stated that when plaintiff

returned to Kaiser late that same night with his chest pain unrelieved by the medication he had been given, Dr. Redding should also have ordered an EKG. According to Dr. Swan, if an EKG had been ordered at those times it could have revealed plaintiff's imminent heart attack, and treatment could have been administered which might have prevented or minimized the attack.

Dr. Swan also testified to the damage caused by the attack. He stated that as a result of the attack a large portion of plaintiff's heart muscle had died, reducing plaintiff's future life expectancy by about one-half, to about 16 or 17 years. Although Dr. Swan acknowledged that some of plaintiff's other coronary arteries also suffer from disease, he felt that if plaintiff had been properly treated his future life expectancy would be decreased by only 10 to 15 percent, rather than half.

Nurse Welch and Dr. Redding testified on behalf of the defense, indicating that the symptoms that plaintiff had reported to them at the time of the examinations were not the same symptoms he had described at trial. Defendant also introduced a number of expert witnesses -- not employed by Kaiser -- who stated that on the basis of the symptoms reported and observed before the

heart attack, the medical personnel could not reasonably have determined that a heart attack was imminent. Additional defense evidence indicated (1) that an EKG would not have shown that a heart attack was imminent, (2) that because of the severe disease in the coronary arteries which caused plaintiff's heart attack, the attack could not have been prevented even had it been known that it was about to occur, and finally (3) that, given the deterioration in plaintiff's other coronary arteries, the heart attack had not affected plaintiff's life expectancy to the degree suggested by Dr. Swan.

In the face of this sharply conflicting evidence, the jury found in favor of plaintiff on the issue of liability and, pursuant to the trial court's instructions, returned special verdicts itemizing various elements of damages. The jury awarded $24,733 for wages lost by plaintiff to the time of trial, $63,000 for future medical expenses, and $700,000 for wages lost in the future as a result of the reduction in plaintiff's life expectancy.[1/] Finally, the jury awarded $500,000 for "noneconomic damages," to compensate for pain, suffering, inconvenience, physical impairment and other intangible damages sustained

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1/ Plaintiff did not claim that the heart attack would reduce his earning capacity during his lifetime.

by plaintiff from the time of the injury until his death.

After the verdict was returned, defendant requested the court to modify the award and enter a judgment pursuant to three separate provisions of MICRA: (1) Civil Code section 3333.2 -- which places a $250,000 limit on noneconomic damages, (2) Civil Code section 3333.1 -- which alters the collateral source rule, and (3) Code of Civil Procedure section 667.7 -- which provides for the periodic payment of damages. The trial court, which had rejected plaintiff's constitutional challenge to Civil Code sections 3333.2 and 3333.1 in a pretrial ruling,[2/] reduced the noneconomic damages to $250,000, reduced the award for past lost wages to $5,430 -- deducting $19,303 that plaintiff had already received in disability payments as compensation for such lost wages -- and ordered defendant to pay the first $63,000 of any future medical expenses not covered by medical insurance

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2/ Plaintiff had anticipated the possible application of sections 3333.2 and 3333.1 before trial and had requested the court to declare the statutes unconstitutional at that time. After full briefing, the court rejected the constitutional attack. The court also ruled at that time that in order to avoid possible confusion of the jury, it would not inform them of the $250,000 limit and that -- since the amounts of the collateral source benefits were not disputed -- it would simply reduce the verdict by such benefits; neither party objected to the court's decision to handle the matter in this fashion.

provided by plaintiff's employer, as such expenses were incurred. At the same time, the court declined to order that the award for future lost wages or noneconomic damages be paid periodically pursuant to Code of Civil Procedure section 667.7, determining that the statute was not "mandatory" and that "under the unique facts and circumstances of this case" a periodic payment award of such damages would "defeat[] rather than promote[]" the purpose of section 667.7.

As noted, both parties have appealed from the judgment. Defendant maintains that the trial court committed reversible error in (1) excusing all Kaiser members from the jury, (2) instructing on the duty of care of a nurse practitioner, (3) instructing on causation, (4) permitting plaintiff to recover wages lost because of his diminished life expectancy, and (5) refusing to order the periodic payment of all future damages. Plaintiff argues that the judgment in his favor should be affirmed, but asserts that the court erred in upholding the MICRA provisions at issue here. Since defendant's claims go to the basic validity of the judgment in favor of plaintiff, we turn first to its contentions.

II

At the outset of the empanelment of the jury, the court indicated that it would excuse from the jury those

prospective jurors who would refuse to go to Kaiser for treatment under any circumstances and also those prospective jurors who were members of the Kaiser medical plan. When defendant noted its objection to the court's exclusion of the Kaiser members without conducting individual voir dire examinations, the court explained to the jury panel: "I am going to excuse you at this time because we've found that we can prolong the jury selection by just such a very long time by going through each and every juror under these circumstances. I'm not suggesting that . . . everyone who goes to Kaiser could not fairly and with an open mind resolve the issues in this case, but we may be here for four weeks trying to get a jury under the circumstances. [¶] I hope you can appreciate that. Probably some of you have sat in on situations where we've tried to get jurors in cases and it just goes on and on and on and on and on because you'll be questioned in great detail." On inquiry, it turned out that 24 of the 60 persons on the initial jury panel were members of Kaiser. They were excused. Voir dire then proceeded in the ordinary fashion, with each party questioning the remaining jurors and exercising challenges for cause and peremptory challenges.

Although defendant does not contend that any of

the jurors who ultimately served on the jury and decided the case were biased against it, it nonetheless asserts that the discharge of the Kaiser members was improper and warrants reversal. In support of its contention, it argues that a potential juror's mere membership in Kaiser does not provide a basis for a challenge for cause under the applicable California statute, Code of Civil Procedure section 602.

Past decisions do not provide a clear-cut answer to the question whether a potential juror's membership in Kaiser would itself render the juror subject to a statutory challenge for cause. Section 602 does not define with precision the degree of "interest" or connection with a party that will support a challenge for cause,[3/] and courts in other states have come to

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3/ Section 602 provides in relevant part: "Challenges for cause may be taken on one or more of the following grounds: . . . [¶] (4) Standing in the relation of . . . master and servant . . . or principal and agent, or debtor and creditor, to either party . . . . A depositor of a bank . . . shall not be deemed a creditor of such bank . . . for the purpose of this subsection solely by reason of his being such a depositor . . . [¶] . . . (6) Interest on the part of the juror in the event of the action, or in the main question involved in the action, except his interest as a member or citizen or taxpayer of a county, city and county, incorporated city or town, or other political subdivision of a county, or municipal water district."

As the above quotation demonstrates, section 602 by its terms establishes that two types of relationships --

different conclusions with respect to the eligibility of potential jurors whose relationship to one of the parties is similar to Kaiser members' relationship to defendant. Some cases have found error when a trial court has failed to excuse such persons for cause (see, e.g., M & A Electric Power Cooperative v. Georger (Mo. 1972) 480 S.W.2d 868, 871-874 [members of "consumer" electrical cooperative]; Weatherbee v. Hutcheson (1966) 114 Ga.App. 761 [152 S.E.2d 715, 718-719] [policyholder of mutual insurance company]); other decisions, on which defendant relies, have found no error when a trial court has refused to excuse such jurors. (Rowley v. Group Health Coop. of Puget Sound (1976) 16 Wn.App. 373 [556 P.2d 250, 252-254] [member of health care cooperative].) In McKernan v. Los Angeles Gas etc. Co. (1911) 16 Cal.App. 280, 283 -- perhaps the closest California case in point -- the court indicated that the mere fact that some of the jurors were customers of the defendant utility company would not, in itself, mandate their excusal for cause.

But whether or not under California law

(Fn. 3 continued.)
(1) the relationship of a bank depositor to a bank and (2) the relationship of a taxpayer to a governmental entity -- do not justify a challenge for cause. The statute does not, however, state whether the designated exceptions are exclusive or illustrative.

membership in Kaiser rendered the prospective jurors excludable for cause under section 602, we believe that it is clear that the trial court's discharge of such members provides no basis for reversing the judgment in this case. To begin with, even if membership in Kaiser is not itself disqualifying, it is not apparent that the trial court abused the broad discretion it retains over the jury selection process (see, e.g., Rousseau v. West Coast House Movers (1967) 256 Cal.App.2d 878, 883-886) by excusing the members in this case. As its comments to the jury suggest, the court had apparently discovered through past experience that in this situation the individual voir dire procedure would prove very time-consuming and unproductive, with a substantial proportion of the Kaiser members ultimately being subject to challenge by one party or the other. Furthermore, the trial court may reasonably have felt that the process of conducting an extensive voir dire of all Kaiser members might itself prejudice prospective jurors who did not belong to Kaiser. From experience, it may have foreseen that such questioning would invariably involve the recounting of specific, potentially prejudicial incidents concerning the prospective jurors and Kaiser, as well as the exploration of the relative satisfaction or dissatisfaction with Kaiser of the particular jurors on

this venire. Such matters would, of course, not be admissible in the actual trial of the case, and the court may have feared that such revelations on voir dire might "taint" all of the other prospective jurors in the courtroom. Under these circumstances, it cannot be said that the trial court abused its discretion in excusing the Kaiser members without individual examination.

Further, even if the trial court did err in this regard, the error clearly would not warrant reversal. This follows from the general rule that an erroneous exclusion of a juror for cause provides no basis for overturning a judgment. (See, e.g., Asevado v. Orr (1893) 100 Cal. 293, 300-301; McKernan v. Los Angeles Gas etc. Co., supra, 16 Cal.App. 280, 283; 1 Cal. Civil Procedure During Trial (Cont.Ed.Bar 1982) § 7.41, p. 298.) As the court explained in Dragovich v. Slosson (1952) 110 Cal.App.2d 370, 371: "'Since a defendant or a party is not entitled to a jury composed of any particular jurors, the court may of its own motion discharge a qualified juror without committing any error, provided there is finally selected a jury composed of qualified and competent persons.'" Although defendant attempts to fit this case within the proviso of the above rule -- on the

theory that the removal of the Kaiser members rendered the jury panel unconstitutionally nonrepresentative (cf. Thiel v. Southern Pacific Co. (1946) 328 U.S. 217 [exclusion of daily wage earners]) -- defendant points to no authority which even remotely supports its claim that Kaiser members are a "cognizable class," and the record in this case provides no evidence to suggest that this group has the kind of shared experiences, ideology or background that have been identified as the sine qua non of such a class. (See, e.g., People v. Fields (1983) 35 Cal.2d 329, 347-349 [plurality opinion]; cf. People v. White (1954) 43 Cal.2d 740, 751 ["The system of jury selection primarily from the membership roster of certain private clubs and organizations [such as the Lions, Rotary and the Chamber of Commerce] would normally tend to result in a systematic inclusion of a large proportion of business and professional people and a definite exclusion of certain classes such as ordinary working people."].) On this record, we cannot find that the jury that tried this matter was any less a cross-section of the community than it would have been had Kaiser members not been excused.

Accordingly, the manner in which the jury was selected provides no basis for reversing the judgment.

III

Defendant next contends that the trial court

misinstructed the jury on the standard of care by which Nurse Welch's conduct should be judged. In addition to the general BAJI instruction on the duty of care of a graduate nurse, the court told the jury that "the standard of care required of a nurse practitioner is that of a physician and surgeon . . . when the nurse practitioner is examining a patient or making a diagnosis." [4/]

We agree with defendant that this instruction is inconsistent with recent legislation setting forth general guidelines for the services that may properly be performed by registered nurses in this state. Section 2725 of the Business and Professions Code, as amended in 1974, explicitly declares a legislative intent "to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of

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4/ The relevant instruction read in full: "It is the duty of one who undertakes to perform the services of a trained or graduate nurse to have the knowledge and skill ordinarily possessed, and to exercise the care and skill ordinarily used in like cases, by trained and skilled members of the nursing profession practicing their profession in the same or similar locality and under similar circumstances. Failure to fulfill either of these duties is negligence. [¶] I instruct you that the standard of care required of a nurse practitioner is that of a physician and surgeon duly licensed to practice medicine in the state of California when the nurse practitioner is examining a patient or making a diagnosis."

The initial paragraph of this instruction tracks BAJI No. 6.25; the second paragraph was an added instruction given at plaintiff's request.

functions within organized health care systems which provide for collaboration between physicians and registered nurses."[5/] Section 2725 also includes, among

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5/ Section 2725 currently provides in relevant part: "In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures which have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems which provide for collaboration between physicians and registered nurses. . . . [¶] The practice of nursing within the meaning of this chapter means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all of the following: [¶] (a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures. [¶] (b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician . . . [¶] (c) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries. [¶] (d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen

the functions that properly fall within "the practice of nursing" in California, the "[o]bservation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and . . . determination of whether such signs, symptoms, reactions, behavior or general appearance exhibit abnormal characteristics . . . ." In light of these provisions, the "examination" or "diagnosis" of a patient cannot in all circumstances be said -- as a matter of law -- to be a function reserved to physicians, rather than registered nurses or nurse practitioners.[6/] Although plaintiff was certainly entitled to have the jury determine (1) whether defendant medical center was negligent in permitting a nurse practitioner to see a patient who exhibited the symptoms of which plaintiff complained and (2) whether Nurse Welch met the standard of care of a reasonably prudent nurse practitioner in conducting the examination

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(Fn. 5 continued.)
in accordance with standardized procedures, or the initiation of emergency procedures."

