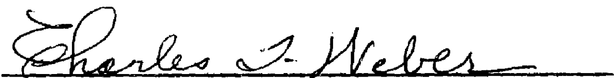
CHANGES IN MICHIGAN'S MEDICAL MALPRACTICE COMPENSATION SYSTEM: DO THEY ADEQUATELY ADDRESS THE CRISIS OF THE 1980's?

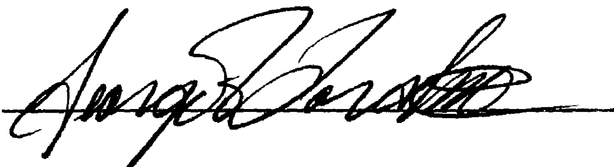
By
MICHAEL W. ARTHUR

IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF PUBLIC ADMINISTRATION

THE UNIVERSITY OF MICHIGAN-FLINT
1989

APPROVED





In 1986 the Michigan Legislature, in response to the medical malpractice liability crisis of the mid 1980's enacted several statutes which alter the state tort laws. This legislation mandates that physicians liable for malpractice must pay higher insurance premiums for their malpractice insurance coverage in subsequent years. Insurance underwriters must provide coverage to all licensed physicians at a cost based on various risk categories. Compensation paid to plaintiffs is based on economic loss not covered by collateral sources. There is a restriction on non-economic damages; limited to $225,000.

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> Most malpractice reforms are hostile to consumers. Few even pretend to address the problems of unreasonably dangerous medical care or injured patients' medical and financial needs. Instead, reform is typically designed simply to reduce malpractice premiums. Reform efforts that see reduced premiums as the 'bottom line' will almost inevitably injure patients.
>
> Sylvia A. Law 1986, p.315

I. INTRODUCTION : NEGLIGENCE UNDER COMMON LAW

The last major medical malpractice crisis occurred in the mid 1980's. The Michigan Legislature responded to this crisis by passing a number of statutes in 1986, which tend to coincide with the recommendations of the National Task Force on Medical Liability and Malpractice. The various statutes enacted have important ramifications for the medical, legal, and insurance communities. While major problems associated with medical malpractice compensation are addressed by these changes, questions as to the extent of the solutions still remain. Comparisons of the recommendations with the statutes and examination of certain variables should help answer these questions.

The medical malpractice crisis is viewed differently by three major power groups in the State of Michigan. The medical care community, the legal community and the insurance underwriters each have their own view of the problem based on economic self interest as well as an honest desire to adequately represent the wishes and needs of their clientele.

Attendant to the malpractice liability crisis is the common law tenet that those who represent themselves to the public as possessors of superior abilities and knowledge assume a greater duty under common law negligence liability than do those citizens who profess no superior ability. The three main interest groups mentioned are at odds as to what changes in the system best represent the interest of the consumer.

There are four elements in a negligence cause of action, (Prosser 1983, p.143). They are:

1) A duty.....recognized by law.....to conform to a certain standard of conduct, for the protection of others against unreasonable risks.
2) A failure on the part of the actor to conform to the standard required.

These first two elements constitute negligence. It is possible, absent a prescribed duty, to be negligent without being liable.

3) A reasonable close causal connection between the conduct and the resulting injury. This is what is commonly known as "legal cause," or "proximate cause."
4) Actual loss or damage resulting to the interests of another. Proof of damage is an essential part of the plaintiff's case. The threat of future harm, not yet realized, is not enough.

Additionally, a special standard of care exists for those who possess superior knowledge, skill and

intelligence. "Professional men in general, and those who undertake any work calling for special skill, are required not only to exercise reasonable care in what they do, but also to possess a standard minimum of special knowledge and ability," (Prosser 1983, p.161).

An underlying assumption is that a crisis existed prior to changes in Michigan's system of medical malpractice liability compensation, and that the major interest groups would have preferred a different solution to their individual versions of this crisis.

An overview of the legal, insurance, and medical positions follows; with emphasis on preferred solutions to perceived inadequacies in the medical malpractice compensation system, prior to 1986.

THE LEGAL CRISIS IN MEDICAL MALPRACTICE

Plaintiff's indemnification in medical malpractice liability law suits is provided by defendant(s) and/or their insurance underwriters. Because contingency fees of 25-40% of the award are common in the legal profession, plaintiff's attorneys find their economic self interest best served by accepting fee arrangements based on a percentage of plaintiff's cash awards in victorious claims. Losing efforts, however, pay nothing. Defendant's attorneys receive and hourly rate, win or lose, because; absent an award or claim, there is no base for percentage calculations. Proponents of

this traditional fee structure oppose contrary legislative actions. Opponents desire reversal of long standing practices in an effort to reduce legal fees connected to huge cash awards.

The 1960's witnessed several legal reforms associated with medical malpractice liability. Relaxation of locality rules through case law decisions resulted in higher standards of care duties for medical practitioners in some states. Under older rules, defendants had to adhere to local standards of care; and evidence of adherence to said standards was a required defense in malpractice law suits. Also, a new doctrine of informed consent provided defendants with a defense against malpractice suits, provided proof of informed consent existed. The plaintiff should both know of, and consent to, the risks involved in a medical treatment or procedure. Increased reliance on the doctrine of *respondeat superior*, (see index), increased the universe of possible tortfeasors subject to negligence suits; as did the general elimination of charitable immunity previously used as a defense by non-profit care givers. Proof requirements have also been loosened, whereby expert witnesses are not required to prove a failure to conform to the prescribed standard. Also, the principle of *res ipsa loquitur*, (see index), served to fill in missing proofs, thereby providing plaintiffs with increased chances of collecting damages. Statutory implementation of less stringent time limitations on causes of action, most notably the discovery rule, changed the time

frame for liability, (Robinson 1986, p. 17).

Resistance to changes in statutory law existed within the several states, possibly due to an unwillingness to offend powerful lobbies representing the major interest groups.

Changes made in the 1960's were followed a decade later by efforts to counterbalance what was perceived as plaintiff's unfair advantage. These included caps on total awards paid and mandatory offset of collateral benefits which led to a general slowdown of claim severity. Other changes; pre-trial screening of claims and shortened statute of limitations; had little impact on the frequency or severity of claims, (Danzon 1986, p.58).

THE INSURANCE CRISIS IN MEDICAL MALPRACTICE AVAILABILITY AND AFFORDABILITY

> First, today's insured malpractice system provides precious little deterrence as it is. The great majority of malpractice payments are not made by the tortfeasor, but by liability insurers that seldom adjust rates individually in response to an insured's conduct.
>
> H.R. 3084 1986

The insurance industry's concerns are the availability and affordability of medical malpractice liability coverage. The severity and frequency of claims contribute to this concern. The result is higher insurance premiums.

Monetary judgments, nationally, rose from $27,408 per incident in 1979 to $53,482 in 1983, while jury awards went

from $404,726 in 1980 to $954,858 in 1984, (Danzon 1986, p. 57). In Michigan, medical malpractice indemnity rose from an average of $25,770 per claim in 1983 to $53,468 per claim in 1988. However, these figures for Michigan represent only the average indemnity paid for favorable judgments. If all closed claims are included, the average cost per claim drops to $24,880 in 1988 because only 879 out of 1889 closed claims were decided in favor of the plaintiff, (Mich. Comm. Ins. May 1989, p. 23).

Frequency of claims per 100 physicians nationally rose from 10.5 in 1980 to 16.3 in 1984, (Danzon 1986, p. 57). In Michigan, frequency of claims rose from 11.7 per 100 physicians in 1983 to 20.7 claims per 100 physicians in 1986. Claims in 1986 represented a peak in Michigan, as the figures fell to 13.7 claims per 100 physicians in 1987, (Mich. Comm. Ins. May 1989, p. 21).

Jury Verdict Research of Solon, Ohio, says malpractice claims are up fourfold since 1980, with 20 awards over $1 million in 1980 and 79 $1 million awards in 1985, (Economist 1987, p. 51). In Michigan, lawsuits initiated after 1978 have accounted for only 5 settlements of $1 million or more, (Mich. Comm. Ins. May 1989, p. 25).

Claims severity and frequency data do not, however, explain where the insurance premium money goes, "By one estimate, the medical malpractice tort system returns to injured patients only twenty-eight cents of each dollar paid in as insurance premium, and of that amount, only 12.5 cents

reimburse the victims for economic losses not already compensated by other sources," (O'Connell 1986, p.127).

One Florida neurosurgeon paid $102,339 in 1987 for malpractice liability insurance, but the average for all physicians was $8,400 per year, and for family practitioners only $4,600 per year, (Pavalon 1987, p.5).

Liability insurance premiums represent 4% of gross revenues for self employed physicians. The average paid loss in 1983 was $72,243, up 70.2% from 1981, (Reynolds, et al 1987, p.2776). In absolute terms, premiums increased 300% in the 1960's, but only represented 1.8% of physicians' income and 4.2% of surgeons' income. This was not a good deal for underwriters because medical malpractice liability coverage was only a small portion of their revenues. Coupled with state insurance commissioners refusal to grant rate increases, this small return for risk taken forced underwriters out of the malpractice market, thus affecting availability of coverage, (Robinson 1986, p.8).

OCCURRENCE VS. CLAIMS MADE:
THE LONG TAIL PROBLEM

Those underwriters who chose to stay in the self correcting market for malpractice liability changed their approach to the crisis. St. Paul Fire and Marine Insurance Company, the leading malpractice underwriter, switched to a "claims made" policy year as opposed to the older "occurrence policy year", (Robinson 1986, p.20). Carriers have difficulty

predicting future claims due to the "long tail" inherent in medical malpractice cases caused by extended state statutes of limitations. Health care providers can now obtain insurance covering claims made in that year. This switch caused some underwriters to miscalculate their reserves resulting in solvency problems when the "tail" caught up with them. Even with this caveat, claims made coverage has captured upwards of 70% of the market, (Posner 1986, p.45).

JOINT UNDERWRITERS ASSOCIATIONS

Consortiums of insurers, faced with rising severity of claims, joined together to share their risk. This was not always a good idea. Some state laws forced all carriers doing business in the state to participate. Others used JUA's as a last resort for high risk and high cost providers. In any event, JUA's started strong in the 1970's and have been going out of business steadily ever since, (Posner 1986, p.41). The "long tail" had severe impact on JUA's because many set rates too low, ignoring actuarial estimates.

PATIENT COMPENSATION FUNDS

To counteract the scarcity of affordable high limit insurance coverage for high risk categories of health care providers, some states authorized the establishment of PCF's. This move broadened the risk pool by charging physicians a surcharge on their basic coverage which went into a high limit pool to cover damage awards above amounts insured. The

"long tail" problem also affected these groups as surcharges in some cases approached 100% of basic premium costs, (Posner 1986, p.41). They were most often underfunded because member carriers feared the "deep pockets" effect a large pool of resources might have on prospective plaintiffs and their attorneys. The Florida PCF collapsed with hospitals and physicians owing $100 million in assessments.

SELF INSURANCE

Hospitals which wish to underwrite their own liability coverage sometimes retain $500,000 to $1,000,000 risk per occurrence and insure any higher amounts. Physicians groups may retain $200,000 to $500,000 per occurrence and insure the rest through an underwriter. This practice reduces money available to spread the risks throughout the health care community, (Posner 1986, p.43). Self insurance has a great impact on the medical crisis in medical malpractice as we will see later. The same "long tail" problem found in PCF's and JUA's apply to self insurers. If not adequately budgeted, the risk pools can run dry in a particularly vulnerable year.

THE MEDICAL CRISIS IN MEDICAL MALPRACTICE

In a 1979 study of 815 consecutive admissions to a hospital, 290 (36%) admitted patients suffered an iatrogenic injury, 76 (9%) developed major complications and 15 (2%) died as a result of iatrogenic complications. An early follow

up study showed that 5% were disabled by the health care management of that hospital, (Meyers 1987, p.1544). Between 5-15% of U.S. physicians are incompetent due to inadequate skills, poor education or drug addiction, (Pavalon 1987, p.5). Note- Eugene I. Pavalon is president of the American Trial Lawyers Association.

These figures may be the result of new complexity in medical sophistication. More complicated treatments and procedures lead to greater malpractice losses because surgery and related treatments are more vulnerable to damage claims than are simpler procedures. "Moreover, when new findings do begin to appear, the law imposes special risks on those who first depart from the old custom, placing a greater burden of proof or persuasion on those who cannot show that they practiced according to established norms," (Havighurst 1986, p.269). Hospital related malpractice claims account for 75% of total claims. High technology leads to greater risk of mistake which leads to more serious injury which leads to higher damage awards. This chain of events makes medical malpractice negligence suits attractive to injured patients and their attorneys. However, non-complex iatrogenic injuries are still most often cited in law suits; injuries such as failure to diagnose fracture, improper treatment of fracture, improper treatment of infection, and birth related injuries, (Robinson 1986, p.11-12).

The crisis in the medical community is difficult to pinpoint because there is no way to know if iatrogenic

injuries have increased since the 1970's when only 10% of incidents resulted in legal claims. Today injury rates are higher and the estimate is that 20% of incidents result in legal claims. One fact known is that the number of surgical procedures per capita is positively related to the frequency of claims. The reasons for this are that surgical mistakes are more obvious and more serious than are other forms of negligence, (Danzon 1986, p.68).

MEDICAL COMMUNITY RESPONSE TO THE CRISIS

Rising malpractice insurance premiums and increased frequency of law suits have pushed physicians and other health care providers into defensive actions including curtailment of practice, increased fees, and defensive medicine. In 1983 The American College of Obstetricians and Gynecologists reported a 9% drop in membership. The 1985 reduction was 12% and 1987 was 20%. In addition, A.C.O.G. reported that 23% of live births were by caesarean section to avoid the possibility of legal action after high risk births, (Economist Ja 1987, p.52).

Defensive medicine, defined as medically unnecessary office visits, tests and medical procedures, now cost $12-$14 billion per year, and some physicians have been forced out of practice by rising costs which jeopardize the public's access to health care, (Meyers 1987, p.1544). Physicians are forced into these measures because "failure to" is a current

trend in legal circles, Such as:

> Failure to take complete medical history

> Failure to perform a physical examination

> Failure to refer and test

> Failure to follow recommended protocol

> Failure to keep records

These all lend weight to failure to diagnose cases, (Flamm 1986, p.84-6).

