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NOTES

Who Is a Health Care Provider?: Statutory Interpretation as a Middle-Ground Approach to Medical Malpractice Damage Caps

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Abstract

Debates over the effectiveness, constitutionality, and fairness of medical malpractice damage caps are as old as the laws themselves. Though some courts have struck down damage caps under state constitutional provisions, the vast majority hesitate to invalidate malpractice reform legislation. Instead, statutory interpretation offers a non-constitutional method of challenging the broad scope of damage caps without fully invalidating legislative efforts to curtail "excessive" malpractice liability. This Note examines the term "health care providers" in construing malpractice reform laws and identifies two predominant forms of statutory interpretation that state courts apply. In doing so, this Note offers recommendations for courts and legislatures to best balance the goals of the malpractice reform movement with patients' interests in recovery for medical injuries.

Keywords: medical malpractice; damage caps; statutory interpretation

Introduction

Few other practice areas spur the same type of polarized attitudes than those adopted by plaintiffs' lawyers and physicians in the field of medical malpractice. On one side, medical professionals blame "ambulance-chasing" lawyers for forcing doctors to practice defensive medicine, thereby raising the cost of health care.[1] On the other, patient advocacy groups argue that enhanced liability holds health care providers responsible and vindicates victims of preventable medical errors.[2] Medical malpractice's

[1] *See* John Gibeaut, *The Med-Mal Divide: As the AMA Talks Up Damage Caps and Specialty Courts, Solving the Medical Malpractice Clash May Require Bridging the Lawyer-Doctor Culture Gap*, ABA J., Mar. 2005, at 39, 41 ("The AMA's suggested legislation rests on the premise that 'under the current system awards often are based on the level of injury, not the incidence of malpractice.' As a result, distrusting physicians avoid lawsuits by practicing defensive medicine, ordering more tests and other procedures or sending patients elsewhere at a cost of 'billions of dollars.'"); Jeffrey A. Singer, *The Case Against National Medical Malpractice Reform*, Reason (Apr. 4, 2017, 12:00 PM), https://reason.com/2017/04/04/the-case-against-national-medical-malpra/ [https://perma.cc/F66G-UCYS] ("Generations of practicing under the threat of malpractice suits have changed the culture of medical practice. Ordering expensive, redundant, and possibly unneeded tests is now baked into the cake. Doctors are trained through medical school and postgraduate residency programs to lean heavily on testing—from blood tests to high-tech imaging—in their diagnosis and treatment.").

[2] *See Op-Ed: To Solve the Malpractice Insurance Crisis, Roll Back Rates, Not Rights*, Consumer Watchdog, (Feb. 6, 2003), https://consumerwatchdog.org/uncategorized/op-ed-solve-malpractice-insurance-crisis-roll-back-rates-not-rights/ [https://perma.cc/7XXC-7XVP] (arguing that California's medical malpractice damage caps undermine "the powerful incentive for quality care provided by the threat of a lawsuit"); *see also* Martin A. Makary & Daniel Michael, *Medical Error-the Third Leading Cause of Death in the US*, 353 Brit. Med. J. 2139, 2140 (2016) (finding that "medical error is the third most common cause of death" in the United States).

impact extends far beyond the contractual obligations of doctor-patient relationships. In the United States in 2013 alone, an estimated 251,000 patients died as a direct result of medical error.[3] Medical errors also impose significant constraints on the U.S. economy, costing roughly twenty-seven billion dollars annually when adjusted for inflation.[4]

High-profile medical malpractice lawsuits and subsequent media attention on medical errors have contributed to a widespread perception of a severe "medical liability crisis." Alongside high injury rates, large jury verdicts against medical device manufacturers and negligent physicians fuel concerns that the medical liability system is broken and prevents physicians from effectively treating patients.[5] While the frequency and number of medical liability lawsuits vary by state and region, politicians and advocacy groups have not hesitated to declare a nationwide "full-blown medical liability crisis."[6] During the third so-called malpractice crisis in the early 2000s, seventy-one percent of surveyed respondents blamed medical malpractice litigation as "one of the primary factors driving up health care expenses," while eighty-four percent believed that medical liability "threatened" health care quality and access by forcing health care providers to "abandon the practice of medicine."[7] Even though plaintiffs currently file medical malpractice claims at "[historically] low" rates, some specialists have reported changing their practices "due to the affordability and/or availability of medical professional liability insurance."[8] To respond to this perceived medical liability crisis, many states limit the amount of some winnable damages in medical malpractice actions through statutory caps.[9]

Malpractice damage caps, along with other procedural malpractice laws, are largely a matter of state law. Caps generally limit damages in medical malpractice claims brought against a health care provider, yet states vary in defining who qualifies as a "health care provider."[10] Since enactment, some state supreme courts have struck down malpractice damage caps on various state constitutional

[3]Makary & Michael, *supra* note 2, at 2140.

[4]Jon Shreve et al., Milliman, The Economic Measurement of Medical Errors 5 (2010), https://www.soa.org/49386b/globalassets/assets/files/research/projects/research-econ-measurement.pdf (reporting that medical errors cost the United States' economy roughly nineteen-and-a-half billion dollars in direct costs and one-and-a-half billion in indirect costs in 2008 alone).

[5]*See* Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 Penn St. L. Rev. 1077, 1079 (2004); Robert Glatter, *Medical Malpractice: Broken Beyond Repair?*, Forbes (Feb. 6, 2013, 7:30 AM), https://www.forbes.com/sites/robertglatter/2013/02/06/medical-malpractice-broken-beyond-repair/?sh=2f029f7d6b78 [https://perma.cc/UJ8G-WZY7] (arguing that the current medical liability system forces physicians to divert time away from patients to address "frivolous" malpractice claims).

[6]*The Medical Liability Crisis*, Am. Coll. of Surgeons, https://www.facs.org/advocacy/federal-legislation/liability/guide-to-liability-reform/the-medical-liability-crisis/#:~:text=A%20Health%20Coalition%20on%20Liability,behind%20rising%20health%20care%20costs [https://perma.cc/9QH2-ET8H] (last visited Apr. 20, 2023) (claiming that more than thirty states "face a 'looming' [medical liability] crisis"); *see* Chad Terhune, *Leading Republicans See A Costly Malpractice Crisis - Experts Don't*, Kaiser Health News (Jan. 4, 2017), https://kffhealthnews.org/news/leading-republicans-see-a-costly-malpractice-crisis-experts-dont/ [https://perma.cc/2F8H-ZTGQ] (describing House Republicans' plan to pass national medical tort reform legislation in response to a "medical malpractice crisis [that] is threatening U.S. health care").

[7]*Data and Resources*, Health Coalition on Liability and Access, https://web.archive.org/web/20040221025636/http://www.hcla.org/polls.html [https://perma.cc/R2JH-DMA4] (Feb. 2003) (last visited Apr. 21, 2023).

[8]Phillip M. Cox, II & Edmund F. Funai, *The Best of Times or the Worst of Times? A Tale of Two Surveys: OB/GYNs' Fear of Being Sued May Be Disproportionate To The Frequency of Malpractice Claims*, 61 Contemporary OB/GYN 26, 27 (2016) (reviewing OB/GYN survey results to conclude that roughly forty percent of respondents report having made changes to their clinical practice due to malpractice insurance trends, such as early retirement, reducing work hours, and transferring to non-clinical settings).

[9]Ctr. for Just. & Democracy, *Fact Sheet: Caps On Compensatory Damages: A State Law Summary* (Aug. 22, 2020), https://centerjd.org/content/fact-sheet-caps-compensatory-damages-state-law-xsummary#_ftnref10 [https://perma.cc/HG93-9JZD] (twenty-two states impose statutory caps on non-economic damages, and six states cap total damages for medical malpractice actions).

[10]*See* Neb. Rev. Stat. Ann. § 44-2803 (2005) (defining health care provider as "(1) A physician; (2) a certified registered nurse anesthetist; (3) an individual, partnership, limited liability company, corporation, association, facility, institution, or other entity authorized by law to provide professional medical services by physicians or certified registered nurse anesthetists; (4) a hospital; or (5) a personal representative…"); Ind. Code Ann. § 34-18-2-14 (2016) (comprehensively defines "health care provider" as "[a]n individual, a partnership, a limited liability company, a corporation, a professional corporation, a facility, or

grounds.[11] Other states explicitly proscribe legislatures from enacting damage caps in their constitutions.[12] However, most states maintain some form of statutory limit on medical malpractice damages, which routinely survive constitutional challenges.[13]

For the time being, most medical malpractice caps are immune to constitutional attack. I propose narrowing interpretations of existing statutes as a middle-ground approach to limiting the effects of existing medical malpractice caps. Specifically, I argue that states should expand medical liability through stricter judicial and legislative definitions of the term "health care provider" in damage caps statutes.