6/ In 1977, the Legislature adopted legislation specifically related to "nurse practitioners," providing that a "nurse practitioner" must be both a registered nurse and also meet the standards for nurse practitioner established by the Board of Registered Nursing. (See Bus. & Prof. Code, § 2834 et seq.) The evidence in this case established that Nurse Welch had been certified as both a registered nurse and a "family nurse practitioner."

and prescribing treatment in conjunction with her supervising physician, the court should not have told the jury that the nurse's conduct in this case must -- as a matter of law -- be measured by the standard of care of a physician or surgeon. (See Fraijo v. Hartland Hospital (1979) 99 Cal.App.3d 331, 340-344. See generally Note, A Revolution in White -- New Approaches in Treating Nurses as Professionals (1977) 30 Vand.L.Rev. 839, 871-879.)

But while the instruction was erroneous, it is not reasonably probable that the error affected the judgment in this case. (See People v. Watson (1956) 46 Cal.2d 818, 836.) As noted, several hours after Nurse Welch examined plaintiff and gave him the Valium that her supervising doctor had prescribed, plaintiff returned to the medical center with similar complaints and was examined by a physician, Dr. Redding. Although there was considerable expert testimony that the failure of the medication to provide relief and the continued chest pain rendered the diagnosis of muscle spasm more questionable, Dr. Redding -- like Nurse Welch -- failed to order an EKG. Given these facts, the jury could not reasonably have found Nurse Welch negligent under the physician standard of care without also finding Dr. Redding -- who had more information and to whom the physician standard of care was properly applicable -- similarly negligent.

Defendant does not point to any evidence which suggests that the award in this case was affected by whether defendant's liability was grounded solely on the negligence of Dr. Redding, rather than on the negligence of both Dr. Redding and Nurse Welch, and, from our review of the record, we conclude that it is not reasonably probable that the instructional error affected the judgment.[7/] Accordingly, the erroneous instruction on the standard of care of a nurse practitioner does not warrant reversal.

IV

Defendant also objects to several instructions on causation. First, defendant contends that an instruction

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7/ The medical experts on both sides agreed that the major infarction probably occurred about nine hours after Dr. Redding's examination. While Dr. Swan did indicate that the chances of preventing or minimizing injury are improved by the earliest possible detection of an impending attack, he also testified that assuming plaintiff were still in the pre-infarctive stage at the time of Dr. Redding's examination -- an assumption shared by the defense experts -- if an EKG had been performed at that time "the same happy outcome could have happened that we projected for the 4:15 intervention [i.e., diagnosis and treatment at the time of Nurse Welch's examination]."

Defendant never suggested to the jury that its verdict should be affected by whether it found only Dr. Redding, and not Nurse Welch, to have been negligent. Its position was simply that in light of the symptoms described and exhibited by plaintiff at the time of the examinations, neither Nurse Welch nor Dr. Redding was negligent in failing to order an EKG, and that, in any event, the heart attack could not have been prevented even if an EKG had been performed at either time.

on concurrent causation[8/] -- though accurately stating the law -- should not have been given because Permanente was the only defendant in the case. As plaintiff points out, however, the evidence suggested that the alleged negligence of a number of different persons employed by Permanente may have contributed to the injury, and the instruction -- worded in terms of the concurrent negligent conduct of more than one "person," not "defendant" -- properly informed the jury that each alleged negligent act could be a proximate cause of the injury regardless of the extent to which other negligent acts also contributed to the result. Although the instruction might not have been strictly necessary, the court did not err in giving it.

Defendant also complains of another of the proximate cause instructions, which informed the jury that "[i]f the conduct of the defendant is a substantial factor in bringing about the injuries or damages to the plaintiff, the fact that the defendant neither foresaw nor should have foreseen the extent or nature of the injuries

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8/ The instruction read: "There may be more than one proximate cause of an injury. When negligent conduct of two or more persons contributes concurrently as proximate causes of an injury, the conduct of each of said persons is a proximate cause of the injury regardless of the extent to which each contributes to the injury. A cause is concurrent if it was operative at the moment of injury and acted with another cause to produce the injury."

or damages, or the manner in which they occurred, does not prevent its conduct from being a proximate cause of such injuries or damages." This instruction simply informed the jury of the general rule that the unforeseeability of the extent or nature of the specific harm suffered by the plaintiff does not mean that the defendant's conduct was not a proximate cause of the injuries. (See, e.g., Bigbee v. Pacific Tel. & Tel. Co. (1983) 34 Cal.3d 49, 58-59. See generally 4 Witkin, Summary of Cal. Law (8th ed. 1974) Torts, § 629, pp. 2911-2912 and cases cited.) Contrary to defendant's contention, this instruction is applicable whether or not there are concurrent tortfeasors. Furthermore, although defendant suggests that the jury could have interpreted the instruction to render it strictly liable for plaintiff's injuries -- imposing liability on defendant even if its failure to have diagnosed (i.e., "foreseen") plaintiff's heart condition was not negligent -- that suggestion ignores the context in which this instruction was given, as well as additional instructions which informed the jury that plaintiff's case depended upon a showing of negligence.[9] Taken as a

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9/ For example, just before reading the instructions on causation, the court read the following instructions: "A plaintiff who was injured as a proximate result of some

whole, the instructions did not suggest that defendant could be held strictly liable.

V

Defendant next argues that the trial court erred in permitting the jury to award damages for the loss of earnings attributable to plaintiff's so-called "lost years," i.e., the period of time by which his life expectancy was diminished as a result of defendant's negligence. (See generally Fleming, The Lost Years: A Problem in the Computation and Distribution of Damages (1962) 50 Cal.L.Rev. 598 [hereafter The Lost Years].)

We believe that this was clearly a proper element of plaintiff's damages. As the United States Supreme Court explained in Sea-Land Services, Inc. v. Gaudet (1974) 414 U.S. 573, 594: "Under the prevailing

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(Fn. 9 continued.)
negligent conduct on the part of a defendant is entitled to recover compensation for such injury from that defendant. [¶] Thus, the plaintiff is entitled to a verdict in this case if you find, in accordance with my instructions: 1. That defendant was negligent; and 2. That such negligence was a proximate cause of injury to the plaintiff."

"In this action, the plaintiff has the burden of establishing by a preponderance of the evidence all of the facts necessary to prove the following issues: 1. The negligence of the defendant. 2. That such negligence was the proximate cause of injury to plaintiff. 3. The nature and extent of plaintiff's damages. . . ." (Italics added.)

American rule, a tort victim suing for damages for permanent injuries is permitted to base his recovery 'on his prospective earnings for the balance of his life expectancy at the time of his injury undiminished by any shortening of that expectancy as a result of the injury.' 2 Harper & James[, The Law of Torts (1956)] § 24.6, pp. 1293-1294 (emphasis in original)." (See also Rest.2d Torts, § 924, coms. d, e, pp. 525-526.)10/

10/ The comments in the Restatement state: "d. Loss or impairment of earning capacity for the future. The extent of future harm to the earning capacity of the injured person is measured by the difference, viewed as of the time of trial, between the value of the plaintiff's services as they will be in view of the harm and as they would have been had there been no harm. This difference is the resultant derived from reducing to present value the anticipated losses of earnings during the expected working period that the plaintiff would have had during the remainder of his prospective life, but for the defendant's act. (On the determination of the prospective length of life, see Comment e.) Accordingly, the trier of fact must ascertain, as nearly as can be done in advance, the difference between the earnings that the plaintiff would or could have received during his life expectancy but for the harm and the earnings that he will probably be able to receive during the period of his life expectancy as now determined. . . . [¶] e. The determination of length of life. In the case of permanent injuries or injuries causing death, it is necessary, in order to ascertain the damages, to determine the expectancy of the injured person's life at the time of the tort. . . . [¶] If the person harmed is alive at the time of trial, ordinarily the opinion of experts on the probable diminution of the plaintiff's life expectancy as a result of the tort is admissible as bearing upon the impairment of future earning capacity. . . ." (Ibid.)

Although, to our knowledge, the lost years issue has not been previously decided in California, recovery of such damages is consistent with the general rule permitting an award based on the loss of future earnings a plaintiff is likely to suffer "because of inability to work _for as long a period of time in the future as he could have done had he not sustained the accident_." (Italics added.) (Robison v. Atchison, Topeka, & S.F. Ry. Co. (1962) 211 Cal.App.2d 280, 288.)

Contrary to defendant's contention, plaintiff's recovery of such future lost wages will not inevitably subject defendant to a "double payment" in the event plaintiff's heirs bring a wrongful death action at some point in the future. In Blackwell v. American Film Co. (1922) 189 Cal. 689, 700-702, we held that in a wrongful death case, a jury was properly instructed that in computing damages it should consider the amount the decedent had obtained from defendant in an earlier judgment as compensation for the impairment of his future earning capacity. Similarly, in the _Sea-Land Services_ case, the Supreme Court recognized that an appropriate set-off may be made in the later wrongful death action. (Sea-Land Services, Inc. v. Gaudet, _supra_, 414 U.S. at pp. 592-594 & fn. 30.)

Defendant alternatively argues that the jury should have been instructed to deduct from plaintiff's prospective gross earnings of the lost years, the "saved" cost of necessities that plaintiff would not incur during that period. Although there is some authority to support the notion that damages for the lost years should be assessed on the basis of plaintiff's "net" loss (see The Lost Years, supra, 50 Cal.L.Rev. 598, 603 & fn. 23), we need not decide that issue in this case because defendant neither requested such an instruction at trial nor presented any evidence of anticipated cost savings that would have supported such an instruction. Under these circumstances, the trial court did not err in failing to instruct on the point. (See LeMons v. Regents of University of California (1978) 21 Cal.3d 869, 875.)

VI

After the jury returned its verdict, defendant requested the trial court to enter a judgment -- pursuant to section 667.7 of the Code of Civil Procedure -- providing for the periodic payment of future damages, rather than a lump-sump award. Although the trial court rejected plaintiff's constitutional challenge to the periodic payment provision -- a conclusion consistent with our recent decision in American Bank -- it

nonetheless denied defendant's request, interpreting section 667.7 as affording a trial court discretion in determining whether to enter a periodic payment judgment and concluding that on the facts of this case the legislative purpose of section 677.7 "would be defeated rather than promoted by ordering periodic payments rather than a lump sum award." Defendant contends that the trial court misinterpreted the statute and erred in failing to order periodic payment of all future damages.

We agree with defendant that the trial court was in error insofar as it interpreted section 667.7 as "discretionary" rather than "mandatory." The statute provides that "[i]n any [medical malpractice action], a superior court _shall_, at the request of either party, _enter a judgment ordering that money damages_ or its equivalent _for future damages_ of the judgment creditor _be paid in whole or in part by periodic payments rather than by a lump-sum payment_ if the award equals or exceeds fifty thousand dollars ($50,000) in future damages." (Italics added.)[11] Although in some contexts the use

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11/ Section 667.7 provides in relevant part: "(a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the

of the term "shall" may be consistent with a "discretionary" rather than a "mandatory" meaning (see, e.g.,

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(Fn. 11 continued.)
judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor. [¶] (b)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor. [¶] (2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees. [¶] (c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision. [¶] (d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security

Estate of Mitchell (1942) 20 Cal.2d 48, 50-52), the legislative history of section 667.7 leaves little doubt that here the Legislature intended to impose a mandatory duty on the trial court to enter a periodic payment judgment in cases falling within the four corners of the section.[12/]

(Fn. 11 continued.)
given, pursuant to subdivision (a) shall revert to the judgment debtor. . . . [¶] (f) It is the intent of the legislature in enacting this section to authorize the entry of judgments in malpractice actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the Legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment."

12/ As originally introduced, the bill which ultimately became section 667.7 provided that a trial court "may," and at the request of either party "shall," provide for periodic payments. (Assem. Bill No. 1 (1975-1976 Second Ex. Sess.) June 6, 1975, § 26.) Thereafter, the bill was amended to provide simply that a court "may" provide for periodic payments. (Assem. Amend. to Assem. Bill No. 1 (1975-1976 Second Ex. Sess.) June 12, 1975, § 26.) Before enactment, however, the bill was again amended to delete the permissive "may" language and to insert the mandatory "shall" language that appears in the current statute. (Sen. Amend. to Assem. Bill No. 1 (1975-1976 Second Ex. Sess.) June 25, 1975, § 26.)

Nonetheless, for several reasons relating to the specific facts of this case, we conclude that the trial court judgment should not be reversed on this ground. To begin with, although the court formally rejected defendant's motion for a periodic payment order, its judgment did provide for the periodic payment of the damages which the jury awarded for plaintiff's future medical expenses, directing the defendant to pay such expenses "as [they] are incurred up to the amount of $63,000."

Second, with respect to the award of noneconomic damages, we find that defendant is in no position to complain of the absence of a periodic payment award. As noted, defendant did not move for a periodic payment award until after the jury had returned its special verdicts. Although the trial court had requested the jury to return a special verdict designating the total amount of its noneconomic damage award -- to facilitate the application of Civil Code section 3333.2, whose constitutionality we discuss below -- the jury was not instructed to designate the portion of the noneconomic damage award that was attributable to future damages, and it did not do so. Instead, it returned an undifferentiated special verdict awarding noneconomic damages of $500,000. Because of

defendant's failure to raise the periodic payment issue earlier, plaintiff was deprived of the opportunity to seek a special verdict designating the amount of "future noneconomic damage." Furthermore, as we have seen, the trial court, acting pursuant to Civil Code section 3333.2, reduced the $500,000 noneconomic damage verdict to $250,000. Given the facts of this case, the $250,000 might well reflect the noneconomic damage sustained by plaintiff up until the time of the judgment. Under the circumstances, we conclude that the interests of justice would be served by affirming the lump-sum noneconomic damage award. (See American Bank & Trust Co. v. Community Hospital, supra, 36 Cal.3d 359, 378.)