Doctor's spend an average of $30,000 per year on defensive medicine broken down like this: 39%-extra time with patients, 41%-follow-up visits and 20%-extra record keeping, (Harris 1987, p.2801). But, according to another commentator, "...evidence of defensive medicine is notoriously unreliable," (Robinson 1986, p.177).

Critics, however, can point to "negative" defensive medicine, such as failure to perform valuable but risky procedures. Or to the belief that patients no longer offer unquestioning deference to professional authority. Or to the belief that fewer than 10% of closed claims ever reach the trial stage, and of those that do, plaintiff wins only 25%. Or to the belief that those suffering iatrogenic injury have no other recourse than to initiate a malpractice law suit, (Bovbjerg 1986, p.324-34). Because of the high incidence of iatrogenic injury, more progressive medical institutions have instituted elaborate risk management and quality assurance programs, which are a definite plus for the consumer, (Posner 1986, p.42-3).

"Most informed judgments support the existence of some inappropriately (named) 'defensive' medicine, but the phenomenon has proved difficult to define or measure empirically: its extent and cost remain poorly estimated," (Zucherman, et al 1986, p.111).

Critics maintain that the "crisis" may be the high level of illness and injury for which there is no compensation; or the lack of confidence in, and the credibility of doctors; or the personality and attitude barriers that keep legitimate damage claims out of the courts. There is no evidence that the medical crisis is a crisis of consumers or lawyers avarice, vindictiveness or greed, (Meyers 1987, p.1547).

II. STATEMENT OF THE PROBLEM

The medical community is concerned with rising insurance premium rates and large monetary judgments which are bad for public relations. The legal community also has public relations concerns. As judgments grow in dollar amounts, attorneys who receive contingency fees are loathe to publicize their fee structure. And the insurance industry is legally mandated to provide liability coverage in a market with dwindling profits. The players' advantages and the rules constantly fluctuate.

One underlying assumption is that the Michigan Legislature, with the passage of the Revised Judicature Act of October 1, 1986, attempted to address these medical malpractice liability problems.

Another assumption is that changes in the law should be beneficial to the electorate and that the legislature will enact legislation adequate to that end. Whether this legislation is more beneficial to the lawyers, or doctors, or insurance underwriters; or to the patients who are the consuming public; can be answered by reviewing the legal changes with emphasis on the before and after effects of the law on the medical malpractice liability compensation system.

The problem is to determine whether these statutory changes are adequate to defuse the crisis as perceived by the major interest groups, i.e. medical, legal, and insurance

groups; while satisfying the electorate's need for beneficial legislation.

III. STATEMENT OF METHOD

In August of 1987 the Secretary of Health and Human Services released a task force report on the state of the medical malpractice crisis in the United States. By comparing and contrasting the recommendations of that task force report with the Michigan tort reforms of 1986, conformity between the two can be measured. This will help answer the question as to whether the changes adequately address the crisis of the 1980's.

An examination of the information provided by the State of Michigan Department of Licensing and Regulation will help determine whether these 1986 tort law changes are beneficial to the major interest groups; medical, insurance and legal; and whether the changes of 1986 are more costly or beneficial to the general electorate who are, after all, the consumers of medical care. This will be a cost and benefit approach rather than analysis, *per se*, because the costs and benefits cannot, in most instances, be quantified to the degree necessary for true analysis. While this method is by no means scientific, it can provide valuable insight into Michigan's attempts at solving the medical malpractice crisis within the state.

The costs of the current system of medical malpractice liability compensation are:

1. Liability insurance premiums
2. Economic loss and pain and suffering
3. Court costs (judges, juries, attorneys, etc.)
4. Effect on medical practices (defensive medicine)
5. Availability of care
6. Impact of delay
7. Time costs: plaintiffs and defendants
8. Damage to reputations: good will

The benefits of the current system of medical malpractice liability compensation are:

1. Injured party "made whole"
2. Deterrence of sub-standard care
3. Retribution
4. Collateral sources in compensation

IV. THE RECOMMENDATIONS OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE AUGUST, 1987

The following recommendations were made by the Task Force in an effort to establish some measure of national uniformity in tort laws in the various states.

1) Educational programs should be established by state licensing boards to assist legislators in writing medical practice acts.
2) States should review licensing board funding to assure

adequate funds for effective disciplinary programs.

3) States should assess licensing board activities with an eye toward implementation of more effective disciplinary programs and the development of educational programs.

4) A vigorous credentialing program for federally employed physicians covering screening, monitoring and discipline will be conducted by the Department of Health and Human Services.

5) Risk management activities should be encouraged .

6) Quality Assurance activities should be encouraged.

7) The federal government and state licensing boards should work together, exchanging information between peer review organizations.

8) Health and Human Services will support initiatives in professional education in medical liability and malpractice.

9) Health and Human Services will develop programs to assist public in understanding the limitations and benefits of modern medicine.

10) States should review and shorten statutes of limitations in medical malpractice. Exception to be made for fraud, concealment and other wrongs .

11) States should consider eliminating ad damnum clauses.

12) States should institute pretrial screening panels in medical malpractice cases with the decisions of the panel admissible as evidence in court.

13) Attorneys' fee arrangements should be in writing. States should set limits on fees in malpractice claims. A sliding scale for plaintiffs' attorneys': 25% of 1st $100,000; 20% of next $100,000; 15% of next $100,000; 10% of all over $300,000.

14) States should eliminate joint and several liability except where plaintiff can show concerted action by defendants resulting in plaintiff injury.

15) States should ensure that only qualified expert witnesses offer medical evidence in malpractice cases.

16) States should place reasonable limits on damage awards for non-economic losses.

17) States should take into account collateral source compensation in determining malpractice damage awards; with exceptions for claims of subrogation, reimbursement or lien.

18) States should limit punitive damages in medical malpractice cases by including them within the non-economic damages.

19) States should provide for periodic payment of future economic damages awarded in malpractice cases in amount exceeding $100,000.

20) The Task Force made no recommendation concerning compensation guidelines in malpractice cases despite pointing out that some states require damage separation into economic and non-economic items.

21) States should explore the economic damage guarantee

approach to medical malpractice.

22) States should encourage voluntary, binding arbitration of medical malpractice claims. Alternative dispute resolution mechanisms should be explored.

23) States should remove any legal obstacles to the development of tort law change by means of contract.

24) Insurers should examine current underwriting practices.

25) States should consider using compensation funds rather than medical liability insurance funding.

26) Health and Human Services will monitor organizations which assist in providing insurance coverage for specific necessary medical services.

27) Insurers and health care consumer organizations should look into patient indemnity insurance.

Not all of these recommendations apply to the State of Michigan, as is shown by the tort law changes contained in the Public Acts of 1986, which appear in Appendix B.

V. COMPARISON OF 1986 MICHIGAN TORT LAW CHANGES WITH RECOMMENDATIONS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES REPORT OF THE TASK FORCE

The latest changes in Michigan's medical malpractice liability statutes took effect on October 1, 1986. These

changes agree with a number of recommendations of the Task Force Report commissioned by the U.S. Department of Health and Human Services. Commentary on specific statutes appears in Appendix B.

RECOMMENDATION #5 - Encouragement of Risk Management Activities

In Michigan: M.C.L.A. *500.2404 (See Appendix B.)

All Commercial Liability Insurers in Michigan are required by this section to adjust their coverage rates according to the risk management techniques developed by their policy holders. Specifically, medical malpractice liability policy holders are subject to a surcharge penalty based on the filing of claims against the individual. Health care providers are therefore encouraged to develop risk management techniques, and penalized for developing poor ones. This would certainly qualify as encouragement.

RECOMMENDATION #6 - Encouragement of Quality Assurance Activities

In Michigan: M.C.L.A. *333.21513 (See Appendix B.)

Owners, operators, or governing bodies of hospitals are responsible for the quality of care provided. In addition, owners must organize staffs with an eye toward review of professional practices. This procedure must include a review of the quality of care; the necessity of care; the preventability of complications, and; the preventability of

deaths in the hospital. This Michigan law goes beyond encouragement, to mandated quality assurance programs.

RECOMMENDATION #10: Shorter Statutes of Limitation In Medical Malpractice Liability Claims

In Michigan, M.C.L.A. *600.5838a (See Appendix B.)

The statute of limitations in Michigan for medical malpractice claims is 6 years from the time of the act or omission which is the basis of the legal claim for damages; or 6 months after the discovery of the cause for claim, whichever is later.

In layman's terms, this means a patient has 6 years to bring legal action against a medical care provider, from the time of the treatment, or lack of treatment, such as misdiagnosis, that results in harm to the patient. The 6 month discovery rule covers those cases where the injury or harm has not come to the attention of the plaintiff. The burden is on the plaintiff to prove they had no knowledge of a cause of action prior to the 6 month discovery rule.

There are, of course, exceptions to the discovery rule limitation of 6 months. They are: 1) fraudulent concealment of the existence of the legal claim by the defendant; 2) foreign body wrongfully left in the body, and; 3) injury to the reproductive system.

These limitations are fair and equitable to both plaintiff and defendant. Obvious negligence on the part of physicians can be addressed in a timely fashion under the 6

year limitation. Cheating, through fraudulent actions, is not rewarded because the exceptions "stop the clock" on legitimate claims. the other exceptions are matters which cannot always be discovered within a 6 year limitation; such as damages to reproductive systems of a child, or; objects which lie benignly inside patients for years before causing medical problems. Those patients then have 6 months to file a claim on a legitimate cause of action.

RECOMMENDATION #12 - Pre-trial Screening Panels

In Michigan: M.C.L.A. *600.4903 (See Appendix B.)

Medical malpractice law suits in Michigan are referred to a mediation panel for evaluation before the cases can be heard in court. This is mandatory and agrees with the first part of the Task Force recommendation.

RECOMMENDATION #12 (cont.) -Pre-trial Screening Panels With Decisions Admissible

In Michigan: M.C.L.A. *600.4913 (See Appendix B.)

Mediation panel evaluations, including attorney statements and the contents of the mediation briefs, are inadmissible in any subsequent court action. This does not go quite as far as the Task Force desired, but does protect the rights of both defendant and plaintiff. Allowing the decision of the panel to be introduced in a trial court would be an injustice because this section disallows testimony during mediation, and specifically states that the Michigan rules of

evidence do not apply.

RECOMMENDATION #13 - Limits on Attorney Fees
In Malpractice Claims

In Michigan: **NONE**

The Task Force recommended that states adopt a sliding scale like this: 25% of 1st $100,000; 20% of next $100,000; 15% of next $100,000, and; 10 of all over $300,000.

Interestingly, the Federal Tort Claims Act, which applies to actions against federally employed health care providers, sets a limit of 25% of the total judgment for attorney fees. It also sets a limit of 20% of judgment for actions settled under the administrative claims process.

RECOMMENDATION #14 - Elimination of Joint and Several
Liability

In Michigan: **M.C.L.A. *500.3030** (See Appendix B.)

No insurance underwriter may be made or joined in a medical malpractice action in Michigan. Not only that, but no mention may be made in the complaint, nor during the trial, concerning insurance liability coverage for liability. This provision serves to eliminate some jurors propensity to dig into "deep pockets." It is fair because the extent of injury caused by negligence cannot be measured by the dollar amount of insurance the defendant carries.

RECOMMENDATION #15 - Qualifications of Expert Witnesses

In Michigan: M.C.L.A. *600.2169 (See Appendix B.)

If the defendant in a medical malpractice action is a specialist, only those witnesses specializing in that same field may produce "expert" testimony. In addition, the expert must have practiced the specialty or taught in a medical school at the time of the occurrence. Also, no expert witness may testify on a contingency fee basis. This section promotes fair legal proceedings and insures that "professional testifiers" will not be employed to muddy the issues at trial.

ALSO

In Michigan: M.C.L.A. *600.4905 (See Appendix B.)

In mediation evaluation hearings, the panel consists of 5 members; 3 attorneys and two medical members, one per defendant and plaintiff. In an instance where the defendant specializes, both medical members of the mediation panel must specialize in the same field. This helps cut through the fluff and get to the applicable standard of care.

RECOMMENDATION #16 - Limits on Non-economic Damages

In Michigan: M.C.L.A. *600.1483 (See Appendix B.)

The 1986 cap placed on non economic damages is $225,000. This seems to coincide with the Task Force recommendation. But, the exceptions to the limit cover those wrongful acts which would influence a jury to award huge damages for non-

economic losses. Lesser injury to a plaintiff would most likely result in judgments considerably lower than the $225,000 cap.

The exceptions are death, intentional wrong, foreign object left in the body, fraudulent conduct by defendant, wrong limbs removed, and loss of vital bodily function. This section complies with the Task Force consensus, but it is so emasculated by the exceptions as to be of little value in reducing damage judgments.

RECOMMENDATION #17 - Collateral Source Compensation

In Michigan: M.C.L.A. *600.6303 (See Appendix B.)

Collateral source compensation is deducted from the verdict dollar amount awarded, before the judgment amount is rendered. Collateral source is defined as benefits from insurance, health care corporations, dental care corporations, HMO's, employee benefits, social security, worker's compensation and medicare. This law agrees with the Task Force, including the protection of lien holder subrogation rights, providing said lien holder demands payment within 20 days of the judgment. These deductions are fair because they keep prevailing plaintiffs from double dipping for the same damages.

RECOMMENDATION #18 - Limit Punitive Damages; Placement Within Non-economic Damages

In Michigan: M.C.L.A. * 600.1483 (See Appendix B.)

Punitive damages provide the plaintiff with retribution; one of the reasons complaints are brought against mal-practitioners. Punitive damages for lesser injuries are included in the $225,000 cap on non-economic loss; any act or omission falling within the proscribed exceptions to the cap, will remove the cap in damage judgments. The Michigan law provides those seriously aggrieved plaintiffs with this avenue toward their day in court.

RECOMMENDATION #19 - Periodic Payment of Future Damages

In Michigan: M.C.L.A. *600.6309 (See Appendix B.)

Michigan law provides for structured payment plans for future damage judgments. The plan can be an agreement between parties, or designed by the presiding judge in medical malpractice actions.

ALSO : M.C.L.A. *600.6307 (See Appendix B.)

In cases where the future damages exceed $250,000 gross present cash value, the defendant or the defendant's liability insurance carrier must purchase an annuity contract with a purchase price of 100% of the future damages , less interest from the trial start date.

