

# A Perspective on Federalism and Medical Malpractice

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This Article develops an analytical framework by which to assess the appropriate federal role in medical malpractice. It identifies a set of non-exhaustive criteria for federal involvement, including: (1) Is there a need for uniformity across states? (2) Are there overriding national interests? (3) Is there consensus on identification of the problem and on the range of potential solutions? (4) Are states actively considering or dealing with the issue? (5) Is

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there a special federal comparative advantage in addressing the issue? On the basis of these various criteria, I establish a continuum of potential federal involvement and suggest some particular areas appropriate for a constructive federal role.

### I. IS THERE A NEED FOR UNIFORMITY?

Products liability presents a strong—though not limitless—case for uniform treatment. Manufacturers typically make products for use in regional or national markets. The costs exacted by state-imposed standards may be considerable and may be exported if economies of scale in production require that the most stringent state standard be adhered to in all state markets. There are, however, constitutional limitations on a state's ability "to impose burdens on the interstate market."<sup>1</sup> Under "principles of state sovereignty and comity,"<sup>2</sup> states must "respect the interests of other States,"<sup>3</sup> which have "autonomy . . . within their respective spheres."<sup>4</sup> Thus, the case for federalization of products liability standards responds to traditional commerce clause and federalism rationales for federal intervention.<sup>5</sup>

Medical treatment decisions, on the other hand, typically occur within and have their major effect within a state.<sup>6</sup> There are few interstate spillover

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1. *BMW of North America, Inc. v. Gore*, 116 S. Ct. 1589, 1597 (1996).

2. *Id.*

3. *Id.*

4. *Id.* (quoting *Healy v. Beer Institute*, 491 U.S. 324, 335-36 (1989)). In *BMW* the Supreme Court acknowledged the limitations on extraterritoriality embodied in the dormant commerce clause. *Id.* (citing *Healy*, *Edgar v. MITE Corp.*, 457 U.S. 624, 643 (1982), and *Gibbons v. Ogden*, 9 Wheat. 1, 194-96 (1824)). *BMW* held that "a State may not impose economic sanctions on violators of its laws with the intent of changing the tortfeasors' lawful conduct in other States" because that "would be infringing on the policy choices of other States." *Id.* Under the dormant commerce clause, state regulation with a legitimate local purpose and merely an incidental effect on interstate commerce will be struck down if interstate commerce is burdened excessively in relation to the putative local benefits. *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970).

5. This does not necessarily mean that a federal approach is warranted; the point is that there is a strong case to be made, even in light of traditional considerations of federalism and state control of products standards, for a more aggressive federal stance in the products liability arena.

6. For many years, the law of medical malpractice focused on the standard of practice in the same or similar community. More recently, courts have moved to a national standard. *See, e.g.*, *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 349 A.2d 245, 248-53 (Md. 1975). To the extent that such national uniformity is desired by states, it can be achieved by state common law or statutory law. At the same time, researchers have acknowledged the existence of clinical uncertainty reflected in widely divergent rates for a variety of procedures. *See, e.g.*, Tavs F. Andersen & Gavin Mooney, *Medical Practice Variations: Where Are We?*, in *THE CHALLENGES OF MEDICAL PRACTICE VARIATIONS* 1 (Tavs F. Andersen & Gavin Mooney eds., 1990); John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, *HEALTH AFF.*, Summer 1984, at 6. Some commentators have questioned the wisdom and ongoing appropriateness of the unitary standard of care, which has characterized medical malpractice doctrine and which has been the engine for the nationalization of the standard of care. *See, e.g.*, James F. Blumstein, *Cost Containment and Medical Malpractice*, in *HEALTH CARE DELIVERY AND TORT: SYSTEMS ON A COLLISION COURSE?* 76, 91-94 (Elizabeth Rolph ed., 1993); John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 *V.A. L. REV.* 439 (1991); Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers*

effects on service-providers and consumers. In addition, there is a tradition of local regulation in the area of medical malpractice.<sup>7</sup> Professional licensure is a traditional state function<sup>8</sup> and quality assurance is a customary element of the licensure process.<sup>9</sup>

### II. ARE THERE OVERRIDING NATIONAL INTERESTS?

Overriding national interests may be commercial or economic; they may also be of a police power or a moral dimension, such as civil rights.<sup>10</sup> Clearly, *some* federal interests exist in the area of medical malpractice. In its role as payor,<sup>11</sup> the federal government has an interest in medical malpractice issues. There has been a longstanding federal interest in the quality of care of medical delivery for federal beneficiaries.<sup>12</sup> The Health Care Quality Improvement Act of 1986 (HCQIA) evinced this strong federal interest in quality of care more generally by providing qualified immunity for certain types of peer review activities.<sup>13</sup> It also established a medical malpractice reporting system designed to increase the amount of information available to hospitals concerning the practice experience of physicians applying for staff privileges.<sup>14</sup> The mobility of physicians necessitated a federal data bank so that all sources of information could be made available to hospital decision-makers. Decisions on qualifications, however, remain with hospitals and their

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from the *Clash of Cultures*, 103 YALE L.J. 1297 (1994).

7. The same arguably can be asserted regarding products standards, but there have been federal inroads on state autonomy in fields such as auto and consumer products safety.

8. See generally *California State Bd. of Optometry v. Federal Trade Comm'n*, 910 F.2d 976 (D.C. Cir. 1990) (barring FTC eyeglass regulation and expressing federalism concerns). One striking feature of the Clinton Administration's healthcare reform proposal was Section 1161, which would have provided that "[n]o state may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals." H.R. 3600, 103d Cong., 1st Sess. § 1161 (1993). This would have constituted a federal challenge to state licensure provisions. For a discussion of the Clinton Administration proposal, see James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 20 n.23 (1994); James F. Blumstein, *The Clinton Administration Health Care Reform Plan: Some Preliminary Thoughts*, 19 J. HEALTH POL., POL'Y & L. 201, 204-05 (1994).

9. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 40-42 (1991).

10. See James F. Blumstein, *Federalism and Civil Rights: Complementary and Competing Paradigms*, 47 VAND. L. REV. 1251, 1257-59 (1994). Unemployment insurance would be an example of a mixture of the commercial and the social welfare policy objectives.

11. The federal government is a payor for its employees, for its military personnel and their dependents, and for its public beneficiaries in programs such as Medicaid and Medicare. The government is also a provider of services through the Indian Health Service and the Veterans Administration.

12. The Professional Standards Review Organization (PSRO) legislation enacted in 1972, see generally Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6 (1975), and its successor, the Peer Review Organization (PRO) program, 42 U.S.C. § 1320c (1994), suggest a strong federal concern with the quality of care paid for by the federal government on behalf of designated federal beneficiaries.

13. 42 U.S.C. §§ 11111-11152 (1994).

14. 42 U.S.C. §§ 11131-11136 (1994).

medical staffs. Regulatory decisions concerning licensure remain with state authorities.<sup>15</sup>

While there is surely some federal stake in medical malpractice, it is not overriding. Where the federal government has intervened, it has pursued a philosophy of shared interests between federal and state governments. Federal initiatives have not been designed to supersede state legislation. Though one can therefore make the case that the federal government is not uninterested in medical malpractice, there is no overriding federal interest in asserting a comprehensive, exclusive federal authority that precludes state policymaking.

### III. IS THERE CONSENSUS ON PROBLEM IDENTIFICATION OR SOLUTION?

There is a value in allowing states to experiment with alternative approaches. Different approaches in different jurisdictions can be studied and evaluated, with states being able to copy, adopt, modify or reject approaches they deem unsuitable. An absence of consensus therefore implies the desirability of further policy development by the states. Prematurely uniform, federal policy can harden the intellectual arteries, potentially stifling innovation and experimentation.

To date, there is no agreed identification of the medical malpractice problem. Malpractice as a policy problem has three possible dimensions—insurance, quality of care, and compensation for victimized patients. Each version of the malpractice problem presents very different solutions. During the perceived medical malpractice crisis of the mid-1980s, the federal government enacted legislation concerning two of these three problems—insurance and quality. In doing so, the federal government focused on issues within its peculiar ken, and was respectful of federalism values and subsidiarity principles. Federal involvement to this point has been incremental, finely-tuned, and carefully targeted to policies where a national interest has been deemed overriding.

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15. The federal government has conferred immunity in a variety of contexts. For example, persons on PSRO-PRO reviewing panels have immunity from liability. 42 U.S.C. § 1320c-6(b) (1994). *See Kwoun v. Southeast Mo. Professional Standards Org.*, 811 F.2d 401 (8th Cir. 1986). Similarly, the PSRO and PRO legislation confers immunity for malpractice on all practitioners who comply with PSRO-PRO standards. 42 U.S.C. § 1320c-6(c) (1994). The rationale for this immunity was to eliminate malpractice risk for practitioners engaged in cost containment efforts. PSRO-PRO immunity was designed to counter the perceived threat of defensive medicine. Its impact has been uncertain. The statutory provision has never been cited as determinative on the standard-of-care issue in any reported medical malpractice appellate case.

The Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11111-11152 (1994), conferred immunity from antitrust liability and other federal and state liability for peer review actions. There are certain limitations to the immunity provisions. With respect to public hospitals, suits under federal civil rights statutes (particularly 42 U.S.C. § 1983 (1994)) are not precluded. Immunity is limited to good faith peer review activities, which appears to be more a codification of pre-existing case law than a break with precedent.

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### A. *Insurance*

If insurance is the policy focus, a number of questions arise.<sup>16</sup> Should public policy emphasize costs, and if so to whom? To doctors? To hospitals? What is the effect of escalating insurance costs? What causes the escalation in insurance costs? Are the increases passed on to patients? Is lack of insurance availability a concern? Why has it been a problem in the past in certain areas? What impact does the unavailability of medical malpractice insurance have on a physician's practice, and on overall patient access to medical care? How significant is the availability problem in the aggregate? If it is not now a concern, how has the problem been resolved and is it likely to recur?

One particular focus is likely to be insurance company profitability, and the question of whether the costs of insurance regulation create unduly high barriers to entering the insurance market, thus immunizing existing carriers from competition.<sup>17</sup> The 1986 amendments to the Risk Retention Act, which may be viewed as a partial federal response to this concern,<sup>18</sup> restricted states' capacity to regulate self-insurers,<sup>19</sup> thus facilitating their entry into the insurance market. The amendments reversed the traditional regulatory power of state insurance commissions over potential entrants. Compliance with regulatory requirements in one state was given greater deference, and the definition of liability insurance covered by the statute was broadened.<sup>20</sup> Clearly, more competition in the industry was contemplated.<sup>21</sup>

The 1986 amendments, enacted during a perceived "crisis" in medical malpractice, would seem to be a response to the medical malpractice problem—at least when the latter is viewed from an insurance perspective. Entry barriers to the insurance market were reduced by concentrating state regulation of liability insurance carriers into single states.<sup>22</sup> This was a form of regulation that necessarily required federal intervention, yet was measured and respectful of state interests in the field.