Third and finally, there is the question of the $700,000 award for lost future earnings. Although in general lost future earnings are a type of future damage particularly suitable to a periodic payment judgment, this case presents a somewhat unusual situation because the damages awarded are solely attributable to the earnings of plaintiff's lost years. If the trial court had ordered such damages paid periodically over the time period when the loss was expected to be incurred, the damages would have been paid in their entirety after plaintiff's expected death, and thus -- if the life expectancy

predictions were accurate -- plaintiff would not have received any of this element of damages. Had defendant presented evidence by which the jury could have determined what proportion of the lost years' earnings would likely be spent for the support of plaintiff's dependents rather than plaintiff himself (see The Lost Years, supra, 50 Cal.L.Rev. 598, 613), and had it raised the periodic payment issue in a timely fashion so that the jury could have made special findings on that question, there might well be a strong argument that the dependents' share of the lost years' earnings should be subject to periodic payment. In the absence of any such apportionment, however, we conclude that the trial court properly determined that section 667.7 did not call for the periodic payment of this element of plaintiff's award.

Thus, in sum, we conclude that none of the defendant's contentions call for a reversal of the judgment.

VII

We now turn to plaintiff's contentions.

As noted, although the jury by special verdict set plaintiff's noneconomic damages at $500,000, the trial court reduced that amount to $250,000 pursuant to Civil Code section 3333.2.[13] Plaintiff challenges this ruling,

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13/ Section 3333.2 provides in relevant part: "(a) In

contending that section 3333.2 is unconstitutional on a number of grounds. In many respects, plaintiff's argument tracks the constitutional objections to other provisions of MICRA that we have recently rejected in American Bank, Barme and Roa.

We begin with the claim that section 3333.2 denies due process because it limits the potential recovery of medical malpractice claimants without providing them an adequate quid pro quo. In rejecting a similar challenge to the periodic payment provision at issue in American Bank, we explained that "[i]t is well established that a plaintiff has no vested property right in a particular measure of damages, and that the Legislature possesses broad authority to modify the scope and nature of such damages. (See, e.g., Werner v. Southern Cal. etc. Newspapers (1950) 35 Cal.2d 121, 129; Feckensher v. Gamble (1938) 12 Cal.2d 482, 499-500; Tulley v. Tranor (1878) 53 Cal. 274, 280.) Since the demise of the substantive due process analysis of Lochner v. New

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(Fn. 13 continued.)
any [medical malpractice] action . . . the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damages. [¶] (b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000)."

York (1905) 198 U.S. 45, it has been clear that the constitutionality of measures affecting such economic rights under the due process clause does not depend on a judicial assessment of the justifications for the legislation or of the wisdom or fairness of the enactment [i.e., the "adequacy" of the quid pro quo]. So long as the measure is rationally related to a legitimate state interest, policy determinations as to the need for, and the desirability of, the enactment are for the Legislature." (Italics added.) (American Bank, supra, 36 Cal.3d 359, 368-369.)

It is true, of course, that section 3333.2 differs from the periodic payment provision in American Bank inasmuch as the periodic payment provision -- in large measure -- simply postpones a plaintiff's receipt of damages whereas section 3333.2 places a dollar limit on the amount of noneconomic damages that a plaintiff may obtain.[14/] That difference, however, does not alter the applicable due process standard of review. As our language in American Bank itself suggests, our past cases

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14/ One feature of the periodic payment provision upheld in American Bank -- terminating payments for future damages, other than damages for loss of earnings, on the plaintiff's death -- clearly does operate to reduce the amount of damages ultimately recovered.

make clear that the Legislature retains broad control over the measure, as well as the timing, of damages that a defendant is obligated to pay and a plaintiff is entitled to receive, and that the Legislature may expand or limit recoverable damages so long as its action is rationally related to a legitimate state interest. In Werner v. Southern Cal. etc. Newspapers, supra, 35 Cal.2d 121, for example, our court applied the "rational relationship" standard in dismissing a due process attack on a statute -- Civil Code section 48a -- which permitted a plaintiff who brought a libel or slander action against a newspaper generally to obtain only "special damages," largely eliminating the traditional right to obtain "general damages" that such a plaintiff had enjoyed before the statute.[15]

In light of our discussion of the legislative history and purposes of MICRA in American Bank, Barme and Roa, it is clear that section 3333.2 is rationally related to legitimate state interests. As we explained in those decisions, in

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15/ The "general damage/special damage" distinction drawn by section 48a is similar to the "noneconomic damage/economic damage" distinction established by section 3333.2. Section 48a defines "general damages" as "damages for loss of reputation, shame, mortification and hurt feelings" and defines "special damages" as "all damages which plaintiff alleges and proves that he has suffered in respect to his property, business, trade, profession or occupation, including such amounts of money as the plaintiff alleges and proves he has expended as a result of the alleged libel, and no other."

enacting MICRA the Legislature was acting in a situation in which it had found that the rising cost of medical malpractice insurance was posing serious problems for the health care system in California, threatening to curtail the availability of medical care in some parts of the state and creating the very real possibility that many doctors would practice without insurance, leaving patients who might be injured by such doctors with the prospect of uncollectible judgments. In attempting to reduce the cost of medical malpractice insurance in MICRA, the Legislature enacted a variety of provisions affecting doctors, insurance companies and malpractice plaintiffs.

Section 3333.2, like the sections involved in American Bank, Barme and Roa, is, of course, one of the provisions which made changes in existing tort rules in an attempt to reduce the cost of medical malpractice litigation, and thereby restrain the increase in medical malpractice insurance premiums. It appears obvious that this section -- by placing a ceiling of $250,000 on the recovery of noneconomic damages -- is rationally related to the objective of reducing the costs of malpractice defendants and their insurers.

There is no denying, of course, that in some cases -- like this one -- section 3333.2 will result in

the recovery of a lower judgment than would have been obtained before the enactment of the statute. It is worth noting, however, that in seeking a means of lowering malpractice costs, the Legislature placed no limits whatsoever on a plaintiff's right to recover for all of the economic, pecuniary damages -- such as medical expenses or lost earnings -- resulting from the injury, but instead confined the statutory limitations to the recovery of noneconomic damages, and -- even then -- permitted up to a $250,000 award for such damages. Thoughtful jurists and legal scholars have for some time raised serious questions as to the wisdom of awarding damages for pain and suffering in any negligence case, noting, inter alia, the inherent difficulties in placing a monetary value on such losses, the fact that money damages are at best only imperfect compensation for such intangible injuries and that such damages are generally passed on to, and borne by, innocent consumers.[16/]

16/ Justice Traynor, in a dissenting opinion in Seffert v. Los Angeles Transit Lines (1961) 56 Cal.2d 498, 511, observed: "There has been forceful criticism of the rationale for awarding damages for pain and suffering in negligence cases. (Morris, Liability for Pain and Suffering, 59 Columb.L.Rev. 476; Plant, Damages for Pain and Suffering, 19 Ohio L.J. 200; Jaffe, Damages for Personal Injury: The Impact of Insurance, 18 Law and Contemporary Problems 219; Zelermyer, Damages for Pain and

While the general propriety of such damages is, of course, firmly imbedded in our common law jurisprudence (see, e.g., Capelouto v. Kaiser Foundation Hospitals (1972) 7 Cal.3d 889, 892-893), no California case of which we are aware has ever suggested that the right to recover for such noneconomic injuries is constitutionally immune from legislative limitation or revision. (See, e.g., Werner v. Southern Cal. etc. Newspapers, supra, 35 Cal.2d 121, 126-128; fn. 15, ante. See generally Morris, Liability for Pain and Suffering (1959) 59 Colum.L.Rev. 476 [urging legislative revision of rules relating to damages for pain and suffering].)

Faced with the prospect that, in the absence of some cost reduction, medical malpractice plaintiffs might as a realistic matter have difficulty collecting judgments

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(Fn. 16 continued.)
Suffering, 6 Syracuse L.Rev. 27.) Such damages originated under primitive law as a means of punishing wrongdoers and assuaging the feelings of those who had been wronged. [Citations.] They become increasingly anomalous as emphasis shifts in a mechanized society from ad hoc punishment to orderly distribution of losses through insurance and the price of goods or of transportation. Ultimately such losses are borne by a public free of fault as part of the price for the benefits of mechanization. [Citations.] [¶] Nonetheless, this state has long recognized pain and suffering as elements of damages in negligence cases [citations]; any change in this regard must await reexamination of the problem by the Legislature." (Italics added.)

for any of their damages -- pecuniary as well as nonpecuniary -- the Legislature concluded that it was in the public interest to attempt to obtain some cost savings by limiting noneconomic damages. Although reasonable persons can certainly disagree as to the wisdom of this provision,[17/] we cannot say that it is not rationally

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17/ In its comprehensive report on the medical malpractice insurance crisis, the American Bar Association's Commission on Medical Professional Liability recommended that no dollar limit be imposed on recoveries for economic loss, but expressly "[took] no position on whether it is appropriate to place a ceiling on the recovery of non-economic loss." (Rep. of Com. on Medical Professional Liability (1977) 102 ABA Ann.Rep. 786, 849.) The commission explained its conclusions as follows: "When liability has been demonstrated, the first priority of the tort system is to compensate the injured party for the economic loss he has suffered. While it is legitimate in the Commission's view to deduct payments to or for the benefit of the plaintiff by collateral sources, it is unconscionable to preclude a plaintiff, by an arbitrary ceiling on recovery, from recovering all his economic damages, even though some lowering of medical malpractice premiums may result from the enactment of such a ceiling. [¶] The Commission has taken no position, however, on whether it is appropriate to place a statutory ceiling on the recovery of non-economic loss. The arguments in favor of limiting non-economic loss are that a ceiling on general damages would contain jury awards within realistic limits, reduce the exposure of insurers (which reductions could be reflected in lowered premiums), lead to more settlements and less litigation, and enable insurance carriers to set more accurate rates because of the greater predictability of the size of judgments. [¶] The arguments against limiting non-economic loss are that medical malpractice should not be distinguished from other areas of professional malpractice or personal injury actions which have no ceiling on general damages, that general damages are as real to the plaintiff as economic

related to a legitimate state interest.[18/]

A number of state courts have invalidated statutory provisions limiting damages in medical malpractice actions on a variety of theories (see, e.g., Wright v. Central Du Page Hospital Assn. (1976) 63 Ill.2d 313 [347

(Fn. 17 continued.)
loss, that a wrongdoer should pay for all the losses he has caused, including pain and suffering, and that the general damages portion of an award provides a fund out of which the plaintiff's attorney's fees can be deducted without leaving the plaintiff economically undercompensated. In addition, it is argued that no immediate cost or premium savings will be generated by a ceiling on non-economic losses because questions regarding the constitutionality of such statutes would have to be finally resolved before the insurance companies would reflect any potential savings in their rates; and because the ceiling might prove to be the norm." (Ibid.)

18/ Indeed, even if due process principles required some "quid pro quo" to support the statute, it would be difficult to say that the preservation of a viable medical malpractice insurance industry in this state was not an adequate benefit for the detriment the legislation imposes on malpractice plaintiffs. As the United States Supreme Court observed in upholding the provisions of the Price-Anderson Act which placed a dollar limit on total liability that would be incurred by a defendant in the event of a nuclear accident: "'It should be emphasized . . . that it is collecting a judgment, not filing a lawsuit, that counts. . . . [A] defendant with theoretically 'unlimited' liability may be unable to pay a judgment once obtained.'" (Duke Power Co. v. Carolina Env. Study Group (1978) 438 U.S. 59, 89-90 [quoting from legislative history].)

Although we do not suggest that the Legislature felt that section 3333.2 alone -- or for that matter any other single provision of MICRA -- was essential to the survival of the medical malpractice insurance system, there is surely nothing in the due process clause which prevents a legislature from making a number of statutory changes which, in combination, provide the requisite benefit to justify the enactment.

N.E.2d 736]; Arneson v. Olson (N.D. 1978) 270 N.W.2d 125, 135-136; Carson v. Maurer (N.H. 1980) 424 A.2d 825, 836-836; Baptist Hosp. of Southeast Texas v. Baber (Tex.Ct.App. 1984) 672 S.W.2d 296, 297-298); others have upheld such limitations. (See, e.g., Johnson v. St. Vincent Hospital, Inc. (Ind. 1980) 404 N.E.2d 585, 600-601; Prendergast v. Nelson (1977) 199 Neb. 97 [256 N.W.2d 657, 668-672] [plurality opinion].) With only one exception, all of the invalidated statutes contained a ceiling which applied to both pecuniary and nonpecuniary damages, and several courts -- in reaching their decisions -- were apparently considerably influenced by the potential harshness of a limit that might prevent an injured person from even recovering the amount of his medical expenses. (See Anderson v. Wagner (1980) 79 Ill.2d 295 [402 N.E.2d 560, 564] [explaining decision in <u>Wright</u>, <u>supra</u>]; Arneson v. Olson, <u>supra</u>, 270 N.W.2d 125, 135.)[19] Section 3333.2, of course, could have no such effect. In any event, as we have explained, we know of no principle of California

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19/ The one exception is <u>Carson</u> v. <u>Maurer</u>, <u>supra</u>, in which the New Hampshire court struck down a provision which imposed a limit only on noneconomic damages, a statute apparently modeled on section 3333.2. As we noted in <u>Roa</u> (<u>ante</u>, p. __, fn. 9), the <u>Carson</u> court -- in invalidating a variety of provisions of its medical malpractice legislation -- applied an "intermediate scrutiny" standard of review that is inconsistent with the standard applicable in this state.

-- or federal -- constitutional law which prohibits the Legislature from limiting the recovery of damages in a particular setting in order to further a legitimate state interest. (See, e.g., Cory v. Shierloh (1981) 29 Cal.3d 430, 437-440 [upholding statute eliminating liability of persons who provide alcohol to drunk driver]; Duke Power Co. v. Carolina Env. Study Group, <u>supra</u>, 438 U.S. 59 [upholding statutory limit on liability in the event of a nuclear accident].) Accordingly, we conclude that section 3333.2 does not violate due process.