RECOMMENDATION #20 - Compensation Guidelines

The Task Force made no recommendation except mention of economic and non-economic divisions.

In Michigan: M.C.L.A. *600.6098 (See Appendix B.)

The presiding judge in medical malpractice actions, upon

receipt of a verdict, will separate damage awards into economic and non-economic losses. The Task Force did not make this recommendation, but many of the recommendations rely upon this very division. Recommendations 16 and 18 would be ineffective without separation of damages.

RECOMMENDATION #22 - Binding Arbitration;
Alternative Dispute Resolution

In Michigan: M.C.L.A. *600.4903 (See Appendix B.)

While rejecting binding arbitration, Michigan tort law does mandate mediation prior to any trial. This alternative to trial is fairer to the parties than binding arbitration because the parties may reject the panel evaluation and proceed to trial. There are penalties for rejecting a good faith evaluation in the event the judgment is lower than the evaluation for the plaintiff. These penalties are described in M.C.L.A. *600.4921.

Whether the changes have had an impact on the medical malpractice crisis can be seen by examining data presented in <u>Claims Experience and Market Conditions for Medical Malpractice Insurance</u>, a publication from the Insurance Bureau, State of Michigan Department of Licensing and Regulations.

VI. CLAIMS EXPERIENCE BEFORE AND AFTER 1986 CHANGES

Even though entry and exit from particular insurance lines is relatively simple, medical malpractice liability insurance in Michigan has been concentrated in just a few insurers. In 1977, 61% of the market was held by 4 insurers; in 1982, 70%; in 1987, 84%. The total premiums paid were up 124% between 1979 and 1989, with 92% of the increase coming during the last major crisis of 1982-1987, (Mich. Comm. Ins. May 1989, p. 2).

The prior crisis, in the mid 1970's resulted in malpractice insurance being written by specialty insurers formed by groups of care providers. These insurers accounted for 80% of the written premiums in 1987. This was indirectly due to the abandonment of the malpractice line by multi-line insurance providers.

Of the large carriers who once carried the malpractice line, only Continental Insurance has tried to re-enter the market for physician's liability in Michigan. Another newcomer, the Butterworth Insurance Exchange, was originally formed by Butterworth Hospital in Grand Rapids to offer in-house coverage for their own medical staff members. Butterworth represents the trend toward captive insurance programs, (Mich. Comm. Ins. May 1989, p. 4).

Most Michigan based malpractice liability underwriters offer only $200,000/$600,000 coverage on a regular basis. Higher limits are available on claims made coverage, but not on occurrence coverage. Risk retention and offshore captive

groups offer higher limits, but, since they are not licensed in Michigan, there is little protection for their policy holders, should they become insolvent, (Mich. Comm. Ins. May 1989, p. 6).

The major malpractice insurance providers in the state offer lower risk ratings for hospitals that:

1. Provide risk management seminars for their staff
2. Offer risk analysis and education programs
3. Develop closed claim review programs, (Mich. Comm. Ins. May 1989, p. 13).

CLAIMS MADE

While proving very attractive at the outset, claims made malpractice insurance coverage rates catch up to occurrence insurance coverage rates after 5 years because back claims against the physicians in a risk category catch up to them, (Mich. Comm. Ins. May 1989, p. 15).

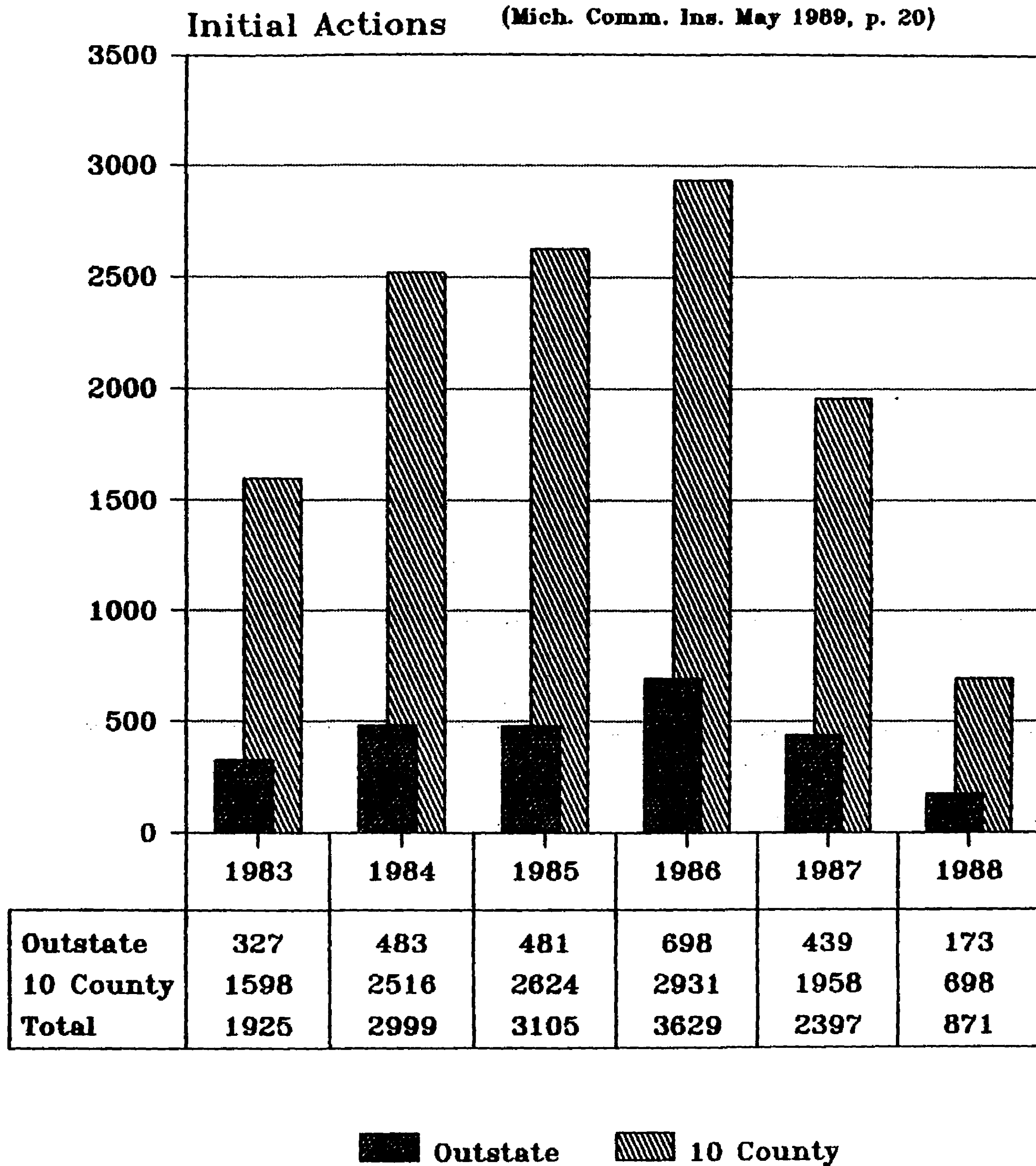
Table #1 (Michigan Department of Licensing and Regulation)

Claims Made Rate Factors
As a Percentage of Occurrence Premiums

Year	MPMLC	PICOM	BUTTERWORTH
1st	50%	50%	50%
2nd	70%	70%	70%
3rd	85%	85%	85%
4th	90%	90%	95%
5th & beyond	95%	95%	100%

Thus it appears that claims made coverage, seen by some as a panacea for the rising costs of malpractice liability

Initial Actions By Year
10 County vs. Outstate



	1983	1984	1985	1986	1987	1988
Outstate	327	483	481	698	439	173
10 County	1598	2516	2624	2931	1958	698
Total	1925	2999	3105	3629	2397	871

Fig.1

coverage, are no better than occurrence coverage rates after 5 years.

MALPRACTICE CLAIMS IN MICHIGAN

A caveat is suggested here. Some Michigan data are skewed because, prior to the 1986 tort law changes, self insured hospitals and doctors were not required to report claims data to the state insurance commissioner. The preceding chart represents data for initial claims 1983-1988 and shows a 1986 peak, possibly due to plaintiff's attorneys trying to beat the tort law changes, (Mich. Comm. Ins. May 1989, p. 20).

The Insurance Bureau of the Department of Licensing and Regulation uses a nine category system for reporting the severity of injury giving rise to a claim. The categories found on form B, closed claims, are:

1. **Emotional Only** - Fright, no physical damage
2. **Temporary, Insignificant** - Lacerations, contusions, minor scars, rash, no delay
3. **Temporary, Minor**-Infections, mis-set fracture, fall in hospital. Recovery delayed
4. **Temporary, Major** - Burns, surgical material left, drug side effect, brain damage. Recovery delayed
5. **Permanent, Minor** - Loss of fingers, loss or damage to

organs. Includes nondisabling injuries

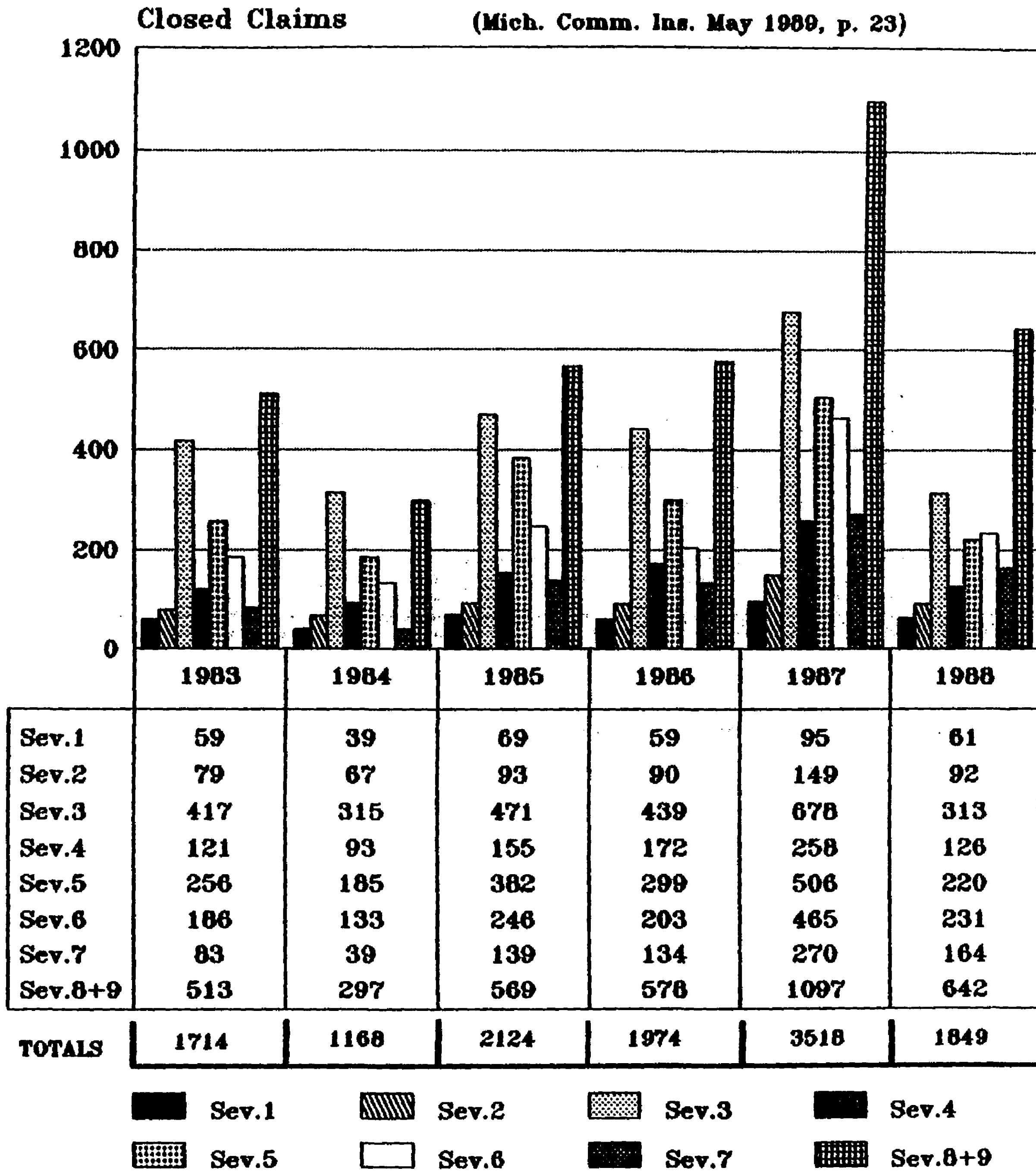
6. **Permanent, Significant** - Deafness, loss of limb loss of eye, loss of one kidney or lung
7. **Permanent, Major** - Paraplegia, blindness, loss of two limbs, brain damage
8. **Permanent, Grave** - Quadriplegia, severe brain damage, lifelong care or fatal prognosis
9. **Death**

The following chart lists closed claims by nine different claims categories used by the Michigan Insurance Bureau to classify claims severity on Form B., (Closed Claims).

Figure 2. shows the closed claims medical malpractice data for the years 1983 through June, 1988. For lack of space, severity categories 8 and 9; Permanent, Grave and Death; have been displayed as one bar. The chart shows that , historically, the greatest number of closed claims have been in severity category 3, Temporary, Minor. However, in every year, categories 8 and 9 have been greater than any others. This would indicate that the severity of medical malpractice injury is greater than apologists would have us believe.

These figures may be skewed toward the low end for 1983-1985 due to the reporting requirements prior to the 1986 Michigan Tort Law changes. M.C.L.A. *500.2477 requires that

Closed Claims By Severity
1983–June 1988



	1983	1984	1985	1986	1987	1988
Sev.1	59	39	69	59	95	61
Sev.2	79	67	93	90	149	92
Sev.3	417	315	471	439	678	313
Sev.4	121	93	155	172	258	126
Sev.5	256	185	382	299	506	220
Sev.6	186	133	246	203	465	231
Sev.7	83	39	139	134	270	164
Sev.8+9	513	297	569	578	1097	642
TOTALS	1714	1168	2124	1974	3518	1849

Fig.2

all insurers of licensed medical practitioners must forward information concerning legal actions to the Michigan Insurance Bureau. Previously, self insured physicians and hospitals were not required to report incidents, nor legal claims.