### B. *Quality of Care*

Under general tort theory, the risk of adverse malpractice judgments—and their associated financial and reputational costs—deters poor quality medical care. From a quality of care perspective, then, the key question is whether this

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16. For a comprehensive discussion of the medical malpractice insurance industry, see FRANK A. SLOAN ET AL., *INSURING MEDICAL MALPRACTICE* (1991).

17. *Id.* at 59-72.

18. Pub. L. 99-563, 100 Stat. 3170 (codified at 15 U.S.C. §§ 3901-3906 (Supp. 1996)).

19. 5 U.S.C. §§ 3901(a)(4), 3902(a) (Supp. 1996).

20. *Id.* §§ 3901(a)(2), 3903(b)(2).

21. Pub. L. 99-563, § 11(b).

22. For a description of the federal risk retention legislation and how it works, see Maureen A. Sanders, *Risk Retention Groups: Who's Sorry Now?*, 19 S. ILL. U. L.J. 531 (1993).

deterrent system works in practice, and the available evidence is not altogether encouraging. We find, in fact, that many more medical injuries are attributable to malpractice than the number of claims filed would suggest.<sup>23</sup> If patients who can file successful malpractice claims are not doing so, the system is not eliminating the problem of poor medical practice. The issue becomes whether the malpractice system is achieving optimal deterrence of poor medical care.

Although physicians express concern that "defensive" medicine requires what they deem to be unnecessary procedures or tests, approaches characterized as "defensive" can sometimes be seen as improving quality-of-care.<sup>24</sup> Malpractice law does not require tests or procedures that are of no benefit. The contentious issue involves the degree of benefit to be derived from a particular test or procedure. The provision of services of no benefit is the easy case, although there is not always a consensus about what interventions bring about zero benefit and risk-averse providers may tend to err on the side of over-provision in the absence of countervailing factors. The appropriate analytical issue is whether optimal deterrence exists regarding the low-benefit but high-cost interventions.

Proponents of medical malpractice as a deterrent of poor quality care would justify some forms of "defensive medicine" as appropriate higher-quality medicine. Decreasing the range of diagnostic uncertainty is expensive. Doing more tests and securing additional increments of data give rise to better, albeit more expensive, science. Medical malpractice law reconfigures the cost/benefit calculation done by providers by putting them at risk for not pursuing tests or procedures that they would deem to be of low benefit and high cost.<sup>25</sup>

What are the consequences of a focus on quality-of-care issues as one's definition of the medical malpractice problem? The Health Care Quality Improvement Act of 1986<sup>26</sup> (HCQIA) was arguably a partial response to this perception of the medical malpractice issue.<sup>27</sup> HCQIA promoted peer review

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23. See HARVARD MEDICAL MALPRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990); PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 12-15 (1991).

24. There is a fundamental question of terminology regarding "defensive medicine." Properly understood, the term cannot apply to any difference in treatment or diagnosis from concerns about legal liability. Some shift in behavior in response to a cue from the tort system is, indeed, the very rationale of the deterrence objective of tort law. What "defensive medicine" must mean is over-deterrence—not just a response to a cue from malpractice law but an inappropriate response to that cue. This fundamental definitional nuance is what (among other methodological factors) makes identifying and measuring the "defensive medicine" phenomenon difficult indeed. For a general discussion of this set of issues, see OFFICE OF TECHNOLOGY ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE (1994).

25. Of course, the quality-enhancement function of medical malpractice can backfire to the extent that administration of additional tests or treatment—an ill-adaptive form of "defensive medicine"—is harmful to health. Malpractice law, however, does not mandate such harmful tests or treatment.

26. 42 U.S.C. §§ 11101-11152 (1994).

27. The legislative findings were quite clearly focused on concerns about quality-oriented aspects of medical malpractice. *Id.* at § 11101(1) (1994).

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activity in order to increase intra-professional oversight and to effect better, more rigorous and systematic monitoring of quality of care. As evidenced by its statutory findings, the clear aim of the Act was to reduce medical malpractice by promoting better quality medical care. Section 402(1), for example, notes that “[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state.”<sup>28</sup>

The legislation was driven, in part, by a sense of a special and appropriate federal interest in providing malpractice data across states.<sup>29</sup> The Act established a national data bank and required the reporting, collection and distribution of data to licensing boards, hospitals, health maintenance organizations and other health care providers that employ, contract with, or give clinical privileges to physicians.<sup>30</sup> Three types of information must be reported under the Act. First, any entity such as an insurance company that makes a payment in settlement of a malpractice claim must report information regarding the claim and associated circumstances, including the amount of payment, the type of malpractice alleged, and the injuries that resulted.<sup>31</sup> Second, any Board of Medical Examiners that sanctions a physician must report its action, the reasons for the action, and information respecting the circumstances.<sup>32</sup> Third, health care entities such as hospitals or HMOs must report on adverse peer review actions concerning a physician’s competence or professional conduct.<sup>33</sup> Reporting on peer review of non-physician providers is permitted but not required.<sup>34</sup> In all three situations, the required information must be reported to the appropriate state licensing board and to the clearing-house set up under contract with the federal government. Ultimate decision-making authority, however, remains unchanged.

### C. Compensation

Finally, with regard to victim compensation, the medical malpractice system is generally regarded as inefficient.<sup>35</sup> As a result of transactions and

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28. *Id.*

29. There was also a fear in Congress, stemming from a then-pending antitrust decision, that federal antitrust legislation might inhibit peer review activity. *See Patrick v. Burget*, 486 U.S. 94 (1988) (holding physicians liable under federal antitrust laws for bad-faith anticompetitive conduct under guise of hospital peer review).

30. 42 U.S.C. §§ 11131-11136 (1994).