I argue that broad, non-exhaustive definitions of "health care providers" in damage caps statutes are inconsistent with those statutes' original policy purposes and unfairly benefit defendants that legislatures did not intend to protect from large damage awards. This Note proceeds in four parts. Part I explains the policy purposes and legal mechanisms of medical malpractice caps, as well as the varying approaches state legislatures use to define "health care providers." Part II explores how a jurisdictional split in statutory interpretation produces different results for plaintiffs and certain types of defendants, such as pharmacies and large medical corporations. Part III discusses the problems inherent in broad definitions of "health care provider." Then, this section proposes that the historical background and policy rationales of damage caps support a narrow reading of "health care providers" within existing statutes. I argue that restricting "health care providers" to individual practitioners and hospitals will still protect those providers from excessive litigation while avoiding windfalls for non-hospital corporate institutions. Finally, Part IV concludes by recommending legal challenges to statutory definitions of "health care providers" as an effective, non-constitutional line of attack for the malpractice reform movement.

I. Background

A. The History of Medical Malpractice Reform

Prior to the medical malpractice reform movement, the common law rules of tort vested the authority to determine damages solely with the fact finder.[14] Though legislatures could modify substantive law

an institution license or legally authorized by this state to provide health care or professional services as a physician, psychiatric hospital, health facility, emergency ambulance service, dentist, …" as well as a "blood bank, community mental health center, community intellectual disability center, community health center, or migrant health center"); Cal. Civ. Code § 3333.2(j)(1) (West 2023) ("any persons licensed or certified pursuant to Division 2," "the legal representatives of a health care providers and the health care provider's employer, professional corporation, …"); S.C. Code Ann. § 15-79-110(3) (2005) ("'Health care provider' means a physician, surgeon, osteopath, nurse, oral surgeon, dentist, pharmacist, chiropractor, optometrist, podiatrist, or any similar category of licensed health care provider, including a health care practice, association, partnership, or other legal entity").

[11] *See* Sofie v. Fibreboard Corp., 112 Wash. 2d 636, 771, 729 (Wash. 1989) (holding that Washington's cap on noneconomic damages violated the state constitution's right to jury trial in undermining the jury's role in determining damages); Carson v. Maurer, 424 A.2d 825, 838 (N.H. 1980) (finding that parts of state medical malpractice statute violated the state constitution's equal protection clause by arbitrarily discriminating against malpractice victims with damages exceeding the statutory cap); Lebron v. Gottlieb Mem'l Hosp., 930 N.E.2d 895, 914 (Ill. 2010) (ruling that state noneconomic damage cap violated the state constitution's separation of powers provision by forcing courts to override juries' independent determinations of damages for malpractice victims).

[12] *See* Ariz. Const. art. II, § 31 ("No law shall be enacted in this state limiting the amount of damages to be recovered for causing death or injury of any person…"); Ark. Const. art. V, § 32 ("[N]o law shall be enacted limiting the amount to be recovered for injuries resulting in death or for injuries to persons or property; and in case of death from such injuries the right of action shall survive, and the General Assembly shall prescribe for whose benefit such action shall be prosecuted"); Ky. Const. § 54 ("The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property."); Wyo. Const. art. X, § 4 ("No law shall be enacted limiting the amount of damages to be recovered for causing the injury or death of any person.").

[13] *See* Ordinola v. Univ. Physician Assocs., 625 S.W.3d 445, 454 (Mo. 2021) (holding that non-economic damage caps did not deprive malpractice plaintiffs of the state constitution's right to trial); Hoffman v. United States, 767 F.2d 1431, 1437 (9th Cir. 1985) (ruling that California's medical malpractice damage cap did not violate the federal Equal Protection Clause); Watson v. Hortman, 844 F. Supp. 2d 795, 802 (E.D. Tex. 2012) (rejecting medical malpractice plaintiffs' argument that Texas's damage caps statute infringes on potential plaintiffs' property rights under the Fifth Amendment Takings Clause).

[14] Shaakirrah R. Sanders, *Deconstructing Juryless Fact-Finding in Civil Cases*, 25 Wm. & Mary Bill Rts. J. 235, 293 (2016) (noting that damage caps "are unlike anything recognizable in the common law"); Watts v. Lester E. Cox Med. Centers,

through statute, fact finders assessed damages on a case-by-case basis and were not subject to one-size-fits-all monetary limits.[15] Legislative damage caps, especially those limiting awards in medical malpractice actions, fundamentally modified the common law by restricting the jury's ability to fully assess damages.[16]

Commentators often defend damage caps by pointing to the "medical malpractice crisis" in the 1970s.[17] If legislatures overturn the caps, they argue, malpractice insurance premiums will once again skyrocket and force doctors to either stop performing higher-risk surgeries or retire.[18] However, the malpractice crisis was not a singular event, but three separate periods of heightened medical malpractice premiums during the mid-1970s, the mid-1980s, and the early 2000s.[19]

In the 1960s and 1970s, American media outlets began to focus on a perceived spike in medical malpractice litigation.[20] Malpractice claims rose during this period, which the media attributed to the "breakdown of the intimate [doctor-patient relationship]."[21] Heightened attention on physician incompetence, highly publicized medical malpractice trials, and large jury awards fueled patients' distrust in doctors, ostensibly encouraging lawsuits in the absence of medical errors.[22]

Heightened attention on rising malpractice premiums prompted lawmakers to craft laws to curb the number and frequency of medical malpractice claims. In the early 1970s, American doctors witnessed an unexpected spike in medical malpractice insurance premiums.[23] Many premiums nearly doubled, and in some cases increased by five-hundred percent.[24] Commentators and politicians dubbed this period of higher rates a "malpractice crisis" and blamed the spike on a "broken medical liability system" that enabled frivolous claims against physicians in high-risk specialty practices.[25] Placing the malpractice "crisis" solely on the shoulders of the tort system further fueled public fears that unaffordable premiums would force out doctors in high-risk specialties.[26] Reports of doctors retiring early and medical residents switching fields of study energized state politicians to commission panels to study the roots of the "medical liability crisis."[27] Some insurers ceased issuing medical malpractice insurance policies altogether, aggravating the situation and tightening an already troubled insurance market.[28] In major metropolitan areas, doctors protested against high malpractice premiums through organized strikes, in some cases refusing to treat non-emergency patients.[29]

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376 S.W.3d 633, 639 (Mo. 2012) (finding that statutory caps on jury awards were foreign to the common law at the time that Missouri ratified its constitution).

[15]Watts, 376 S.W.3d, at 639.

[16]Sanders, *supra* note 14, at 239.

[17]Breanna Hardy, *Doctors Speak Out On Malpractice Proposition Coming Before Voters*, Bus. J. (Dec. 10, 2021, 1:19 PM), https://thebusinessjournal.com/doctors-speak-out-on-malpractice-proposition-coming-before-voters/ [https://perma.cc/CKM3-CNLU] (reporting that California doctors argue that the legislature's proposal to raise malpractice damage caps will reignite another malpractice crisis and drive doctors out of rural areas).

[18]*Id.*

[19]Leonard J. Nelson, III et. al., *Medical Malpractice Reform in Three Southern States*, 4 J. Health & Biomedical L. 69, 71-72 (2008).

[20]Nathanson, *supra* note 5, at 1079.

[21]*Id.* at 1080.

[22]*Id.*

[23]*Id.* at 1079.

[24]Frank A. Sloan, *State Responses to the Malpractice Insurance "Crisis" Of the 1970s: An Empirical Assessment*, 9 J. Health Pol. Pol'y L. 629, 629 (1985).

[25]Am. Med. Ass'n, *From the AMA.: Medical Malpractice Reform*, N.Y. Times, Oct. 15, 2011, https://www.nytimes.com/2011/10/16/opinion/sunday/from-the-ama-medical-malpractice-reform.html [https://perma.cc/8HUZ-LXVZ]; Marc A. Rodwin, Justin Silverman, & David Merfield, *Why the Medical Malpractice Crisis Persists Even When Malpractice Insurance Premiums Fall*, 25 Health Matrix 163, 167 (2015) (referring to state and federal legislators expressing concern that rising insurance premiums will force specialists out of practice and deter medical students from entering specialized fields).