The apparent peak in the 1987 figures is misleading because the "long tail" inherent in medical malpractice liability cases helps delay the resolution of cases. Claims are decided under the laws that existed at the time of the initial action.

Also, these figures are not representative of verdicts or judgments, only resolution. The following chart represents a breakdown of closed claims by settlement method; mediation, private settlement by parties, trial verdict, and arbitration.

It should be noted that, for record keeping purposes, the insurance bureau sorts data into two groups; the ten largest counties as area #1, and the rest of the state as area #2. The largest counties are Wayne, Oakland, Macomb, Genesee, Ingham, Kent, Washtenaw, Kalamazoo, Jackson, and Saginaw.

The four major medical malpractice liability underwriters of Michigan use variations of the insurance bureau's method for record keeping.

The Michigan Physicians Mutual Liability Company (MPMLC) divides the state into three territories; #1 being Wayne, Oakland and Macomb counties; territory #2 including the next

16 largest counties; and the rest of the state in territory #3.

The Physicians Insurance Company of Michigan (PICOM) uses only two territories. #1 includes Wayne, Oakland and Macomb, with the rest of the state comprising territory #2.

The Medical Protective Company (MPC) divides the state into two areas. Area #1 is Wayne, Oakland, Macomb and Genesee counties. Area #2 is the rest of the state.

The Butterworth Insurance Exchange uses two territories: #1 is Wayne, Oakland and Macomb; with the rest of the counties making up territory #2.

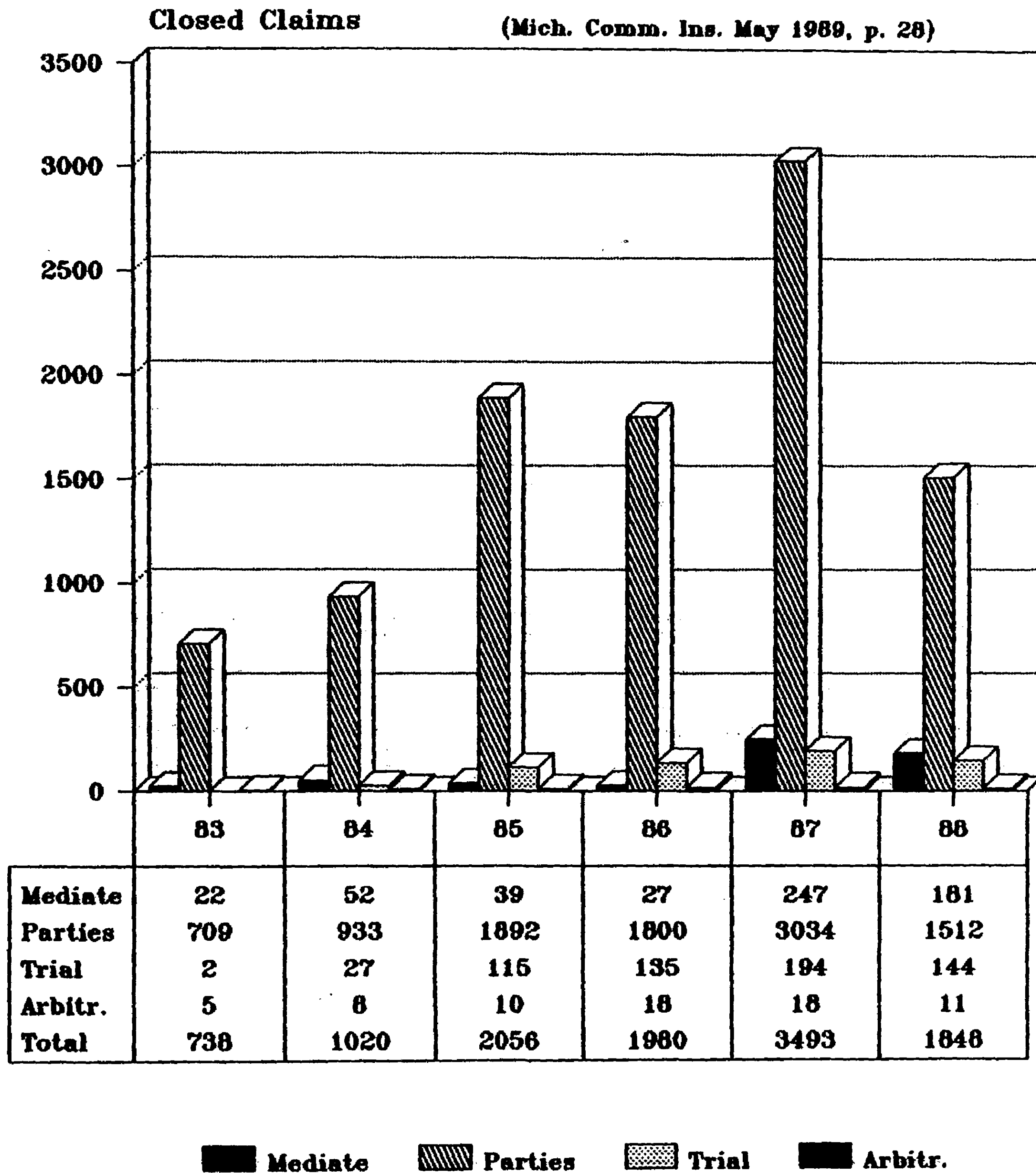
Insurance underwriters in Michigan use geographical data in an effort to confuse physicians shopping for liability coverage. Identical basic coverage offered by all underwriters would promote competition based upon cost per coverage dollar amount. Such a policy would decrease profits for the industry as a whole.

MEASURING COSTS OF CLOSED CLAIMS

The Michigan Insurance Bureau measures the cost of medical malpractice liability by tracking the closed claims paying an indemnity greater than $0 against the total number of closed claims. The following chart displays this information for the years 1983 through June, 1988.

As Fig.3 shows, private settlement of medical

Closed Claim Resolution
1983 through June 1988



	83	84	85	86	87	88
Mediate	22	52	39	27	247	181
Parties	709	933	1892	1800	3034	1512
Trial	2	27	115	135	194	144
Arbitr.	5	8	10	18	18	11
Total	738	1020	2056	1980	3493	1848

Fig.3

malpractice claims has, for the reported period, been the preferred settlement method. Again, the figures are most likely under reported for the years 1983-1985.

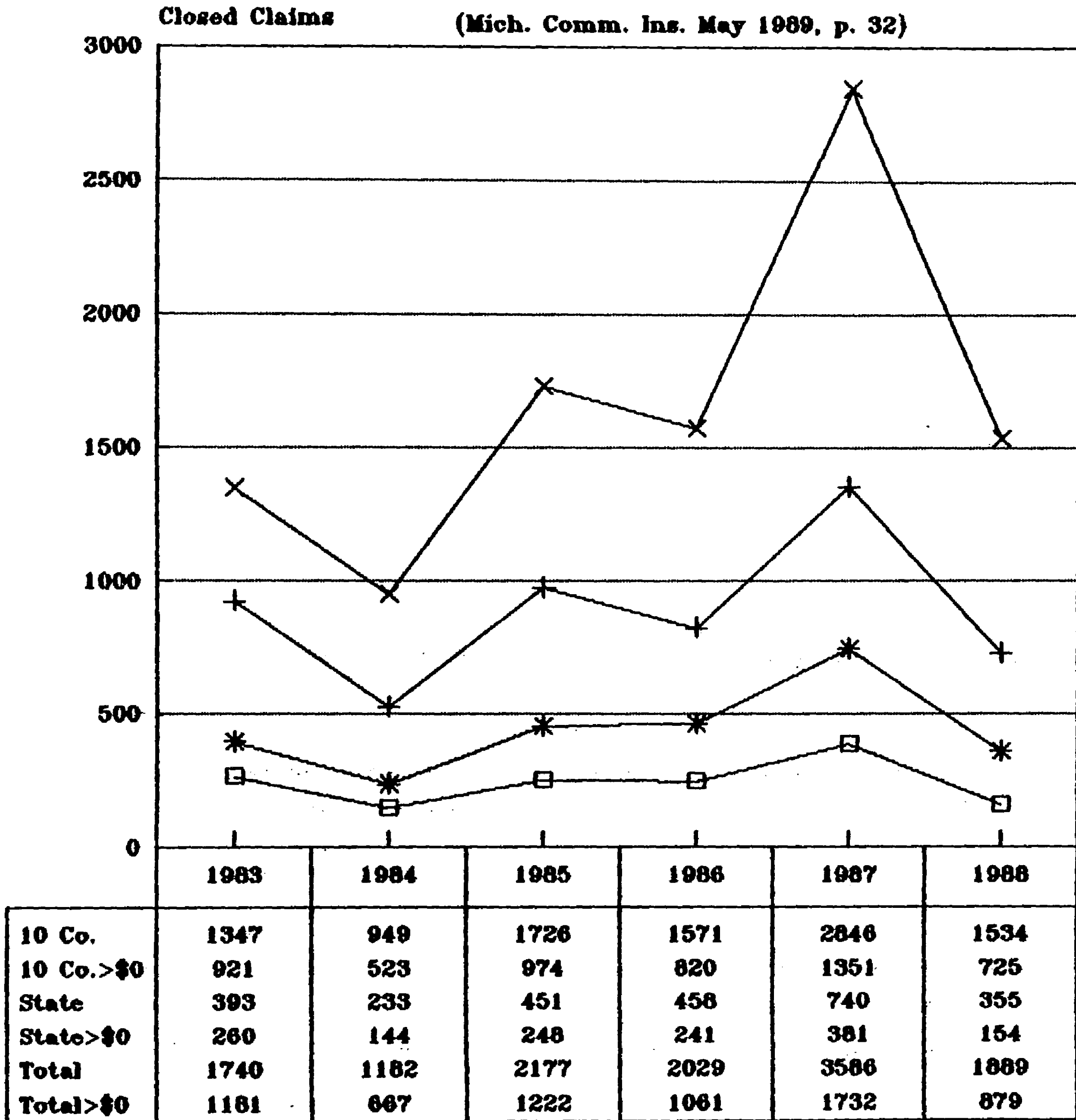
There is a clear increase in the number of settlements through mediation for the years 1987 and 1988 when the tort changes of 1986 were in effect. This may be due to the fact that Michigan rules of evidence are not followed in mediation panel evaluations. Mediation may also be responsible for weeding out frivolous lawsuits, as the 1986 tort changes penalize those who pursue claims lacking legal merit; M.C.L.A. *600.2591, M.C.L.A. * 600.4921.

Figures 1. and 2. totals for 1988 represent cases only through June and could be extrapolated by a figure of 2 without skewing the amounts by much. Extrapolation would show a tremendous increase in trial verdicts, possibly explained by a "rush to trial" mentality; for the 1986 changes do not reward delay.

Fig.4 represents closed medical malpractice claims charted against closed claims with indemnity over $0, which denotes winning claims. The lines run approximately parallel until 1987 when a smaller percentage of closed claims paid an indemnity than in years past. This coincides with the 1987 peak in **Fig.3**, which represents claims settled by the parties; attributable to the 1986 changes in tort law.

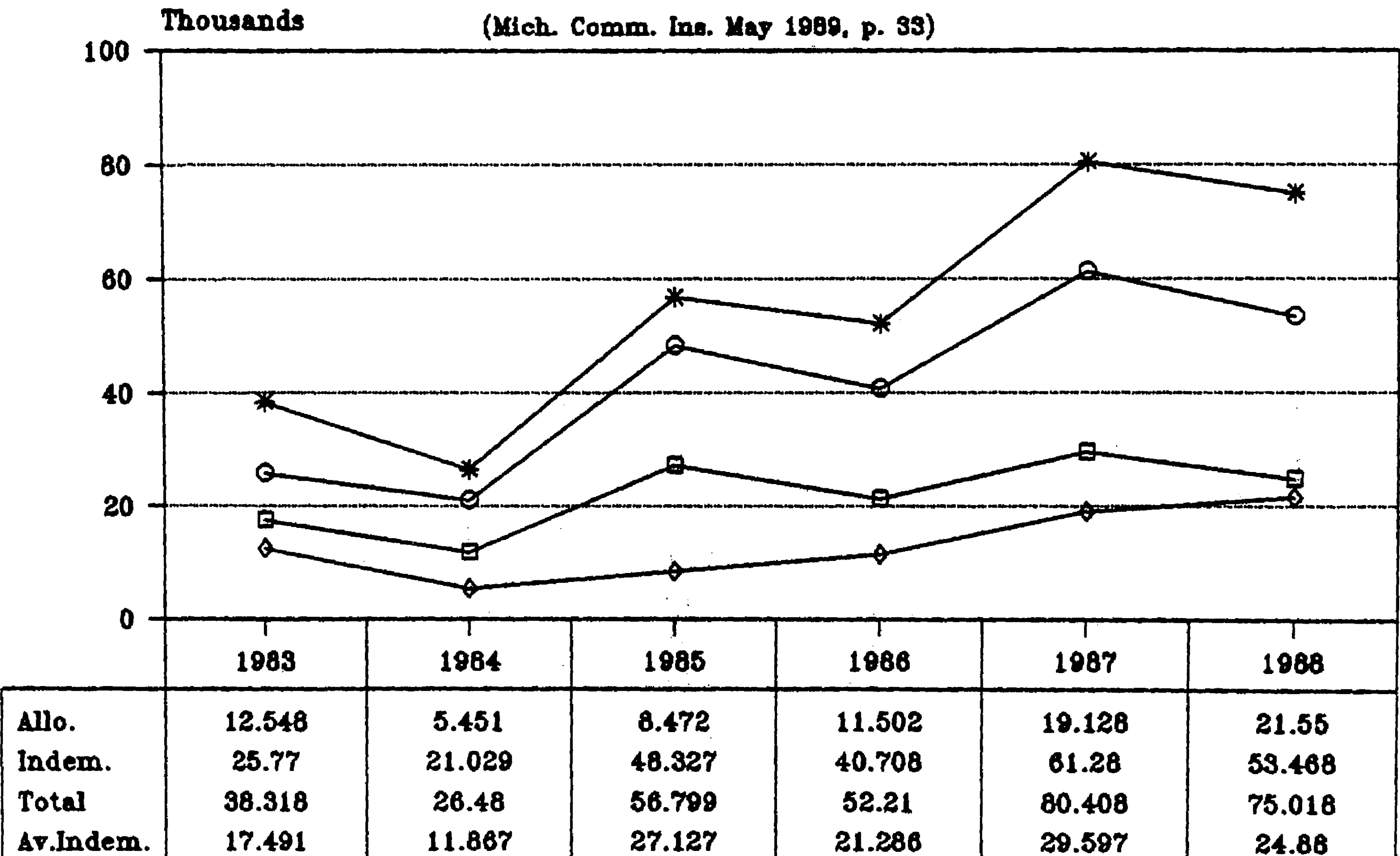
Fig.5 represents the costs of closed claims for the years 1983 through June 1988. This chart shows an indemnity peak of $61,280 average for claims which paid more than $0 in

Total Claims Closed Vs. Indemnity over $0 1983–June 1988



	1983	1984	1985	1986	1987	1988
10 Co.	1347	949	1726	1571	2846	1534
10 Co.>$0	921	523	974	820	1351	725
State	393	233	451	458	740	355
State>$0	260	144	248	241	381	154
Total	1740	1182	2177	2029	3586	1889
Total>$0	1181	667	1222	1061	1732	879

Fig.4



	1983	1984	1985	1986	1987	1988
Allo.	12.548	5.451	8.472	11.502	19.128	21.55
Indem.	25.77	21.029	48.327	40.708	61.28	53.468
Total	38.318	26.48	56.799	52.21	80.408	75.018
Av.Indem.	17.491	11.867	27.127	21.286	29.597	24.88

Fig.5

1987. This represents a huge jump from the preceding years. However, Fig.2, the severity chart, indicates that 1987 and 1988 showed an abnormal rise in the number of closed claims in severity categories 8 and 9, which represent the most severe injury due to medical negligence, and which would then tend to result in higher indemnity to plaintiff.