31. *Id.* § 11131.

32. *Id.* § 11132.

33. *Id.* § 11133(a).

34. *Id.* § 11133(b).

35. *See generally* PATRICIA A. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 186-207 (1985). The justification for retention of the medical malpractice system is its role in quality assurance—the traditional deterrence effect of a tort regime.

other administrative costs associated with the filing and paying of claims, including the costs of full-scale litigation, a relatively low percentage of total dollars in the system is devoted directly to victim compensation.<sup>36</sup> This piece of the medical malpractice puzzle is perhaps the hardest to tackle from a federal perspective through instruments that are peculiarly proper for federal intervention. Even at the state level, these matters are still very much up in the air. Overall, there is little consensus on the solution to this aspect of the current malpractice problem.

#### IV. THE RECORD AND PROMISE OF STATE-BASED REFORM

State legislatures have a history of actively considering medical malpractice matters. A number of states have enacted so-called tort reform legislation in this area. Overall, medical malpractice has undoubtedly been a high priority issue on state political agendas.<sup>37</sup> There are reasons, however, to be skeptical of state political processes.

##### A. *State Statutory Barriers*

While some commentators propose private, contractual solutions to the medical malpractice problem,<sup>38</sup> the law in most states is hostile to the enforcement of contracts in this area.<sup>39</sup> These laws and doctrines are apparently premised on concerns about the insufficiency of consumer information and the disparity in bargaining power between provider and consumer.<sup>40</sup> Despite these concerns, however, there is no inherent reason why state political processes cannot accommodate appropriate contractual arrangements. All that is required is some legislative intervention at the state level.

With better information and improved bargaining parity, state law can be made more receptive to private contracting arrangements.<sup>41</sup> Principles of disclosure will become extremely important.<sup>42</sup> Bargaining imparities can be

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36. *Id.*

37. For a discussion of these medical malpractice reforms, see Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499, 511-55 (1989). For an evaluation of an earlier round of malpractice reforms, see Frank A. Sloan, *State Responses to the Medical Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. HEALTH POL., POL'Y & L. 629 (1985).

38. See, e.g., CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 265-302 (1994); Glen O. Robinson, *Rethinking the Allocation of Malpractice Risks between Patients and Providers*, LAW & CONTEMP. PROBS., Spring 1986, at 173, 182-99.

39. See HAVIGHURST, *supra* note 38, at 310.

40. See, e.g., *Tunkl v. Regents of the Univ. of Cal.*, 383 P.2d 441, 445-47 (Cal. 1963).

41. For a discussion of this set of issues, see HAVIGHURST, *supra* note 38, at 310-18.

42. See, e.g., *Madden v. Kaiser Foundation Hosps.*, 552 P.2d 1178, 1180-82, 1184 n.11 (Cal. 1976) (upholding arbitration clause in HMO contract negotiated by employer with adequate bargaining power and who adequately represented the interests of its employees despite possible lack of actual knowledge of arbitration clause by plaintiff employee).



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reduced by negotiating before the onset of disease.<sup>43</sup> Those negotiating on behalf of patients—probably a union or other employee group representative—should probably be patient fiduciaries.<sup>44</sup> State courts are likely to be more skeptical of contractual arrangements entered into by employers and health care providers on behalf of their employees.<sup>45</sup>

### B. State Constitutional Barriers

In some jurisdictions, state constitutional barriers may prove more formidable obstacles to contract-based reform.<sup>46</sup> Various state courts have interpreted state constitutional provisions more stringently than federal courts have construed parallel federal constitutional provisions. Where federal courts would apply a very deferential standard of review in equal protection analysis of special malpractice rules or damages caps,<sup>47</sup> a number of state courts have been much more searching in their scrutiny of state legislative reforms of this type.<sup>48</sup> Using an intermediate standard of scrutiny, some state courts have held that statutorily-based limitations on liability violate state equal protection provisions.<sup>49</sup>

In addition, there are constitutional theories unique to state constitutional interpretation; no parallel provisions exist in the federal constitution. In some jurisdictions, state constitutional provisions guaranteeing access to the courts require a quid pro quo for the abrogation or curtailment of common law remedies, and have thus been held to invalidate damages caps.<sup>50</sup> Courts

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43. See, e.g., *Emory Univ. v. Porubiansky*, 282 S.E.2d 903 (Ga. 1981) (declining enforcement of waiver of right to sue for negligence presented to patient at time procedure performed).

44. Cf. *Doe v. Group Hospitalization & Medical Servs.*, 3 F.3d 80 (4th Cir. 1993) (holding insurance carrier, in making benefits determination under medical insurance policy, to fiduciary standard).

45. See Blumstein, *supra* note 6, at 94-95.

One can hypothesize that judicial deference to and respect for contracting models will depend in part on the perception by courts of whether these cost-containment programs are redistributive takeaways, or whether they are aimed at rationalizing decisionmaking by encouraging decisionmakers to balance quality with cost. Similarly, one can predict that the confluence of interest between the beneficiary and the negotiator (e.g., an employee and an employee group) will be an important factor in legitimizing the contractual arrangement.

*Id.*

46. See generally James F. Blumstein & David R. Smith, *Constitutional Attacks on Medical Malpractice Laws*, in *LEGAL LIABILITY AND QUALITY ASSURANCE IN NEWBORN SCREENING* 167 (Lori Andrews ed. 1985).

47. See *Duke Power Co. v. Carolina Envtl. Study Group, Inc.*, 438 U.S. 59 (1978); *Davis v. Omitowoju*, 883 F.2d 1155, 1158-59 (3d Cir. 1989); *Boyd v. Bulala*, 877 F.2d 1191, 1196-97 (4th Cir. 1989).