[26]Rodwin, *supra* note 25, at 167.

[27]*Id.*

[28]Nathanson, *supra* note 5, at 1080.

[29]Rodwin, *supra* note 25, at 168.

States swiftly enacted malpractice regulations in response to the first malpractice premium spike.[30] State legislatures passed medical malpractice caps as part of a series of a broader "medical malpractice reform" movement.[31] Reform legislation often modified common law tort doctrine through narrowing statutes of limitations, mandating physician-staff medical tribunals for potential claimants, and capping some forms of damages in malpractice lawsuits.[32] By the late 1970s, nearly every state had passed procedural and substantive limitations on medical liability.[33]

Some scholars still dispute the precise causes of the malpractice insurance crises.[34] The conventional view blames premium hikes on increases in successful medical malpractice claims and high jury awards.[35] Others argue that the malpractice insurance industry, rather than the tort litigation system, incited an industry-wide panic in what was actually a short period of localized loss.[36] On this view, larger malpractice insurers experienced a downturn in profitability in the mid-1970s due to losses in the stock market, which spurred the rest of the industry into a widespread overreaction.[37] Some evidence exists to credit this theory, as government agencies have recognized decreased competition and insurance investments as contributing to later malpractice premium hikes.[38]

B. Medical Malpractice Damage Caps

Plaintiffs may recover a variety of damages in successful medical malpractice lawsuits. While economic damages may encompass past, present, and future physical harms stemming from medical injury, non-economic damages compensate victims of medical error for non-pecuniary harms affecting quality of life.[39] Non-economic damages might include loss of consortium, pain and suffering, and loss of life enjoyment.[40] Punitive damages, rather than compensating plaintiffs, target intentional and wanton conduct by imposing additional monetary awards on tortfeasors.[41]

Despite failed calls for national tort reform, states vary substantially in their medical malpractice laws. Twenty-nine states currently enforce legislative caps on damages in civil medical malpractice litigation.[42] While most states enforce caps on non-economic damages, six states limit the total damages in medical malpractice claims, including punitive and economic damages.[43] In Louisiana, most plaintiffs may not recover more than five-hundred-thousand dollars total in successful medical malpractice lawsuits, regardless of the plaintiff's actual injuries.[44] In addition to states with total caps, thirteen states impose caps on punitive damages for medical liability.[45]

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[30]Sloan, *supra* note 24, at 633.

[31]Nelson, *supra* note 19, at 71-72.

[32]Sloan, *supra* note 24, at 633-636.

[33]Medical Malpractice, Ins. Info. Inst., https://www.iii.org/issue-update/medical-malpractice [https://perma.cc/QL8N-NMZW] (last visited Apr. 21, 2023).

[34]Sloan, *supra* note 24, at 635.

[35]*Id.* at 632.

[36]Sylvia Law & Steven Polan, Pain and Profit: The Politics of Malpractice 171 (1978).

[37]*See* Sloan, *supra* note 24, at 632-633; Law & Polan, *supra* note 36, at 171.

[38]U.S. Gen. Acct. Off., Rep. No. GAO-03-702, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, 15 (June 2003), http://www.gao.gov/new.items/d03702.pdf (finding "insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates have all contributed to rising [malpractice] premium rates.").

[39]Sue Ganske, *Noneconomic Damages Caps in Wrongful Death Medical Malpractice Cases - Are They Constitutional?*, 14 Fla. St. U. Bus. Rev. 31, 31-32 (2015).

[40]*Id.* at 31.

[41]*Id* at 31-32.

[42]Ctr. for Just. & Democracy, *supra* note 9.

[43]*Id.*

[44]La. Stat. Ann. § 40:1231.2(B)(1) (2015).

[45]W. McDonald Plosser, *Sky's The Limit? A 50-State Survey Of Damage caps And The Collateral Source Rule*, Mondaq (Dec. 11, 2018), https://www.mondaq.com/unitedstates/insurance-laws-and-products/762574/sky39s-the-limit-a-50-state-survey-of-damages-caps-and-the-collateral-source-rule [https://perma.cc/48UB-R3NH].

States differ in the amounts, requirements, and types of damages capped, yet most adopt a similar formula for determining when a statutory cap applies. To qualify, a court must find that the defendant is a "health care provider" within the statute's meaning, the claim concerns medical treatment or neglect rendered by the defendant, and that the defendant's action caused the injury.[46] If a defendant satisfies all the requirements, judges must reduce the jury's awards to the statutory limit.

Some states define the relevant terms directly in the statute, exhaustively listing all qualifying health care providers.[47] In these fixed-definition statutes, legislatures will identify specific health care providers and institutions in long lists, using language such as "any of the following" to restrain application to only those entities listed.[48] If states wish to expand the definition to include additional entities, legislatures in fixed-meaning states must explicitly amend the statutes to incorporate other qualifying defendants.[49] Indiana adopts this view, defining a health care provider as:

> An individual, a partnership, a limited liability company, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a physician, psychiatric hospital, hospital, health facility, emergency ambulance service, dentist, registered or licensed practical nurse, physician assistant, certified nurse midwife, anesthesiologist assistant, optometrist, podiatrist, chiropractor, physical therapist, respiratory care practitioner, occupational therapist, psychologist, paramedic, advanced emergency medical technician, or emergency medical technician, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.[50]

Other states adopt a more flexible approach. These states do not provide a comprehensive list of "health care providers," but instead provide examples and general standards for courts to extrapolate.[51] These regimes employ broader definitions that tend to describe health care providers with a higher level of generality. Flexible statutory regimes shift the burden of defining qualifying defendants onto courts, thereby minimizing legislative responsibilities to further clarify legislative intent. These statutes often employ language like "associated with" and "similar categories," rather than fixing the definition to specific defendants.[52] Flexible statutes tend to be shorter than their fixed-definition counterparts, placing all additional types of providers within the catch-all language of "similar categories."[53] In theory, flexible

[46]*See, e.g.*, City of Houston v. Houston, 608 S.W.3d 519, 524 (Tex. App. 2020).

[47]*See* Ind. Code Ann. § 34-18-2-14(1) (2016); Mont. Code Ann. § 25-9-411 (2023) (a health care provider is any "physician, dentist, podiatrist, optometrist, chiropractor, physical therapist, or nurse licensed under Title 37 or a health care facility licensed under Title 50, chapter 5").

[48]*See* La. Stat. Ann. § 40:1231.1(10) (defining "health care provider" as over thirty different professionals and professional corporations); Alaska Stat. Ann. § 09.55.560(2) (2005) (limiting "health care providers" to specific professions, such as acupuncturist, chiropractor, dentists, physicians, podiatrist, etc.).

[49]*See* Ind. Code Ann. § 34-18-2-14(1) (2016) (adding four additional categories of "health care providers" to the medical malpractice liability statute since original enactment in 1998); Noelke v. Heartland Indep. Living Ctr., 637 S.W.3d 378, 381 (Mo. Ct. App. 2021) (noting that that medical tort liability statute only extends to entities "enumerated" as health care providers or is licensed to provide health care).

[50]Ind. Code Ann. § 34-18-2-14(1) (2016).

[51]*See* N.C. Gen. Stat. Ann. § 90-21.11(1) (2017) (defining health care provider "without limitation" to list of enumerated individual practitioners and entities); Utah Code Ann. § 78B-3-403(13) (West 2022) (health care providers are "any person, partnership, association, corporation, or other facility or institution who causes to be rendered or who renders health care or professional services as [other listed providers]"); Mo. Ann. Stat. § 538.205(6) (2020) (health care providers are "any physician, hospital, …., and any other person or entity that provides health care services under the authority of a license or certificate").

[52]N.C. Gen. Stat. Ann. § 90-21.11(1) (2017); S.C. Code Ann. § 15-32-210 (2005) (defining health care providers as any "similar category of" enumerated entities).

