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Ohio's Attempts to Halt the Medical Malpractice Crisis: Effective or Meaningless

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LEGISLATION NOTES

OHIO'S ATTEMPTS TO HALT THE MEDICAL MALPRACTICE CRISIS: EFFECTIVE OR MEANINGLESS?

I. INTRODUCTION

Liability insurance premiums for health-care professionals escalated at an alarming rate during the 1960's and 1970's. From 1960 to 1970, surgeons' premiums rose 942.2% and nonsurgeons' premiums rose 540.8%.[1] Over the same period, hospital insurance costs jumped 262.7%.[2] Predominant among the reasons for such increases were the rising frequency of medical malpractice suits and the upward spiraling damage awards typical of such claims.[3] Medical insurers responded to these events by adjusting their rate-making tables to reflect the upward climb in payout costs,[4] and, in some instances, by abandoning the medical market altogether.[5]

As insurance premiums rose, physicians and hospitals developed methods to minimize the risk of malpractice suits and avoid the resulting higher premiums. Some of these methods included the avoidance of high-risk medical specialties, relocation to lower-risk geographic areas, practice of defensive medicine[6] through the increasing use of secondary and follow-up procedures, and shifting of increases in insurance costs to patients.[7] But each of these defensive actions represented a potential

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1. U.S. DEP'T OF HEW, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 13 (1973) [hereinafter cited as HEW REPORT]; Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 759–60 (1977).

2. HEW REPORT, *supra* note 1, at 13; Redish, *supra* note 1, at 759–60.

3. HEW REPORT, *supra* note 1, at 41; Redish, *supra* note 1, at 760–61. Approximately 55 to 86% of the insurance premium is attributable to adjustments reflecting increases in losses sustained by the insurer. HEW REPORT, *supra* note 1, at 41.

4. HEW REPORT, *supra* note 1, at 41–42.

5. Buckeye Union Insurance, Inc., one of Ohio's largest medical insurers, left the market. *PICO: Just what Doctors Ordered*, Columbus Dispatch, May 8, 1983, at 8, col. 1 [hereinafter cited as *PICO*].

6. "[D]efensive Medicine is the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted." HEW REPORT, *supra* note 1, at 14.

7. HEW REPORT, *supra* note 1, at 12–13; Redish, *supra* note 1, at 760. "Doctors' fees rise by 9.1 percent for every 100 percent increase in doctors' premiums when these premiums re-

threat to those requiring medical care and services. As the situation worsened, concerned commentators and legislators labeled it the medical malpractice "crisis."[8]

Existence of the crisis evoked widespread fears as to the affordability of liability insurance for health-care professionals. This in turn left in doubt the continued availability of adequate health care in general.[9] Legislatures across the country responded to pressure from alarmed health-care professionals and insurance carriers by enacting new statutory provisions designed to alleviate this "crisis."[10] Most of these enactments sought to reduce the uncertainty in predicting the frequency and magnitude of claims, to inject a degree of stability into the volatile medical insurance market. Today, the effectiveness of these measures in actual practice remains a controversial question in Ohio and elsewhere.

II. BACKGROUND

The success of the insurance industry is based on the art of prediction. Insurers must of course accurately predict the number and cost of claims which will be paid out with respect to each insured per premium year.[11] To the extent that insurers are uncertain as to the accuracy of these predictions, they must increase the price of the insured's policy to maintain a reserve fund for unexpected liabilities.[12] In the medical field, the significance of this certainty becomes even more obvious when one considers that medical malpractice insurance has traditionally been sold on an occurrence basis;[13] that is, the insurer is liable for all claims arising from "occurrences" involving the insured during a given premium year no matter when those claims are made.[14] If the insurer cannot forecast the number of claims per year with any certainty, it must keep large sums on reserve to protect against the possibility of future

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present only about 4 percent of total costs, and hospital prices rise by 8.9 percent for every 100 percent increase in hospital premiums when these premiums represent less than 1 percent of total costs . . . ." Greenwald & Mueller, *Medical Malpractice and Medical Costs*, in THE ECONOMICS OF MEDICAL MALPRACTICE 65, 82 (S. Rottenberg ed. 1978).

8. H. 682, 111th Ohio General Assembly, 1st Reg. Sess., 136 OHIO HOUSE J. 687 (1975); *Medical Association Predicts That Health Care Crisis Imminent in Ohio*, Gongwer News Serv., Inc., Ohio Report, July 1, 1975, at 3 [hereinafter cited as *Health Care Crisis*].

9. *See* HEW REPORT, *supra* note 1, at 3–4.

10. *See* TEXAS HOUSE-SENATE HEALTH CARE STUDY STAFF, REACTION TO CRISIS: A STATE BY STATE REVIEW OF MEDICAL MALPRACTICE LEGISLATION ENACTED IN 1975 (1979); Ripps, *The Ohio Medical Malpractice Statute: An Analysis*, 4 OHIO N.U.L. REV. 24 (1977).

11. *See* HEW REPORT, *supra* note 1, at 41–42.

12. *See* Kendall, *Expectations, Imperfect Markets, and Medical Malpractice Insurance*, in THE ECONOMICS OF MEDICAL MALPRACTICE 167, 181–89 (S. Rottenberg ed. 1978).

13. Redish, *supra* note 1, at 765.

14. *Id.*

claims.[15]

Recent developments in medical malpractice litigation have placed obstacles in the path of insurers' efforts to form accurate predictions of liability. In the medical field, insurers had become uncertain as to the liability they would incur per claim because of variable and atypically high damage awards in malpractice suits.[16] Additionally, the variation from an actuarial prediction of claims increases proportionately in relation to the length of time during which such claims may be made.[17] And it is this time period which has been lengthened by certain state courts' interpretation and application of statutes of limitation.[18] Consequently, as the time period within which a patient may enforce his or her claim lengthens, a greater degree of uncertainty is factored into the insurer's predictions.

To reduce this uncertainty, state legislatures have created many limitations and requirements unique to medical malpractice actions.[19] Specifically, most new laws set shorter statutes of limitation for medical malpractice suits as well as absolute outer time limits for filing a claim.[20] Also, many of the new provisions require arbitration of medical malpractice suits and limit the allowable maximum damage award.[21]

In Ohio, the effects of the malpractice crisis and the legislative reaction were similar to those in most states. On July 1, 1975, the Ohio State Medical Association informed Ohio's General Assembly that, according to its survey, "within the next several days, the number of physicians unable to continue medical practice in Ohio because of lack of adequate malpractice coverage will reach crisis proportions."[22] Heeding that warning, the legislature quickly passed Amended Substitute House Bill 682 (H. 682)[23] as an emergency measure effective July 28, 1975. The main thrust of H. 682 was aimed at "guaranteeing the availability of medical malpractice insurance."[24] In furthering this goal, the bill

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15. Comment, *Statutes of Limitation: The Rise, Fall and Rise Again of the Discovery Rule in Medical Malpractice Actions in Georgia*, 33 MERCER L. REV. 377, 387 (1981).

16. *See* Munch, *Causes of the Medical Malpractice Insurance Crisis: Risks and Regulations*, in THE ECONOMICS OF MEDICAL MALPRACTICE 125, 137–38 (S. Rottenberg ed. 1978).

17. *See* HEW REPORT, *supra* note 1, at 42.

18. *See infra* notes 33–37 and accompanying text.

19. *See* Redish, *supra* note 1, at 763–69.

20. *See id.* at 765–66; 1 S. SPEISER, C. KRAUSE & A. GANS, THE AMERICAN LAW OF TORTS § 5.36, at 1007–14 (1983) [hereinafter cited as SPEISER].

21. *See* Redish, *supra* note 1, at 763.

22. *Health Care Crisis, supra* note 8, at 3.

23. Act of July 24, 1975, 1975 Ohio Legis. Serv. 4–160 (Baldwin) (codified in scattered sections of chs. 13, 17, 23, 27, 39 & 47 OHIO REV. CODE ANN.).

24. *Senate to Focus Its Attention Next Week on Medical Malpractice Bill*, Gongwer News Serv., Inc., Ohio Report, July 11, 1975, at 2.

made substantial changes in Ohio's statute of limitations for medical malpractice claims. It also established compulsory nonbinding arbitration for medical malpractice actions, a $200,000 damage recovery limit, and various other procedural changes designed to alleviate the "crisis" situation.[25]

III. CHANGES IN OHIO'S STATUTE OF LIMITATIONS

Prior to 1975, Ohio's statute of limitations stated that medical malpractice claims "shall be brought within one year after the cause thereof accrued . . . ."[26] Although strict on its face, the courts' interpretation of "accrual" soon rendered the statute's one-year limitation largely meaningless.[27] The courts extended the time of accrual far beyond the date of the actual negligent act or ommission, effectively thwarting the statute's protection afforded potential defendants from prosecution of stale claims. In response, Ohio legislators took a strong prodefendant stance in amending the statute in 1975. H. 682 essentially retained the language of the prior statute but specifically included physicians and hospitals within its scope.[28] Of greater significance was the bill's amendment of Ohio Revised Code section 2305.11(B). The amended provision now states that "*[i]n no event* shall any medical claim against a physician . . . or a hospital be brought more than four years after the act or omission constituting the alleged malpractice occurred."[29] The unequivocal language of this provision clearly reveals the legislature's intent to halt further extensions of the statute of limitations.