Plaintiff alternatively contends that the section violates the equal protection clause, both because it impermissibly discriminates between medical malpractice victims and other tort victims, imposing its limits only in medical malpractice cases, and because it improperly discriminates within the class of medical malpractice victims, denying a "complete" recovery of damages only to those malpactice plaintiffs with noneconomic damages exceeding $250,000.

With respect to the first contention, it should be evident from what we have already said that the Legislature limited the application of section 3333.2 to medical malpractice cases because it was responding to an insurance "crisis" in that particular area and that the

statute is rationally related to the legislative purpose. American Bank, Barme and Roa make clear that under these circumstances, plaintiff's initial equal protection claim has no merit. (See American Bank, supra, 36 Cal.3d 359, 370-374; Barme, supra, 37 Cal.3d 174, 181-182; Roa, supra, ___ Cal.3d. ___, ___.)

As for the claim that the statute violates equal protection because of its differential effect within the class of malpractice plaintiffs, the constitutional argument is equally unavailing. First, as we have already explained, the Legislature clearly had a reasonable basis for drawing a distinction between economic and noneconomic damages, providing that the desired cost savings should be obtained only by limiting the recovery of noneconomic damage. (See pp. ___-___, ante.)*/ The equal protection clause certainly does not require the Legislature to limit a victim's recovery for out-of-pocket medical expenses or lost earnings simply because it has found it appropriate to place some limit on damages for pain and suffering and similar noneconomic losses. (See, e.g., Werner v. Southern Cal. etc. Newspapers, supra, 35 Cal.2d 121, 126-128.)

Second, there is similarly no merit to the claim

*/ Pages 36-40, ante.

that the statute violates equal protection principles because it obtains cost savings through a $250,000 limit on noneconomic damages, rather than, for example, through the complete elimination of all noneconomic damages. Although plaintiff and a supporting amicus claim that the $250,000 limit on noneconomic damages is more invidious -- from an equal protection perspective -- than a complete abolition of such damages on the ground that the $250,000 limit falls more heavily on those with the most serious injuries, if that analysis were valid a complete abolition of damages would be equally vulnerable to an equal protection challenge, because abolition obviously imposes greater monetary losses on those plaintiffs who would have obtained larger damage awards than on those who would have recovered lesser amounts. Just as the complete elimination of a cause of action has never been viewed as invidiously discriminating within the class of victims who have lost the right to sue, the $250,000 limit -- which applies to all malpractice victims -- does not amount to an unconstitutional discrimination.

Nor can we agree with amicus' contention that the $250,000 limit is unconstitutional because the Legislature could have realized its hoped-for cost savings by mandating a fixed-percentage reduction of all noneconomic

damage awards. The choice between reasonable alternative methods for achieving a given objective is generally for the Legislature, and there are a number of reasons why the Legislature may have made the choice it did. One of the problems identified in the legislative hearings was the unpredictability of the size of large noneconomic damage awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag which different juries placed on such losses. The Legislature could reasonably have determined that an across-the-board limit would provide a more stable base on which to calculate insurance rates. Furthermore, as one amicus suggests, the Legislature may have felt that the fixed $250,000 limit would promote settlements by eliminating "the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble." Finally, the Legislature simply may have felt that it was fairer to malpractice plaintiffs in general to reduce only the very large noneconomic damage awards, rather than to diminish the more modest recoveries for pain and suffering and the like in the great bulk of cases. Each of these grounds provides a sufficient rationale for the $250,000 limit.

In light of some of the dissent's comments, one

additional observation is in order. Contrary to the dissent's assertion, our application of equal protection principles in American Bank, Barme, Roa and this case is not inconsistent with the principles enunciated in Brown v. Merlo (1973) 8 Cal.3d 855, Cooper v. Bray (1978) 21 Cal.3d 841, or like cases. As Cooper explains, under the traditional, rational relationship equal protection standard, what is required is that the court "conduct 'a serious and genuine judicial inquiry into the correspondence between the classification and the legislative goals.'" (21 Cal.3d at p. 848 [quoting Newland v. Board of Governors (1977) 19 Cal.3d 705, 711, italics added in Cooper].) We have conducted such an inquiry in all of these cases, and have found that the statutory classifications are rationally related to the "realistically conceivable legislative purpose[s]" (Cooper, supra, 21 Cal.3d at p. 851) of MICRA. We have not invented fictitious purposes that could not have been within the contemplation of the Legislature (see Brown v. Merlo, supra, 8 Cal.3d at p. 865, fn. 7) nor ignored the disparity in treatment which the statute in realistic terms imposes. (Id. at p. 862.) But Brown and Cooper have never been interpreted to mean that we may properly strike down a statute simply because we disagree with the

wisdom of the law or because we believe that there is a fairer method for dealing with the problem. (See Cory v. Shierloh, supra, 29 Cal.3d 430, 437-439.) Our recent decisions do not reflect our support for the challenged provisions of MICRA as a matter of policy, but simply our conclusion that under established constitutional principles the Legislature had the authority to adopt such measures. As Justice Traynor explained in Werner v. Southern Cal. etc. Newspapers, supra, 35 Cal.2d 121, 129: "[A] court cannot eliminate measures which do not happen to suit its tastes if it seeks to maintain a democratic system. The forum for the correction of ill-considered legislation is a responsive legislature."

Accordingly, we conclude that section 3333.2 is constitutional. The trial court did not err in reducing the noneconomic damage award pursuant to its terms.

VIII

For similar reasons, plaintiff's constitutional challenge to Civil Code section 3333.1 -- which modifies this state's common law "collateral source" rule -- is also without merit.

Under the traditional collateral source rule, a jury, in calculating a plaintiff's damages in a tort action, does not take into consideration benefits -- such

as medical insurance or disability payments -- which the plaintiff has received from sources other than the defendant -- i.e., "collateral sources" -- to cover losses resulting from the injury. (See, e.g., Helfend v. Southern Cal. Rapid Transit Dist. (1970) 2 Cal.3d 1.) Section 3333.1 alters this rule in medical malpractice cases.[20] Under section 3333.1, subdivision (a), a medical malpractice defendant is permitted to introduce evidence of such collateral source benefits received by or payable to the plaintiff; when a defendant chooses to introduce such evidence, the plaintiff may introduce

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20/ Section 3333.1 provides in relevant part: "(a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensatin act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence. [¶] (b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant."

evidence of the amounts he has paid -- in insurance premiums, for example -- to secure the benefits. Although section 3333.1, subdivision (a) -- as ultimately adopted -- does not specify how the jury should use such evidence, the Legislature apparently assumed that in most cases the jury would set plaintiff's damages at a lower level because of its awareness of plaintiff's "net" collateral source benefits.[21/]

21/ As we noted in Barme (37 Cal.3d at p. 179, fn. 5): "Earlier drafts of section 3333.1, subdivision (a) required the trier of fact to deduct such collateral source benefits in computing damages, but -- as enacted -- subdivision (a) simply provides for the admission of evidence of such benefits, apparently leaving to the trier of fact the decision as to how such evidence should affect the assessment of damages."

In this case, it is not clear from the record whether the parties and the trial court recognized that section 3333.1, subdivision (a) simply authorizes the reduction of damages on the basis of collateral source benefits, but does not specifically mandate such a reduction. As noted earlier (see p. _, fn. 2, ante), after rejecting plaintiff's pretrial constitutional challenge to this statute, the trial court indicated that in order to avoid any confusion of the jury and because the amount of collateral source benefits was not in dispute, the evidence would not be admitted at trial and the court would simply reduce the jury award by the amount of such benefits. Plaintiff did not object to this procedure and raises no claim with respect to this aspect of the court's ruling on appeal.

Plaintiff does raise a minor contention, however, which is somewhat related to this matter. In awarding damages applicable to plaintiff's future medical expenses, the trial court indicated that defendant was to pay the first $63,000 of such expenses that were not covered by employer-provided medical insurance. Plaintiff, pointing out that he may not be covered by medical insurance in the future, apparently

In addition, section 3333.1, subdivision (b) provides that whenever such collateral source evidence is introduced, the source of those benefits is precluded from obtaining subrogation either from the plaintiff or from the medical malpractice defendant. As far as the malpractice plaintiff is concerned, subdivision (b) assures that he will suffer no "double deduction" from his tort recovery as a result of his receipt of collateral source benefits; because the jury that has learned of his benefits may reduce his tort award by virtue of such benefits, the Legislature eliminated any right the collateral source may have had to obtain repayment of those benefits from the plaintiff. As for the malpractice defendant, subdivision (b) assures that any reduction in malpractice awards that may result from the jury's

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(Fn. 21 continued.)
objects to any reduction of future damages on the basis of potential future collateral source benefits. Under the terms of the trial court's judgment, however, defendant's liability for such damages will be postponed only if plaintiff does in fact receive such collateral benefits; thus, it is difficult to see how plaintiff has any cause to complain about this aspect of the award. Indeed, if anything, the trial court may have given plaintiff more than he was entitled to, since it did not reduce the jury's $63,000 award by the collateral source benefits plaintiff was likely to receive, but instead imposed a continuing liability on defendant to pay up to a total of $63,000 for any noncovered medical expenses that plaintiff may incur in the future as a result of the injury. Defendant has not objected to this portion of the judgment.

consideration of the plaintiff's collateral source benefits will inure to its benefit rather than to the benefit of the collateral source.

In our recent case of Barme v. Wood, _supra_, 37 Cal.3d 174, we addressed a constitutional challenge to section 3333.1, subdivision (b) brought by a "collateral source" whose subrogation rights against a malpractice defendant had been eliminated by the statute. In upholding the section's constitutionality, we explained that a collateral source has no vested due process right to subrogation and that section 3333.1, subdivision (b) is rationally related to the purposes of MICRA since it reduces the costs imposed on medical malpractice defendants by shifting some of the costs in the area to other insurers.

This case is not controlled by _Barme_, because here plaintiff challenges the validity of subdivision (a), rather than subdivision (b), and contends that the statute violates the rights of a malpractice plaintiff, rather than the rights of a collateral source. Nonetheless, plaintiff's constitutional challenge is still without merit.

Again, we begin with the due process objections to the statute. Although, by its terms, subdivision (a)

simply adds a new category of evidence that is admissible in a medical malpractice action, we recognize that in reality the provision affects the measure of a plaintiff's damage award, permitting the jury to reduce an award on the basis of collateral source benefits of which -- but for the statute -- the jury would be unaware. Nonetheless, as we have already explained in our discussion of section 3333.2, a plaintiff has no vested property right in a particular measure of damages. Thus, the fact that the section may reduce a plaintiff's award does not render the provision unconstitutional so long as the measure is rationally related to a legitimate state interest.

Because section 3333.1, subdivision (a) is likely to lead to lower malpractice awards, there can be no question but that this provision -- like section 3333.2 -- directly relates to MICRA's objective of reducing the costs incurred by malpractice defendants and their insurers. And, as we have seen, the Legislature could reasonably have determined that the reduction of such costs would serve the public interest by preserving the availability of medical care throughout the state and by helping to assure that patients who were injured by medical malpractice in the future would have a source of medical liability insurance to cover their losses.

Moreover, the Legislature clearly did not act irrationally in choosing to modify the collateral source rule as one means of lowering the costs of malpractice litigation. In analyzing the collateral source rule more than a decade ago in Helfend v. Southern Cal. Rapid Transit District, _supra_, 2 Cal.3d 1, we acknowledged that most legal commentators had severely criticized the rule for affording a plaintiff a "double recovery" for "losses" he had not in reality sustained,[22/] and we noted that many jurisdictions had either restricted or repealed it. (_Id_. at pp. 6-7, & fns. 4, 5 & 6.) Although we concluded in _Helfend_ that a number of policy considerations counseled against judicial abolition of the rule, we in no way suggested that it was immune from legislative revision, but, on the contrary, stated that the changes proposed by legal commentators "if desirable, would be more effectively accomplished through legislative reform." (_Id_. at p. 13.) In the mid-1970s, California

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22/ See, e.g., 2 Harper and James, The Law of Torts (1968 Supp.) section 25.22, at page 52; Fleming, _The Collateral Source Rule and Loss Allocation in Tort Law_ (1966) 54 Cal.L.Rev. 1478; James, _Social Insurance and Tort Liability: The Problem of Alternative Remedies_ (1952) 27 N.Y.U.L.Rev. 537; Schwartz, _The Collateral Source Rule_ (1961) 41 B.U.L.Rev. 348; West, _The Collateral Source Rule Sans Subrogation: A Plaintiff's Windfall_ (1963) 16 Okla.L.Rev. 395; Note, _Unreason in the Law of Damages: The Collateral Source Rule_ (1964) 77 Harv.L.Rev. 741.

was only one of many states to include a modification of the collateral source rule as a part of its medical malpractice reform legislation (see Comment, An Analysis of State Legislative Responses to the Medical Malpractice Crisis (1975) Duke L.J. 1417, 1447-1450), and the American Bar Association's Commission on Medical Professional Liability also recommended abolition of the rule as one appropriate response to the medical malpractice "crisis." (See Rep. of Com. on Medical Professional Liability, supra, 102 ABA Ann. Rep. 786, 849-850.) Under the circumstances, we think it is clear that the provision is rationally related to a legitimate state interest and does not violate due process.

Plaintiff's equal protection challenge to section 3333.1 is equally without merit. As with all of the MICRA provisions that we have examined in recent cases, the Legislature could properly restrict the statute's application to medical malpractice cases because the provision was intended to help meet problems that had specifically arisen in the medical malpractice field.