[53]*See* S.C. Code Ann. § 15-32-210(5-6) (2005); *see also* Utah Code Ann. § 78B-3-403(13) (West 2022).

statutory definitions of "health care providers" enable courts to recognize unenumerated defendants as qualifying health care providers. For example, a health care provider in North Carolina is:

> A person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, or psychology.[54]

Scrutinizing language such as "including" and "similar categories" may at first seem trivial. However, the definitions sections within medical liability statutes function as a gatekeeper for medical malpractice litigation. As this Note explores in Part II, courts in flexible statutory regimes can freely choose to extend statutory protections to unenumerated categories of defendants. Courts routinely exercise their authority to interpret the meaning of malpractice statutes' definitions, even if the interpretation directly contradicts the law's specific wording.[55]

With some exceptions, courts are reluctant to overturn damage caps.[56] Common constitutional claims allege that damage caps violate state and federal constitutions' equal protection, right to jury trial, and separation of powers clauses.[57] State courts often uphold the laws on state constitutional grounds, and in some cases have reinstated the damage caps after prior findings of unconstitutionality.[58] Courts are even less receptive to federal constitutional challenges to damage caps.[59] Though some plaintiffs argue that damage caps violate the Fourteenth Amendment's Equal Protection Clause and Due Process Clause, federal courts routinely apply a deferential form of analysis when analyzing states' medical malpractice statutes.[60] Therefore, unless state and federal courts unexpectedly reverse course, legislative action remains the primary avenue for reforming medical liability laws.

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[54]N.C. Gen. Stat. Ann. § 90-21.11(1)(a) (2017).

[55]*See* Phillips v. Larry's Drive-In Pharmacy, Inc., 647 S.E.2d 920, 927 (W. Va. 2007) (holding that damage cap statute's phrase "including, but not limited to" in defining health care providers did not recognize additional types of providers not listed in the statute).

[56]Ctr. for Just. & Democracy, *supra* note 9 (nine states' damage caps were struck down as unconstitutional and have not been reenacted, compared to the twenty-nine states with currently valid statutes); Victor E. Schwartz & Christopher E. Appel, *Perspectives on the Future of Tort Damages: The Law Should Reflect Reality*, 74 S.C. L. Rev. 1, 37 (2022) (the majority of state courts have "generally respected" noneconomic damage caps as a rational policy solution to lowering large damage awards).

[57]Constitutional Challenges to State Caps on Non-Economic Damages, Am. Med. Ass'n, https://www.ama-assn.org/media/14451/download (last updated Sep. 2017) (state and federal courts considered constitutional trial right challenges to damage caps in twenty states, equal protection challenges in eighteen states, and separation of powers challenges in nine states); *see also* Beason v. I. E. Miller Servs., Inc., 441 P.3d 1107, 1109 (Okla. 2019) (holding that Oklahoma's damage cap law violated state constitution's prohibition on special laws); Hilburn v. Enerpipe Ltd., 442 P.3d 509, 524 (Kan. 2019) (ruling that noneconomic damage cap for medical malpractice actions deprived plaintiffs of the right to a jury trial under the state constitution); Busch v. McInnis Waste Sys., Inc., 468 P.3d 419, 433 (Or. 2020) (finding that noneconomic damage cap violated state constitution's remedy clause); Siebert v. Okun, 2021-NMSC-016, 485 P.3d 1265, 1274 (N.M. 2021) (ruling that New Mexico's noneconomic damage cap did not violate the right to a jury trial under the state's constitution).

[58]*See* Am. Med. Ass'n, *supra* note 57; Condon v. St. Alexius Med. Ctr., 926 N.W.2d 136, 143 (N.D. 2019) (finding that while previous version of damage cap violated the state's equal protection clause, current reiteration of the law did not impermissibly classify "seriously injured victims of medical negligence" and "other victims of medical negligence").

[59]Am. Med. Ass'n, *supra* note 57 (finding that no federal court has struck down a state's non-economic damage caps); Schwartz & Appel, *supra* note 56, at 38 (noting that no state's high court has struck down a damage cap statute as unconstitutional under the United States Constitution).

[60]*See, e.g.*, Hoffman v. United States, 767 F.2d 1431, 1437 (9th Cir. 1985) (ruling that California's medical malpractice damage cap did not violate the federal Equal Protection Clause); Watson v. Hortman, 844 F. Supp. 2d 795, 802 (rejecting medical malpractice plaintiffs' argument that Texas's damage caps statute infringes on potential plaintiffs' Fifth Amendment Takings Clause rights).

C. Policy Purposes

Malpractice damage caps have impacted medical malpractice litigation and the general medical field in a variety of ways. As expected, plaintiffs in states with damage caps win lower average payouts than malpractice plaintiffs in states without caps.[61] Damage caps directly reduce the profitability of medical malpractice lawsuits, thereby disincentivizing specialized medical malpractice attorneys from pursuing such claims in the first place.[62] Damage caps and other strict tort reform measures may also deter plaintiffs from filing claims altogether.[63]

State legislatures clearly understood the foreseeable impact of medical malpractice reform on individual physicians, especially in the context of damage caps. The malpractice insurance crises primarily impacted individual physicians and other medical practitioners.[64] During the first malpractice crisis, individual practitioners, especially those in high-risk specialties, suffered the greatest from higher malpractice insurance premiums.[65] In fact, legislators and commentators consistently pointed to the undue burden on physicians as evidence of an unhinged medical liability system.[66] Some of the statutes explicitly state the purposes of the legislation by expressing concern for the "threatened loss of physicians" and the need to "encourage physicians to enter [and remain in] the practice of medicine."[67] State courts also recognized fixing "the health care crisis attributable to malpractice premium costs" and "[assuring] the availability of affordable medical services to the public" as the original goals of malpractice reform.[68] Legislators were especially concerned for high-risk physicians performing procedures with a higher risk of adverse effects, even if the doctor followed the standard of care.[69] Without proper safeguards, physicians feared that juries would disproportionately award damages to plaintiffs suing specialists, thereby driving up those fields' malpractice premiums and discouraging physicians from specializing altogether.[70]

The drafters of medical malpractice reform legislation likely did not envision expansive procedural protections for defendants beyond the scope of physicians and hospitals. Instead, legislators were acutely concerned with the effect of the malpractice insurance crisis on individual doctors, specifically specialists.[71] Numerous studies examined the effects of malpractice premium hikes on specialists, in some cases

[61]Frank A. Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J. Health Pol. Pol'y & L. 663, 678 (1989) (finding that malpractice damage caps reduce average recovered noneconomic damages by thirty-one percent); Albert Yoon, *Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South,* 3 Am. L. & Econ. Rev. 199, 203 (2001) (average medical malpractice plaintiff recovery in Alabama "decreased by roughly $20,000" after the legislature enacted damage caps, but "roughly double[d]" after the state's high court invalidated the caps).

[62]Stephen Daniels & Joanne Martin, *Plaintiffs' Lawyers, Specialization, and Medical Malpractice*, 59 Vand. L. Rev. 1051, 1072-1073 (2006) (respondent malpractice specialists experienced significant drops in malpractice suits immediately after Texas imposed noneconomic damage caps).

[63]Ronen Avraham, *An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments*, 36 J. Legal Stud. S183, S188-S189 (2007).

[64]Rodwin, *supra* note 25, at 168.

[65]Nancy T. Greenspan, *A Descriptive Analysis of Medical Malpractice Insurance Premiums,1974-1977*, Health Care Fin. Rev. 65, 66 (1979).

[66]Texas House Journal, 2003 Reg. Sess. No. 40 (proposed amendment to Texas's malpractice statute stating "[the medical malpractice insurance crisis] has had a substantial impact on the physicians and hospitals of Texas and the cost to physicians and hospitals for adequate medical malpractice insurance has dramatically risen in price"); Luther v. IOM Co. LLC, 130 So. 3d 817, 822 (La. 2013) (finding that "the [Louisiana] legislature intended the [Medical Malpractice Act] to reduce or stabilize medical malpractice insurance rates and to assure the availability of affordable medical services to the public"); McDougall v. Schanz, 597 N.W.2d 148, 176 n. 9 (Mich. 1999) (noting that the purpose of Michigan's medical malpractice reform was to ameliorate the "malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns").

[67]Neb. Rev. Stat. § 44-2801(1) (2022); W. Va. Code Ann. § 55-7B-1 (2015).

[68]Luther v. IOM, 130 So. 3d at 822; Coe v. Superior Ct., 220 Cal. App. 3d 48, 53 (Ct. App. 1990).

[69]Greenspan, *supra* note 65, at 66.

[70]Rodwin, *supra* note 25, at 167.