48. See, e.g., *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156, 165-70 (Ala. 1991); *Brannigan v. Usitalo*, 587 A.2d 1232 (N.H. 1991). However, "the durability of tort reforms exceeds their general reputation." Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 N.W. U. L. REV. 908, 970 (1989).

49. See, e.g., *Carson v. Maurer*, 424 A.2d 825, 830-32, 836-39 (N.H. 1980).

50. *Kansas Malpractice Victims Coalition v. Bell*, 757 P.2d 251, 260 (Kan. 1988) ("[W]hen a common-law remedy is modified or abolished, an adequate substitute remedy must be provided to

applying the quid-pro-quo doctrine "substantively evaluate the fairness of the [reform provision], requiring that a cut-back in a common-law right be accompanied by a provision of a 'reasonable alternative remedy or commensurate benefit.'"<sup>51</sup> The lack of an adequate quid pro quo can only be justified, under this doctrine, by a state's establishing an "overpowering public necessity for the abolishment of the right and no alternative method of meeting such public necessity."<sup>52</sup>

State constitutional decisions that apply heightened scrutiny to invalidate various reforms such as damages caps do restrict the flexibility of state legislatures to enact medical malpractice reforms.<sup>53</sup> Nevertheless, these state court decisions reflect a minority viewpoint. Most state jurisdictions have either upheld state medical malpractice reforms<sup>54</sup> or failed to address the issue directly. This raises a rather fundamental question about the deference owed to state constitutional provisions. A strongly federalist position would defer to state political and constitutional processes. A non-deferential strategy might suggest federally-set standards.<sup>55</sup> An intermediate position would federally authorize state legislative reform, thereby in effect overruling state constitutional obstacles and allowing state legislative judgments to control.

Unless strong national interests are otherwise involved, the inability of state legislatures to respond because of state constitutional constraints should not be considered a deficiency in the state political system, nor thought to show that the issue of medical malpractice is not being actively debated within state politics. To the contrary, the state court decisions noted *supra* arise precisely because the issue *is* part of an active political debate, else there would be no reason for state judicial intervention. Alternative reforms may yet be found

replace it.").

51. Bovbjerg et al., *supra* note 48, at 971 n.264 (quoting *Smith v. Department of Ins.*, 507 So.2d 1080, 1088 (Fla. 1987)); *see also* *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988).

52. *Smith*, 507 So. 2d at 1088.

53. Note that damages caps have also been held to violate state constitutional rights to jury trial. The leading case is *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989); *see also* *Moore v. Mobile Infirmary Ass'n*, 592 So. 2d 156 (Ala. 1991). The leading state case rejecting the jury trial theory is *Etheridge v. Medical Center Hosps.*, 376 S.E.2d 525 (Va. 1989). For a discussion of this issue, *see* Bovbjerg et al., *supra* note 48, at 972-74.

Seventh Amendment jury trial challenges to damages caps under the federal constitution have been rejected. *Davis v. Omitowaju*, 883 F.2d 1155 (3d Cir. 1989); *Boyd v. Bulala*, 877 F.2d 1191 (4th Cir. 1989). Moreover, the Supreme Court has questioned whether the Seventh Amendment applies to the remedies phase of civil litigation. *See* *Tull v. United States*, 481 U.S. 412, 426 n.9 (1987) ("Nothing in the [Seventh] Amendment's language suggests that the right to a jury trial extends to the remedy phase of a civil trial . . . . We have been presented with no evidence that the Framers meant to extend the right to a jury to the remedy phase of a civil trial.").

54. *See, e.g.*, *Fein v. Permanente Medical Group*, 695 P.2d 665 (Cal. 1985), *appeal dismissed*, 474 U.S. 892 (1985); *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585 (Ind. 1990); *Peters v. Saft*, 597 A.2d 50 (Me. 1991); *Murphy v. Edmonds*, 601 A.2d 102 (Md. 1992); *Adams v. Children's Mercy Hosp.*, 832 S.W.2d 898 (Mo. 1992); *Etheridge v. Medical Center Hosps.*, 376 S.E.2d 525 (Va. 1989).

55. The House of Representatives has twice approved damages caps for medical malpractice awards in the 1995-96 session.

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viable within the constraints imposed by state constitutions.

### C. Federal Constraints

Further restraints on state-based reforms are imposed by existing federal legislation. Under the Supremacy Clause of the United States Constitution,<sup>56</sup> the federal government can preempt state legislation if acting pursuant to federal legislative power.<sup>57</sup> Malpractice preemption concerns arise in a number of areas, especially antitrust, labor, and employee benefits and pensions law. Where existing federal rules constrain state legislative flexibility, federally-based reform rests on a firmer foundation.

#### 1. Antitrust Law

Prior to the enactment of the Health Care Quality Improvement Act of 1986 (HCQIA),<sup>58</sup> there was concern about the ability of states to provide for hospital peer review. Since, by definition, peer review consists of evaluation by a physician's potential competitors, there was a risk that federal antitrust laws would prohibit the enforcement of peer review as anticompetitive.<sup>59</sup> HCQIA immunizes good faith peer review against the reach of federal antitrust law, thereby allowing states to pursue quality assurance through this approach.<sup>60</sup>

#### 2. Labor Law

By tradition, federal labor law preemptively and entirely precludes state legislative action in the field of labor-management collective-bargaining relations.<sup>61</sup> Consequently, any state legislative initiative to give legal effect to

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56. U.S. CONST. art. VI, cl.2.

57. See JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW 319 (5th ed. 1995).

58. 42 U.S.C. § 11111-11152 (1994).