Accordingly, the trial court did not err in upholding section 3333.1.[23/]

23/ The majority of out-of-state cases that have passed on the issue have upheld the validity of provisions modifying the collateral source rule in medical malpractice cases. (See, e.g., Eastin v. Broomfield (1977) 116 Ariz. 576 [570 P.2d 744, 751-753]; Rudolph v. Iowa Methodist Medical Ctr. (Iowa 1980) 293 N.W.2d 550, 557-560; Pinillos v. Cedars of Lebanon Hospital Corp. (Fla. 1981) 403 So.2d 365, 367-368. Contra, Carson v. Maurer, supra, 424 A.2d 825, 835-836.)

IX

The judgment is affirmed. Each party shall bear its own costs on appeal.

KAUS, J.

WE CONCUR:

BROUSSARD, J.
GRODIN, J.
LUCAS, J.

C O P Y

FEIN v. PERMANENTE MEDICAL GROUP

S.F. 24336

DISSENTING OPINION BY BIRD, C.J.

With today's decision, a majority of this court have upheld, in piecemeal fashion, statutory provisions that require victims of medical negligence to accept delayed payment of their judgments (American Bank & Trust Co. v. Community Hospital (1984) 36 Cal.3d 359 [hereafter American Bank]), that prohibit them from paying the market rate for legal representation (Roa v. Lodi Medical Group (1985) ___ Cal.3d ____), that deprive them of compensation for proven noneconomic damages greater than $250,000 (maj. opn., ante, at pp. ___-___ [typed opn. at pp. 32-47]), and that divest them of the benefit of their own insurance policies (id., at pp. ___-___ [typed opn. at pp. 47-55]).

While the majority have considered the cumulative financial effect of these provisions on insurers to support their conclusion that MICRA might have some

desirable impact on insurance rates (see maj. opn., ante, at p. ___, fn. __ [typed opn. at p. 36]), they have insisted upon assessing the human impact of each provision on injured victims in isolation. However, it is no longer possible to ignore the overall pattern of the MICRA scheme. In order to provide special relief to negligent healthcare providers and their insurers, MICRA arbitrarily singles out a few injured patients to be stripped of important and well-established protections against negligently inflicted harm.

Crisis or no crisis, this court is duty-bound to apply the constitutional guarantee against irrational and invidious legislative classifications. Today's majority opinion represents a sad departure from this court's previously proud tradition of fulfilling that important duty.

By now, the story of MICRA is a familiar one. (See generally, American Bank, supra, 36 Cal.3d at p. 364.) Enacted in 1974 amidst a nationwide "medical malpractice crisis," it includes a number of provisions that seek to relieve healthcare providers and their insurers from some of the costs of medical malpractice litigation. Victims of medical negligence -- especially those afflicted with severe injuries -- have been singled out to provide the bulk of this relief. These plaintiffs have been deprived

of the benefit of various general rules that normally govern personal injury litigation. (See, e.g., Code Civ. Proc., § 667.7 [exception to general rule requiring immediate lump sum payment of a judgment]; Bus. & Prof. Code § 6146 [special restrictions on attorney fees]; Civ. Code, § 3333.2 [special limit on noneconomic damages];[1/] § 3333.1 [abrogation of collateral source rule].)

As political scientist Paul Starr has observed, "[a] crisis can be a truly marvelous mechanism for the withdrawal or suspension of established rights, and the acquisition and legitimation of new privileges." (Quoted in Jenkins & Schweinfurth, California's Medical Injury Compensation Reform Act: An Equal Protection Challenge (1979) 52 So.Cal. L.Rev. 829, 935 [hereafter California's MICRA.) However, now that the medical malpractice "crisis" is fading into the past, courts around the country are taking a closer look at medical malpractice legislation. At the time of this court's first MICRA decision, only three courts had invalidated medical malpractice legislation on equal protection grounds. (American Bank, supra, 36 Cal.3d at p. 370, fn. 10.) In the past year alone, that number has doubled. (See Austin v. Litvak (Colo. 1984) 682 P.2d 41; Baptist Hosp. of

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1/ Henceforth, all statutory references are to the Civil Code unless otherwise specified.

Southeast Texas v. Bader (Tex.Ct.App. 1984) 672 S.W.2d 296; Kenyon v. Hammer (Ariz. 1984) 688 P.2d 961.)

Unfortunately, a majority of this court today decline to join this growing trend. Instead, they continue to defer to the Legislature's resolution of the "crisis," with dire consequences both for victims of medical negligence and for well-established principles of constitutional law.

The problems of this approach are rapidly becoming apparent as the courts begin to confront its human consequences. Less than one year ago, this court rejected the first MICRA challenge, upholding the periodic payment provision. (See American Bank, supra, 36 Cal.3d 359.) Already, that provision has been severely limited. In American Bank itself, this court mandated special procedures to offset the provision's worst effects (id., at pp. 376, 377, fn. 14) and declined to apply it to the case at bar. (Id., at p. 378.) Today, in "the interests of justice," this court approves the trial court's refusal to apply the provision to all but a small portion of the present plaintiff's award. (Maj. opn., ante, at p. ___ [typed opn. at p. 31].)

While the majority have upheld the various provisions of MICRA out of deference to the Legislature, it is unlikely that such ad hoc judicial adjustments to

the act will ultimately produce a result that is more respectful of the Legislature than a clear-cut constitutional invalidation followed by a legislative revision of the scheme. The majority's well meaning attempt at "deference" serves only to perpetuate a fundamentally unjust statutory scheme.

I.

For the first time, this court is confronted with a provision of MICRA that directly prohibits plaintiffs from recovering compensation for proven injuries. In contrast to the provisions so far upheld by this court, there is no pretense that the $250,000 limit on noneconomic damages affects only windfalls (compare American Bank, supra, 36 Cal.3d at p. 369), that it protects plaintiffs' awards (compare ibid; Roa v. Lodi Medical Group, supra, ___Cal.3d at p. ___ [typed opn. at p. 19]), or that it discourages nonmeritorious suits (compare id., at p.___ [typed opn. at pp. 17-18].) The statute plainly and simply denies severely injured malpractice victims compensation for negligently inflicted harm.

Also for the first time, the weight of authority from other jurisdictions supports the constitutional challenge. A substantial majority of the courts of the nation that have addressed the constitutionality of

medical malpractice damage limits have invalidated the challenged provisions. (See Wright v. Central Du Page Hospital Association (Ill. 1976) 347 N.E.2d 736, 743; Carson v. Maurer (N.H. 1980) 424 A.2d 825, 838 [hereafter Carson]; Arneson v. Olson (N.D. 1978) 270 N.W.2d 125, 136; Baptist Hosp. of Southeast Texas v. Baber, supra, 672 S.W.2d at p. 298; Simon v. St. Elizabeth Medical Center (Ohio Ct.Comm.Pleas 1976) 355 N.E.2d 903, 906-907 (dictum); cf. Jones v. State Board of Medicine (Idaho 1976) 555 P.2d 399, 416, cert. den., 431 U.S. 914 [remanding for factual determination on whether a medical malpractice crisis actually existed]; but see Johnson v. St. Vincent Hospital, Inc. (Ind. 1980) 404 N.E.2d 585, 601.)

In Carson, supra, 424 A.2d at page 838, the New Hampshire Supreme Court struck down a damage limit identical to the present one. The court explained that "[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." (Id., at p. 837.)2/

2/ The majority attempt to distinguish Carson on the grounds that the New Hampshire Supreme Court applied an "intermediate" form of equal protection scrutiny, which is not appropriate under the California Constitution. (See maj. opn., ante, at p. ___, fn. __ [typed opn. at p. 41, fn. 19].) However, the Carson court's conclusion that it was "unreasonable" to require

(fn. continued)

The majority suggest that, with the exception of Carson, the decisions of other jurisdictions are factually distinguishable from the present case. It is argued that the invalidated statutes were more oppressive than the present one since they restricted recovery for all types of injury. (See maj. opn., *ante*, at p. ___ [typed opn. at p. 41.) However, in Baptist Hosp. of Southwest Texas v. Bauer, *supra*, 672 S.W.2d 296, a Texas appellate court invalidated a $500,000 limit that applied only to damages other than medical expenses. Also, in Simon v. St. Elizabeth Medical Center, *supra*, 355 N.E.2d 903, an Ohio appellate court stated in dictum that a $200,000 limit on "general" damages, similar to the limit on "noneconomic" damages involved in the present case, violated the United States and Ohio Constitutions. These provisions were not markedly more severe than MICRA's $250,000 limit on noneconomic damages.

Moreover, for many plaintiffs the present limit may be no less harsh than the $500,000 limit on total damages struck down by the Illinois Supreme Court in Wright v. Central DuPage Hospital Association, *supra*,

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(Fn. 2 continued)

the most severely injured victims of medical negligence to support the medical care industry is no less relevant under a lower form of scrutiny. The Carson court found no rational basis for the fixed limit.

347 N.E.2d at page 741. Depending on the relative size of a particular plaintiff's economic and noneconomic damages, the present limit might produce more or less harsh results than the Illinois statute. Only the North Dakota and Ohio statutes imposed substantially more stringent restrictions. (See Arneson v. Olson, supra, 270 N.W.2d at p. 135 [$300,000 limit on total damages]; Jones v. State Board of Medicine, supra, 555 P.2d at p. 410 [$150,000 limit on total damages].)

The burden on medical malpractice victims is no less real by virtue of the fact that it is "noneconomic" injury which goes uncompensated. Noneconomic injuries include not only physical pain and loss of enjoyment, but also "fright, nervousness, grief, anxiety, worry, mortification, shock, humiliation, indignity, embarrassment, apprehension, terror or ordeal." (Capelouto v. Kaiser Foundation Hospitals (1972) 7 Cal.3d 889, 892-893.)

For a child who has been paralyzed from the neck down, the only compensation for a lifetime without play comes from noneconomic damages. Similarly, a person who has been hideously disfigured receives only noneconomic damages to ameliorate the resulting humiliation and embarassment.

Pain and suffering are afflictions shared by all human beings, regardless of economic status. For poor

plaintiffs, noneconomic damages can provide the principal source of compensation for reduced lifespan or loss of physical capacity. Unlike the attorney in the present case, these plaintiffs may be unable to prove substantial loss of future earnings or other economic damages.

At first blush, $250,000 sounds like a considerable sum to allow for noneconomic damages. However, as amici California Hospital Association and California Medical Association candidly admit, most large recoveries come in cases involving permanent damage to infants or to young, previously healthy adults. Spread out over the expected lifetime of a young person, $250,000 shrinks to insignificance. Injured infants are prohibited from recovering more than three or four thousand dollars per year, no matter how excruciating their pain, how truncated their lifespans, or how grotesque their disfigurement. Even this small figure will gradually decline as inflation erodes the real value of the allowable compensation.

The majority are able to cite only a single decision upholding a limit on medical malpractice damages.[3/] In Johnson v. St. Vincent Hospital, Inc.,

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3/ The majority erroneously cite a second case, Prendergast v. Nelson (Neb. 1977) 256 N.W.2d 657, as upholding a damage limit. In Prendergast a three-justice plurality of the Nebraska Supreme Court expressed their view that a $500,000 limit on damages should be upheld.
(fn. continued)

supra, 404 N.E.2d 585, 601, the Indiana Supreme Court upheld a $500,000 limit on total damages. However, the Indiana statute did more than restrict malpractice victims' recoveries. In order to obtain the benefits of the limit, health care providers were required to contribute to a state-run compensation fund. (Id., at p. 601; Ind. Code, tit. 16, art. 9.5, ch. 2-1.)

By contrast, the present limit is not linked to any public benefit. Insurers and health care providers are free to retain any savings for private use. Moreover, the Legislature had before it no evidence that the immense sacrifices of victims would result in appreciable savings to the insurance companies. In the years preceding the enactment of MICRA, an insignificant number of individuals (at maximum, 14 in a single year) received compensation of over $250,000 in noneconomic and economic damages combined. (See Cal. Auditor General, The Medical Malpractice

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(Fn. 3 continued)

(Id., at p. 669.) An equal number contended that the limit was unconstitutional. (Id., at pp. 675-677 (conc. & dis. opn. of White, J.), (dis. opn. of McCown, J.), (dis. opn. of Boslaugh, J.).) The seventh justice expressed no opinion on the merits of the constitutional challenge, but dissented from the result and pointed out that the plurality opinion did not decide the constitutional questions. (Ibid. (dis. opn. of Clinton, J.).)

In short, four out of seven justices concluded either that the limit was unconstitutional or that the question of its constitutionality was not justiciable.

Insurance Crisis in California (1975) p. 31 [hereafter Report of the Auditor General].) Further, it does not appear that the Legislature had access to any data specifically relating to noneconomic damages. (Id., at pp. 30-31; see generally, California's MICRA, supra, at p. 951.)

As in American Bank and Roa, this court is urged to apply a heightened level of equal protection scrutiny. (Cf. Carson v. Maurer, supra, 424 A.2d 825.) However, I do not find it necessary to address that issue, since the limit cannot survive any "'serious and genuine judicial inquiry into the correspondence between the classification and the legislative goals.'" (Cooper v. Bray (1978) 21 Cal.3d 841, 848, quoting Newland v. Board of Governors (1977) 19 Cal.3d 705, 711.)

Only one legitimate purpose is advanced in support of the statute: that of preserving medical malpractice insurance so that plaintiffs will be able to collect on the unrestricted portions of their judgments. (Maj. opn., ante, at p. ___ [typed opn. at p. 36].) Admittedly, the objective of preserving insurance is legitimate. And, the Legislature might reasonably have determined that special relief to medical tortfeasors and their insurance companies would effectuate that purpose. (See American Bank, supra, 36 Cal.3d at p. 372.)

However, it is not enough that the statute as a whole might tend to serve the asserted purpose. Each statutory classification "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." (Brown v. Merlo (1973) 8 Cal.3d 855, 861; see also Cooper v. Bray, _supra_, 21 Cal.3d at p. 848; Newland v. Board of Governors, _supra_, 19 Cal.3d at p. 711.)