[71]*See* Texas House Journal, 2003 Reg. Sess. No. 40; *Luther*, 130 So. 3d at 822; McDougall, 597 N.W.2d at 176 n. 9.

breaking down the premium increases in each specialty.[72] On the other hand, very few studies at the time of rising insurance rates looked at the crises' impact on non-hospital healthcare corporations.[73] While those institutions were likely affected, politicians and reformers rarely mentioned laboratories, pharmacies, or behavioral treatment facilities when discussing the civil liability system.[74] A possible explanation is that the malpractice crisis did not impact large medical groups and healthcare corporations in the same way as it did individual physicians and hospitals. Considering states' acute concerns for retaining doctors and hospitals, legislators primarily intended for damage caps to shield less-secure health care providers from astronomical malpractice premiums.

Despite inconclusive evidence of damage caps' efficacy, state courts have generally avoided questioning the efficacy of caps, and will only strike down the laws upon findings of unconstitutionality.[75] For example, in *Judd v. Drezga*, the Utah Supreme Court declined to examine whether "increased malpractice insurance premiums [were caused by] the possibility of unlimited awards for quality of life damages."[76] In doing so, the court sidestepped the question of deciding whether the legislature "made wise policy" when enacting damage caps.[77] Instead, state courts aim to interpret the statutes consistently with the legislatures' stated purpose, namely, counteracting the malpractice insurance crises.[78]

II. Functionalism, Formalism, and Judicial Interpretations of "Health Care Providers"

Like most state laws, state courts do not analyze malpractice reform statutes under a uniform method of interpretation. In defining "health care providers" for purposes of damage caps statutes, state courts adopt one of two approaches. No other works have attempted to delineate these separate approaches; thus, I adopt the labels "statutory functionalism" and "statutory formalism." Courts do not officially adopt labels of "functionalism" or "formalism" when interpreting "health care providers," but will adopt interpretive language indicative of either camp.

Some state courts apply a functionalist method of interpretation when defining the term "health care providers" in malpractice reform statutes. Functionalist courts accept the underlying purpose of damage caps statutes and interpret the legislative intent as a broad mandate to combat rising malpractice premiums.[79] When plaintiffs sue defendants not otherwise mentioned in the statute, functionalist courts will reason by analogy, and compare the present defendants to the statute's enumerated examples.[80] If a defendant tends to "perform the sorts of acts that one ordinarily associates with 'health care' [and other enumerated defendants]," functionalist courts will extend statutory coverage to the unenumerated class

[72] *See* Greenspan, *supra* note 65, at 65; Sloan, *supra* note 24, at 629.

[73] Stephen Zuckerman, Christopher F. Koller & Randall R. Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, Law & Contemp. Probs., 85, 89 (1986).

[74] *See* W. Va. Code Ann. § 55-7B-1 (2015) (purpose of malpractice reform was meant to address West Virginia's "loss and threatened loss of physicians"); Colo. Rev. Stat. Ann. § 13-64-102(1) (2003) (legislature intended to combat rising insurance rates "for medical care institutions and licensed medical care professionals" in enacting procedural limitations on medical liability); Colo. Rev. Stat. Ann. § 13-64-501(1) (1998) (defining "health-care institution" as "any licensed or certified hospital, health-care facility, dispensary, or other institution for the treatment or care of the sick or injured").

[75] Schwartz & Appel, *supra* note 56, at 37.

[76] Judd v. Drezga, 103 P.3d 135, 140 (Utah 2004).

[77] *Id.*

[78] *See, e.g.*, Luther v. IOM, 130 So. 3d at 822; Coe v. Superior Ct., 220 Cal. App. 3d at 53 (holding that the original policy purposes of California's MICRA law would be consistent with extending statutory coverage to blood banks).

[79] *See* Platts v. Parents Helping Parents, 947 P.2d 658, 663 (Utah 1997) (holding that court of appeals erred in concluding that "troubled youth" treatment program was not a "health care provider" solely because the specific type of facility was not mentioned in the statute); Williams v. Quest Diagnostics, Inc., 816 S.E.2d 564, 566 (S.C. 2018) (ruling that diagnostic laboratory qualified as a health care provider within state medical liability statute despite no mention of laboratories under the definition of "health care provider").

[80] *See* Platts, 947 P.2d at 663; *Williams*, 816 S.E.2d at 566.

of defendants.[81] According to this view, statutory terminology like "including" automatically renders the enumerated list of health care providers "nonexclusive."[82] Especially under regimes with flexible definitions of health care providers, functionalist courts can recognize other types of actors and institutions as "health care providers" as common understandings of "health care" and "health care services" evolve over time.[83]

The South Carolina Supreme Court's majority opinion in *Williams v. Quest Diagnostics* encapsulates the functionalist model for interpreting medical malpractice statutes.[84] In *Williams*, the plaintiff sued Quest Diagnostics, a "federally licensed genetic testing laboratory," for medical negligence due to the defendant's alleged failure to diagnostically test for a child's genetic condition.[85] After Quest Diagnostics contended that the state's medical malpractice statute of repose barred the claim against it as a "licensed health care provider," the federal district court certified the case to the South Carolina Supreme Court to determine whether a "federally licensed genetic testing laboratory" constitutes a "licensed health care provider."[86] Although the case concerned the definition of "health care providers" within the meaning of the state's statute of repose, the statute at issue contained nearly-identical language to the state's damage caps law.[87] Both statutes define "health care providers" to include generic defendants like "physicians" and "surgeons," but expand the definition beyond those examples by encompassing any "similar category of licensed health care provider."[88] The court in *Williams* concentrated on the statute's "similar category" language to conclude that "the genetic testing laboratory fits within the category provided by one of the specified designations in [the statute], a hospital."[89] In particular, the *Williams* Court decided that "when the Legislature uses words of particular and specific meaning followed by general words, the general words are construed to embrace only persons or things of the same general kind or class as those enumerated."[90] In doing so, the Court analyzed the core functions of a genetic laboratory to determine whether such a facility performs similar activities to any of the enumerated health care providers in the statute.[91] According to the majority, when a physician orders lab tests "for the purpose of assisting the treating physician in detecting an existing disease or disorder," that lab performs the same functions as an in-hospital laboratory.[92] The response to *Williams* was highly critical, with some criticizing the Court's classification of lab corporations as hospitals as inconsistent with the statute's legislative intent.[93]

The South Carolina Supreme Court is not alone in employing a functionalist approach for statutory construction. In *Platts v. Parents Helping Parents*, the Utah Supreme Court found that the state law's phrase "others rendering similar care" rationally extends coverage to "all [other defendants] rendering care and services similar to explicitly identified [health care providers]."[94] The *Platts* Court outlined a similar approach to statutory construction as *Williams*, finding that courts must only interpret statutes in

[81]Verticor, Ltd. v. Wood, 509 S.W.3d 488, 497 (Tex. App. 2015) (dismissing malpractice claim against medical device manufacturer since product manufacturers do not render "health care services" or act similarly to traditional health care providers and institutions).

[82]Christus Health v. Beal, 240 S.W.3d 282, 286 (Tex. App. 2007).

[83]*See* Utah Code Ann. § 78B-3-403(13) (West 2022).

[84]816 S.E.2d, at 566.

[85]*Id.* at 564.

[86]*Id.*

[87]S.C. Code Ann. § 38-79-410 (1988).

[88]*Compare* S.C. Code Ann. § 38-79-410 (1988) *with* S.C. Code Ann. § 15-79-110(3) (2005).

[89]Williams, 816 S.E.2d at 566.

[90]*Id.* at 565.

[91]*Id.*

[92]*Id.*

[93]Timothy Nicolette, *Williams v. Quest: The South Carolina Supreme Court's Misdiagnosis of Quest Diagnostics As A Health Care Provider and the Poor Prognosis for Plaintiffs in Medical Malpractice*, 13 Charleston L. Rev. 393, 408 (2019) (distinguishing hospitals from laboratories in that hospitals treat underlying diseases and offer twenty-four hour care for overnight patients, while laboratories do not).