The 1984-1986 allocated expenses average per closed claim show a general decline per claim. This can be explained by again referring to Fig.2 where we see that minor severity claims represent a greater percentage of all claims than they did in 1987 and 1988.

The allocated expenses cover court costs, defendant attorney fees, witness fees, filing fees, and so forth. These expenses will tend to fluctuate, on the average, depending on the severity of the injury which is the basis for the claim.

Also, 1987 and 1988 saw a dramatic increase in the number of claims closed through malpractice trials, as shown in Fig.3. This could explain the increase in average indemnity paid per winning claim.

VII. THE COST/BENEFIT SUMMARY

The 1986 changes in Michigan tort law have considerable affect upon the costs and benefits of the compensation to plaintiffs receiving a favorable settlement judgment; whether from trials, mediation, arbitration, or private

parties settlement.

COSTS

As listed in the Statement of Method, the current costs of medical malpractice liability compensation are:

1. Liability insurance premiums
2. Economic loss and pain and suffering
3. Court costs (judges, juries, attorneys, etc.)
4. Effect on medical practices (defensive medicine)
5. Availability of care
6. Impact of delay
7. Time costs: plaintiffs and defendants
8. Damage to reputation: good will

1. Liability Insurance Premiums

In Michigan, the cost of malpractice liability insurance is dependent upon the availability of specialized lines of coverage from licensed insurers authorized to write policies in the state. The Insurance Bureau uses the percentage of the market covered by surplus suppliers; those authorized, but not licensed to write policies in the state; as a measure of the availability of insurance, (Mich. Comm. Ins. December 1988, p. 8).

M.C.L.A. *500.1910(4) mandates that the Insurance Bureau publish a list of the insurance lines unavailable in Michigan's traditional insurance market. As of October 15, 1988, the only medical specialty on that list was #15,

Podiatric professional liability.

The cost of liability insurance coverage is also dependent upon the overall efficiency and profitability of the particular line of insurance. The insurance industry uses the overall profitability ratio to measure the profitability in a given year. This is figured by dividing the incurred losses by the earned premiums in that line, minus the investment gain ratio.

In 1985, the Michigan profitability ratio was 189.7, (Mooney, p.8). However, according to the Insurance Bureau, ratios figured by using losses and premiums for the same calendar year are skewed because of the "long tail" problem inherent in medical malpractice negligence cases. This allows investments to influence the figures, which result in a higher loss ratio. The Insurance Bureau specifically states that loss ratios are not valid for setting coverage rates, (Mich. Comm. Ins. December 1988, p. 27).

The 1986 tort law changes tie insurance rates to the risk category that the medical care provider falls into. This is dependent upon the professional action of the medical care giver that may result in legal actions. Thus, the insurance rates in Michigan depend on risk categories which are influenced by the actions of the policy holders. M.C.L.A. *500.814 allows insurers to base rates on surcharges applied to medical care providers whose actions result in a loss to the insurer.

The overall result of insurance changes, due to

M.C.L.A., will be to reduce costs for the majority of practitioners and place the financial burden on those who, through their own actions or inactions, incur abnormal risks.

2. Economic Loss and Pain and Suffering

The 1986 changes in Michigan's tort law provide full coverage for plaintiffs' economic losses, including future damages. M.C.L.A. *600.6301 and .6303 cover this item.

Pain and suffering, being a non-economic damage, is covered by the $225,000 cap placed on non-economic damages under M.C.L.A. *600.1483, with exceptions for grievous wrongs which are specified.

The overall result of the separation of damages into economic and non-economic categories will be to lower judgment amounts, except in those cases where the liable defendant has done grievous harm. Those practitioners will then face the double penalty of a lost lawsuit, as well as higher insurance premiums based on a surcharge formula. These penalties may force less skillful practitioners to move out of Michigan in search of a state with more favorable laws.

3. Court Costs

Mandatory mediation of medical malpractice actions, M.C.L.A. *600.4903, will result in fewer cases going to trial due to the penalties assessed a party who rejects a good faith offer and , subsequently, receives a judgment less

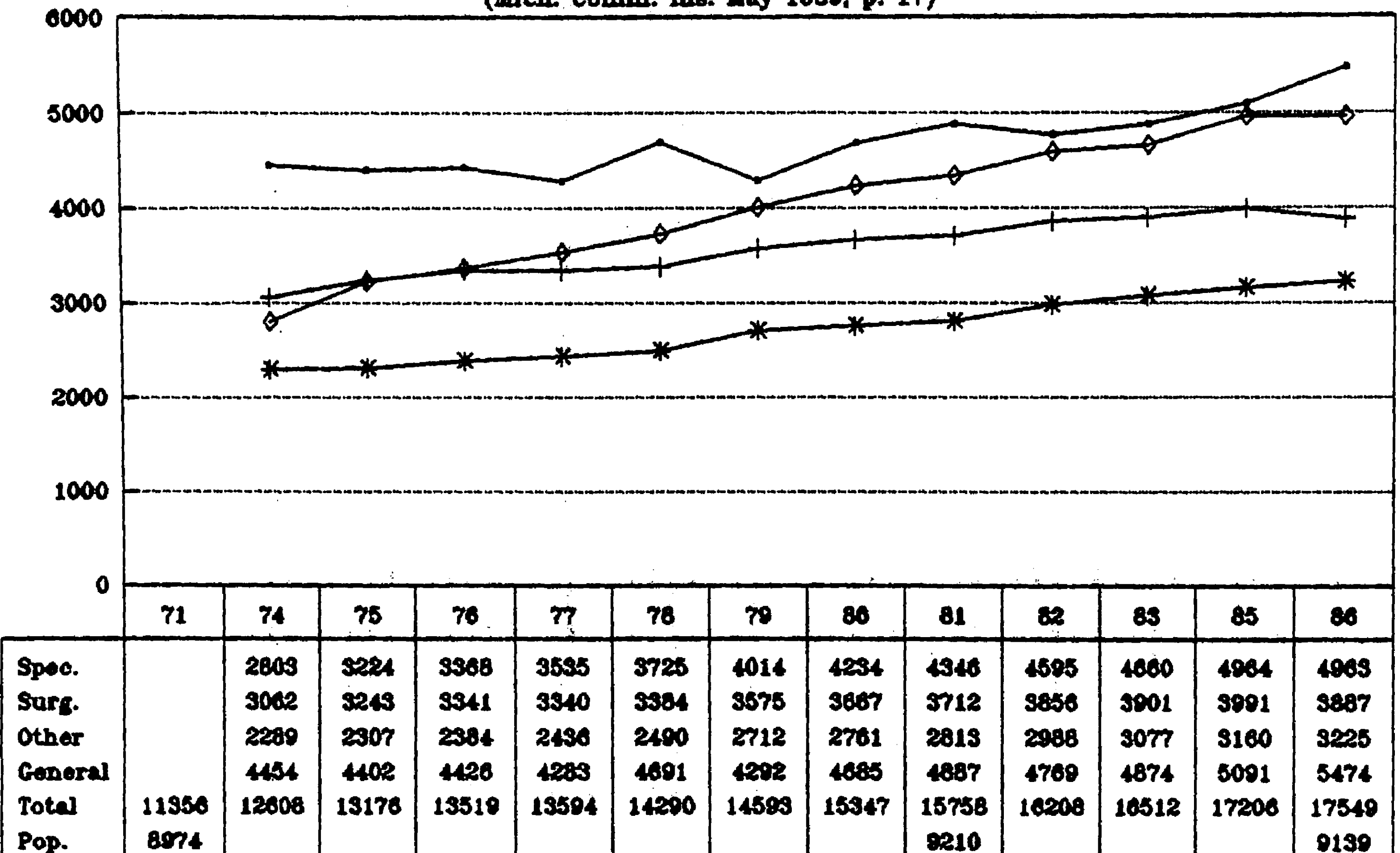
favorable than the mediation panel evaluation. The overall 1986 changes can be credited for the overall trend toward negotiated settlements, represented in Fig.3, (as Mediation, Parties Settled and Arbitration). There are also penalties for frivolous lawsuits, M.C.L.A. *600.2591. Combined, these changes may explain the trend, shown in Fig.5, toward lower allocated expenses and a leveling off of indemnity amounts.

In the long run, these changes will result in fewer lawsuits reaching courts; which will lower court costs.

4. Effect on Medical Practices (defensive medicine) .

The establishment of mandatory risk management and quality assurance programs; plus improved record keeping methods; by M.C.L.A. *500.2404, *333.20175, and *333.21513, may result in higher costs. Higher health care costs are inevitable as physicians and hospitals incorporate risk management, quality assurance, and improved record keeping into their operating costs. And, fear of lawsuits, the bugbear of the medical profession, has been shown to increase costs through unnecessary tests and treatments.

However, these statutes have the specific purpose of reducing morbidity and mortality, as well as justifying treatment. Initially, the costs will increase, pending effective reduction of iatrogenic injury; at which point the added medical costs should be offset by fewer injuries to patients. Either way, the costs cannot be measured accurately in dollar values.



	71	74	75	76	77	78	79	80	81	82	83	85	86
Spec.		2803	3224	3368	3535	3725	4014	4234	4346	4595	4660	4964	4963
Surg.		3062	3243	3341	3340	3384	3575	3667	3712	3856	3901	3991	3887
Other		2289	2307	2384	2436	2490	2712	2761	2813	2988	3077	3160	3225
General		4454	4402	4426	4283	4691	4292	4685	4887	4769	4874	5091	5474
Total	11356	12608	13176	13519	13594	14290	14593	15347	15758	16208	16512	17206	17549
Pop.	8974								9210				9139

Fig. 6

5. Availability of Care

The myth that rising medical malpractice costs drive practitioners from their profession can be debunked by examining Fig.6, a representation of physicians practicing in Michigan, 1971 through 1986, according to A.M.A. data.

Availability of medical care in Michigan has risen steadily since 1971, while the population has remained fairly constant. In 1971 there were 50.7 physicians per 100,000 population; in 1981, 197.8 per 100,000; and 1986, 217.9 physicians per 100,000 population.

Since the 1986 tort changes are designed to reduce the risks of practicing medicine, availability of medical care should remain constant.

This rosy outlook cannot be connected to the 1986 tort law changes, because available figures stop at 1986. Although Michigan has traditionally had medical care availability below the national average, it is now approaching the national figure.

Table 2 (Michigan Department of Licensing and Regulation)

Physicians per 100,000 Population

	Michigan	United States
1971	50.7/per	163.2/per
1986	217.9/per	225.9/per

For Fig.6, Spec. = specialists practicing

cardiovascular, dermatology, gastroent, internal, pediatrics, and pulmonary, medicine. Surg. = general, neuro, obstetrics and gynecologyl, ophthalmology, orthopedic, plastic, and urology surgery. Others = anesthesiology, diag radiology, neurology, occupational medicine, psychiatry, pathology, and radiology.