59. See generally James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, 51 LAW & CONTEMP. PROBS. 7 (Spring 1988).

60. See *id.* at 32-34, 82-86. Prior to the enactment of HCQIA, states could provide for peer review as a form of quality assurance under the state-action antitrust immunity doctrine. See *Parker v. Brown*, 317 U.S. 341 (1943). To qualify for state-action protection, the arguably anticompetitive restraint must be "one clearly articulated and affirmatively expressed as state policy." *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980) (quoting *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978)). In addition, "the State must supervise actively any private anticompetitive conduct." *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 57 (1985). The "active supervision" component has been construed to require the actual exercise of decisionmaking authority by government—"serious, ongoing state involvement in the nitty gritty of decisionmaking . . ." James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1502 (1994). The kind of general hospital regulation that typifies most state laws is insufficient to satisfy state-action requirements. See *Patrick v. Burget*, 486 U.S. 94 (1988).

61. See *Lodge 76, Int'l Ass'n of Machinists & Aerospace Workers v. Wisconsin Employment Relations Comm'n*, 427 U.S. 132 (1976); *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236 (1959).

or put constraints upon labor-management collective agreements<sup>62</sup> with respect to medical malpractice standards or remedies must be consistent with federal labor law. To the extent that state legislative initiatives are barred by federal labor policy,<sup>63</sup> federal legislation could be justified as allowing state experimentation to proceed.

### 3. *Employee Benefits and Pensions Law*

A similar set of issues arises with respect to federal preemption under the Employee Retirement Income Security Act of 1974 (ERISA).<sup>64</sup> ERISA's preemption provision is quite broad, barring any state law that "relate[s] to" qualified employee benefit plans,<sup>65</sup> and has been construed by the Supreme Court to preempt state legislation that has "a connection with or reference to such a plan,"<sup>66</sup> even where state law is of general application and not directed explicitly at ERISA plans.<sup>67</sup> ERISA therefore places considerable limits upon state legislation.<sup>68</sup>

The interrelationship between the ERISA preemption provision and state medical malpractice claims has recently received considerable attention from the federal courts. In *Corcoran v. United HealthCare, Inc.*,<sup>69</sup> the Fifth Circuit staked out a strong ERISA preemption position. An employee under an ERISA health plan sued the employer's utilization review company for negligent denial of hospital inpatient certification that allegedly resulted in a miscarriage. The court upheld the dismissal of the suit on grounds of ERISA preemption. Even though a utilization review decision has a medical decisionmaking component, the court concluded that those decisions were "part and parcel" of

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62. See, e.g., *Allis-Chambers Corp. v. Lueck*, 471 U.S. 202 (1985) (holding state tort claim for bad-faith handling of an insurance claim preempted under federal labor law and therefore subject to collective bargaining agreement).

63. Cf. *Livadas v. Bradshaw*, 114 S. Ct. 2068 (1994) (holding state statute preempted by federal labor law).

64. ERISA's preemption provision is at 29 U.S.C. § 1144(a) (1994).

65. ERISA contains a saving clause that exempts from preemption state laws that regulate the business of insurance. 29 U.S.C. § 1144(b)(2)(A) (1994). This manifests respect for the states' traditional role in the regulation of insurance. However, state laws that purport to regulate the business of insurance cannot deem an employee benefit plan to be in the business of insurance. 29 U.S.C. § 1144(b)(2)(B) (1994).

66. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983).

67. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) ("[A] state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect.").

68. Some greater flexibility in the health regulation arena is suggested by the Supreme Court's recent decision *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995) (upholding hospital surcharges under ERISA challenge). See generally Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255 (1996).

69. 965 F.2d 1321 (5th Cir. 1992), cert. denied, 113 S. Ct. 812 (1992).

determining “what benefits are available” under the employer’s ERISA plan.<sup>70</sup> Accordingly, plaintiffs were “attempting to recover for a tort allegedly committed in the course of handling a benefit determination.”<sup>71</sup> ERISA preempted such a claim,<sup>72</sup> even if based on a theory of medical malpractice.<sup>73</sup>

*Corcoran* admittedly left plaintiffs without a remedy for what may have been an error in medical judgment, and that troubled the Fifth Circuit.<sup>74</sup> From a federalism perspective, such restrictions on traditional state malpractice actions are problematic, especially where preemption of state tort policies and associated remedies leaves a potential victim remediless. Indeed, though *Corcoran* has been followed elsewhere,<sup>75</sup> certain other circuits have taken a different tack. In *Pacificare of Oklahoma, Inc. v. Burrage*,<sup>76</sup> the Tenth Circuit found that ERISA did not preempt a medical malpractice claim based on vicarious liability against an ERISA HMO for the conduct of one of its doctors.

Similarly, in *Dukes v. U.S. Healthcare, Inc.*,<sup>77</sup> the Third Circuit rejected an ERISA preemption attack on a medical malpractice action against an HMO. The decisionmaking body challenged in *Corcoran* “only performed an administrative function inherent in the ‘utilization review.’”<sup>78</sup> Preemption therefore followed. In *Dukes*, however, the defendant HMOs arranged for and supervised the physicians who actually provided medical treatment to plan participants. In arranging for treatment—in contrast to engaging in utilization review—the HMOs were not in a position to deny ERISA benefits. For the *Dukes* court, only the utilization-review role was protected by ERISA preemption; when arranging for members’ medical treatment, ERISA HMOs would not be immune from conventional state actions for medical malpractice.<sup>79</sup>

A strong case for federal legislation can be made when state legislative reform is constrained by existing federal restrictions. Although subsequent decisions have offset many of the misgivings engendered by *Corcoran*, it is nevertheless appropriate to ask whether, as the court in that case intimated, federal liberalization to accommodate state tort policies is worth further consideration. Clearly, it is costly to reinvent the wheel on a state-by-state basis. The pro-federalism position, however, would assert that the advantages

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70. The court seemed to acknowledge that a purely medical-treatment decision would not result in preemption. *Id.* at 1333 n.16.