[94]Utah Code Ann. § 78B-3-403(13) (West 2022); Platts, 947 P.2d at 663 (Utah 1997).

a way that would not "[render] portions of, or words in, a statute superfluous or inoperative."[95] *Platts* was unique, and arguably the best example of statutory functionalism, because the majority implicitly acknowledged the impact of a broad statutory construction on medical malpractice claims. By recognizing that the legislature passed the statute to "control rising costs of malpractice insurance," the *Platts* majority understood the non-exhaustive definition of "health care provider" as a mission to curb medical malpractice claims.[96] Specifically, the Utah Supreme Court recognized that a broader statutory coverage of "health care providers" would help reduce the impact of medical malpractice claims on medical defendants. In other words, extending the statutory protections of "health care provider" status to non-traditional defendants, such as a youth behavioral treatment program, will inevitably limit damage amounts and disincentivize litigation against malpractice claim defendants.[97] Unique to functionalism, then, is an implied validation of malpractice reform's effect on medical liability in general.

Formalist courts, on the other hand, apply a strict textualist alternative to statutory interpretation. Unlike functionalists, formalists narrowly construe damage caps to protect only statutorily enumerated defendants. Formalists view every word in a statute to be intentional, with each carrying an independent and significant meaning. For example, courts in Louisiana and West Virginia categorize defendant-providers as "qualifying health care providers" only if the defendant is listed in the statute.[98] Louisiana's Medical Malpractice Act ("MMA") confines the term "health care providers" to an exhaustive list of individual practitioners, related entities, and institutions.[99] This distinction matters in a state like Louisiana, where qualified health care providers are protected from most damages exceeding five-hundred thousand dollars in medical malpractice suits.[100] Given the statute's broad scope to include not only enumerated health care providers, but also professionals employed by those providers, Louisiana courts generally do not construe the definition beyond the statute's plain text.[101] Louisiana's Fourth Circuit Court of Appeals framed the standard succinctly, stating that if "a [category of defendant] is not included in the definition of 'health care provider'… [that category] is not automatically afforded the protections of the MMA."[102]

Formalism's black-or-white distinction forces the responsibility to review and update statutory definitions onto legislatures, rather than the courts. Under the formalist view, if a statute's definition of a health care provider is in any way ambiguous, any form of judicial expansion removes that issue's resolution from the democratic process. West Virginia courts closely follow this approach, and have directly resisted attempts to identify statutes' legislative intent from legislative history materials.[103] In *Phillips v. Larry's Drive-in Pharmacy*, the Supreme Court of Appeals of West Virginia explicitly rejected the functionalist approach.[104] The plaintiff in *Phillips* filed suit against a local pharmacy after the defendant allegedly failed to print sufficient medication instructions on the plaintiff's drug label.[105] Responding to the defendant's contention that the statute's "including, but not limited to" language allows for any licensed medical corporation to enjoy the protection of damage caps, the court cautioned that it could not "add to statutes something the Legislature purposely omitted."[106] The court concluded

[95]947 P.2d at 662.

[96]*Id.* at 660.

[97]*See id.*

[98]*See* Phillips, 647 S.E.2d at 927; Morris v. Administrators Of Tulane Educ. Fund, 891 So. 2d 57, 61 (La. App. 4 Cir. 2004) (malpractice statute's lack of mention of athletic trainers automatically excludes athletic trainers from eligibility for damage caps).

[99]La. Stat. Ann. § 40:1231.1(10) (2020).

[100]La. Stat. Ann. § 40:1231.2(B)(1) (2015) (limiting total damages recoverable for medical malpractice and wrongful death actions to five hundred thousand dollars "plus interest and cost," except for "future medical care and related benefits").

[101]*See* Roberson v. Arcadia Healthcare Ctr., Inc., 850 So. 2d 1059, 1065 (La. App. 2 Cir. 2003).

[102]Morris, 891 So. 2d at 61.

[103]*See* Phillips 647 S.E.2d at 925.

[104]*Id.* at 927.

[105]*Id.* at 923.

[106]*Id.* at 927.

that since the state's Medical Professional Liability Act ("MPLA") did not include pharmacies within the ambit of "health care providers," the defendant pharmacy could not benefit from the damage caps.[107] The majority ruled that courts must narrowly interpret the terms of a statute as long as the statute alters the common law, so as to preserve the legislature's intent in modifying the state's common law tort doctrine.[108] In doing so, the *Phillips* majority formally disavowed the functionalist approach, stating that "when there is any doubt about the meaning or intent of a statute in derogation of the common law, the statute is to be interpreted in the manner that makes the least rather than the most change in the common law."[109] Furthermore, the court reasoned that by modifying the common law through enacting damage caps, the legislature specifically intended to exclude any entity not listed as a health care provider in the statute from the law's coverage.[110]

West Virginia and South Carolina share similar statutory definitions of "health care providers," yet each state's courts employ polar opposite methods of statutory interpretation. Even though the *Phillips* Court fixed "health care providers" to the enumerated examples in the statute, the MPLA prefaces the list of enumerated health care providers with the phrase "including, but not limited to."[111] The MPLA's use of the phrase "including, but not limited to" denotes a flexible approach, yet the *Phillips* Court refused to expand the definition of "health care providers" beyond the enumerated entities.[112] This approach is markedly different from the *Williams* Court, considering that the MPLA grants an even greater degree of interpretive discretion than South Carolina's statute. The South Carolina statute provided a list of "licensed health care providers," but also included "any similar category of licensed health care providers."[113] Similarly, the MPLA specifically used the terms "including, but not limited to," a phrase ordinarily connoting a non-exhaustive list of examples.[114] However, the West Virginia Supreme Court of Appeals relied on the common law to resist any expansive definitions that would betray the legislature's intent, while the *Platts* and *Williams* Courts attempted to limit the effect of malpractice liability.[115] Therefore, the formalist standard frames the danger from misinterpreting legislative intent as potentially preventing plaintiffs from recovering appropriate damages from certain providers. A formalist interpretation thus restrains the power of the courts and foists the duty to change the laws onto the legislature. If a statute's original policy rationale supports a narrower view of "health care providers," a formalist approach would best realize the legislature's original intent to curb malpractice awards for individual practitioners and hospitals.

The distinction between formalism and functionalism substantially shapes the outcomes in medical malpractice litigation. Juries award less in non-economic damages to medical malpractice plaintiffs in states with damage caps compared to states with no such limitations.[116] Since damage caps also disincentivize plaintiffs from filing malpractice claims, the scope of those statutes may impact which kinds of defendants plaintiffs decide to sue.[117] Texas courts apply a functionalist standard, and as a result have recognized aquatic therapy centers,[118] hospital management consultants,[119] oxygen delivery

[107] *Id.*
[108] *Id.*
[109] *Id.* at 928.
[110] *Id.*
[111] W. Va. Code Ann. § 55-7B-2(g) (2022).
[112] *See* Phillips 647 S.E.2d at 925.
[113] S.C. Code Ann. § 38-79-410 (1988).
[114] W. Va. Code Ann. § 55-7B-2 (2015).
[115] Phillips 647 S.E.2d at 925; Platts 947 P.2d at 662; Williams 816 S.E.2d at 566.
[116] *See* David M. Studdert, et al, *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 Health Affs. 54, 61-62 (2004) (finding noneconomic damage caps reduce the amount of winnable medical malpractice damages anywhere between one-hundred thousand and one-and-a-half million dollars).
[117] H.E. Frech III, et al., *An Economic Assessment of Damage Caps in Medical Malpractice Litigation Imposed by State Laws and the Implications for Federal Policy and Law*, 16 Health Matrix 693, 700 (2006) (malpractice caps do not deter strong potential malpractice claimants but do deter those with weaker claims).
[118] Aquatic Care Programs, Inc. v. Cooper, 616 S.W.3d 615, 623 (Tex. App. 2020).
[119] Hollingsworth v. Springs, 353 S.W.3d 506, 515 (Tex. App. 2011).

services,[120] and pharmacies[121] as "health care providers" under the Texas Medical Liability Act ("TMLA"). While not every potential malpractice plaintiff will know which defendants courts have designated "health care providers," the expansive coverage for any health care-adjacent practitioner and corporation may contribute to a state's defendant-friendly culture and further discourage claims. Louisiana's courts apply formalism, yet the MMA provides a long list of enumerated providers that protects most types of malpractice defendants.[122] In formalist jurisdictions, malpractice lawyers might feel more comfortable litigating malpractice claims without worrying about the courts generating new classes of protected defendants.

III. State Courts Should Adopt the *Phillips* Formalist Standard When Determining Who Qualifies as a "Health Care Provider"

Courts should adopt a formalist method of interpretation when interpreting the term "health care provider" under malpractice damage caps for three reasons. First, under the reasoning in *Phillips*, courts should narrowly define "health care providers" to minimize alterations to the common law rule of damages. Second, the original policy purposes of damage caps and legislative intent surrounding the medical malpractice reform movement do not support a broader reading of "health care providers" beyond hospitals and individual practitioners. Finally, functionalism upsets the separation of powers by granting courts legislative capacity to shape and create new laws outside of the traditional democratic process. This Part addresses each of these arguments in turn.