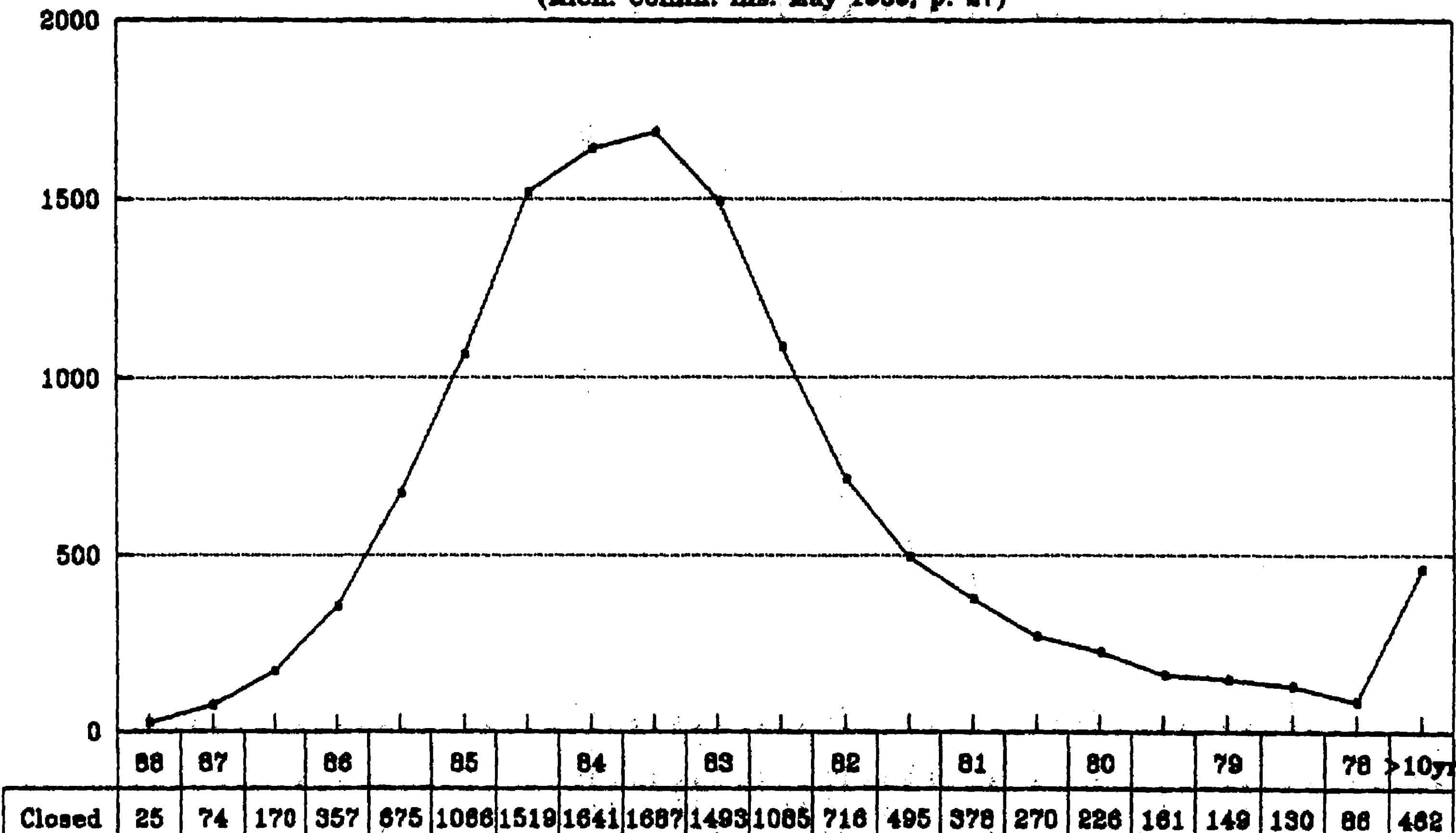
General practitioners make up the balance of the total. Also, these figures are from the A.M.A. and as such, do not include doctors of osteopathy. The available figures for DO's, practicing in Michigan, show a 56.9% gain from 2,168 in 1971 to 3,401 in 1986.

The growth in medical care availability is a positive gain that is not related to the 1986 tort law changes.

6. Impact of Delay

The median indemnity for cases resolved within 3 1/2 years is $0. It does not rise above $5,000 until cases 10 years+ old are included in the figures, (Mich. Comm Ins. May 1989, p. 24). The following chart shows the number of cases resolved between 1983 and June of 1988 at 6 month intervals, with both average indemnity and median indemnity shown.

While delay does not add appreciably to the indemnity paid, it does have an impact on the financial needs of the injured party, dependent upon the severity of the injury. The 1986 tort law changes are designed to speed up the process for claims resolution, especially for claims in mediation; M.C.L.A. *600.4903 and *600.4919. Likewise, as seen in Fig.3,



	88	87		86		85		84		83	
Closed	25	74	170	357	675	1086	1519	1641	1687	1493	1085

	82		81		80		79		78	>10yr
Closed	716	495	378	270	226	161	149	130	86	462

Fig. 7

the trend is toward private party settlements, as well as mediated resolution of claims. Plaintiffs, for the most part, also qualify for collateral source income pending resolution, and therefore, wait only for a lump sum settlement and are not denied necessary medical attention, however costly it may be.

These changes, law and trends, act in concert to reduce the impact of delay.

7. Time Costs: Plaintiffs and Defendants

If a case referred to mediation is resolved at that level, the time costs for plaintiffs and defendants is negligible, because; #1, parties do not attend hearings, and; #2, attorneys bear the brunt of time costs, and these are included under court costs.

Defendants time costs should be reduced due to the penalties against frivolous lawsuits in M.C.L.A. *600.2591, which should reduce the percentage of cases going to trial. Fig.3 seems to contradict this statement, but since the average claim is closed 3 1/2 to 5 years after initiation, the rise in trial verdict resolutions for 1987 and 1988 cannot be fully attributed to the 1986 tort law changes. The "long tail" problem of medical malpractice liability lawsuits continues to muddy the analysis of trends. A clearer picture should be available by 1991.

Michigan is also experiencing a surge in the number of cases settled through private negotiations between parties

that also helps reduce overall time costs.

8. Damage to Reputations

Defendant medical care providers receiving a favorable judgment are not damaged. Defendants who receive an unfavorable ruling are assessed damages which, for the most part, are paid by insurers. The physicians costs show up in higher premiums paid for liability insurance coverage under merit ratings plans. But monetary damages are not synonymous with damages to reputations. In fact, peer review findings and complaints reported to the Insurance Bureau are confidential according to M.C.L.A. *500.2477 and *333.20175.

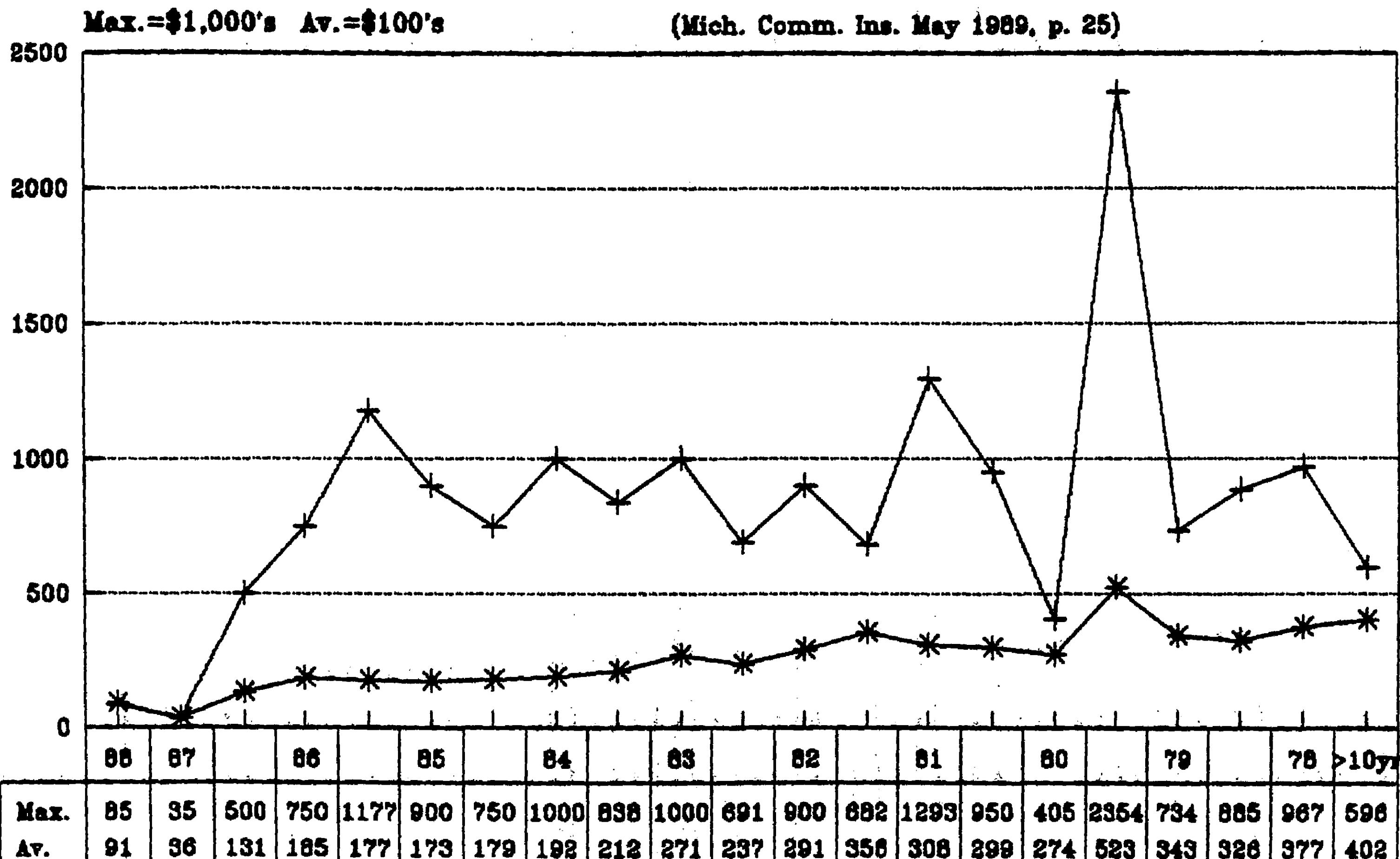
Unfavorable judgments in medical malpractice actions raise insurance premium costs through the addition of surcharges based on risk category rates. If these increases cause certain physicians to leave the state, or the practice of medicine, the public gains. The result is that increasing penalties for malfeasance will drive malpractitioners from the State of Michigan.

BENEFITS

1. Injured Party Made Whole

While no amount of monetary damages can repair severe iatrogenic injury; or, undo death; the Michigan Legislature went to great lengths in 1986 to insure that all financial losses due to malpractice would be included in trial verdicts

Maximum/Average Indemnity
6 Month Intervals: 1983–June 1988



	88	87		86		85		84		83		82		81		80		79		78	>10yr
Max.	85	35	500	750	1177	900	750	1000	838	1000	691	900	682	1293	950	405	2354	734	885	967	596
Av.	91	36	131	185	177	173	179	192	212	271	237	291	356	308	299	274	523	343	326	377	402

Fig. 8

and the resultant judgments. M.C.L.A. *600.6303 insures that favorable judgments for plaintiffs include future medical costs, rehabilitation costs, loss of earnings, and loss of earning capacity; as well as applicable interest payments. To insure that plaintiff is not made more than whole, collateral source payments are deducted from verdict totals prior to judgment. The impartial limits this particular section of Public Acts 1986 - No. 178 sets are beneficial to both winning plaintiff and losing defendant. Losers don't have to pay as much, due to mandatory offsets, and winners are "made whole".

2. <u>Deterrence of Sub-standard Care</u>

This benefit is the reverse of damage to reputation in the costs of the medical malpractice compensation system. The monetary penalties through merit rating plans in M.C.L.A. *500.814 combined with the additional reports to the Insurance Bureau mandated by M.C.L.A. *500.814, *500.2477, *333.20175, *333.21029 and *333.21513; including quality assurance and risk management programs; should raise a warning flag to medical malpractitioners that Michigan intends to improve the quality of care provided in the state.

These moves can be seen as a major benefit to the consumer public, as well as the medical professions.

3. <u>Retribution</u>

The 1986 tort law changes in Michigan provide for those

with a "get even" mentality through M.C.L.A. *600.1483 exceptions to the $225,000 cap on non-economic damages. These exceptions are death, intentional tort, foreign object left in the body, injury to the reproductive system, discovery prevented by fraud, limb or organ wrongfully removed and loss of vital bodily function. Cases where these exceptions are proven, as a matter of legal fact, have no limit on monetary damages.

Fig.8 shows the maximum monetary awards for claims resolution of actions. The years denote the year of injury; all claims were closed within the period 1983 through June 1988.

The claims that fall within the $225,000 cap also provide some measure of retribution. This could possibly explain why some plaintiffs go to trial rather than accept negotiated settlements; the jury is more easily swayed than are defendant's attorneys.

While this provision in the law is beneficial to the successful plaintiff, there exists the possibility that the overall compensation system will not be affected to any great degree. Again, a clearer picture of the effect awaits the 1991 figures; due to the "long tail".

4. Collateral Sources

Collateral source compensation provisions in the 1986 tort law changes are covered by M.C.L.A. *600.6303. Prior to recently mandated offsets, collateral source payments allowed

a prevailing plaintiff to "double dip" on losses. This is no longer the case. This change reduces the overall costs of the compensation system. This is definitely beneficial and should be reflected in future average indemnity figures.

IX. CONCLUSION

One goal of the Task Force study of the medical malpractice crisis in the United States is to increase uniformity of tort laws throughout the country. When the various states have discrepancies citizens are not protected from iatrogenic harm at the same level. Likewise, practicing physicians in different states operate under uncertain, and for the most part, unyielding compensation schemes. The medical needs of the country, as a whole, are better served when physicians are allowed to focus their efforts toward mastery of their chosen profession, rather than legal questions. Uniformity of law serves that end. On that note, the State of Michigan seems destined to fall in line with a national norm in medical malpractice tort law. Mandatory mediation and collateral source considerations promise to speed the process, while providing more equitable compensation for injured parties.

Plaintiffs' rights of retribution toward incompetent medical personnel are protected by the exceptions to the non-economic losses. This should satisfy all parties. Examination of the severity of claims prove to dispel the belief that

medical malpractice "nickel and dimes" the profession through inconsequential claims. Severe injuries account for more actions than do minor ones; this is a medical problem, not a legal one.

The real 'crisis' in Michigan has been the lack of medical care, compared to the national average of physicians per 100,000 population. This problem has been resolved, though the 1986 changes were not responsible. Insurance coverage has been available to medical practitioners, though not at a price they are always willing to pay. Those practicing in high risk specialties, with high surcharge rates, suffer from self inflicted insurance rates. Practitioners who do not lose malpractice actions, do not pay the highest rates.

The crisis of huge damage payments did not, nor does it now, exist in the state of Michigan. Inspection of the closed claims for the period 1983 through June 1988, shows that most medical malpractice claims are settled by private parties. This trend not only promises to continue, but demonstrates that large damage compensation is not being awarded by juries subject to the influence of emotion or empathy toward the injured party, but rather, by insurance underwriters and defendants' attorneys. This trend, plus the rise in mediated settlements, should act to lower the average cost per claim in medical malpractice compensation. The figures for 1991; those which will compensate for the average 5 year tail on malpractice suits; promise to bear this out, and; are eagerly

awaited from this quarter.

Because the law is a dynamic process, the task, like cleaning the Aegean stables, is never at an end. What remains is for the Michigan Legislature to dot some I's and cross some T's. Consolidation of medical malpractice information, channeled through the Insurance Bureau, should help identify which I's and T's. The figures for 1991 are the key to this process.