The fixed cutoff limitation is primarily a tool to counteract "long-tail liability" resulting from judicial extensions of the one-year limit. "Long-tail liability" describes a situation in which a patient's cause of action accrues much later in time than the date of the alleged negligent act or omission upon which it is based.[30] By extending the statutory period within which the physician remains open to potential liability, the courts frustrated insurers' attempts to set premium rates and contingent reserve levels to cover all claims arising from treatment during any given year.[31] For example, a patient might conceivably bring his or her malpractice suit ten to twenty years after the alleged negligent

25. *See supra* note 10 and accompanying text.

26. OHIO REV. CODE ANN. § 2305.11 (Page 1981).

27. *See infra* notes 31–34 and accompanying text.

28. OHIO REV. CODE ANN. § 2305.11(A) (Page Supp. 1982).

29. *Id.* § 2305.11(B) (emphasis added).

30. *See* HEW REPORT, *supra* note 1, at 42; Mann, *Factors Affecting the Supply Price of Medical Malpractice Insurance*, in THE ECONOMICS OF MEDICAL MALPRACTICE 155, 156–57 (S. Rottenberg ed. 1978).

31. *See* HEW REPORT, *supra* note 1, at 41–42.

treatment. The insurer would thereby be forced to maintain a reserve of funds to cover the possibility of such an extended claim. In enacting the absolute limit of section 2305.11(B), the legislature sought to reduce long-tail liability and restore some degree of certainty in insurers' rate setting.[32] How effectively this objective has been met in application appears questionable, however, in light of the judiciary's varied interpretations and rulings under the amended statute.

A. Judicial Reaction to the 1975 Changes

Ohio courts have long battled over when a patient's cause of action accrues under section 2305.11(B). The determination of accrual of the cause of action is of paramount importance because the later in time the cause of action accrues, the more extended the statute of limitations. Until very recently, the general rule in Ohio was that a patient's cause of action accrued at the termination of the doctor-patient relationship.[33] The termination rule was grounded in a finding of an implied contractual relationship and a resulting duty of care which runs from the doctor to the patient until their relationship ends.[34]

Sound policy considerations seemed to support the rule. In *Ishler v. Miller*,[35] the Ohio Supreme Court explained that abrogation of the termination rule would destroy the essential mutual confidence in the doctor-patient relationship.[36] The court noted that the patient would be placed "in the unacceptable situation of deciding whether to continue the ongoing treatment and thus risk the chance of forfeiting his right to bring suit at a later date, or terminate the relationship, and, perhaps, deny the physician the opportunity of correcting his error."[37]

Use of the termination rule also often resulted in a more equitable time period within which to bring an action than a rule which would permit suit after only one year from the date of the physician's alleged negligence. However, the rule also frequently resulted in barring the patient's claim before he or she became aware of its existence. The termination rule was also inherently problematic inasmuch as it bore no logical relationship to the injury sustained.[38] A physician may, for

32. *See* Comment, *Medical Malpractice and the Statute of Limitations in Ohio*, 10 CAP. U.L. REV. 771, 772–73 (1981).

33. *See* Ishler v. Miller, 56 Ohio St. 2d 447, 384 N.E.2d 296 (1978); Millbaugh v. Gilmore, 30 Ohio St. 2d 319, 285 N.E.2d 19 (1972); Wyler v. Tripi, 25 Ohio St. 2d 164, 267 N.E.2d 419 (1971); Delong v. Campbell, 157 Ohio St. 22, 104 N.E.2d 177 (1952); Bowers v. Santee, 99 Ohio St. 361, 124 N.E. 238 (1919); Gillette v. Tucker, 67 Ohio St. 106, 65 N.E. 865 (1902).

34. *Gillette*, 67 Ohio St. at 106, 65 N.E. at 865.

35. 56 Ohio St. 2d 447, 384 N.E.2d 296 (1978).

36. *Id.* at 449, 384 N.E.2d at 298.

37. *Id.*

38. 30 OHIO ST. L.J. 425, 430 (1969).

example, diagnose a patient as having a serious heart condition and prescribe treatment accordingly. After terminating treatment with that physician and going to another, the patient may discover ten years later that he or she never had heart problems. Instead of a heart condition, the patient may find that he or she had a completely different ailment which required different treatment. Under the termination rule, this patient would most likely be placed in the inequitable position of possessing a valid claim against the physician without a corresponding avenue of recovery. Insofar as the appearance of an illness or injury did not correspond with the time period of the physician-patient relationship, the injury frequently barred the plaintiff from relief.[39]

Change was slow in coming. Although Ohio courts expressed dissatisfaction with the termination rule, they looked to the legislature to effect an overall change.[40] In specific cases, however, the courts over time reacted to the continuing inequity by adopting the so-called discovery rule.[41] Under the "discovery rule," a cause of action accrues when the patient discovers, or in the exercise of reasonable care and diligence, should have discovered, his or her claim.[42] The discovery rule represents a balance between two competing interests: protection of defendants from stale claims versus insulation from meritorious ones.[43] "Stale" claims are thought to implicate such problems as loss of evidence, loss of witnesses, and memory failure—all of which frustrate attempts to prove or disprove liability for injuries. This problem is compounded in the context of medical malpractice litigation where treatments are often extremely complex and the typical physician treats countless patients per year. On the other hand, when a patient has attempted to discover what, if anything, went wrong with his or her prior

39. Types of injuries having no relation to the physician-patient relationship include foreign objects left inside a patient's body, misdiagnoses, and failures to notice progressive diseases. *See* Oliver v. Kaiser Community Health Found., 15 Ohio St. 3d 111, 449 N.E.2d 438 (1983); O'Stricker v. Jim Walter Corp., 4 Ohio St. 3d 84, 447 N.E.2d 727 (1983); Melnyk v. Cleveland Clinic, 32 Ohio St. 2d 198, 290 N.E.2d 916 (1972).

40. In Wyler v. Tripi, 25 Ohio St. 2d 164, 267 N.E.2d 419 (1971), the court reluctantly held that "[i]n consideration of the obvious and repeated disinclination of the General Assembly to amend its malpractice statute of limitations, we are compelled to adhere to our former decisions on the question and refrain from judicially adopting that which has so clearly been legislatively rejected." *Id.* at 172, 267 N.E.2d at 424. *See Delong*, 157 Ohio St. at 29–30, 104 N.E.2d at 179–80.

41. *See* Melnyk v. Cleveland Clinic, 32 Ohio St. 2d 198, 290 N.E.2d 916 (1972).

42. Annot., 80 A.L.R.2d 332, 336, 337, 339 (1966 & Supp. 1983); D. HARNEY, MEDICAL MALPRACTICE § 38.5 (1973); 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ch. 13 (1983); 3 S. PEGALIS & H. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE § 36.9 (1981); SPEISER, *supra* note 20, § 5.36.

43. *See* Harig v. Johns-Manville Prod. Corp., 284 Md. 70, 394 A.2d 299 (1978); Morgan v. Grace Hosp., Inc., 149 W. Va. 783, 144 S.E.2d 156 (1965); Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKE L.J. 1417, 1429–36.

treatment but has been unable to do so because of factors beyond his or her control, it is clearly inequitable to prevent that patient from obtaining appropriate relief.

Melnyk v. Cleveland Clinic[44] marked the courts' first major break from precedent; it embraced the discovery rule for cases in which a physician negligently fails to remove a foreign object from his or her patient's body during surgery.[45] The gradual shift from the use of the termination rule was made complete by the Ohio Supreme Court's recent ruling in *Oliver v. Kaiser Community Health Foundation.*[46] Overruling voluminous precedent, the court expressly embraced the discovery rule as determinative of when a cause of action accrues with respect to *all* types of medical malpractice suits.[47] Adoption of the discovery rule in the medical malpractice area was consistent with the rule in other tort litigation contexts[48] as well as the trend in other jurisdictions.[49] It is clear that the courts' use of the discovery rule may permit fairer adjudication of a patient's claim. Concomitant with the rule's fairness, however, is its pervasive impact on health care and insurance practitioners by virtue of its tendency to further extend the statute of limitations.

B. The Discovery Rule

A major point of controversy surrounding the adoption of the discovery rule by the Ohio Supreme Court focuses on whether the judici-

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44. 32 Ohio St. 2d 198, 290 N.E.2d 916 (1972).

45. In *Melnyk*, the court stated:

> [W]e base our reasoning not only upon an absence of the vexatious inequities usually associated with the entertaining of "stale" medical claims, but also upon matters of sound public policy, springing from the absolute and irrevocable dependence of patient upon surgeon during surgery and from the huge increase in societal or public medicine with its lamentable but concomitant lessening of the fiercely private surgeon-patient relationship of years past.

Id. at 202–03, 290 N.E.2d at 918–19 (footnotes omitted).