A. Courts Must Narrowly Interpret Statutes Because They Substantially Alter Common Law

While legislatures are not bound to follow the common law and enjoy full discretion to modify tort law through statute, broad judicial interpretations of statutory language risks disturbing common law tort doctrine outside of the legislative process. As discussed, legislative damage caps substantively abridged the jury's full authority to assess and deliver tort damages under the common law.[123] Rather than allowing juries to award damages to malpractice plaintiffs in an amount proportional to their suffering, damage caps reigned in that power in the name of preserving medical availability.[124] Such a significant change vests considerable weight not only in the legislature to repeal, modify, and expand the caps, but also to the courts charged with interpreting the laws consistently with the original legislative intent. Without the legislature's explicit guidance as to if and how courts should expand damage caps to additional entities, any interpretation of "health care providers" transcending the statute's plain text risks further altering the common law beyond the legislature's original intent. Thus, any reliable interpretation of a damage cap statute requires clear evidence that the legislature intended to expand significant protections to a number of additional undefined entities.

The *Phillips* rule of statutory construction for defining "health care providers" faithfully interprets damage caps while minimizing unnecessary modifications to the common law. Under the West Virginia Supreme Court of Appeals' reasoning, when any doubt exists as to the meaning of statutory language, courts should interpret the statute "in the manner that makes the least rather than the most change in the common law."[125] Damage caps statutes like the MPLA do not articulate clear rules of construction for determining which entities qualify as health care providers.[126] Though statutes might contain legislative intent sections that articulate the purpose of damage caps in general, they lack any clear intent as to which

[120]San Antonio Extended Med. Care, Inc. v. Vasquez, 327 S.W.3d 193, 198 (Tex. App. 2010).
[121]Turtle Healthcare Grp., L.L.C. v. Linan, 338 S.W.3d 1, 6 (Tex. App. 2009).
[122]La. Stat. Ann. § 40:1231.1(10) (2020).
[123]Sanders, *supra* note 14, at 239.
[124]Sanders, *supra* note 14, at 239.
[125]Phillips, 647 S.E.2d at 928.
[126]W. Va. Code Ann. § 55-7B-1 (2015).

undefined defendants the legislatures sought to protect.[127] Flexible language, like "such as" or "including, but not limited to" implies that the listed providers are nonexclusive, but by itself offers no guidance for future expansion. Functionalists might argue that flexible language denotes an intent to expand those definitions over time, but the scope of such a mandate is too indeterminate for courts to decipher on their own. As damage caps substantially altered the common law rules on damages, a statute's use of the words "such as" is insufficient to broadly construe that statute to include defendants that did not exist at the time of enactment. Rather than attempting to ascertain the legislature's intent from speculative analogies, formalism lowers the risk of misinterpreting statutes by assuming that "omissions [of unenumerated entities] from a statute by the Legislature are intentional."[128] Without stronger evidence of that legislative intent, courts must err on the side of caution to avoid misinterpreting the statutes in a way that limits larger jury awards for entities not envisioned by the laws' drafters.[129]

B. Policy Purposes of Malpractice Reform Support a Formalist Interpretation of Damage Caps

The purposes of the medical malpractice reform movement do not justify expanding damage caps to non-hospital and non-individual practitioner defendants. State legislatures recognized the threat of large jury awards and rising malpractice insurance costs, yet still understood the importance of maintaining a functioning civil liability system. Legislative intent sections' framing of malpractice reform as an emergency fix rather than a long-term solution suggests that the impending threat of a doctor exodus and hospital closures warranted some limitations to an otherwise necessary tort system.[130] For example, West Virginia's MPLA affirmed that civil litigation is "essential … in providing adequate and reasonable compensation to those persons who suffer … as a result of professional negligence."[131] Key to the statutes, then, was balancing the public's interest in retaining doctors and health care facilities with patients' interests in recovering from medical harm.[132]

The original goals of medical malpractice reform support a formalist judicial standard of interpretation for determining which defendants qualify as "health care providers." Of course, a formalist approach for statutes that clearly state an intent for courts to expand their definitions over time would be practically identical to modern day functionalism. However, few, if any, malpractice reform laws reflect that goal. Even South Carolina's statute, one of the most flexible in the country, does not indicate such a legislative intent.[133] Instead, legislative intent sections frequently reference the plight of individual "physicians" under the strain of soaring malpractice premiums.[134] The laws' focus on individual doctors and other practitioners, rather than medical-adjacent entities, reflects the sense of anxiety that drove

[127] *See* Neb. Rev. Stat. Ann. § 44-2801(1) (1976); Wis. Stat. Ann. § 893.55(1d)(a) (2008); Colo. Rev. Stat. Ann. § 13-64-102 (2003).

[128] Phillips, 647 S.E.2d at 928.

[129] *See id.*

[130] *See* Neb. Rev. Stat. Ann. § 44-2801(1) (1976) (declaring that "[i]t is essential in this state to assure continuing availability of medical care and to encourage physicians to enter into the practice of medicine in Nebraska and to remain in such practice as long as such physicians retain their qualifications."); Wis. Stat. Ann. § 893.55(1d)(a) (2008) (stating that "[t]he objective of the treatment of this section is to ensure affordable and accessible health care for all of the citizens of Wisconsin while providing adequate compensation to the victims of medical malpractice" and that "[a]chieving this objective requires a balancing of many interests."); Ala. Code § 6-5-540 (2023) (asserting that procedural malpractice restrictions must be "given effect immediately to help control the spiraling cost of health care and to insure its continued availability" and to combat the "crisis threaten[ing] the delivery of medical services to the people of Alabama").

[131] W. Va. Code Ann. § 55-7B-1 (2015).

[132] *See* Wis. Stat. Ann. § 893.55(1d)(a) (2008); Fla. Stat. Ann. § 766.201(1)(d) (2003) (stating that "[t]he high cost of medical negligence claims in the state can be substantially alleviated by requiring early determination of the merit of claims … and by imposing reasonable limitations on damages, *while preserving the right of either party to have its case heard by a jury*") (emphasis added).

[133] S.C. Code Ann. § 15-32-210 (2005).

[134] W. Va. Code Ann. § 55-7B-1 (2015); Neb. Rev. Stat. Ann. § 44-2801(1) (1976); Wis. Stat. Ann. § 893.55(1) (2008); Ala. Code § 6-5-540 (2023); Fla. Stat. Ann. § 766.201(1)(a) (2003).

state legislatures to substantially alter the common law in a short period of time. The risk of losing specialists, especially in highly populated states like California, motivated legislatures to act quickly and decisively.[135] In fact, West Virginia's MPLA specifically references "the state's loss and threatened loss of physicians" stemming from rising malpractice insurance premiums as a motivating factor for procedural limitations on medical liability.[136]

The drafters of tort reform laws envisioned malpractice caps as a measure to reduce large damage awards for hospitals and individual providers, but not for non-hospital corporate entities. Though each state defines health care providers differently, all but two of those states explicitly designate both hospitals and individual practitioners within the ambit of "health care provider" and "health care institution."[137] While states disagree over whether a pharmacy or nursing facility qualifies as a "health care provider," the near universal inclusion of physicians and hospitals in damage caps statutes indicates a widespread concern that both of those entities deserved additional protection from the malpractice crises. Even though some large hospital systems may share the sophisticated corporate structure, high profitability, and national presence of other non-hospital corporate institutions, the pervasive statutory recognition of hospitals as health care providers and institutions suggests that legislators and malpractice reform advocates believed that hospitals faced similar risks of closures and relocation from large jury awards as individual physicians.[138] News articles and empirical studies fixated on the "out-of-control" legal system's effect on doctors and hospitals, but rarely mentioned negative impacts on pharmacies, independent labs, and non-hospital corporate institutions.[139] Politicians and commentators were profoundly aware of these effects, and constantly invoked the threat of doctor strikes, hospital closures, and early physician retirement whenever they discussed malpractice reform.[140] Missing from these declarations, contemporary articles, and case law is evidence of any shared concern for those medical entities outside of private practitioners and hospitals.