There is no logically supportable reason why the most severely injured malpractice victims should be singled out to pay for special relief to medical tortfeasors and their insurers. The idea of preserving insurance by imposing huge sacrifices on a few victims is logically perverse. Insurance is a device for spreading risks and costs among large numbers of people so that no one person is crushed by misfortune. (See generally, Keeton, Basic Insurance Law (1960) p. 484.) In a strange reversal of this principle, the statute concentrates the costs of the worst injuries on a few individuals.

The result is a fundamentally arbitrary classification. Under the statute, a person who suffers a severe injury -- for example loss of limbs or eyesight -- late in life may receive up to $250,000 for the resulting

loss of enjoyment during his or her final years. An infant with identical injuries is limited to the same compensation for an entire lifetime of blindness or immobility.

Such arbitrary treatment cannot be justified with reference to the purpose of the statute. Without speculating on the wisdom of the possible alternatives, it is plain that the Legislature could have provided special relief to health care providers and insurers without imposing these crushing burdens on a few arbitrarily selected victims. Most obviously, the burden could have been spread among all of the statute's beneficiaries -- health care consumers or, more broadly, the taxpayers. Alternately, the Legislature could have reduced all noneconomic damage awards in medical malpractice actions by a pro rata amount. (See California's MICRA, supra, 52 So.Cal. L.Rev. at p. 952.)

The majority suggest three rationales for singling out the most severely injured plaintiffs to bear the burden. First, it is suggested that "[t]he Legislature could reasonably have determined that an across-the-board limit would provide a more stable base on which to calculate insurance rates." (Maj. opn., ante, at p. ___ [typed opn. p. 45].) However, the same could be said of any restriction on recoveries, regardless of the existence or nature of classifications among tort victims. In effect,

this rationale ignores the fact that plaintiff is challenging a classification among tort victims.

Next, the majority hypothesize that "the Legislature may have felt that the fixed $250,000 limit would promote settlements by eliminating 'the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble.'" (Maj. opn., ante, at p. ___ [typed opn. at p. 45].) Again, any restriction on recoveries might make plaintiffs less willing to face the risk of litigation. Like the "stability" rationale, this theory fails to address the nature of the classifications among plaintiffs.

Finally, it is suggested that "the Legislature simply may have felt that it was fairer to malpractice plaintiffs in general to reduce only the very large noneconomic damage awards, rather than to diminish the more modest recoveries for pain and suffering and the like in the great bulk of cases." (Maj. opn, ante, at p. ___ [typed opn. at p. 45].) The notion that the Legislature might have concentrated the burden of medical malpractice on the most severely injured victims out of considerations of fairness certainly has the advantage of originality.

While many courts have concluded that fixed malpractice damage limits are grossly unfair (see cases cited ante, at p. ___ [typed dis. opn. at pp. 4-5]), none has suggested the possibility of fairness as a legitimate

basis for such a limit. If "fairness" can justify the present limit, it is hard to imagine a statute that could be invalidated under the majority's version of equal protection scrutiny.

The majority's acceptance of rationales so broad and speculative that they could justify virtually any enactment calls attention to the implications of the MICRA cases for equal protection doctrine in this state. In American Bank, supra, 36 Cal.3d at page 398 (dis. opn. of Bird, C.J.), I joined a majority of this court in rejecting the notion of "intermediate" equal protection scrutiny. However, I conditioned that rejection on the belief -- grounded in the past practice of this court -- that the alternative was a two-tier system with a meaningful level of scrutiny under the lower tier. (Id., at pp. 398-401; see also Hawkins v. Superior Court (1978) 22 Cal.3d 584, 607-610 (conc. opn. of Bird, C.J.).)

In particular, I relied on Brown v. Merlo, supra, 8 Cal.3d 855. In Brown, this court conducted a serious and sensitive inquiry into the nature and purposes of the automobile guest statute. The court demanded not only that the enactment might tend to serve some conceivable legislative purpose, but also that each classification bear a fair and substantial relationship to a legitimate purpose. (Id., at p. 861.) The guest statute failed to

pass this level of scrutiny since the classification of all automobile guests bore an insufficiently precise relation to the asserted purposes. For example, the classification was held to be overinclusive with regard to the purpose of preventing collusive suits. (Id., at p. 877.) Brown was subsequently followed in Cooper v. Bray, supra, 21 Cal.3d 841.

If applied in the present case, the mode of analysis used in Brown and Cooper would compel invalidation of the $250,000 limit, which is grossly underinclusive by any standard. Millions of healthcare consumers stand to gain from whatever savings the limit produces. Yet, the entire burden of paying for this benefit is concentrated on a handful of badly injured victims -- fewer than 15 in the year MICRA was enacted. (See Report of the Auditor General, supra, at p. 31.) Although the Legislature normally enjoys wide latitude in distributing the burdens of personal injuries, the singling out of such a minuscule and vulnerable group violates even the most undemanding standard of underinclusiveness.

However, the MICRA majority opinions have made no attempt to assess the over- or under-inclusiveness of the legislative classifications at issue. American Bank, Barme, and Roa could arguably be distinguished from Brown

and Cooper on the ground that the MICRA provisions at issue did not directly deny malpractice victims compensation for negligently inflicted harm. However, if Brown and Cooper retain any vitality today, their analysis must be applied in the present case.

At a bare minimum the court should honestly confront the existence of Brown and Cooper. In my view, it is remarkable that neither of these decisions -- previously considered to be leading opinions on the application of equal protection analysis in the personal injury area -- is capable of being distinguished in any MICRA majority opinion.

In conclusion, there is no rational basis for singling out the most severely injured victims of medical negligence to pay for special relief to health care providers and their insurers. Hence, the $250,000 limit on noneconomic damages cannot withstand any meaningful level of judicial scrutiny.

II.

Plaintiff also challenges section 3333.1, which deprives medical malpractice victims of the benefits of the longstanding collateral source rule.[4]

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[4] For the relevant text of section 3333.1, see the majority opinion, ante, at page ___ [typed opn. at p. 48, fn. 20].

The collateral source rule bars the deduction of collateral compensation, such as insurance benefits, from a tort victim's damage award. (See Hrnjak v. Graymar, Inc. (1971) 4 Cal.3d 725, 729; see generally, Schwartz, The Collateral-Source Rule (1961) 41 B.U. L.Rev. 348, 354.) The effect of the rule is to prevent tortfeasors and their insurers from reaping the benefits of collateral source funds, which "are usually created through the prudence and foresight of persons other than the tortfeasor, frequently including the injured person himself." (Gypsum Carrier, Inc. v. Handelsman (9th Cir. 1962) 307 F.2d 525, 534-535.)

As this court has observed, the collateral source rule embodies "the venerable concept that a person who has invested years of insurance premiums to assure his medical care should receive the benefit of his thrift. The tortfeasor should not garner the benefits of his victim's providence." (Helfend v. Southern Cal. Rapid Transit Dist. (1970) 2 Cal.3d 1, 9-10 [hereafter Helfend].) In the present case, the plaintiff collected workers' compensation, which he earned indirectly from his employment.

It is not disputed that section 3333.1 must be reviewed under the rational relationship test. That test requires that legislative classifications bear a rational

relationship to a legitimate state purpose to pass constitutional muster. (See Brown v. Merlo, supra, 8 Cal.3d at p. 882; Cooper v. Bray, supra, 21 Cal.3d at p. 848.)

The proponents of section 3333.1 have suggested that it serves two purposes. First, it seeks to eliminate double recoveries by victims. (See Keene, California's Medical Malpractice Crisis, in A Legislator's Guide to the Medical Malpractice Issue (Warren & Merritt edits. 1976) p. 31.) However, there is no apparent reason why legislation enacted for this purpose should be limited to medical malpractice victims. (See Graley v. Satayatham (Ohio Ct. Common Pleas 1976) 343 N.E.2d 832, 836-838.)

Moreover, as this court has recognized, the collateral source rule "does not actually render 'double recovery' for the plaintiff." (Helfend, supra, 2 Cal.3d at p. 12.) Tort victims are not fully compensated for their injuries by their judgments alone. The jury is directed to award damages only in the amount of the plaintiff's injuries. Yet, plaintiffs must pay attorney fees and costs out of their recoveries. Generally, fees and costs account for a substantial proportion of the recovery in medical malpractice actions. (See U.S. Dept. of Health, Ed. & Welf., Rep. of Sect.'s Com. on Medical Malpractice (1973) p. 32.)

The collateral source rule enables the plaintiff to recover some of these costs from collateral sources. Hence, the rule "will not usually give him a 'double recovery,' but partially provides a somewhat closer approximation to full compensation for his injuries." (Helfend, supra, 2 Cal.3d at p. 13.) Section 3333.1 will prevent many tort victims from obtaining this relatively full compensation simply because they were injured by a doctor instead of some nonmedical tortfeasor.

Furthermore, while supposedly eliminating victims' "windfalls," section 3333.1 provides a windfall to negligent tortfeasors. Under section 3333.1, negligent healthcare providers obtain a special exemption from the general rule that negligent torteasors must fully compensate their victims. "No reason in law, equity or good conscience can be advanced why a wrongdoer should benefit from part payment from a collateral source. . . . If there must be a windfall certainly it is more just that the injured person shall profit therefrom, rather than the wrongdoer . . . ." (Grayson v. Williams (10th Cir. 1958) 256 F.2d 61, 65; see also Helfend, supra, 2 Cal.3d at p. 10.)

The second purpose advanced to justify section 3333.1 is that of reducing the cost of medical malpractice insurance, the overall goal of MICRA. (See Stats. 1975, Second Ex. Sess. 1975-1976, ch. 2, § 12.5,

p. 4007.) It is argued that the Legislature rationally singled out medical malpractice actions in order to alleviate a "crisis" in medical malpractice insurance rates.

However, the relationship between section 3333.1 and the reduction of malpractice insurance premiums is entirely speculative. There is no requirement that physicians' insurers pass on their savings in the form of lowered premiums. Hence, insurance companies may simply retain their windfall for private purposes. Further, section 3333.1 operates only as a rule of evidence. Juries may choose not to offset collateral compensation. Hence, "a degree of arbitrariness may frustrate the relationship between this provision and attainment of MICRA's goal." (California's MICRA, supra, 52 So.Cal. L.Rev. at p. 949.)

The courts of other jurisdictions have had occasion to address the constitutionality of similar provisions. In Arneson v. Olson, supra, 270 N.W.2d 125, 137, the North Dakota Supreme Court unanimously invalidated a statute that effectively abolished the collateral source rule in medical malpractice cases. The court found that there was no "'close correspondence between [the] statutory classification and [the] legislative goals'" (Id., at pp. 133, 137), and noted that the provision gave the

tortfeasor "the benefit of insurance privately purchased by or for the tort victim . . . ." (Id., at p. 128.)

Similarly, in Carson v. Maurer, supra, 424 A.2d at pages 835-836, the New Hampshire Supreme Court unanimously overturned a kindred provision, reasoning that it "arbitrarily and unreasonably discriminate[d] in favor of the class of health care providers." And, in Graley v. Satayatham, supra, 343 N.E.2d at page 836, the court struck down a requirement that collateral benefits be listed in medical malpractice complaints, reasoning that it unconstitutionally discriminated against medical malpractice victims.

Some jurisdictions have upheld similar provisions. (See Eastin v. Broomfield (Ariz. 1977) 570 P.2d 744, 751-753; Pinillos v. Cedars of Lebanon Hospital Corp. (Fla. 1981) 403 So.2d 365, 367-368; Rudolph v. Iowa Methodist Medical Center (Iowa 1980) 293 N.W.2d 550, 552-560.) Two of these decisions were made by sharply divided courts. (See Pinillos, supra, 403 So.2d at pp. 369-371 (dis. opn. of Sundberg, C.J.); Rudolph, supra, 293 N.W.2d at pp. 561-568 (dis. opn. of Reynoldson, C.J.).) Moreover, the decisions reflect a highly deferential approach that is not consistent with the California courts' rigorous application of the rational relationship test to classifications affecting tort victims. (See,

e.g., Brown v. Merlo, <u>supra</u>, 8 Cal.3d 855; Cooper v. Bray, <u>supra</u>, 21 Cal.3d 841; Monroe v. Monroe (1979) 90 Cal.App.3d 388; Ayer v. Boyle (1974) 37 Cal.App.3d 822.)

In conclusion, section 3333.1 permits negligent healthcare providers and their insurers to reap the benefits of their victims' foresight in obtaining insurance. This departure from the general rule prohibiting the deduction of collateral source benefits from a judgment is not rationally related to any legitimate state purpose. Hence, section 3333.1 should be declared unconstitutional.

BIRD, C.J.

I CONCUR:

WOODS, JPT*

*Assigned by the Chairperson of the Judicial Council.

C O P Y

FEIN v. PERMANENTE MEDICAL GROUP

S.F. 24336

DISSENTING OPINION BY MOSK, J.

I dissent.

The well-reasoned dissent of the Chief Justice reaches a conclusion consistent with the duty of a democratic society to protect malpractice victims and to refrain from creating specially favored economic insulation for those who commit malpractice.

I part company with the Chief Justice only in regard to the equal protection test employed. The case before us is a paradigm demonstrating the impracticality of either the strict scrutiny or the rational relationship test. My colleagues persist in denying the existence of an intermediate test, and cling to the inflexible two-tier rule with a tenacity that suggests it originated with the Delphic oracle. Yet an intermediate test of equal protection has received frequent approval from many reputable sources. (See the numerous authorities cited in my separate opinion in Hawkins v. Superior Court (1978) 22 Cal.3d 584, 595-603.)