46. 5 Ohio St. 3d 111, 449 N.E.2d 438 (1983). The court held that "[u]nder R.C. Section 2305.11(A), a cause of action for medical malpractice accrues and the statute of limitations commences to run when the patient discovers, or, in the exercise of reasonable care and diligence should have discovered, the resulting injury." *Id.* at 117–18, 449 N.E.2d at 438–39.

47. *Id.*

48. The Ohio Supreme Court first adopted the discovery rule in 1972 in the *Melnyk* case. 32 Ohio St. 2d 198, 290 N.E.2d 916 (1972). The Ohio Legislature later adopted the discovery rule for injuries due to exposure to asbestos. OHIO REV. CODE ANN. § 2305.10 (Page 1981 & Supp. 1982). The Ohio Supreme Court recently adopted the discovery rule for legal malpractice. Skidmore v. Rottman, 5 Ohio St. 3d 210, 484 N.E.2d 364 (1983).

49. The discovery rule is the most widely applied rule of accrual with respect to medical malpractice causes of action. States employing the discovery rule include California, Hawaii, Illinois, Idaho, Louisiana, Maryland, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, New Jersey, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Washington, and West Virginia. *See generally* SPEISER, *supra* note 20, at 1022–47.

ary's endorsement of the rule is, as asserted in *Wyler v. Tripi* "that which has so clearly been legislatively rejected."[50] The supreme court in *Oliver* concluded that the legislature's failure to enact the discovery rule despite opportunities to do so did not " 'disable [them], in a proper case, from considering the questions presented by such proposals and from abandoning prior conclusions that now seem inappropriate.' "[51] The court also noted that where the legislature has not defined the accrual of a cause of action, the decision is left to the judiciary,[52] for " '[a] determination that the time of accrual is the time of discovery is no more judicial legislation than a determination that it is the time of the commission of the act.' "[53] Inasmuch as Ohio's judiciary originally established the termination rule as governing the time of accrual,[54] they are free to now change to the discovery rule. In any event, a significant factor supporting judicial change in this area is the fact that the legislature made no attempt to codify or restrict the prevailing termination rule at the time it amended section 2305.11.[55] Forbearance in this area in the face of a perceived emergency situation supports the court's conclusion that what triggers accrual remains an area for judicial determination.[56]

The discovery rule, although "ameliorat[ing] the obvious and flagrant injustice frequently resulting from the operation of the termination rule,"[57] may in practical effect have some undesirable consequences upon the course of litigation in medical malpractice suits. Use of the discovery rule may operate to ban pretrial disposition of claims by summary judgment. It is therefore likely that more claims will proceed to trial on their merits, increasing costs for the litigants and caseloads for the courts. Upon a party's motion pursuant to Ohio Civil Rule 56,[58] a court may grant summary judgment if it finds that there is no genuine issue as to any material fact and that the movant is entitled

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50. 25 Ohio St. 2d 164, 167, 267 N.E.2d 419, 424 (1971).

51. *Oliver*, 5 Ohio St. 3d at 115, 449 N.E.2d at 442 (1983) (quoting Franklin v. Albert, 381 Mass. 611, 617, 411 N.E.2d 458, 462 (1980)).

52. *Oliver*, 5 Ohio St. 3d at 116, 449 N.E.2d at 442 (citing O'Stricker v. Jim Walter Corp., 4 Ohio St. 3d 84, 87, 447 N.E.2d 727, 730 (1983)). *See* Harig v. Johns-Manville Prod. Corp., 284 Md. 70, 75, 394 A.2d 299, 302 (1978).

53. *Oliver*, 5 Ohio St. 3d at 116, 449 N.E.2d at 443 (quoting Berry v. Bramer, 245 Or. 307, 313, 421 P.2d 996, 999 (1966)).

54. Gillette v. Tucker, 67 Ohio St. 106, 65 N.E. 865 (1902).

55. *Health Care Crisis, supra* note 8, at 3.

56. *See Harig*, 284 Md. at 75, 394 A.2d at 302; *Berry*, 245 Or. at 313, 421 P.2d at 998–99.

57. *Oliver*, 5 Ohio St. 3d at 117, 449 N.E.2d at 443.

58. OHIO R. CIV. P. 56 states that "[a] summary judgment shall not be rendered unless it appears . . . that reasonable minds can come to but one conclusion and that conclusion is adverse to the party against whom the motion for summary judgment is made . . . ."

to judgment according to law.[59] Due to the vagueness inherent in the factual underpinnings of "discovery," the discovery rule has a significant effect on the requirement of rule 56 that there be no remaining factual issues necessitating resolution at trial.

One problematic area exists with respect to the degree of knowledge needed to trigger discovery. Currently, there are no clearly defined or consistent guidelines delineating how much the patient must be aware of to begin the one-year period. Judicial definitions of discovery range from knowledge of every element in a cause of action (injury, duty, breach of duty, and causation),[60] to mere knowledge of an injury.[61] In *United States v. Kubrick*,[62] the Supreme Court held that the medical malpractice claimant's cause of action accrues "when the plaintiff knows both the existence and the cause of his injury."[63] In that case, the plaintiff was notified by a subsequent physician that his hearing loss was probably the result of the neomycin treatment previously administered at a hospital.[64]

Taking the requisite knowledge of cause in *Kubrick* one step further, the court in *Roper v. Markle*[65] held that "the limitations period does not begin to run until there exists actual or constructive knowledge of both a physical problem and that *someone* is or may be at fault for its existence."[66] Clearly, the courts have been applying no uniform standard as to what constitutes discovery. Without a definitive standard, however, there will almost always be a factual question for litigation concerning whether the patient possessed enough knowledge to begin the running of the statute of limitations. Ohio courts have given no guidelines as to how knowledgeable the patient must be to satisfy discovery. The supreme court, in adopting the discovery rule, simply stated that the patient's cause of action accrues upon discovery of the "resulting injury."[67] The court has not clarified this definition.

Various definitions of discovery employed by other jurisdictions reveal these jurisdictions' sense of an equitable balance between the physician's and patient's interests. Clearly, the most patient-biased construction of discovery requires knowledge of all elements in a cause of action since it gives the patient more time to bring his or her claim.

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59. *Id.*
60. *See* Zeidler v. United States, 601 F.2d 527 (10th Cir. 1979).
61. *See* Lind v. Zekman, 77 Ill. App. 3d 432, 395 N.E.2d 964 (1979).
62. 444 U.S. 111 (1979).
63. *Id.* at 123.
64. *Id.* at 114 (construing the Federal Torts Claims Act, 28 U.S.C. § 2401(b) (1976 & Supp. V 1981)).
65. 59 Ill. App. 3d 706, 375 N.E.2d 934 (1978).
66. *Id.* at 713, 375 N.E.2d at 939 (emphasis added).
67. *Oliver*, 5 Ohio St. 3d at 118, 449 N.E.2d at 443–44.

Conversely, the approach most favorable to the physician requires only knowledge of the existence of an injury since this often occurs much sooner than the remaining elements in the cause of action. In view of the courts' renewed emphasis upon the patient's right to recovery, the former definition might well be embraced by future Ohio courts in their attempts to reach an equitable result.

The definition of "discovery" is not the only area of uncertainty under the discovery rule. A second and more prominent area of dispute centers on when discovery should have been made in the exercise of reasonable care and diligence.[68] The discovery rule rests on the underlying philosophy that a patient should not be irreparably penalized for being "blamelessly ignorant of the fact that a tort has occurred."[69] However, what qualifies as "blameless" ignorance is primarily a factual issue.[70] If the defendant moves for summary judgment, he or she is likely to contend that had the patient employed due diligence, he or she would have made discovery at an earlier point; the patient would therefore be barred by the statute of limitations.[71] In response, the patient will undoubtedly contend that he or she did exercise due diligence in making discovery.[72] Clearly, what constitutes a reasonable time to diligently make discovery depends upon the particular facts and circumstances surrounding each case.[73]

One such circumstance that a court will examine is the existence of any special knowledge or experience of the patient such as would imply constructive discovery. In *Sanders v. United States*,[74] one federal court found it important that a plaintiff was a registered nurse, concluding that due to her training and the fact that she possessed her medical records, she should have discovered her claim earlier.[75] When a patient possesses his or her medical records, knowledge of any cause of action revealed by such records is sometimes imputed to the patient.[76] Therefore, it appears that a patient's medical knowledge, experience, or possession or access to informative medical records may well

68. *See* Simons v. Conn, 151 Ga. App. 525, 260 S.E.2d 402 (1979).

69. Harig v. Johns-Manville Prod. Corp., 284 Md. 70, 83, 394 A.2d 299, 306 (1978).

70. *See, e.g., Simons*, 151 Ga. App. 525, 260 S.E.2d 402 (1979).

71. *See, e.g.*, Enfield v. Hunt, 91 Cal. App. 3d 417, 154 Cal. Rptr. 146 (1979); *Simons*, 151 Ga. App. 525, 260 S.E.2d 402 (1979); Leyson v. Krause, 92 Mich. App. 759, 285 N.W.2d 451 (1979).