71. *Id.* at 1332.

72. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987).

73. For a thoughtful discussion of the *Corcoran* case, see Frankel, *supra* note 6, at 1310-14.

74. 965 F.2d at 1338-39.

75. See *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir. 1993).

76. 59 F.3d 151 (10th Cir. 1995).

77. 57 F.3d 350 (3d Cir. 1995).

78. *Id.* at 360.

79. *Id.* at 360-61. *Accord* *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995).

of experimentation outweigh such costs. An efficiency argument can be made where a clear and uniform approach with a national consensus exists. This is surely not the situation in the medical malpractice arena in any broad, comprehensive sense. Except, possibly, with regard to existing federal constraints on state legislative authority, the case for significant or comprehensive federal regulation has not been made.

## V. COMPARATIVE FEDERAL ADVANTAGES

There are a number of areas in which the federal government might have a special comparative advantage. First, it has a special interest in developing pilot programs.<sup>80</sup> These demonstration projects would be of national benefit. In economic terms, any state that carries on an experiment is providing an external benefit to other states. The benefit accrues to others, yet the single state puts up the money for the demonstration. There is therefore a strong economic argument for the federal government to sponsor demonstrations that nationally internalize benefits external to any individual state.

The federal government also has a particular interest in the malpractice problem as it relates to its own employees and public beneficiaries. Public dollars are expended with the provision of services to federal civilian and military employees (covered under the federal employee health benefits programs CHAMPUS and FEHBP) and to public beneficiaries (Medicare and Medicaid recipients). Here, the federal government has a clear concern with quality of care and cost issues, and, to the extent that medical malpractice occurs, with victim compensation also. If systemic inefficiencies raise the costs of achieving compensation goals, the government as payor has a particular interest, and to the extent that the system of medical malpractice is not performing its deterrence function adequately, the federal government as payor has a particular quality-of-care concern with respect to these groups.

A third area in which the federal government has a special comparative advantage focuses upon research and data distribution. Research benefits accrue broadly to the entire nation, which suggests that federal financing is appropriate for such public goods. Federal requirements for recordkeeping, data acquisition and dissemination help to perfect the market in ways that are unavailable to individual states. Since state jurisdictions are more limited than regional or national medical markets, requirements for recordkeeping and data acquisition can be more effectively and efficiently enforced at the federal level. This seems to be the rationale behind the federal data bank established under HCQIA.

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80. The Clinton Administration's healthcare reform proposal included an enterprise liability experiment. For a description of the enterprise liability concept and its rationale, see Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381 (1994).

## VI. A CONTINUUM OF POTENTIAL FEDERAL INVOLVEMENT

Based upon the foregoing considerations regarding federal intervention, one can develop a continuum of potential federal involvement. At one end of the spectrum, the federal government could simply ignore federalism. The Supreme Court has construed the Commerce Clause so broadly that large-scale federal intervention in the medical malpractice area is almost certainly constitutionally valid. The federal government could therefore act comprehensively, as if it were a state legislature. Based upon the preceding analysis, however, this would be unwise and certainly premature. There is no evidence that Congress has any such plans under consideration at present.<sup>81</sup>

The federal government could embark on a more modest preemption strategy. If the federal government were to embrace a pilot program strategy, for example, it could develop a legal framework applicable to that pilot program and preempt state legislation that would otherwise be applicable to the participants in the pilot program. This strategy would give some integrity to the experimental character of a federally-sponsored program, but would not intrude upon state prerogatives in other areas—or at least not until the results of the experiments were analyzed and digested.

Another type of federal involvement would be a federal requirement that mandates state consideration, but not enactment, of a set of federally-specified alternatives. This approach was used in the Public Utility Regulatory Policies Act (PURPA),<sup>82</sup> and subsequently upheld against constitutional challenge by the Supreme Court.<sup>83</sup> It would set a timetable and agenda for state legislative consideration of potential approaches set forth in federal legislation, but not mandate enactment of any particular alternative. This type of approach might seem justified were states failing to grapple with medical malpractice issues. But this does not seem to be the case. State legislatures have a history of dealing with medical malpractice questions as the perceived need arises. The issue percolates to the top of state legislative agendas on its own. The PURPA-type approach appears needlessly intrusive for the area of medical malpractice.

A further alternative would be to authorize state action in reliance on federal legislation.<sup>84</sup> This would overcome state constitutional limits to state

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81. Congress has acted comprehensively with regard to national standards for products liability. That legislation was vetoed by President Clinton. The federalism case for or against national products liability standards must rise or fall on its own merits, but clearly the interstate dimension of products standards makes them *prima facie* more suitable for federal involvement. *See supra* Part I.

82. 16 U.S.C. §§ 2601-2645 (1994); 15 U.S.C. §§ 3201-3211 (1994); 16 U.S.C. § 324A-3 (1994).

83. *Federal Energy Regulatory Comm'n v. Mississippi*, 456 U.S. 742 (1982). The present status of this decision, however, is somewhat uncertain. *See New York v. United States*, 112 S. Ct. 2408 (1992) (barring federal commandeering of state government to accomplish federal policy objectives).