Now an intermediate test has been adopted by the Supreme Court of New Hampshire in one of the most persuasive

opinions in the country invalidating legislative provisions comparable to MICRA in California. In Carson v. Maurer (N.H. 1980) 424 A.2d 825, 831, the court held that in determining the validity of MICRA-type legislation, "the test is whether the challenged classifications are reasonable and have a fair and substantial relation to the object of the legislation. [Citations.] Whether the malpractice statute can be justified as a reasonable measure in furtherance of the public interest depends upon whether the restriction of private rights sought to be imposed is not so serious that it outweighs the benefits sought to be conferred upon the general public."

The Supreme Court of New Hampshire concluded that the act "arbitrarily and unreasonably discriminates in favor of the class of health care providers. Although the statute may promote the legislative objective of containing health care costs, the potential cost to the general public and the actual cost to many medical malpractice plaintiffs is simply too high." (Id. at p. 836.)

Once again we have an opportunity to employ a test carefully crafted to avoid the rigid extremes of the anachronistic two-tier test of equal protection. As I wrote in Hawkins, supra, 22 Cal.3d at page 595, "the ultimate acceptance of an intermediate test is foreordained in Supreme Court opinions: the question is not whether, but when, the third test will become standard. I regret that our court has failed

to forthrightly assume leadership among the states on this important question of constitutional law."

MOSK, J.

FEIN v. PERMANENTE MEDICAL GROUP - S.F. 24336

COUNSEL FOR PARTIES:

For Appellant

Thelen, Marrin, Johnson & Bridges
Curtis A. Cole
333 South Grand, Suite 3400
Los Angeles, CA 90071
(213) 621-9800

For Respondent

Morten L. Friedman, Esq.
7750 College Town Drive, Suite 300
Sacramento, CA 95826
(916) 381-9011

Sacramento Superior Court, Number 265659
The Honorable Michael J. Virga, Judge

Memorandum

Donald A. Wilson
President

TESTIMONY OF THE KANSAS HOSPITAL ASSOCIATION
BEFORE THE HOUSE JUDICIARY COMMITTEE
MARCH 26, 1985

THANK YOU, MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE. I AM SISTER ELIZABETH STOVER, ADMINISTRATOR OF ST. JOSEPH'S HOSPITAL IN CONCORDIA, KANSAS. I AM APPEARING TODAY ON BEHALF OF THE KANSAS HOSPITAL ASSOCIATION, AN ORGANIZATION REPRESENTING 165 HOSPITALS IN THE STATE OF KANSAS. THIS PAST YEAR I SERVED AS CHAIRWOMAN OF THE BOARD OF THE KANSAS HOSPITAL ASSOCIATION.

THE KANSAS HOSPITAL ASSOCIATION STRONGLY SUPPORTS THE PROVISIONS OF SUBSTITUTE FOR SENATE BILL 110. WE FEEL IT IS AN EFFECTIVE MEANS OF BRINGING MUCH NEEDED REFORMS TO OUR PRESENT SYSTEM.

IN COLD FACTS AND FIGURES, THE EFFECT OF THE CURRENT MALPRACTICE PROBLEM ON HOSPITALS CLOSELY PARALLELS THE SITUATION OF PHYSICIANS. FOR EXAMPLE, THE FREQUENCY OF MALPRACTICE CLAIMS AGAINST HOSPITALS HAS STEADILY INCREASED. THE ST. PAUL COMPANIES, WHICH INSURE 1550 HOSPITALS IN 46 STATES, ADVISE THAT SINCE 1979, THE NUMBER OF HOSPITAL CLAIMS REPORTED ON A CALENDAR YEAR BASIS INCREASED 76 PERCENT. THIS, OF COURSE, HAS LED TO INCREASES IN LIABILITY INSURANCE PREMIUMS FOR HOSPITALS. KANSAS HOSPITALS HAVE SEEN AN AVERAGE OF AN 80 PERCENT INCREASE IN PREMIUMS FOR PRIMARY COVERAGE OVER THE LAST YEAR, ALONG WITH A CORRESPONDING INCREASE IN THE HEALTH CARE STABILIZATION FUND

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March 26, 1985

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SURCHARGE. THE COST OF EXCESS INSURANCE FOR HOSPITALS IN THE STATE HAS ALSO JUMPED DRASTICALLY. IT IS NOW ESTIMATED THAT IF NOTHING IS DONE TO CURB THE PRESENT MALPRACTICE SITUATION, KANSAS HOSPITALS CAN ANTICIPATE A 200 - 300 PERCENT INCREASE IN THE COST OF INSURANCE BY THE END OF 1985.

DESPITE THESE DIRECT COSTS, KANSAS HOSPITALS ARE MORE CONCERNED THAT THE CURRENT MALPRACTICE SITUATION IS THREATENING PATIENT ACCESS TO AFFORDABLE AND EFFECTIVE HEALTH CARE. FOR EXAMPLE, HEALTH CARE CONSUMERS ARE ALREADY PICKING UP THE TAB FOR THE COSTS OF "DEFENSIVE MEDICINE," THE ALTERATION OF MEDICAL PRACTICE PATTERNS TO REDUCE THE THREAT OF LAWSUITS BROUGHT BY PATIENTS. ONE ESTIMATE IS THAT BETWEEN 25 PERCENT AND 40 PERCENT OF MEDICAL CHARGES IN CERTAIN SITUATIONS, SUCH AS THE MANAGEMENT OF HIGH-RISK PREGNANCIES AND DELIVERIES, ARE ASCRIBABLE TO THE PRACTICE OF DEFENSIVE MEDICINE. THE AMERICAN MEDICAL ASSOCIATION ESTIMATES DEFENSIVE MEDICINE ADDS $15.1 BILLION ANNUALLY TO THE NATION'S HEALTH CARE BILLS.

THE PRACTICE OF DEFENSIVE MEDICINE ALSO THREATENS CONTINUED ACCESS TO HEALTH CARE FOR SOME. A 1982 STUDY BY THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS SHOWED THAT ABOUT 1/3 OF THE OBSTETRICIANS IN THE NATION CUT BACK ON HIGH-RISK DELIVERIES AND ABOUT 10 PERCENT LEFT THE FIELD ALTOGETHER. OTHERS HAVE TAKEN EARLY RETIREMENT. THIS IS NOT SURPRISING WHEN FIGURES SHOW THAT 60 PERCENT OF THE OBSTETRICIANS IN THE UNITED STATES HAVE BEEN SUED AT LEAST ONCE.

BESIDES THESE PROBLEMS, SOME KANSAS COMMUNITIES FACE THE ADDITIONAL DIFFICULTY OF COMPETING FOR DOCTORS WITH NEBRASKA, WHICH HAS A $1 MILLION CAP ON AWARDS. SOME PHYSICIANS IN THE NORTHERN PORTION OF THE STATE HAVE EXPRESSED THE CONCERN THAT THE COST OF MALPRACTICE PREMIUMS

IN KANSAS IS DRIVING THEM ACROSS THE BORDER TO NEBRASKA, WHERE THE COST IS SIGNIFICANTLY LOWER.

WHEN A COMMUNITY LOSES A PHYSICIAN OR PHYSICIAN SERVICES, NO MATTER WHAT THE REASON, ACCESS TO CARE IS REDUCED. IN RURAL KANSAS, WHERE MANY OF OUR SMALL HOSPITALS ARE STRUGGLING TO SURVIVE, ACCESS IS ALREADY LIMITED. IF THESE HOSPITALS ARE TO REMAIN A VIABLE SOURCE OF HEALTH CARE, THEY MUST BE ABLE TO ATTRACT AND KEEP PHYSICIANS AND SERVICES WITHOUT FEAR OF LOSING THEM TO THE MEDICAL MALPRACTICE CRISIS.

ULTIMATELY, SOCIETY PAYS FOR THE MALPRACTICE CRISIS, WHETHER IN TERMS OF DEFENSIVE MEDICINE, LIABILITY INSURANCE PREMIUMS OR REDUCED ACCESS TO HEALTH CARE. ALTHOUGH IT DOES NOT CONTAIN ALL THE PROVISIONS IN THE ORIGINAL PROPOSAL, SUBSTITUTE FOR SENATE BILL 110 IS A REASONABLE EFFORT TO REDUCE THESE COSTS. IT HELPS TO CREATE A CLIMATE WHICH WILL ENCOURAGE, INSTEAD OF DISCOURAGE, PHYSICIANS TO PRACTICE IN RURAL AREAS OF OUR STATE.

THE KANSAS HOSPITAL ASSOCIATION URGES THAT THIS BILL BE RECOMMENDED FAVORABLY FOR PASSAGE.

Kansas Association of Osteopathic Medicine

TESTIMONY OF THE KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE
ON SUBSTITUTE FOR S.B. 110

Mr. Chairman and Members of the Committee:

My name is Dr. James Rider, and I am an osteopathic physician practicing in Valley Falls, Kansas. In addition to practicing in rural Kansas, I also serve as Legislative Committee Chairman of the Kansas Association of Osteopathic Medicine. On behalf of the practicing osteopathic physicians in Kansas, I urge your serious consideration and support for Substitute for Senate Bill 110.

We supported all the provisions of the original Senate Bill 110. Though it has been considerably stripped down, we still strongly support passage of the bill as a starting place. We also urge that the other proposals of the original bill be considered in the interim.

It is unfortunate that this issue has been viewed as Physicians vs. Attorneys. While lawyers and doctors are the main players in the issue of this bill, a far more overriding concern is the impact upon the health-consuming public of inaction, regarding the very real problem of rapidly spiraling malpractice insurance rates.

It is our understanding that those rates are scheduled to take another dramatic leap upward this year. This makes the action by this Legislature even more important, and we think the provisions of this bill are a good start.

As you know, the osteopathic profession in Kansas consists largely of physicians in general, or family practice. Though we have specialists in practice, about ninety percent of our physicians are in general practice--many in rural areas and small towns. Though the dollar figure of premiums paid by these general practitioners may not be as dramatic as those of specialists (as a percentage of gross), they paint a serious picture. And, in rural areas and small towns, they post a special set of problems. I personally know, from talking with many of my D.O. colleagues, that many have made changes in their practice, or are planning to do so in short of malpractice premium relief.

About two months ago, the Kansas Osteopathic Association conducted a written survey of its membership. The response rate was about seventy-eight percent, and included among responses were the following:

*** APPROXIMATELY 25% OF RESPONDING D.O.S ARE CONSIDERING EARLIER RETIREMENT THAN PLANNED, BECAUSE OF MALPRACTICE PREMIUM COSTS.

*** APPROXIMATELY 20% OF RESPONDING D.O.S HAVE CONSIDERED LEAVING KANSAS TO SEEK A LOCATION WITH LOWER MALPRACTICE PREMIUMS.

*** APPROXIMATELY 35% OF RESPONDING D.O.S HAVE MADE A MAJOR CHANGE IN THEIR PRACTICE, BECAUSE OF MALPRACTICE PREMIUMS. THE MOST FREQUENT CHANGES ARE CEASING ALL, OR PART, OF THEIR OBSTETRICAL PRACTICE AND CEASING TO CONDUCT MINOR SURGERY (SO AS TO DROP DOWN INTO A NON-SURGICAL RATE CLASSIFICATION).

*** APPROXIMATELY 44% ARE CONSIDERING A MAJOR CHANGE IN THEIR PRACTICE, DUE TO MALPRACTICE PREMIUMS. AGAIN, MOST FREQUENTLY MENTIONED ARE THOSE IN OBSTETRICS.

Attach 5

We, the physicians, do not want to make these changes. And, probably some will not carry through with them. But, enough of them already have that we know the malpractice rates have probably more to do with practice changes than any single phenomenon of recent times, particularly in rural areas and small towns in Kansas.

In northwest Kansas, for example, one of our physicians ceased doing any cesarean sections. For him to continue would have required a premium increase greater than the amount of income generated for the few such surgeries he did each year. That physician is considering ceasing obstetrics all together. AND THIS IS REPEATED IN NUMEROUS COMMUNITIES IN RURAL KANSAS THROUGHOUT THE STATE.

Physicians want to practice medicine! The overwhelming majority of them practice with great care, and we are in concurrance with those policing efforts that insure that this remains the case. But, due to a combination of circumstances over which the physician has little control, we now face premiums that have and will continue to affect how much practice and what kind of medical care services we deliver.

In my four years of practice, my malpractice premiums have increased two hundred and seventy percent. I assure you that none of my fees have increased anywhere near that much! I practice in Valley Falls, and in some rural hospitals. They are in trouble and their problems are compounded by my own costs in staying in the business of being a physician. Malpractice costs are now my most serious problem.

Whatever you hear in testimony on this bill, it is important that you and the legal profession understand that bad results do not always suggest poor physician performance.

What we seek is reasonable relief that is fair for all parties concerned. We do not think the present system is fair to physicians. And from the cost perspective, if physicians are to continue to practice, sooner or later those costs must be allocated, and we all know that the ultimate settling will be on the patients---thus, becoming a part of the statistic of spiraling health care costs. This is why we urge you to act in this session. Given a year of continuing trends, I fear for physician services in rural Kansas.

In conclusion, Mr. Chairman, I want to state that the Insurance Commissioner's Committee examining malpractice is an important step, but not a reason to delay legislative action. For all osteopathic physicians in Kansas, we urge you to act now, and enact into law the provisions of this Substitute Bill, as well as call for further consideration of remedial relief in the interim.

Thank you for this opportunity to appear before you today, and I will be pleased to respond to any questions you may have.