72. *See, e.g., Enfield*, 91 Cal. App. 3d 417, 154 Cal. Rptr. 146 (1979); *Simons*, 151 Ga. App. 525, 260 S.E.2d 402 (1979); *Leyson*, 92 Mich. App. 759, 285 N.W.2d 451 (1979).

73. *See* Waits v. United States, 611 F.2d 550 (5th Cir. 1980).

74. 551 F.2d 458 (D.C. Cir. 1977).

75. *Id.* at 460.

76. *See* Addison v. Health & Hosp. Governing Comm'n, 56 Ill. App. 3d 533, 371 N.E.2d 1060 (1979).

affect the court's evaluation of the plaintiff's diligence. Again, when confronted with the almost inevitable conflict on this issue, the courts will often be unable to award summary judgment under rule 56.

C. *The Continued Vitality of the Absolute Limit*

Regardless of how Ohio courts choose to construe discovery, section 2305.11(B) imposes a relative degree of certainty into the confusion. The unconditional language of section 2305.11(B) reflects the legislature's attempt to combat medical insurance disaster by establishing a fixed cutoff on the time within which a patient may seek recovery.[77] Section 2305.11(B) mandates that "[i]n *no event* shall *any* medical claim against a physician . . . or a hospital be brought more than four years after the act or omission constituting the alleged malpractice occurred."[78] A maximum statutory limit on potential claims of this variety enables insurance companies to more accurately predict the number of suits arising from acts of the insured during a given premium year.[79] And insofar as insurers can lower their risk of unforeseen losses, they may also lower the amount of funds held on reserve for such contingencies.[80] It is unclear after the decision in *Oliver v. Kaiser Community Health Foundation*,[81] however, whether the absolute four-year limitation of section 2305.11(B) will be enforced. The majority rendered no opinion as to whether the appellant's action, filed four years and one day after the occurrence of the allegedly negligent act, was timely under its adoption of the discovery rule.[82] The dissenting opinion by Justice Holmes did express concern as to the possibility that the majority was abandoning the absolute four-year limit in its adoption of the discovery rule.[83] Justice Holmes noted:

> I must dissent in part from the majority opinion in that, in its broad application of the "discovery rule" to medical malpractice cases, the majority has completely disregarded the specific public policy as pronounced by the General Assembly. By establishing the broad principle that the discovery rule shall apply to the medical malpractice action statute of limitations contained in R.C. 2305.11(A), the court completely

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77. *See* Comment, *supra* note 32, at 772–73.

78. OHIO REV. CODE ANN. § 2305.11(B) (Page Supp. 1982) (emphasis added).

79. *See supra* notes 11–17 and accompanying text.

80. Actuarial rate making is based on the objective of setting rates to generate "a sufficient premium volume to (1) cover the losses that will occur during the period, (2) cover the administrative expenses of running the business, and (3) provide a small margin for the unknown contingencies . . . ." HEW REPORT, *supra* note 1, at 41–42. An additional cost factor is the inflationary effect on the size of damage awards.

81. 5 Ohio St. 3d 111, 449 N.E.2d 438 (1983).

82. *Id.* at 112, 118 n.11, 449 N.E.2d at 439, 444 n.11.

83. *Id.* at 118–19, 449 N.E.2d at 444–45 (Holmes, J., dissenting).

overlooks the import and meaning of R.C. 2305.11(B).

I am willing to concede that in keeping with the announced "discovery rule" as being applicable to R.C. 2305.10, fundamental fairness would also reasonably extend such rule to toll the statute of limitations in R.C. 2305.11(A) for medical malpractice actions. However, the General Assembly has determined as a matter of law that such tolling shall not continue indefinitely. With the enactment of R.C. 2305.11(B), the General Assembly again declared a public policy of the state of Ohio which was to the effect that the increase of medical malpractice actions presented a public concern and, in keeping with such concern, enacted as an emergency measure the absolute four-year statute of limitations, regardless of when the action accrued.[84]

The justice seems to be implying that the majority's adoption of the discovery rule would allow a cause of action even if discovered beyond the absolute limit. Thus, he explains the holding he would reach:

The result which I would propose would permit the extension of the "discovery rule" to medical malpractice actions insofar as tolling the one-year limitations period until discovery of the injury, but would recognize the absolute four-year statute of limitations in malpractice actions, the latter of which was enacted by the General Assembly as a specific public policy of this state. That policy should be recognized and followed by this court.[85]

Under the discovery rule, the statute of limitations is often extended far beyond four years.[86] And undeniably, four years is but an arbitrary cutoff, lacking any logical connection to the injury suffered. However, without strict application of an outside maximum, the discovery rule subjects health-care professionals to potential liability unreasonably long after the occurrence of the provoking act or omission. Notwithstanding the flagrant clash with the legislative intent behind section 2305.11(B), judicial disregard of the absolute limit circumvents a valuable method of alleviating long-tail liability. In most states employing the discovery rule, a maximum statutory limit is consistently applied.[87] An absolute limit partially offsets the practical and economic dangers associated with the rule.[88] Such time limits are an effective

84. *Id.* at 118, 449 N.E.2d at 444 (Holmes, J., dissenting).

85. *Id.* at 119, 449 N.E.2d at 445 (Holmes, J., dissenting).

86. *See, e.g.*, Melnyk v. Cleveland Clinic, 32 Ohio St. 2d 198, 290 N.E.2d 916 (1972) (considering the plaintiff's claim timely under the discovery rule even though it had not been filed until almost eleven years after the allegedly negligent surgery).

87. *See, e.g.*, CAL. CIV. PROC. CODE § 340.5 (Deering Supp. 1979) (3 years); OR. REV. STAT. § 12.110 (1981) (5 years); TEX. REV. CIV. STAT. ANN. art. 4590 (Vernon Supp. 1982–83) (2 years); VT. STAT. ANN. tit. 12, § 521 (1983) (7 years).

88. *See* Note, *Tort Law—Statute of Limitations in Medical Malpractice Actions*, 1970 WIS. L. REV. 915.

means to protect the health-care provider from excessively stale claims and unlimited liability while at the same time preserving the patient's right to vindicate her or his claim.[89]

IV. Other Major Provisions of the Act

As well as amending the statute of limitations, the Ohio Medical Malpractice Act introduced many other significant statutory provisions. The most notable examples were the provisions for arbitration,[90] the $200,000 recovery limitation,[91] the elimination of the ad damnum clause from the pleading requirements,[92] and the partial abrogation of the collateral source rule.[93] Unlike the statute of limitations provisions, these provisions have not undergone any recent interpretive changes. They have, however, been the subject of persistent litigation.[94]

For the purpose of encouraging settlements and screening nonmeritorious claims,[95] Ohio employs a compulsory, nonbinding system of arbitration.[96] Under this system, claims must be submitted to an arbitration panel before they can proceed to trial.[97] The panel is composed of three members: each party is permitted to select one member while the court selects a chairperson.[98] After a decision has been rendered by the panel, either party may elect to take the case to trial.[99] At trial, the decision of the arbitration panel is admissible if the court finds that the decision was made without error or prejudice.[100]

In an effort to restrict damage awards, Ohio has a ceiling on the amount of damages recoverable.[101] Any medical malpractice claim not involving death cannot now exceed $200,000 in general damages.[102] In addition, damages have been further restricted by the legislature's partial abrogation of the collateral source rule.[103] The proplaintiff collateral source rule provides that a defendant cannot be credited for money

89. *See* Comment, *supra* note 32, at 775–77.
90. Ohio Rev. Code Ann. § 2711.21 (Page 1981).
91. *Id.* § 2307.43.
92. *Id.* § 2307.42(C).
93. *Id.* § 2305.27.
94. *See generally* Beatty v. Akron City Hosp., 67 Ohio St. 2d 483, 424 N.E.2d 586 (1981); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (C.P. Ct. Montgomery County 1976); Graley v. Satayatham, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (C.P. Ct. Cuyahoga County 1976).
95. Ripps, *supra* note 10, at 35.
96. Ohio Rev. Code Ann. § 2711.21 (Page 1981).
97. *Id.*
98. *Id.*
99. *Id.*
100. *Id.*
101. *Id.* § 2307.43.
102. *Id.*
103. *Id.* § 2305.27.

or services rendered to the plaintiff by a third party.[104] As an exception to this rule, the Ohio Medical Malpractice Act now allows a defendant's damages to be reduced by any collateral sources except insurance proceeds that are paid by or on behalf of the injured victim or payments directly from the victim's employer.[105]

A less direct method for keeping damage awards to a minimum is provided by the pleading requirements. The special pleading rules state that no complaint which sets forth a medical claim shall contain the amount of damages that the claimant is seeking to recover.[106] This requirement deviates from the standard pleading rules set out by the Ohio Rules of Civil Procedure[107] and is premised on the theory that damage awards will be reduced if juries do not acquire inflated ideas of what claims are worth.[108]

V. CONSTITUTIONAL ISSUES

A. Equal Protection

Since H. 682 was specifically designed to alleviate the plight of only medical malpractice defendants, it was not surprising that equal-protection challenges followed its inception. Shortly after the bill became law, two common pleas courts sustained now-common equal-protection arguments.[109] The first of these cases was *Graley v. Satayatham*.[110] In declaring the recovery limit, the collateral source rule modification, and the preclusion of the ad damnum clause unconstitutional, the *Graley* court stated that these provisions violated the equal-protection clauses of both the United States and Ohio Constitutions because they conferred benefits on the medical malpractice defendant that were not available to other tort defendants.[111] Another common pleas court in *Simon v. St. Elizabeth Medical Center* extended this equal-protection analysis, deciding that arbitration, as well as the provisions that were addressed in *Graley*, was also unconstitutional.[112]

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104. Note, *Ohio's RX for the Medical Malpractice Crisis: The Patient Pays*, 45 U. CIN. L. REV. 90, 105 (1976).