84. Federal legislation could authorize private contractual reforms, thus clarifying the legal authority for such conduct. *See supra* Section IV. To the extent that federal labor law or ERISA impedes

legislation. The proposed federal damages cap on medical malpractice awards for noneconomic loss<sup>85</sup> can arguably be explained—albeit not justified—on this basis.<sup>86</sup> An alternative to a federal damages cap might be the extension of the federal data-gathering mission from reporting money paid out from malpractice claims (under HCQIA) to specific identification of and inclusion of jury awards in medical malpractice actions. These national data could then enable states to implement proposals for modified scheduling of damages for pain and suffering, the most variable components of damage awards.<sup>87</sup> This federal data collection role, already in place in the broad context of malpractice awards and settlements, would be expanded under proposed legislation;<sup>88</sup> the particularized data requirements for achieving some form of modified scheduling could easily be added to the existing system or the proposed expanded system. Moreover, this approach would comport with an appropriate federal role in gathering and providing data while not coercing or substituting for state policy.<sup>89</sup>

A final approach would be for the federal government to place conditions on specific or general federal spending programs. This has been the approach used in the area of organ transplantation.<sup>90</sup> Any center that gathers or transplants organs must participate in a national network if it wishes to retain its participation in and reimbursement from Medicare. In theory, this approach is less intrusive on state autonomy, because it places conditions on federal spending programs from which the states are free to abstain. The degree of federal intrusion is directly related to the centrality of the federal programs to which the conditions are linked. Participation in Medicare or Medicaid, for example, is so fundamental that linkage to either of those programs is virtually identical in practice to a comprehensive federal regulatory system. Linkage to

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that development, a strong federalism argument can be made in support of such an initiative. Explicit legislative authorization may be unnecessary, however, since at least one court of appeals has suggested that ERISA may authorize private contracting with regard to medical malpractice issues:

It may well be that an employer and an HMO could agree that a quality of health care standard articulated in their contract would replace the standards that would otherwise be supplied by the applicable state law of tort. We express no view on whether an ERISA plan sponsor may thus by contract opt out of state tort law and into a federal law of ERISA contract.

*Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 359 (3d Cir. 1995).

85. Health Coverage Availability and Affordability Act of 1996, H.R. 3103, 104th Cong., 2d sess., § 282(a)(1) (1996) (limiting noneconomic loss to \$250,000).

86. See *supra* Section IV.

87. See James F. Blumstein et al., *Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury*, 8 YALE J. ON REG. 171 (1991). In jurisdictions that have invalidated damages caps, implementation of a modified scheduling approach would likely pass constitutional muster. See Bovbjerg et al., *supra* note 48, at 969-74.

88. H.R. 3103, 104th Cong., 2d Sess., § 221 (establishing data collection system for civil judgments against health care providers, suppliers or practitioners "related to the delivery of a health care item or service").

89. This would leave to the states the actual substantive implementation of such an approach.

90. See generally James F. Blumstein, *Federal Organ Transplantation Policy: A Time for Reassessment?*, 22 U.C. DAVIS L. REV. 451 (1989).



## Federalism and Medical Malpractice

more modest federal programs is obviously less potent but also, for that reason, shows greater respect for state autonomy.<sup>91</sup>

### CONCLUSION

In conclusion, there is a continuum of potential federal intervention regarding medical malpractice issues. There has been federal intervention on insurance questions and on quality of care through peer review, as well as recent activity regarding damages caps for noneconomic loss in medical malpractice cases. For sound reasons, there has been relatively little federal initiative on medical malpractice standards. I have suggested, as an alternative, a federal data-gathering role consistent with the existing medical practice data bank. Such an approach would facilitate state adoption of a form of modified scheduling and other approaches toward normalizing awards for pain and suffering, the most divergent and unpredictable element of damages in medical malpractice awards. It would also be consistent with federal comparative advantages and would not intrude on state policymaking.

In addition, the federal government might consider a pilot program for its own special constituencies—federal employees who participate in the CHAMPUS and FEHBP programs, and public beneficiaries who participate in the Medicare and Medicaid programs. The pilot program could authorize private contracting in a certain set of circumstances. Presumably, it would specify criteria for dissemination of information, disclosure by providers to their patients, and establishing parity of bargaining power between employee/beneficiary patients and their providers. Such a program should also specify the scope of provisions within a contract that could be subject to negotiation: limitations on punitive damages; development of an HMO standard of care to govern medical malpractice actions; development of informed consent rules different from existing state law; contracting for a schedule of damages. For purposes of the pilot program, the federal government could preempt state law to allow the pilot to serve as an experiment, providing information to policy analysts and policy makers.<sup>92</sup>

Finally, the federal government might look at the immunity provision of the existing PRO law. The provisions of the PRO law (and of the preceding PSRO legislation) have never been cited as definitively establishing a defense in a reported appellate case. It would be useful to inquire why that immunity provision has never been used. Its disuse is unlikely to mean that the law has

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91. The Supreme Court has expressed little interest in developing significant constitutional obstacles to the linkage of federal spending and federally-imposed conditions on that spending. *See South Dakota v. Dole*, 483 U.S. 203 (1987).

92. Other demonstration programs could encompass systems of enterprise liability and/or development and implementation of a system of modified scheduling of damages for pain and suffering.

been very effective. If it has in fact been ineffective, then it is useful to ask why and to determine whether that type of immunity provision should be re-worked. This issue is likely to become of particular significance as managed care becomes of greater importance for Medicare and Medicaid beneficiaries because of the cost-containment incentives stemming from pre-payment and capitation (paying a specified amount per enrollee). The relationship between fixed-payment schemes and alternative practice styles and medical malpractice—and the role of the PRO immunity provision—is certainly worthy of further investigation at the federal level.