MEMORANDUM

TO: House Judiciary Committee

FROM: William W. Sneed
Legislative Counsel
Kansas Association of Defense Counsel

RE: Senate Bill No. 110

DATE: March 25, 1985

As Legislative Counsel for the Kansas Association of Defense Counsel, a group of Kansas lawyers specializing in the defense of civil cases, please accept this memorandum regarding Senate Bill No. 110 which is now in front of the House Judiciary Committee. The KADC's position is that the concepts which are enumerated in Senate Bill No. 110 are ones which we are in favor of and as such we believe such legislation deserves your utmost attention.

As the committee is aware our association requested and you granted introduction of House Bill No. 2457 which is a proposal concerning punitive damages and providing certain procedural safeguards in all civil matters. Further, the KADC supports constructive changes to collateral source rules and to that end we introduced House Bill No. 2458 regarding the admissibility of remarriage to mitigate damages. Thus, our association conceptually agrees with those points being brought out in Senate Bill No. 110.

We are aware that the legislature is currently involved in a situation where an alarming number of significant punitive damages verdicts occurring throughout the state of Kansas. Some interest groups are suggesting the abolishment of punitive damages. They point out that there is a growing number of legal scholars in this country who question the wisdom of punitive damages in civil negligence cases and suggest that the assessment of punishment should be relegated to the area of criminal law.

On the otherhand, there are equal numbers of legal authorities who subscribe to the view that punitive damages still serve a legitimate public purpose in protecting the public from misconduct that is characterized as wanton, reckless, malicious and indifferent.

However, if one subscribes to the view that punitive damages are necessary in civil suits and that such damages act as a deterrent against reckless and indifferent conduct, the question remains as to why a particular plaintiff who has been fully compensated for his or her injuries by an actual damage verdict should have the windfall of a punitive damage verdict.

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To that end KADC sponsored House Bill No. 2457 in an attempt to reform punitive damages. Although Senate Bill No. 110 is not precisely on point with our association's bill, we do believe that the concepts being debated in Senate Bill No. 110 are equivelent to those issues which we brought up in House Bill No. 2457.

The KADC believes that there should be a balance between awarding damages to a Kansan who has been wrongfully damaged and those of the defendants whose very existence depends upon its ability to do their work in such an atmosphere which will promote economic growth in our state. The KADC beleives that the legislature should take affirmative action to retain the concept of punitive damages as a protection against the public but also provide safe-guards that are needed in today's society.

Respectfully submitted,

William W. Sneed
Legislative Counsel, KADC

Kansas Chiropractic

ASSOCIATION

TESTIMONY BEFORE THE HOUSE
COMMITTEE ON JUDICIARY
RE: Substitute for SENATE BILL NO. 110

March 26, 1985

Mr. Chairman, members of the committee, the Kansas Chiropractic Association appreciates the opportunity to comment on substitute for Senate Bill 110. My name is Sherman A. Parks,Jr. I serve as the executive director of the Kansas Chiropractic Association, representing approximately 86% of the doctors of chiropractic in Kansas. I submit testimony before this committee in support of substitute for Senate Bill 110.

Malpractice insurance in Kansas has been skyrocketing in recent years and is effecting all branches of the healing arts. The Kansas Chiropractic Association (KCA) feels it is time to re-examine our present Kansas malpractice laws. If no action is taken on malpractice insurance increases, then regular health care as we know it today will become something most people can't afford in a few years from now. It is not the intent of the KCA to make it harder to bring or win a legitimate suit or not to get doctors "off the hook" when they are negligent, but to reduce costs while preserving the rights of injured patients to have their day in court.

Public policy, as expressed by many of the Kansas statutes, fully recognizes the doctor of chiropractic as an integral part of the health care delivery system in Kansas. In the Kansas Healing Arts Act, K.S.A. 65-2801, the doctor of chiropractic is specifically listed as a member of the healing arts. Since the Kansas Legislature has granted us this status, the Kansas doctor of chiropractic and the KCA have done a lot to reduce the incidence of malpractice in our state.

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March 26, 1985

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In 1976, we supported successful legislation requiring doctors of chiropractic to carry malpractice insurance and to participate in the Kansas Health Stablization Fund so that Kansas patients can't be left out in the cold. This legislation made the State of Kansas the only state in the United States to have statutory mandated malpractice insurance for doctors of chiropractic. Many doctors of chiropractic in other states do carry malpractice insurance, however, not all doctors do. Kansas citizens have the "peace of mind" that before a Kansas doctor of chiropractic is granted a license to practice in Kansas, they have met the statutory malpractice insurance requirement. Since 1976, there have been less than twenty successful malpractice suits in Kansas, against Kansas D.C.s. There has only been one judgement large enough to have the Kansas Health Stablization Fund assist in the payment of the judgement. Considering the millions of patients the Kansas doctor of chiropractic has seen, this is an excellent "track record" and a tribute to the high standards the Kansas doctor of chiropractic has.

When Kansas became one of the first states to require all doctors of the healing arts to participate in continuing education every year, Kansas became the first state in the United States to mandate continuing education for doctors of chiropractic. Since that legislation was introduced in Kansas, a few other states have required D.C.s to have continuing education. However, Kansas has the highest standards of continuing education for D.C.s in the United States. The Kansas doctor of chiropractic is required, like the other branches of the healing arts in Kansas, to have fifty (50) hours each and every year. The few other states that require continuing education for D.C.s require only twelve (12) hours or less. I feel this is a factor in the very small number of successful malpractice suits in Kansas against doctors of chiropractic.

We have supported legislation which has established a process in which a doctor's claims history is reviewed by fellow physicians working for our patient's compensation fund.

We have supported legislation which beefed up the disciplinary system of the State Board of Healing Arts, and increased its legal staff - whose only job is investigating doctors.

The reason why Kansas doctors of chiropractic and the KCA have supported these pieces of legislation is because we feel the Kansas doctors of chiropractic are the best in the United States and the few negligent ones make it tougher - and more expensive - for the rest of us. KCA and the Kansas Legislature have done alot in the past to reduce the chance of malpractice, now is the time to do something more.

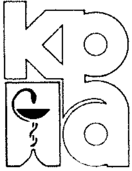
Skyrocketing malpractice insurance has had a great impact on rural Kansas. We have few enough rural doctors of chiropractic as it is. Unless something is done soon, the number of rural Kansas doctors of chiropractic can only become worse. When a rural doctor considers early retirement or thinks about leaving the state of Kansas because he or she can't afford the premiums, surcharges, or the risk of a suit, something has to be done quickly.

KCA felt that the original SB 110 should have been passed as drafted. However, we feel Substitute for SB 110 is still the vehicle to slow down the rising malpractice insurance problem.

We appreciate the status the Kansas Legislature has granted us, - the highest standards for doctors of chiropractic in the United States - however, unless the legislature takes some action now on the rising cost of malpractice insurance, thousands of Kansas citizens may be deprived continued chiropractic availability.

KCA supports substiture SB 110 and ask that the committee pass substitute SB 110.

Thank you for your consideration of our comments.



THE KANSAS PHARMACISTS ASSOCIATION
1308 WEST 10TH
PHONE (913) 232-0439
TOPEKA, KANSAS 66604

KENNETH W. SCHAFERMEYER, M.S., CAE
PHARMACIST
EXECUTIVE DIRECTOR

STATEMENT TO HOUSE JUDICIARY COMMITTEE

MARCH 26, 1985

SUBJECT: SENATE BILL 110 REGARDING MODERATION OF MALPRACTICE INSURANCE RATES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

MY NAME IS KEN SCHAFERMEYER AND I AM EXECUTIVE DIRECTOR OF THE KANSAS PHARMACISTS ASSOCIATION - AN ORGANIZATION REPRESENTING APPROXIMATELY 1,000 PRACTICING PHARMACISTS IN THE STATE OF KANSAS. I APPRECIATE THE OPPORTUNITY TO ADDRESS YOU IN SUPPORT OF SENATE BILL 110 WHICH WILL HELP MODERATE MALPRACTICE INSURANCE RATES.

SOME OPPONENTS OF THIS BILL HAVE REFERRED TO IT AS A "FINANCIAL RELIEF MEASURE FOR THE RICH DOCTORS." THIS, OF COURSE, IS A DISTORTION OF THE ISSUE.

AS YOU KNOW, ALL PRACTICING PHARMACISTS MUST PURCHASE MALPRACTICE INSURANCE. MANY MEMBERS OF OUR ASSOCIATION ARE EMPLOYEES AND THEIR SALARIES GENERALLY START IN THE MID AND HIGH 20's. MOST EMPLOYEE PHARMACISTS PAY FOR THEIR OWN MALPRACTICE INSURANCE AND THESE COSTS CANNOT BE RECOVERED BY PASSING THEM ON TO THE PUBLIC.

WHILE PHARMACISTS' MALPRACTICE INSURANCE WOULD NOT SEEM TO BE VERY EXPENSIVE IN COMPARISON TO PHYSICIANS, THESE INSURANCE RATES HAVE DOUBLED IN THE LAST YEAR OR TWO AND WILL INCREASE AGAIN. IN TWO YEARS KANSAS HAS GONE FROM THE LOWEST PHARMACIST MALPRACTICE

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INSURANCE RATE IN THE COUNTRY TO ONE OF THE HIGHEST. NATURALLY, PHARMACISTS ARE CONCERNED ABOUT THIS TREND. THIS RATE INCREASE HAS OCCURRED DESPITE THE FACT THAT THE HEALTH CARE STABILIZATION FUND HAS NOT YET MADE ANY AWARDS FOR PHARMACISTS' MALPRACTICE.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, WE STRONGLY SUPPORT THE POSITIONS OF THE KANSAS MEDICAL SOCIETY, THE KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE AND THE KANSAS HOSPITAL ASSOCIATION. THE MEDICAL MALPRACTICE SITUATION IS NOT A MATTER OF CONCERN ONLY TO PHYSICIANS BUT TO ALL HEALTH PROFESSIONALS AND THE PUBLIC IN GENERAL. WE URGE YOUR SUPPORT. THANK YOU.

SEDGWICK COUNTY HEALTH CARE COST CONTAINMENT ROUNDTABLE
Representing the following businesses and organizations in health care matters:

Wichita Manufacturers and Businesses
Wichita Labor Unions
Sedgwick County Medical Society
Wichita Hospitals
Health Insurance Companies

STATEMENT BEFORE THE
HOUSE JUDICIARY COMMITTEE
MARCH 26, 1985

Mr. Chairman, members of the committee, my name is Don Snyder, Chairman of the Sedgwick County Health Care Cost Containment Roundtable. The Roundtable was formed in 1979 as a collective effort to address the community's problem of escalating health care costs, involving representatives from labor unions, businesses, medical society and health insurance companies. Recently, representatives from area hospitals and a Health Maintenance Organization were added. Sample participants include Beech, Boeing, Cessna, Coleman, Kansas Gas and Electric Company, Eby Construction Company, International Association of Machinists and Aerospace Workers, and the Federation of Teachers. Smaller businesses are represented through the Wichita Industrial Relations Council. The Roundtable has been effective in promoting health care cost containment through the cooperative efforts of health professionals, business leaders, union officials and insurance companies.

I appreciate the opportunity today to express our support for most of the provisions of Senate Bill 110. The high cost of medical malpractice insurance must be brought under control. However, any attempt to bring control must reasonably protect the rights of the injured party when negligence has occurred. To do so requires that the problem of skyrocketing malpractice costs be studied as a whole since many diverse parties and interests are involved.

1102 South Hillside, Wichita, KS 67218
(316) 683-7557 (316) 681-8650

Senate Bill 110 is only a partial step. Additional legislation must be developed and passed by the legislature. We believe that with appropriate legislation, the net compensation paid to negligently injured parties can be increased while at the same time stabilizing the amount of gross premiums paid.

The Sedgwick County Health Care Cost Containment Roundtable supports Senate Bill 110 but suggest the following modifications:

- Punitive Damages.

  Actions which produce exemplary or punitive damages must be defined and specified. Also, in the situation of a group practice, who is liable for punitive damages, the individual or the group? Does the 25% limitation apply to the group's gross income or just the gross income of the negligent physician?

- Collateral Sources of Income.

  Since sources of other income are often used by the injured party to pay their exorbitant legal fees, it is not fair to reduce the award when such sources exist, especially when the injured party has purchased with their own money a right to the benefit without regard to the malpractice event. If attorney fees were admitted in the trial and the injured party compensated for such, then consideration of other income would be more fair but still difficult to justify in all circumstances. Life insurance proceeds and inheritances are sometimes

purposely intended to increase the beneficiary's status of wealth rather than merely compensate for the loss of income.

Refunding the amount of premium paid as suggested in Section 2(b) is not fair. When a person purchases insurance, he or she purchases coverage for unknown potential losses. Who knows what the purchaser sacrificed in order to afford the needed coverage.

- Pain and Suffering Limit.

  The amount stated in the current bill is excessive and further consideration should be given to a lower limit.

Without regard to Senate Bill 110, legislation regarding the following issues needs to be enacted:

- Scheduled Limit on Attorney Fees.

  Exorbitant attorney fees must be dramatically reduced so that the injured party will receive a larger proportion of the compensation. This is only fair if limits on the awards are established.

- Reasonable limit on awards must be set without compromising the injured party's ability to receive needed medical care. If ultimate medical expenses exceed the maximum limit, excess medical expenses could then be directly reimbursed from the health care stabilization fund.

- Because medicine is not perfect and because treating illnesses and

injuries involve risk, this fact must be statutorily protected. Physicians who competently provide care according to accepted standards of care while competently programming and documenting such care must be protected from malpractice liability.

- Physicians should be permitted to obtain "humanistic" informed consents since faith in the healing process is sometimes just as beneficial as the treatment.

- Insurance companies must maintain a well-documented file demonstrating that each claim has been investigated in a competent and timely fashion. If negligence exists, immediate settlement discussions should be required and documented.

We urge the adoption of Senate Bill 110 and offer our assistance in the development of any future legislation dealing with medical malpractice. Thank you.