105. OHIO REV. CODE ANN. § 2305.27 (Page 1981).

106. *Id.* § 2307.42(C).

107. *See* Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (C.P. Ct. Montgomery County 1976).

108. *See* Keeton v. Mansfield Obstetrics & Gynecology Ass'n, No. C80-1573A, slip op. at 6 (N.D. Ohio filed Mar. 5, 1981).

109. *See* Graley v. Satayatham, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (C.P. Ct. Cuyahoga County 1976); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (C.P. Ct. Montgomery County 1976).

110. 74 Ohio Op. 2d 316, 343 N.E.2d 832 (C.P. Ct. Cuyahoga County 1976).

111. *Id.* at 321, 343 N.E.2d at 836.

112. *Simon*, 3 Ohio Op. 3d at 167, 355 N.E.2d at 906–07.

However, other courts in Ohio have not been persuaded by the *Simon* and *Graley* decisions,[113] reflecting the climate of disagreement which has pervaded the equal-protection issue in general.[114]

In the equal-protection field, the standards of review adopted by the courts have, in practical effect, come to determine the success of claims. Although the Supreme Court has set guidelines to govern which one of three standards is to be used in a given situation,[115] courts continue to disagree over which standard should be used in this area of the law. At one pole is the traditional rational-basis standard; at the other is strict scrutiny.[116] More recently, an intermediate standard has been developed which is sometimes referred to as the "means-focused" test.[117] To pass this test, the challenged legislation must bear a substantial relationship to its objective.[118] While the means-focused standard affords a legislature greater flexibility than the strict-scrutiny test, it also requires that the state demonstrate a greater justification for the classification than does the rational-basis standard.[119]

In most of the leading cases, courts have either used the means-focused or the rational-basis standards of review.[120] Not surprisingly, courts which have selected the means-focused standard have sustained equal-protection attacks,[121] while most courts using the rational-basis test have rejected similar challenges.[122] It should be noted, however,

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113. *See, e.g.*, Beatty v. Akron City Hosp., 67 Ohio St. 2d 483, 424 N.E.2d 586 (1981) (Ohio Supreme Court upheld constitutionality of arbitration statute); Keeton v. Mansfield Obstetrics & Gynecology Ass'n, No. C80-1573A (N.D. Ohio filed Mar. 5, 1981) (United States District Court upheld constitutionality of $200,000 recovery limit).

114. *Compare* Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) (Supreme Court of New Hampshire held abolition of collateral source rule to be a violation of equal protection) *and* Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978) (Supreme Court of North Dakota held that a $300,000 recovery limit was a violation of equal protection) *with* Johnson v. St. Vincent Hosp., 76 Ind. 131, 404 N.E.2d 585 (1980) (Supreme Court of Indiana upheld a $500,000 recovery limit over an equal protection attack) *and* Rudolph v. Iowa Methodist Medical Center, 293 N.W.2d 550 (Iowa 1980) (Supreme Court of Iowa rejected an equal protection challenge to abolition of collateral source rule).

115. *See generally* Taylor & Shields, *The Limitation on Recovery in Medical Negligence Cases in Virginia*, 16 U. RICH. L. REV. 799, 835–36 (1982).

116. *Id.* at 835.

117. *Id.* at 836.

118. *See generally id.* at 836–38.

119. Redish, *supra* note 1, at 772.

120. *See* Taylor & Shields, *supra* note 115, at 836–40.

121. *See* Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied*, 431 U.S. 914 (1977), *on remand*, No. 55586 (4th Dist. Ct. Ada County, Idaho Nov. 3, 1980); *Carson*, 120 N.H. at 939–44, 424 A.2d at 835–38; *Arneson*, 270 N.W.2d at 135–36.

122. *See* Di Antonio v. Northampton-Accomak Memorial Hosp., 628 F.2d 287 (4th Cir. 1980); Woods v. Holy Cross Hosp., 591 F.2d 1164 (5th Cir. 1979); Johnson v. St. Vincent Hosp., 76 Ind. 131, 404 N.E.2d 585 (1980); Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).

that courts which have employed the rational-basis test have not necessarily concurred in the wisdom of the legislation. For instance, in rejecting a challenge to Ohio's $200,000 recovery limit, the court in *Keeton v. Mansfield Obstetrics & Gynecology Association*[123] stated:

> The real rationale for this legislation is that the legislation is aimed at shifting the risk of practicing medicine from the health care provider to the health care receiver . . . . It is the opinion of this Court that the shifting of the risk of loss to those least able to afford it, rather than to those who are most able to afford it, is an ill-conceived legislative choice.[124]

Despite such criticism, the court upheld the statute on the ground that a rational nexus existed between smaller damage awards and the stabilization of malpractice insurance—both of which are thought to inure to adequate health care.[125] Currently, this approach appears to be the rule in Ohio in light of the Ohio Supreme Court's decision in *Beatty v. Akron City Hospital*.[126] In rejecting an equal-protection challenge to the malpractice arbitration statute, the court stated:

> Concluding as they must have that the increased number of medical claims was the cause of the dramatic rise in the cost of medical malpractice insurance, and thus the cause of the rise in the cost of providing medical services to the public, it was only rational for the General Assembly to deal with such claims in the manner provided in the Act.[127]

B. Narrower Issues: Right to Jury Trial, Due Process, and Conflict with the Ohio Rules of Civil Procedure

Several other constitutional infirmities have been asserted with respect to other provisions of the Act. The first of these to be addressed will be the argument of the plaintiff's right to a jury trial, in the context of the Act's arbitration provisions.[128]

Due to the fact that section 2711.21 of the Ohio Medical Malpractice Act permits the decision of the arbitration panel to be admissible at trial,[129] it was inevitable that the right to a jury trial would be implicated. Indeed, shortly after the inception of the Act, the plaintiff in *Simon v. St. Elizabeth Medical Center* was successful in arguing that

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123. *Keeton*, slip op. at 13–14.
124. *Id.*
125. *Id.* at 29.
126. 67 Ohio St. 2d 483, 424 N.E.2d 586 (1981).
127. *Id.* at 495, 424 N.E.2d at 594.
128. *See, e.g.*, Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 167, 355 N.E.2d 903, 907 (C.P. Ct. Montgomery County 1976).
129. OHIO REV. CODE ANN. § 2711.21 (Page 1981).

the provisions of the statute violated her right to a jury trial.[130] In concluding that this right had been infringed upon, the court noted that the admissibility of the arbitration decision would substantially reduce a party's ability to prove his or her case to a jury due to the weight which juries have traditionally accorded the testimony of experts.[131]

More recently, however, the issue was resolved by the Ohio Supreme Court in *Beatty v. Akron City Hospital*.[132] The court was not persuaded by the appellants' argument that jurors may choose to rely on the arbitration decision rather than upon their own judgment.[133] In contending that jurors will not give undue regard to the arbitration decision, the court urged that the scheme of the statute is such that the arbitrators' decision is just one facet of the adversarial proceeding.[134] The court also stated that the statutory scheme prevents the issues of the case from being presented to the jury in a manner that would favor either party. Moreover, the court made note of the number of jurisdictions which have upheld against court challenge some form of arbitration.[135]

It cannot be denied that the court's reasoning provides theoretical support for the constitutionality of Ohio's arbitration procedure. In practice, however, the court's rationale has been shown less than persuasive. The court's reasoning has been belied by evidence of the costs that are associated with arbitration. The process has evolved into an extremely expensive process—largely because of the impact that attorneys feel the arbitration decision has at trial.[136] Although the actual impact of the arbitration decision upon a jury cannot be assessed, it seems quite possible that it is more than just "one facet" of the trial.

Some have also urged the $200,000 recovery limit provision of the Act unconstitutional.[137] It has been asserted that the limit is a violation of due process inasmuch as it removes the common-law right to seek full redress for personal injuries without granting the plaintiff a substitute remedy as a *quid pro quo*.[138] The problem with this argument is that it is not clear whether the United States Supreme Court has mandated the granting of a *quid pro quo* when common-law rights are removed.[139] The *quid pro quo* doctrine originated in the case of *New*

130. *See Simon*, 3 Ohio Op. 3d at 168, 355 N.E.2d at 908.
131. *Id.*
132. 67 Ohio St. 2d 483, 424 N.E.2d 586 (1981).
133. *Id.* at 487, 424 N.E.2d at 589.
134. *Id.*
135. *Id.* at 487–90, 424 N.E.2d at 589–91.
136. *See infra* text accompanying notes 177–80.
137. OHIO REV. CODE ANN. § 2307.43 (Page 1981).
138. Note, *supra* note 104, at 103.
139. *See Duke Power Co.*, 438 U.S. at 88.