One last note; the confidentiality of peer review findings, as mandated by M.C.L.A. *333.20175, is a disservice to prospective patients of incompetent medical personnel and should be eliminated. Under the current tort laws, the damage to reputations is negligible, allowing incompetent physicians to continue the practice of medicine in Michigan.

APPENDIX A Some Legal Definitions

Ad damnum. In pleading, "To the damage." The technical name of the clause of the writ, declaration, or, more commonly, the complaint, which contains a statement of the plaintiff's money loss, or the damages which he claims. Fed.R.Civil P. 8(a).

Additur. The power of trial court to assess damages or increase amount of an inadequate award made by jury verdict, as condition of denial of motion for new trial, with consent of defendant whether or not plaintiff consents to such action.

Iatrogenic\ adj : induced by a physician; an inadvertent injury .

Joinder of parties. The act of uniting as parties to an action all persons who have the same rights or against whom rights are claimed, as either co-plaintiffs or co-defendants.

Joint and several liability. A liability is said to be joint and several when the creditor may sue one or more of the parties to such liability separately, or all of them together at his option.

Made. Filed.

Made known. Where a process or other legal paper has been actually served upon a defendant, the proper return is that its contents have been "made known" to him.

Remittitur. The procedural process by which a verdict of the jury is diminished by subtraction.
If money damages awarded by a jury are grossly excessive as a matter of law, the judge may order the plaintiff to remit a portion of the award. In the alternative, the court may order a complete new trial or a trial limited to the issue of damages.

Res ipsa loquitur. The thing speaks for itself. Rebuttable presumption or inference that defendant was negligent, which arises upon proof that instrumentality causing injury was in defendant's exclusive control, and that the accident was one which ordinarily does not happen in absence of negligence......is rule of evidence whereby negligence of alleged wrongdoer may be inferred from mere fact that accident happened provided character of accident and circumstances attending it lead reasonably to belief that in absence of negligence it would not have occurred and that thing which caused injury is shown to have been under management and

control of alleged wrongdoer.

Respondeat superior. Let the master answer. This maxim means that a master is liable in certain cases for the wrongful acts of his servant, and a principal for those of his agent........Doctrine applies only when relation of master and servant existed between defendant and wrongdoer at time of injury sued for, in respect to very transaction from which it arose. Hence doctrine is inapplicable where injury occurs while servant is acting outside legitimate scope of authority.

Tort. A private or civil wrong or injury, other than breach of contract, for which the court will provide a remedy in the form of an action for damages. A violation of a duty imposed by general law or otherwise upon all persons occupying the relation to each other which is involved in a given transaction.

Tort-feasor. A wrong-doer; one who commits or is guilty of a tort.

APPENDIX B Specific Sections of Revised Judicature Act

M.C.L.A. *600.1483. Medical malpractice action; noneconomic loss; damages

Sec. 1483. (1) In an action for damages alleging medical malpractice against a person or party specified in section 5838a,[1] damages for noneconomic loss which exceeds $225,000.00 shall not be awarded unless 1 or more of the following circumstances exist:

(a) There has been a death.

(b) There has been an intentional tort.

(c) A foreign object was wrongfully left in the body of the patient.

(d) The injury involves the reproductive system of the patient.

(e) The discovery of the existence of the claim was prevented by the fraudulent conduct of a health care provider.

(f) A limb or organ of the patient was wrongfully removed.

(g) The patient has lost a vital bodily function.

(2) In awarding damages in an action alleging medical malpractice, the trier of fact shall itemize damages into economic and noneconomic damages.

(3) "Noneconomic loss" means damages or loss due to pain, suffering, inconvenience, physical impairment, physical disfigurement, or other noneconomic loss.

(4) The limitation on noneconomic damages set forth in subsection (1) shall be increased by an amount determined by the state treasurer at the end of each calendar year to reflect the cumulative annual percentage increase in the consumer price index. As used in the subsection, "consumer price index" means the most comprehensive index of consumer prices available for this state from the bureau of labor statistics of the United States department of labor.

M.C.L.A. *600.5838. Malpractice claim; exception for medical malpractice; accrual; limitations

Sec. 5838. (1) Except as otherwise provided in section 5838a,[1] a claim based on the malpractice of a person who is, or holds himself or herself out to be, a member of a state licensed profession accrues at the time that person discontinues serving the plaintiff in a professional or pseudo-professional capacity as to the matters out of which the claim for malpractice arose, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim.

(2) Except as otherwise provided in section 5838a,[1] an action involving a claim based on malpractice may be commenced at any time within the applicable period prescribed in sections 58052 or 5851 to 5856,[3] or within 6 months after the plaintiff discovers or should have discovered the existence of the claim, whichever is later. The burden of proving that the plaintiff neither discovered nor should have discovered the existence of the claim at least 6 months before the expiration of the period otherwise applicable to the claim shall be on the plaintiff...............

M.C.L.A. *600.5838a. Medical malpractice claim; accrual; definitions; limitations

Sec. 5838a. (1) A claim based on the medical malpractice of a person who is, or holds himself or herself out to be, a licensed health care professional, licensed health facility or agency, employee or agent of a licensed health facility or agency who is engaging in or otherwise assisting in medical care and treatment, or any other health care professional, whether or not licensed by the state, accrues at the time of the act or omission which is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim. As used in this subsection:

(a) "Licensed health facility or agency" means a health facility or agency licensed under article 17 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22181 of the Michigan Compiled Laws.

(b) "Licensed health care professional" means an individual licensed under article 15 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws. Licensed health care professional does not include a sanitarian or a veterinarian.

(2) Except as otherwise provided in this subsection, an action involving a claim based on medical malpractice may be commenced at any time within the applicable period prescribed in sections 58051 or 5851 to 5856,[2] or within 6 months after the plaintiff discovers or should have discovered the existence of the claim, whichever is later. However, the claim shall not be commenced later than 6 years after the date of the act or omission which is the basis for the claim. The burden of proving that the plaintiff, as a result of physical discomfort, appearance, condition, or otherwise, neither discovered nor should have discovered the existence of the claim at least 6 months before the expiration of the period otherwise applicable to the claim shall be on the plaintiff. A medical malpractice action which is not commenced within the time prescribed by this subsection is barred. This subsection shall not apply, and the plaintiff shall be subject to the period of limitations set forth in subsection (3), under 1 or more of the following circumstances:

(a) If discovery of the existence of the claim was prevented by the fraudulent conduct of a health care provider.

(b) If a foreign object was wrongfully left in the body of the patient.

(c) If the injury involves the reproductive system of the plaintiff.

(3) An action involving a claim based on medical malpractice under the circumstances described in subsection (2)(a) to (c) may be commenced at any time within the applicable period prescribed in sections 5805 or 5851 to 5856, or within 6 months after the plaintiff discovers or should have discovered the existence of the claim, whichever is later. The burden of proving that the plaintiff, as a result of physical discomfort, appearance, condition or otherwise, neither discovered nor should have discovered the existence of the claim at least 6 months before the expiration of the period otherwise applicable to the claim shall be on the plaintiff. A medical malpractice action which is not commenced within the time prescribed by this subsection is barred.

M.C.L.A. *600.6098. Medical malpractice and personal injury actions; review of verdict; new trial

Sec. 6098. (1) A judge presiding over an action alleging medical malpractice shall review each verdict to determine if the limitation on noneconomic damages provided for in section 14831 applies. If the limitation applies, the court shall set aside any amount of noneconomic damages in excess of the amount specified in section 1483.

(2) A judge presiding over a personal injury action shall review each verdict returned by the jury and shall do 1 of the following:

(a) Concur with the award.

(b) Upon motion by any party, within 21 days of entry of the judgment of the court, grant a new trial to all or some of the parties, on all or some issues, whenever their substantial rights are materially affected, for any of the following reasons:

(i) Irregularity in the proceedings of the court,

jury, or prevailing party.

(ii) An order of the court or abuse of discretion which denied the moving party a fair trial.

(iii) Misconduct of the jury or the prevailing party.

(iv) Excessive or inadequate damages appearing to have been influenced by passion or prejudice.

(v) A verdict clearly or grossly inadequate or excessive.

(vi) A verdict or decision against the great weight of the evidence or contrary to law.

(vii) Material evidence, newly discovered, which could not with reasonable diligence have been discovered and produced at trial.

(viii) Error of law occurring in the proceedings or mistake of fact by the court.

(ix) Other grounds as may be provided for by court rule.

(c) Within 21 days after entry of a judgment, the court on its own initiative may order a new trial for any of the reasons set forth.............

SPECIFIC CHANGES IN MICHIGAN TORT LAW, 1986

Public Acts 1986-No. 173

M.C.L.A. *500.810

This section states that all insurers doing business in Michigan must maintain reserves adequate to cover all claims they 'may' be liable for. This protects the insureds as well as insuring the solvency of the insurance companies. The insurance commissioner examines reserves annually, as well as investment income of all medical malpractice insurers in the state.

M.C.L.A. *500.813

The insurance commissioner's annual report contains information on the number of insurers who wrote policies while maintaining inadequate reserves, as well as; those lines of insurance written with inadequate loss reserves, and; the measures taken by underwriters to eliminate the inadequate loss reserve problem. The report does not identify underwriters by name.

M.C.L.A. *500.814

Reported loss reserves are certified by the insurance commissioner's actuaries.

M.C.L.A. *500.2404

(1) Insurers are mandated by this section to develop merit rating plans to adjust insurance rates on the basis of risk management techniques of the policy holders. This subsection applies to all Commercial Liability Insurers.

(2) Medical malpractice insureds are subject to a premium surcharge based on filing of claims against the individual. The surcharge plan must be filed with the Insurance commissioner. Surcharges cannot be based on any action that occurred 3 years prior to the issue date or the renewal date of the policy. No surcharges can be based on actions where the insured was adjudged not liable, been dismissed, or settled without indemnity paid on behalf of the insured. The

surcharge cannot be based on any action where the insurer paid indemnity and loss adjustment expenses that total less than 51% of the annual premium for that policy period.

M.C.L.A. *500.2477

Insurers of persons licensed by the Michigan Board of Medicine, Michigan Board of Osteopathic Medicine and Surgery, Michigan Board of Podiatric Medicine and Surgery, Michigan Board of Dentistry, and hospitals licensed by the Michigan Department of Public Health must provide data to the Insurance Commissioner with respect to any complaint filed against that insured in any court where the complaint seeks damages for personal injury caused by negligence relating to the insured's professional services, or performance of services without consent or without informed consent, or breach of warranty or contract for medical results.

The report must identify the name of the insured, the license number, the date of the injury, the filing date of the complaint, the nature of the complaint, and any other information the commissioner may want.

The information must be sent to the insurance bureau licensing board, or if the insured is a hospital, the state Department of Public Health, within 30 days of a judgment, dismissal, or settlement. The report must contain the date of the disposition of the case, the amount of any judgment, whether the settlement was negotiated by law suit or without the filing of a complaint for damages, the percentage attributed to economic damages, percentage attributed to

non-economic damages, and any other information the commissioner may want.

State licensing boards and the Department of Public Health must maintain confidential records which are not released absent good cause. This is not considered public information. If the information should be released for good cause, the names of the underwriter must be omitted.

M.C.L.A. *500.3030

This section states that no insurer may be made or joined in medical malpractice cases, and may not be referred to in the original complaint nor mentioned during the resultant trial.

Public Acts 1986-No. 174

M.C.L.A. *333.20175

This section deals with medical records which must be kept by health facilities on all tests, exams, observations, treatments and the reason for hospitalization. Failure to maintain these records can result in a $10,000 fine. A hospital's failure to guard against altered or destroyed records may result in a $10,000 fine. These records are public records for the purpose of licensing and certification. All clinical records are confidential and may not identify individuals absent a court order. All disciplinary actions against medical personnel must be

reported. No professional review data collected may be made public; those records are not subject to court subpoena.

M.C.L.A. *333.21029

All health maintenance organizations must notify the appropriate licensing board of any disciplinary action that results in change of employment status or limits placed on professional privileges. This includes offers of resignation in lieu of discipline.

M.C.L.A. *333.21513

All owners, operators, or governing bodies of hospitals are responsible for all phases of the operation, including staff selection and quality of care provided. They are also responsible for insuring that all licensed personnel are currently licensed. The privileges extended to physicians and dentists must be consistent with the training, experience and other qualifications of the staff. The owners must organize the medical staff in such a way that effective review of professional practices is possible. This should reduce morbidity and mortality, and improve care provided. The review must include the quality and necessity of care, and the preventability of complications and deaths in the hospital. Hospitals are also subject to the disciplinary requirements of M.C.L.A. *333.21029.

Public Acts 1986-No. 175

M.C.L.A. *691.1406

This section allows a government agency to subrogate and recover contributions from each co-defendant, and joint and several tortfeasor where such action is within the law.

M.C.L.A. *691.1407

This section establishes governmental immunity from tort liability, with the exceptions of ownership of hospitals or county medical facilities and their agents or employees. Hospitals are defined as facilities offering inpatient, overnight care, services for observation, diagnosis, active treatment of a patient with medical, surgical, obstetric, chronic or rehabilitative condition needing direction or supervision of physicians. Hospitals owned or operated by the state Department of Mental Health and the Department of Corrections are still granted governmental immunity from tort liability.

Public Acts 1986-No. 178

M.C.L.A. *600.1483

This section places a $225,000 cap on non-economic damages in malpractice cases with the following exceptions:

1. Death
2. Intentional tort
3. Foreign object left in the body
4. Injury to the reproductive system

5. Discovery prevented by fraudulent conduct by defendant
6. Limb or organ wrongfully removed
7. Patient lost vital bodily function

M.C.L.A. *600.2169

If the defendant in a medical malpractice case is a specialist, no testimony may be taken from an "expert" witness unless the witness specialized in the same specialty as the defendant at the time of the occurrence; devotes substantial time to active clinical practice or instruction in a medical school in the same field as the defendant. The witness must be educated and trained in the area of specialization, with extensive experience. The testimony must also be relevant to the case. No "expert" witness may testify on a contingency fee basis.