York Central Railroad Co. v. White,[140] when the United States Supreme Court stated that "it perhaps may be doubted whether the State could abolish all rights of action on the one hand, or all defenses on the other, without setting up something adequate in their stead."[141] However, since the legislation challenged in that case had already provided an adequate *quid pro quo*, it was unnecessary for the Court to reach the issue of whether it would have upheld the legislation without one.[142] Similarly, in the more recent case of *Duke Power Co. v. Carolina Environmental Study Group, Inc.*,[143] the Court was able to evade the issue by concluding that the legislation under attack already provided a "reasonably just substitute" for the rights it replaced.[144]

Therefore, this issue remains another gray area in which courts and scholars are in sharp disagreement.[145] In Ohio, the *Simon* court seemed to suggest that a *quid pro quo* was requisite for the removal of a claimant's right to seek more than $200,000 of damages[146] while the *Keeton* court disagreed with that proposition.[147] Nevertheless, both courts did agree that, assuming a *quid pro quo* were an imperative, the Ohio Medical Malpractice Act did not provide for one.[148] Although proponents of the law argue that injured plaintiffs will receive an exchange benefit in the form of reduced health-care costs, this contention has little apparent merit.[149] Thus, if the Supreme Court were to conclusively adopt the position that common-law rights could not be abrogated in the absence of a *quid pro quo*, Ohio's $200,000 recovery limit

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140. New York Cent. R.R. Co. v. White, 243 U.S. 188 (1917).

141. *Id.* at 201.

142. In this case, New York's workmen's compensation laws had replaced the rules of the common law with respect to employers' liabilities for employee injuries. In exchange for the employee's right to sue under the common law, the assurance of a moderate remedy without having to prove negligence or the amount of damages was an adequate substitute. *Id.*

143. Duke Power Co. v. Carolina Envtl. Study Group, Inc., 438 U.S. 59 (1978).

144. *Id.* at 88. In *Duke*, the plaintiffs challenged the constitutionality of the Price-Anderson Act which placed a $560 million ceiling on the amount recoverable from licensed private companies and the government due to a single nuclear accident. In upholding the Act, the Court was of the opinion that the Act's guarantee of a $560 million recovery fund, in light of the express commitment to " 'take whatever action is deemed necessary and appropriate to protect the public from the consequences of' a nuclear accident," was a "fair and reasonable substitute" for common-law remedies. *Id.* at 90–91.

145. *Compare* Wright v. Central Du Page Hosp. Ass'n., 63 Ill. 2d 313, 347 N.E.2d 736 (1976) (Illinois Supreme Court held that a $500,000 recovery cap on medical malpractice actions did not satisfy the *quid pro quo* doctrine) *with Jones*, 97 Idaho at 869, 555 P.2d at 409 (Iowa Supreme Court rejected the *quid pro quo* doctrine with regard to the state's recovery limit) *and* Redish, *supra* note 1, at 785–87 (author suggests that there is no valid premise for the doctrine).

146. *Simon*, 3 Ohio Op. 3d at 170, 355 N.E.2d at 910.

147. *Keeton*, slip op. at 27.

148. *Simon*, 3 Ohio Op. 3d at 170, 355 N.E.2d at 910; *Keeton*, slip op. at 26.

149. *See* Note, *supra* note 104, at 104. The limit is not likely to reduce malpractice premiums since the vast majority of awards are less than $200,000. *Id.*

would be vulnerable to a due-process challenge.

The legislature's actions with respect to the arbitration provision and the preclusion of the ad damnum clause have sustained constitutional challenges as well. Since both of these provisions are arguably "procedural" law,[150] it has been contended that they are violative of the Ohio Constitution which purportedly proscribes any laws that come into conflict with the Ohio Rules of Civil Procedure.[151] Specifically, article IV, section 5(B) of the Ohio Constitution provides that

> [t]he Supreme Court shall prescribe rules governing practice and procedure in all courts of the state, which rules shall not abridge, enlarge, or modify any substantive right. . . . All laws in conflict with such rules shall be of no further force or effect after such rules have taken effect.[152]

Two rules of Ohio Civil Procedure have been found in conflict with the elimination of the ad damnum clause.[153] The first is rule 8(A), requiring claimants to state "a demand for judgment for the relief to which he deems himself entitled."[154] Secondly, rule 54(C) provides that upon the award of a default judgment, the amount of money damages shall be limited by the amount stated in the demand.[155] However, in the unreported case of *Hearing v. Delaney*,[156] the Franklin County Court of Appeals held that the language of the constitution applied only to those statutes in force at the time the Ohio Civil Rules became effective: on July 1, 1970.[157] Since section 2307.42(C) was enacted subsequently to those statutes, the court held that it did not violate the Ohio Constitution.[158]

Arbitration has also been thought constitutionally suspect as discordant with the Ohio Rules of Civil Procedure. This notion was asserted by Justice Brown in his dissenting opinion in *Beatty*.[159] Rejecting the proposition that arbitration was a substantive rather than a procedural matter, Justice Brown contended that the arbitration statute conflicted with rule 38(A) which provides that the right to a jury trial

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150. It cannot be contended that arbitration is a procedural matter because it has been treated as being substantive for choice-of-law purposes. *See Beatty*, 67 Ohio St. 2d at 498 n.3, 424 N.E.2d at 596 n.3.

151. *Id.* at 498, 424 N.E.2d at 595–96.

152. OHIO CONST. art. IV, § 5(B).

153. *See Graley*, 74 Ohio Op. 2d at 318, 343 N.E.2d at 836; *Simon*, 3 Ohio Op. 3d at 165–66, 355 N.E.2d at 905–06.

154. OHIO R. CIV. P. 8(A).

155. OHIO R. CIV. P. 54(C).

156. Hearing v. Delaney, No. 79AP-483 (Ohio 10th Dist. Ct. App. Dec. 21, 1976).

157. *Id.*

158. *Id.*

159. *Beatty*, 67 Ohio St. 2d at 483, 424 N.E.2d at 586.

"shall be preserved to the parties inviolate."[160] Because the majority did not specifically address the issue, however, the question remains unresolved.

VI. ARBITRATION

The Ohio Medical Malpractice Act included a provision for the arbitration of claims in order to facilitate the screening of nonmeritorious suits and to encourage the early settlement of claims that parties would not prefer to contest.[161] Furthermore, proponents of the procedure were no doubt relying upon it to reduce jury-imposed damage awards.[162] In theory, then, arbitration was to reduce both the overall cost of litigation and the excessiveness of awards, and thereby act as a buffer on insurance rates.

Today, while it appears that arbitration has been an effective means of resolving disputes,[163] it has proven not nearly as successful in reducing awards and litigation costs. Ironically, the procedure has evolved into an extremely expensive process[164] with arbitration panels rendering some very large awards.[165] These factors have produced a most unpredictable change of positions among Ohio attorneys. The plaintiffs' bar, initially opposed to arbitration, have experienced some favorable results with it.[166] On the other hand the defendants' bar, while initially supportive of arbitration, might now prefer to abolish the procedure.[167] It should be noted, however, that although this trend prevails throughout most of the state, there are some counties in which arbitration decisions appear to be more favorable to defendants.[168]

The disenchantment that has developed in the defendants' bar in most parts of the state and in the plaintiffs' bar in other parts of the state is largely attributable to the composition of the panels. Since two

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160. *Id.*

161. Ripps, *supra* note 10, at 35.

162. *See* Turner, *Medical Malpractice Arbitration on the Erie Railroad*, 11 U. TOL. L. REV. 1, 24 (1979).

163. Telephone interview with William Zavarello, of A. William Zavarello Co., L.P.A., Akron, Ohio, co-chairman of Ohio Bar Association Subcommittee on Medical Malpractice (Oct. 7, 1983) [hereinafter cited as Zavarello interview]; Telephone interview with Willis P. Jones, of Jones, Schell & Schaefer, Toledo, Ohio (Oct. 14, 1983) [hereinafter cited as Jones interview].

164. Zavarello interview, *supra* note 163; Telephone interview with William A. Davis, of Kamito, Nurenburg, Plevin, Jacobson, Heller & McCarthy Co., L.P.A., Columbus, Ohio (July 20, 1983) [hereinafter cited as Davis interview].

165. Jones interview, *supra* note 163.

166. Jones interview, *supra* note 163; Address by Walter J. Wolske, of Wolske & Blue, Columbus, Ohio, chairman of the Ohio Academy of Trial Lawyers' "1983 Medical Malpractice Seminar," Columbus, Ohio (Sept. 24, 1983) [hereinafter cited as Wolske address].

167. Zavarello interview, *supra* note 163.

168. Wolske address, *supra* note 166.

of the three members are selected by the parties themselves,[169] there is a deliberate bias built into the system. Naturally, each party will select an advocate as its arbitrator in hopes of obtaining an arbitrator "biased" in its favor.[170] Thus, the outcome of the decision may inevitably rest on the vote of the chairperson. And due to the method by which the chairperson is appointed, another flaw in the system has surfaced. In most counties, a list is maintained from which the chairperson is selected.[171] These lists are basically composed of attorneys who normally represent either injured plaintiffs or defendant insurance companies.[172] Thus, even the panel chairperson is likely to possess a bias. Insofar as those with litigation experience in this area are perhaps the only group knowledgeable enough to sit on such panels,[173] a better solution is not readily obvious, however.

Although partiality among panel chairpersons presents a perplexing situation, several measures have in fact been taken to ameliorate it. For instance, in Lucas County efforts are being made to acquire a like number of representatives from both "sides" to sit as chairpersons.[174] Perhaps an even better scheme has been implemented in Montgomery County. It is there unnecessary for the courts to conduct a selection process. Rather, the county's arbitration rules provide for the appointment of a chief arbitrator to serve as the chairperson for *all* arbitration proceedings.[175] Provided that the chief arbitrator is selected carefully, this type of system is probably more capable of insuring against partiality. Although congested court dockets may prevent some counties from maintaining a single chief arbitrator, the lists could be reduced in an effort to provide chairpersons who merit the approval of all segments of the bar. Additionally, one commentator has espoused the implementation of an evaluation process whereby a panel chairperson could be subject to removal upon a showing of cause.[176] In any event, the disenchantment that exists in the Ohio Bar with regard to the fairness of panel decisions is a problem that should be faced in order that

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169. OHIO REV. CODE ANN. § 2711.21 (Page 1981).

170. Letter from Richard E. Lerner, associate general counsel for the American Arbitration Association (Sept. 27, 1983).

171. Telephone interview with Michael F. Lyon of Keating, Ritchie, & Lyon Co., L.P.A., co-chairman of the Ohio Academy of Trial Lawyers' "1983 Medical Malpractice Seminar" (Oct. 6, 1983) [hereinafter cited as Lyon interview].

172. *Id.*

173. Davis interview, *supra* note 164.

174. Jones interview, *supra* note 163.

175. MONTGOMERY COUNTY CT. C.P.R. 2.55 (on file with University of Dayton Law Review).

176. Sakayan, *Arbitration and Screening Panels: Recent Experience and Trends*, 17 A.B.A. F. 682, 689 (1981–82).

panel decisions be accorded greater respect throughout all parts of the state.

Likewise, efforts must be made to curtail the burdensome expense that arbitration can impose on medical malpractice claims. Essentially, arbitration has come to take on the complexion of a full-scale trial.[177] If claims are appealed, the total cost of resolving the dispute is of course substantially increased.[178] While both parties are affected by this compounded expense, it is extremely burdensome to the individual plaintiff who, unlike the defendant insurance company, may not have the capital to subsidize two full-scale proceedings.[179]

The expenditures that are being channeled into arbitration proceedings reflect the impact that attorneys feel that arbitration decisions will have in the courtroom.[180] However, if the arbitration decision were not admissible at trial, it is doubtful that the system could still be an effective screening device. A more plausible solution was recently considered by an Ohio State Bar Association Subcommittee on Medical Malpractice Reform. The subcommittee was preparing to submit a recommendation to the Ohio State Bar Association that the arbitration procedures be amended so that they could be waived upon the consent of both parties.[181] Such an amendment would preclude judges from forcing parties to arbitrate,[182] which would ultimately result in cost reductions in many cases.

Due to a recent change of position among a group of attorneys representing the medical profession, it is questionable whether this amendment will be implemented. This group is now advocating the complete elimination of arbitration.[183] On the other hand, many attorneys representing plaintiffs prefer to maintain some form of arbitration in order to assure that they will have a forum in which to bring their claims.[184] This concern apparently arises from the substantially greater number of claims that are now being filed in the courts.

Thus, Ohio's arbitration system will almost certainly undergo a significant change in the near future due to the surprising results that it has produced. Hopefully, there will be an accommodation of interests

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177. Davis interview, *supra* note 164.

178. Zavarello interview, *supra* note 163.

179. *Id.*

180. Davis interview, *supra* note 164; Telephone interview with Mike McGee, liability claims supervisor for St. Paul Fire & Marine Insurance Co., Cincinnati, Ohio (Oct. 21, 1983).

181. Zavarello interview, *supra* note 163.

182. State *ex rel.* Juguilon v. Guzzo, 6 Ohio St. 3d 20, 450 N.E.2d 1175 (1983) (Ohio Supreme Court rejected mandamus action which was brought to compel judge to allow waiver of arbitration proceeding).

183. Zavarello interview, *supra* note 163; Wolske address, *supra* note 166.

184. Zavarello interview, *supra* note 163.

rather than a total elimination of the procedure. In order to achieve such an accommodation, a nonbinding, "waivable" system might be implemented so that injured victims will not have to wait an unreasonable period of time before gaining access to a forum. Additionally, the decisions of the panel chairpersons might in the future be scrutinized in order to assure both parties a fair decision.

VII. Recovery Limit

The policy behind the enactment of the $200,000 damage recovery limit was aimed at reducing the amount needed to insure health-care professionals by restricting the amount recoverable.[185] It would be pointless to attempt to evaluate whether the limitation has had any impact on insurance rates because courts and arbitration panels have essentially declined to enforce it.[186] Since the law has never been challenged at the appellate level, its enforcement remains within the discretion of the trial courts. Thus, the only purpose that the limit may be serving is that it may provide a bargaining chip for insurance companies during the course of settlements. In other words, the possibility that the limit might be enforced[187] could induce a claimant to settle for less than what he or she would otherwise agree to.

The treatment that Ohio courts have given the recovery limit reflects the loss of vitality that such laws have experienced throughout the country. In some jurisdictions, state supreme courts have declared the limits unconstitutional.[188] Moreover, attorneys in Virginia, Texas, and California have reported that the limits in those states may be reviewed by their supreme courts during the next year.[189] Aside from the constitutional infirmities that continue to encumber their validity, recovery limits also suffer from a practical weakness.

Even if the limits were uniformly enforced, it is doubtful that they would have a significant impact on insurance rates. For instance, Virginia statistics indicate that only 1.5% of all awards between 1976 and 1981 exceeded $100,000.[190] There has been no evidence of any correla-

185. Keeton v. Mansfield Obstetrics & Gynecology Ass'n, No. C80-1573A, slip op. at 11 (N.D. Ohio filed Mar. 5, 1981).

186. *See, e.g.*, Novak v. St. Charles Hosp., No. 81-1014 (C.P. Ct. Lucas County, Ohio Sept. 29, 1983) (arbitration panel rendered $4 million award).

187. *See, e.g.*, Johnson v. Stein, No. 82-2471 (C.P. Ct. Montgomery County, Ohio Aug. 2, 1983) (common pleas court upheld constitutionality of $200,000 limit).

188. *See* Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978).

189. *Controlling Malpractice Recovery*, Nat'l L.J., Aug. 15, 1983, at 10, col. 2.

190. Taylor & Shields, *supra* note 115, at 827.

tion between these losses and the alleged "crisis" situation.[191] Therefore, one commentator concluded that "it was impossible for large verdicts to have had any real effect on rates for malpractice insurance in Virginia."[192] It was similarly noted by another commentator shortly after the enactment of Ohio's $200,000 limit that it was unlikely that the limit would reduce malpractice premiums due to the infrequency of awards in that range.[193] Although it should be noted that in states such as New York and Florida such a limit may have the capacity to reduce premiums,[194] the malpractice climate in Ohio is not on a par with these states.[195]

A recent surge in the number of large malpractice awards rendered in Ohio[196] may suggest that a greater percentage of insurance losses will be stemming from recoveries that exceed $200,000. However, even if it could be demonstrated that such awards placed a substantial burden on insurance premiums, the current limit would still not be justified. The clear message from Ohio's courts seems to be that $200,000 is simply not enough to compensate a severely injured victim. Indeed, in those states in which recovery limits have survived constitutional challenges, the limits have generally been in the vicinity of $500,000, with Virginia's limit recently escalating to $1,000,000.[197] If conditions in Ohio ever came to justify the need for a recovery limit, it should be one that is more accommodating to the losses of the injured victim.

One final justification for the imposition of a recovery limit could be that large awards have generally exceeded the amount of damages suffered by the recipients of such sums.[198] However, it was recognized shortly after the limits were enacted that there was no evidence to support such a proposition.[199] Moreover, it is doubtful that such evidence could be adduced because of the subjectivity involved in calculating damages for pain and suffering.[200]

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191. *Id.* at 843.

192. *Id.*

193. Note, *supra* note 104, at 104.

194. FLORIDA MEDICAL ASS'N, REASON '83, at 2, 11 (1983).

195. *PICO, supra* note 5, at 8, col. 2.

196. Jones interview, *supra* note 163.

197. *Controlling Malpractice Recovery, supra* note 189, at 10, col. 2.

198. Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489, 504 (1977).