M.C.L.A. *600.2591

If a civil action or defense of a civil action is frivolous, the prevailing party is awarded costs and fees to +e paid by the opposing party and the opposing attorney. Frivolous means:

1. Harassment, embarrassment, or injury to the other party
2. No reasonable basis for belief in the facts underlying the legal position taken

3. Party's legal position is devoid of arguable legal merit

M.C.L.A. *600.2912

Security for costs in the amount of $2,000 must be filed within 91 days of any medical malpractice complaint. A written opinion from a licensed health care provider stating that the claim is meritorious may be substituted for the surety. If no security is filed, the court may increase the amount of the surety required. If payment is not made, the complaint is dismissed without prejudice. These rules apply to the defendant as well. If a defendant fails to post a surety, a default judgment is entered against the defendant.

M.C.L.A. *600.4903

An action alleging medical malpractice must be heard by a mediation panel. The presiding judge will refer each case to a panel within 91 days of the court's receipt of the answer to the complaint.

M.C.L.A. *600.4905

Mediation panels are composed of 3 attorneys, one licensed health care provider for the defendant , and one licensed health care provider for the plaintiff. If the defendant is a specialist, then the two medical panel members must also specialize in the same field. No judge may preside

over any medical malpractice case after hearing that same case as a mediation panel member.

M.C.L.A. *600.4909

The mediation fee is $75. The court clerk must receive a concise brief containing the party's factual and legal position prior to the mediation hearing.

M.C.L.A. *600.4913

Although no testimony is allowed at a mediation hearing, an injured party may attend to demonstrate scars, disfigurement, or unusual conditions. The Michigan rules of evidence do not apply. Factual information should be supported by documentary evidence. Each party is permitted 15 minutes for oral presentations. The mediation panel may request information on insurance policy limits and may ask about settlement negotiations. Statements by attorneys and the contents of mediation briefs are inadmissible in any subsequent court proceedings.

M.C.L.A. *600.4915

A panel evaluation will be available within 14 days of the hearing. It will contain specific findings concerning the applicable standard of care. The evaluation must state whether findings are unanimous. If there is a unanimous determination of frivolity, and the case proceeds to trial, the frivolous party must post a surety of $5,000 for each

opposing party. If that party loses in court, the surety is used to offset the costs of the prevailing parties. The evaluation must contain separate awards for each cross-claim, counter claim or 3rd party claim.

M.C.L.A. *600.4917

Each party has 28 days to file an acceptance or rejection of mediation panel evaluations. Failure to file means acceptance.

M.C.L.A. *600.4919

Acceptance of an evaluation means judgment for that amount. In a non-jury trial, the trier of fact does not know the dollar amount, nor the acceptance or rejection status of the parties until after judgment is entered. Jurisdictional limitation questions can be handled by the court clerk.

M.C.L.A. *600.4921

A party who rejects the evaluation dollar amount and proceeds to court is liable for the opposing parties actual costs unless the court verdict is more favorable than the evaluation. There are adjustments; add the costs and interest on the verdict amount from the complaint date to the mediation evaluation date. After adjustment, a court verdict is more favorable to the defendant if it is more than 10% below the evaluation figure. The verdict is more favorable to the plaintiff if it is more than 10% above the evaluation

figure. Actual costs are taxable costs and reasonable attorney fees. Costs can only be awarded to the prevailing party if the mediation panel evaluation was unanimous.

M.C.L.A. *600.5838a

Medical malpractice accrues at the time of the act or omission that is the basis for the complaint. They may be commenced any time within the applicable time or within 6 months of the discovery of the reason for the complaint. No claims may be commenced later than 6 years after the date of the act or omission. The burden of proof is on the plaintiff as to why the cause of the complaint was not discovered as a result of physical discomfort, appearance or condition.

This subsection does not apply if:

1. The existence of the claim was prevented by fraudulent conduct by the health care provider
2. A foreign body was wrongfully left in the body
3. Injury to the reproductive system

If the plaintiff cannot prove ignorance of the existence of a cause of action within the 6 month discovery provision, the complaint is estopped.

M.C.L.A. *600.5851

Plaintiffs who were insane or imprisoned at the time of their claim accrual have 1 year after their disability is removed to file a complaint, even if the limitation has run.

1. Insanity is a medical term, not a legal one

2. Plaintiff must be disabled at the time of the claim
3. Disabilities cannot be tacked on one to another
4. An insane minor in prison has the benefit of this subsection until the last disability has terminated
5. For plaintiffs 13 years of age, or less, actions must be brought on or before their 15th birthday. Minors over the age of 13 are treated as adults

M.C.L.A. *600.6098

The presiding judge will separate monetary awards into economic and non-economic damage awards. The judge may concur with the verdict, or , upon motion by one of the parties, grant a new trial for:

1. Irregularities in the proceedings
2. Fair trial denied by abuse of discretion
3. Misconduct by a jury member or the prevailing party
4. Excessive or inadequate damages influenced by passion or prejudice
5. Verdict clearly, grossly inadequate or excessive
6. Verdict against the great weight of evidence or contrary to law
7. Newly discovered evidence that was unavailable at time of the trial
8. Error of law in the proceedings or mistake of fact

There can also be a new trial on the initiative of the trial judge. There will be a new trial for inadequate or

excessive damages unless the prevailing party agrees to an amount that the evidence will support. If a non-moving party prevails at the appellate level, the original verdict is reinstated. Judicial orders granting *additur* or *remittitur* are affirmed on appeal unless the trial judge abused discretion.

M.C.L.A. *600.6301

Future damages accrue after the damage findings in medical malpractice law suits. They include medical treatment, care and custody, loss of earnings, loss of earning capacity, loss of bodily function, and pain and suffering. Personal injury is defined as bodily harm, sickness, disease, death, and emotional harm resulting from bodily harm.

M.C.L.A. *600.6303

After a verdict for plaintiff in medical malpractice cases, but before judgment is entered on the verdict, evidence to establish future medical care costs, rehabilitation costs, loss of earnings, loss of earning capacity, and other economic losses is accepted. That portion covered by collateral sources, in whole or part, is offset from the verdict amount. This offset cannot be more than the total economic loss or more than the total collateral amount. The economic amount is also reduced by the premiums which are paid by those other than the plaintiff.

Contractural lien holders with subrogation rights lose those rights unless they file a demand for payment within 20 days of the judgment.

Collateral sources are benefits payable from insurance policies, health care corporations, dental care corporations, H.M.O.'s, employee benefits, social security, workers compensation, and medicare. This does not include life insurance benefits paid for by lien holders.

M.C.L.A. *600.6304

After the judge, or jury, determines the total amount of a damage award for the plaintiff, they then determine the percentage of total fault attributable to each tortfeasor. They also determine the nature of the conduct of the party at fault and the extent of the causal relationship between that conduct and the damages.

No person shall pay more than their percentage of fault unless:

1. Uncollectible obligations exist. These are reallocated to the other tortfeasors according to their percentage of fault, up to the amount of the original fault.
2. Reallocated parties are still subject to contribution.
3. Government agencies are immune to contribution, unless that agency is a hospital.

M.C.L.A. *600.6305

The judgment by the trier of fact is to include past economic and non-economic damages, future damages per year for the remaining life of the plaintiff for medical costs, lost wages or wage capacity, and non-economic losses.

M.C.L.A. *600.6306

Judgments are to include:

1. Past economic damages minus collateral source payments
2. Past non-economic damages
3. Future economic damages minus medical and health care costs and minus collateral source payments, reduced to present cash value
4. Future medical and health care costs reduced to gross present cash value
5. Future non-economic damages reduced to gross present cash value
6. All taxable and allowable costs (including interest)

The gross present cash value is reduced to present value at a rate of 5% per year for the years of accrual. If one or more tortfeasors in a multiple defendant case has settled out of court, the total judgment is reduced by the amount of the settlement. The judge is allowed to set the ratio between past and future damages for the purpose of reductions. Should the plaintiff be assigned a percentage of fault by the trier

of fact, the total judgment is reduced by that percentage.

M.C.L.A. *600.6307

Should future damages exceed $250,000 present cash value, defendant or defendant's insurance carrier must purchase an annuity contract with a price of 100% of future damages minus the pre-judgment interest rate multiplied by the future damages. This must be purchased from a life insurance carrier authorized to sell in the state of Michigan.

M.C.L.A. *600.6309

This section covers structured payment plans for future damages. Mutual agreement plans may be followed if filed within 35 days of the judgment. Otherwise, the trial judge has discretion in formulating a plan. Defendant's insurance carrier may assign to plaintiff any annuity purchased under M.C.L.A. *600.6307 rules, at which point the insurance carrier is relieved of obligation to the plaintiff. Payments are made to the plaintiff or the survivors of the plaintiff.

M.C.L.A. *600.6311

It is not necessary to purchase an annuity for plaintiffs beyond the age of 60.

M.C.L.A. *600.6455

From 7-9-84 through 1-1-87 the interest rate shall be 12% per year compounded annually. From 1-1-87 through the date of filing, and forward, the interest rate will be 1% plus the interest rate on 5 year U.S. Treasury Notes. For complaints filed after 10-1-86, there will be no interest on future damages from the filing date to the judgment date. Good faith offers made and rejected, subsequently filed with the court, stop the interest from the filing date through the judgment date. If plaintiff's offer of settlement is rejected, the interest rate will be 2% plus the rate on 5 year U.S. Treasury Notes.

As seen in the listings above, the Michigan tort law changes of 1986 ran parallel to the "hard" recommendations of the Task Force Report of August, 1987. Specifically, these are recommendations numbered 5, 6, 10, 12-19, plus numbers 20 (a non-recommended item) and 22.

Bibliography

Black, Henry Campbell. Black's Law Dictionary. St. Paul Minnesota : West Publishing Co., 1979.

Bovbjerg, Randall R. "Medical Malpractice on Trial: Quality of Care is the Important Standard." Law and Contemporary Problems 49 (Spring 1986): 321-48.

Bradner, James H. Jr., ed., Advancing Justice: May We Approach the Bench? Schaumburg, Illinois: Alliance of American Insurers, [1987].

Danzon, Patricia M. "The Frequency and Severity of Medical Malpractice Claims: New Evidence." Law and Contemporary Problems 49 (Spring 1986): 57-87.

Economist 302 (January 1987): 51-2.

Economist 307 (1988): 71-2.

Editorial, "H.R. 3084: A More Rational Compensation System for Medical Malpractice." Law and Contemporary Problems 49 (Spring 1986): 117-24

Epstein, Richard A., "Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services." Law and Contemporary Problems 49 (Spring 1986): 201-12

Fine, Max W., "Malpractice Reform Through Consumer Choice and Consumer Education: Are New Concepts Marketable?" Law and Contemporary Problems 49 (Spring 1986): 213-22

Flamm, Martin B. "Cases of Failure to Diagnose Cancer." Trial 22 (September 1986): 82-7.

Ginsburg, William H., and Kahn, Steven J., and Thornhill, Michael C., and Gambardella, Steven C., "Contractual Revisions to Medical Malpractice Liability." Law and Contemporary Problems 49 (Spring 1986): 253-64

Harris, Jeffrey E. "Defensive Medicine: It Costs, but Does it Work?" Journal of the American Medical Association 257: 2801-2.

Havighurst, Clark C., " Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles." Law and Contemporary Problems 49 (Spring 1986): 143-72

Havighurst, Clark C., "Altering the Applicable Standard of Care." Law and Contemporary Problems 49 (Spring 1986): 265-75

Henderson, James A. Jr., "Agreements Changing the Forum for Resolving Malpractice Claims." Law and Contemporary Problems 49 (Spring 1986): 244-51

Johnson, James A. "Radiation Therapy." Trial 23 (May 1987): 25-35.

Law, Sylvia A. "A Consumer Perspective on Medical Malpractice." Law and Contemporary Problems 49 (Spring 1986): 305-20

Malone, Patrick A. "Undiagnosed Heart Attack." Trial 23 (May 1987): 48-53.

Meyers, Allan R. "'Lumping It' : The Hidden Denominator of the Medical Malpractice Crisis." American Journal of Public Health 77 (December 1987): 1544 8.

Michigan Commissioner of Insurance , Report on the Condition of the Commercial Liability Insurance Market in Michigan, State of Michigan Department of Licensing and Regulation, Insurance Bureau, (Dec. 1988).

Michigan Commissioner of Insurance, Claims Experience and Market Conditions for Medical Malpractice Insurance, State of Michigan Department of Licensing and Regulation, Insurance Bureau, (May 1989).

MICH. COMP. LAWS ANN., West Publishing (1987)

Mooney, Sean. Commercial Liability Insurance: Profitability in the United States and in the State of Michigan. Lansing, Michigan: Insurance Information Institute, [Sept. 1986].

O'Connell, Jeffrey, "Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives." Law and Contemporary Problems 49 (Spring 1986): 125-41

Ottinger, Mary Ann. "Juror Bias in Medical Negligence Cases." Trial 23 (June 1987): 34-5.

Pavalon, Eugene I. "Putting a Premium on Solutions." Trial 23 (October 1987): 5.

Plager, S. Jay and Sundwall, David N., Report of the Task Force on Medical Liability and Malpractice, United States Department of Health and Human Services, (Aug. 1987).

Posner, James R. "Trends in Medical Malpractice Insurance, 1970-1985." Law and Contemporary Problems 49 (Spring 1986): 37-56.

Prosser, William L., Law of Torts. St. Paul, Minnesota: West Publishing Company, 1983.

Reynolds, Roger A. et al. "The Cost of Medical Professional Liability." Journal of the American Medical Association 257 (May 1987): 2776-81.

Robinson, Glen O. "The Medical Malpractice Crisis of The 1970's: A Retrospective." Law and Contemporary Problems 49 (Spring 1986): 5-35.

Robinson, Glen O., "Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers." Law and Contemporary Problems 49 (Spring 1986): 173-99

Vollmer, Virginia. "Exploring Hospital Records." Trial 23 (May 1987): 23-4.

Wall Street Journal, 6 January 1987, p. 64
12 January 1987, p. 10
12 January 1987, p. 52
3 June 1987, p. 44
8 June 1987, p. 24
11 June 1987, p. 12
24 June 1987, p. 36
25 June 1987, p. 27
29 June 1987, p. 14
2 July 1987, p. 5
3 July 1987, p. 2
10 August 1987, p. 12
25 November 1987, p. 17

Windom, Robert E. Public Health Reports 102 (November/December 1987): 573-4.

Zuckerman, Stephen, and Koller, Christopher F., and Bovbjerg, Randall R., "Information on Malpractice: A Review of Empirical Research on Major Policy Issues." Law and Contemporary Problems 49 (Spring 1986): 85-111