199. *Id.*

200. *Id.*

VIII. COLLATERAL SOURCE RULE AND AD DAMNUM CLAUSE

The abrogation of both the collateral source rule[201] and the ad damnum clause[202] was a less drastic means for reducing damage awards than were the recovery limit provisions. The theory behind omitting the demand for damages from pleadings is to prevent the jury from being unduly impressed by the amount of damages sought in the petition.[203] Proponents of such legislation contend that the public can acquire inflated ideas of what claims are worth through the ad damnum clause.[204] By countering the psychological impact of large awards, it was hoped that the size of malpractice judgments would shrink to acceptable levels.[205] The modification made to the collateral source rule is very straightforward in design. Quite simply, the reasoning was that damage awards could be reduced by allowing certain insurance benefits of the plaintiff to contribute to the award.[206]

Unlike the recovery limit changes, courts have been enforcing these provisions.[207] In fact, some courts have extended the abrogation of the collateral source rule beyond its statutory limitation.[208] Thus, even insurance coverage which has been paid for by the injured victim has sometimes been used to offset the damage award.[209] Although the impact of these provisions can only be speculated upon, it is doubtful that they have made a significant contribution to the stabilization of insurance rates.

First, although twenty-eight states have either eliminated the ad damnum clause or restricted jury access to information contained in it,[210] jury verdicts nationwide have continued to climb.[211] The average verdict in medical malpractice cases rose from $146,632 in 1972 to $251,472 in 1981.[212] The effect that modifications of the collateral source rule have had on insurance rates is probably insignificant. Although insurance rates in Ohio have stabilized since the passage of the

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201. OHIO REV. CODE ANN. § 2305.27 (Page 1981).

202. *Id.* § 2307.42(C).

203. Keeton v. Mansfield Obstetrics & Gynecology Ass'n, No. C80-1573A, slip op. at 6 (N.D. Ohio filed Mar. 5, 1981).

204. *Id.*

205. *Id.*

206. Note, *supra* note 104, at 105–06.

207. Lyon interview, *supra* note 171; Jones interview, *supra* note 163.

208. Lyon interview, *supra* note 171.

209. *Id.*

210. *Keeton*, slip op. at 5 n.2.

211. *See* 1 PERS. INJ. VALUATION HANDBOOKS (Jury Verdict Research, Inc.) No. 270, at 18 (1980).

212. This statistic excludes $1,000,000 verdicts. *Id.*

Act,[213] this has generally been attributed to the adjustment that underwriters have made in charging adequate premium rates.[214]

In light of the possibility that these provisions have contributed little to the stabilization of premium rates, the issue arises whether courts should be compelled to continue their enforcement. This issue becomes particularly acute with regard to the collateral source rule, since its abrogation conflicts with many well-rooted principles of social policy.[215] Among these principles is the proposition that the victim's insurance rates should not be penalized as a result of contributing to the damage caused by a negligent tortfeasor.[216] Additionally, it has been argued that a reduction in the tortfeasor's liability will diminish the deterrent effect of liability.[217] Although it may have appeared necessary to supplant certain principles of social policy to proposed solutions of the "crisis" situation which prevailed eight years ago, that situation no longer exists.[218] To the contrary, medical malpractice underwriting in Ohio now appears to be quite a lucrative field.[219] Such changed factual circumstances certainly merit renewed consideration from the legislature, especially in light of the statutes' uncertain constitutional status.

IX. THE ROOTS OF THE MEDICAL MALPRACTICE CRISIS—BEYOND LEGISLATIVE REFORM

In 1980, a study of closed insurance claims released by the National Association of Insurance Commissioners indicated that the wave of legislative reform enacted in the mid-1970's had done little to alleviate the problems state legislatures had set out to cure.[220] The study

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213. Telephone interview with Tony Shannon, employee of the Ohio Insurance Department, Columbus, Ohio (Oct. 7, 1983) (on file with University of Dayton Law Review). One of the functions of the Ohio Insurance Department is to calculate appropriate rate-level adjustments for specific segments of the insurance business. The following schedule is an illustration of adjustments that were made to malpractice premium rates for physicians, surgeons, and dentists in the State of Ohio over the last seven years:

DATE OF ADJUSTMENT	AMOUNT OF ADJUSTMENT
June 1, 1976	145% increase
June 15, 1980	30% decrease
December 1, 1981	33% increase
April 1, 1983	17.9% increase

214. *PICO, supra* note 5, at 8, col. 3.

215. *See* Jenkins, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. CAL. L. REV. 829, 948 (1979).

216. *Id.*

217. *Id.*

218. *PICO, supra* note 5, at 8, col. 2.

219. *Id.*

220. *See* Curran, *Closed-Claims Data for Malpractice Actions in the United States*, 71

covered the period from July of 1975 to December of 1978. Among its findings were:

> 1) The average award in medical malpractice cases rose from $26,565 to $45,187, an increase of forty-two percent, adjusted for inflation.
> 2) The average time from a reported incident to a final disposition rose from thirty-seven to forty-six months.
> 3) The percentage of claims actually disposed of by court verdicts rose from seven to eighteen percent.[221]

Although it may be unfair to pass judgment on these legislative reforms so soon, it might reasonably be hypothesized that the statutory changes have been less than successful. Indeed, one expert noted in 1981 that a national trend toward a greater number of claims was very likely due to the inability of legislative reforms to bring about substantive changes in what the Commission on Medical Malpractice found to be the basic causes of liability.[222] In their extensive study, the Commission concluded that these causes were "patient injuries, aggravated by lack of personal rapport in the doctor-patient relationship, unsatisfactory handling of complaints, inadequate information leading to unrealistic expectations about the probable outcome of treatment, and the societal disposition to litigiousness."[223] In order to counter these problems, the Commission suggested that health-care providers should be educated to enhance communications and rapport with patients; they also urged that patients should be educated as to what they can reasonably expect from medical treatment.[224] Additionally, the Commission espoused the establishment of better patient grievance systems in hospitals.[225] It would seem, therefore, that the frequency and severity of claims in Ohio might be curtailed if the medical profession itself would direct its efforts at implementing such basic proposals. Special legislation is unlikely to provide any sustained improvement.

In addition to the causes enumerated by the Commission on Medical Malpractice, a further reason for the "crisis" situation of the mid-1970's was the inability of malpractice underwriters to accurately forecast premium rates.[226] Before the crisis arose, many companies were basing their rates on little more than guesses. Consequently, when

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AM. J. PUB. HEALTH 1066 (1981).

221. *Id.*

222. Cunningham, *Rise in Malpractice Claims Forces Look at Previous Scare*, HOSP., Mar. 16, 1981, at 85, 88.

223. *Id.* at 88.

224. *Id.* at 90.

225. *Id.* at 88.

226. *PICO, supra* note 5, at 8, col. 2.

claims soared, many insurers were caught with insufficient reserves.[227]

Fortunately, the medical malpractice insurance market in Ohio has stabilized and such problems are unlikely to arise again. According to Joseph K. Gilmore, president of Physicians Insurance Company of Ohio (PICO), the answer to successful underwriting in this area is to charge adequate premiums.[228] PICO, created by Ohio physicians in 1977, has been extremely instrumental in the recovery of Ohio's market for medical malpractice insurance underwriting.[229] This recovery has been so strong that PICO's executive vice president, David P. Kaechele, contends that there is absolutely no chance of a repeat crisis in Ohio.[230]

On the basis of that statement, it appears that Ohio's insurers have weathered the storm and successfully adjusted to the crisis situation of the mid-1970's. This has been accomplished despite the apparent ineffectiveness of arbitration, the recovery limit, the modifications in the collateral source rule, and the elimination of the ad damnum clause.

X. CONCLUSION

With the *Oliver* decision, the statute of limitations for medical malpractice claims in Ohio will now be guided by the discovery rule. This rule clearly provides the most logical and equitable method for determining the accrual date of a cause of action. In addition to the discovery rule, the period of limitation must also be governed by a four-year limitation rule. This limit is essential to preventing runaway insurance costs and unlimited liability for physicians.

Although eight years have passed since the passage of the Ohio Medical Malpractice Act, the constitutional status of many provisions of the Act are still at issue. The Ohio Supreme Court has ruled only on the arbitration provisions, and although the court upheld their constitutionality, certain changes should be considered to relieve the frustration that many attorneys have experienced with the system. These changes include allowing the adversaries to agree to waive the procedure and instituting an evaluation system for panel chairpersons.

The courts have essentially refused to enforce the $200,000 recovery limit; one should expect this refusal to continue unless Ohio jury awards escalate well beyond the bounds today thought possible. Furthermore, without a showing that the modifications to the collateral

227. *Id.*
228. *Id.*
229. *Id.*
230. *Id.*

source rule and the pleading requirements have assisted in the effort to stabilize malpractice premiums, legislative reconsideration of the statutes' utility would now seem warranted.

In the final analysis, it is doubtful that legislative reform is the answer to curtailing the incidence and severity of malpractice claims. Rather, any lasting solution will lie in the reform of physician-patient relations and in hospital sensitivity to patient complaints. Furthermore, accurate rate adjusting on the part of insurance companies is essential if another "crisis" is to be prevented. Such cures, however, address themselves not to the province of the legislature, but rather to the medical and insurance professions.

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