C. Functionalism Upsets Separation of Powers Between Courts and Legislatures

The authority to change a statute's meaning is inherently legislative. Though courts have a general responsibility to interpret laws, expanding the scope of medical liability laws to pharmacies and aquatic therapy centers resembles the legislative amendment process. Extending statutory coverage to parties

[135] *See* Lacey Fosburgh, *Doctors Limit Care In Protest on Coast*, N.Y. Times, May 2, 1975, https://www.nytimes.com/1975/05/02/archives/doctors-limit-care-in-protest-on-coast-doctors-cut-care-in-coast.html (reporting that California doctors struck in protest of rising malpractice insurance premiums and refused to render non-emergency care to patients).

[136] W. Va. Code Ann. § 55-7B-1 (2015).

[137] *See, e.g.*, Md. Code Ann., Cts. & Jud. Proc. § 3-2A-01(f)(1) (West 2005) (defining "health care provider" as "a hospital, … a medical day care center, a hospice care program, an assisted living program, a freestanding ambulatory care facility …, a physician, an osteopath, an optometrist, a chiropractor, a registered or licensed practical nurse, a dentist, a podiatrist, a psychologist, a licensed certified social worker- clinical, and a physical therapist, licensed or authorized to provide one or more health care services in Maryland"). *But see* N.D. Cent. Code § 32-42-01(6) (1995) (a health care provider is "a *person* who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession) (emphasis added); Mont. Code Ann. § 25-9-411(5)(b) (1995) ("'Health care provider' means a physician, dentist, podiatrist, optometrist, chiropractor, physical therapist, or nurse licensed under Title 37 or a health care facility licensed under Title 50, chapter 5").

[138] *See* William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 23 Health Affs. 10, 15-17 (2004).

[139] *See* Laurie Garrett, *The Malpractice Crisis Care Bows to Costs Insurance Rates Are Driving Obstetricians from the Delivery Room in Record Numbers*, Newsday, July 12, 1988, *available at* 1988 WLNR 201089; Rosemary Goudreau, *Doctors Shun Pregnant Woman's Case Patient's Epilepsy Marks Her As High Malpractice Risk*, Orlando Sentinel, Jun. 8, 1986, *available at* 1986 WLNR 1473232.

[140] *Id*; Wis. Stat. Ann. § 893.55(1d)(a) (2008) (finding that noneconomic damage caps are necessary to alleviate the effects of the malpractice practice "[b]ased upon documentary evidence, testimony received at legislative hearings, and other relevant information"); Neb. Rev. Stat. Ann. § 44-2801(1) (1976) (declaring that malpractice reform "is in the public interest that competent medical and *hospital services* be available to the public in the State of Nebraska at reasonable costs") (emphasis added).

that the drafters did not deem "health care providers" removes legislatures and citizens from the democratic process. Legislatures, unlike many judges, are directly accountable to their constituents through the electoral process and thus must take the specific needs of their constituents into account when crafting laws. Additionally, reading in meanings not contemplated by a law's drafters risks undermining that law's underlying rationales. The *Phillips* Court directly acknowledges this issue, warning that statutes "may not, under the guise of 'interpretation,' be modified, revised, amended, or rewritten."[141] Therefore, under the *Phillips* standard, any changes to the term "health care provider" must pass through the legislative process, rather than the courts.

Courts cannot effectively balance the competing policy interests of damage caps without clear legislative intent. Legislatures define statutory terms to guide and restrict courts in applying substantive law, yet doing so should not grant courts broad authority to expand the statute through mere analogy. Treating statutory language as open-ended risks upsetting the balance between patient compensation and healthcare availability. The *Williams* case exemplifies that exact risk. South Carolina's definitions section opened the door for additional coverage by inserting the phrase "similar category" after a short list of enumerated examples.[142] Due to that ambiguity, the majority in *Williams* arrived at the conclusion that a corporate diagnostic laboratory constitutes a "hospital" because it performs similar functions to an in-hospital laboratory.[143] It is unlikely that South Carolina's legislature was concerned about the effect of malpractice premiums on Quest Diagnostics, an international corporation, when crafting emergency solutions to the widespread malpractice "crises." Those broad rulings disrupt the balance of interests at the heart of malpractice reform legislation. If courts accept the premise that the medical malpractice system is still out of control, it would be consistent for functionalist courts to deem any and all health care-adjacent defendants immune from extensive liability. Due to functionalism's limitless scope, courts may then freely misinterpret damage caps statutes based on erroneous understandings of legislative intent. Even if a legislature intended for courts to expand the laws beyond the enumerated entities, ambiguous language such as "associated with" and "including, but not limited to" fails to adequately guide courts as to which additional defendants deserve statutory protection.[144] If a court's reading encompasses a health care provider beyond the statute's original intent, correcting the decision would require legislatures to amend the laws in response to every erroneous ruling.

Some might argue that differently worded laws deserve different standards of judicial interpretation, and that courts should apply a functionalist standard for statutes with flexible definitions. Courts often fail to follow this distinction, however. Utah and West Virginia's statutes are similar in multiple respects. Both define a large swath of health care entities and practitioners within the ambit of "health care providers."[145] Both states also enacted damage caps in the context of an ongoing malpractice insurance "crisis," intending to quell the rise in insurance premiums and ensure the availability of health care.[146] Yet, each state's high court adopted polar opposite standards. The Utah Supreme Court's decision in *Platts* demonstrated an unflinching commitment to mitigating the impact of increased malpractice litigation, while the *Phillips* Court declined to expand coverage to a pharmacy despite the statute's use of the phrase "including, but not limited to."[147] Thus, a statute's phrasing alone does not independently determine courts' methods of defining "health care providers."

Even if courts applied a formalist approach to fixed-definition statutes and a functionalist standard for flexible statutes, the former better serves the original intent of malpractice reform for both types of statutes. As discussed, when a statute diverges from the common law, legislatures should articulate any and all deviations in that statute. Many states passed malpractice reforms as a response to an ongoing

[141]Phillips, 647 S.E.2d at 927.
[142]S.C. Code Ann. § 15-32-210(5) (2005).
[143]Williams, 816 S.E.2d at 566.
[144]N.C. Gen. Stat. Ann. § 90-21.11(1) (2017); W. Va. Code Ann. § 55-7B-2(g) (2022).
[145]W. Va. Code Ann. § 55-7B-2(g) (2022); Utah Code Ann. § 78B-3-403(13) (West 2022).
[146]W. Va. Code Ann. § 55-7B-1 (2015); Utah Code Ann. § 78B-3-402(1) (West 2008).
[147]*See* Platts, 947 P.2d at 662; Phillips, 647 S.E.2d at 927.

"emergency" requiring immediate attention, a situation which counseled against careful deliberation and predictions of the laws' long-term impacts.[148] Legislative intent is an important consideration for statutory construction, but fixating on policy considerations without clear evidence of the legislature's intent risks courts assuming legislative power to assert unintended meanings into the law.

State courts should apply the *Phillips* standard to damage caps when determining who qualifies as a "health care provider." Specifically, when deciding if a class of defendants constitutes a health care provider within the meaning of statutory damage caps, courts should only extend coverage to those parties explicitly enumerated in the statute.[149] Damage caps are significant legislative measures that limit injured patients' potential damages and overall access to medical malpractice attorneys.[150] In most states, a defendant's status as a health care provider may prevent plaintiffs from recovering for substantial, long-term non-economic harms.[151] In others, "health care provider" status deprives otherwise successful plaintiffs from receiving compensation proportionate to their physical and medical injuries.[152] Functionalist courts thus maintain the authority to potentially preclude entire categories of plaintiffs from receiving just compensation for legitimate medical negligence.

D. Advice for Legislatures

To avoid this problem of interpretation, legislatures should amend malpractice reform statutes to restrict the definition of "health care provider" to exhaustive, enumerated categories of potential defendants. Alternatively, if states are unwilling to roll back protections to individual practitioners and hospitals, legislatures should at least remove all flexible language and fix the definition to enumerated classes. Even if legislatures find it necessary to define larger corporations as "health care providers," ambiguous definitions allow courts to stray from the original intent of malpractice reform. Exhaustive definitions of "health care providers" preserve the original intent of damage caps and preclude judges from reading in "reasonable" extensions to statutory definitions. Given the impact of damage caps on attorney availability and awards, democratically elected legislators alone should bear the burden of amending malpractice legislation. Any other solution deprives citizens from effectively holding their representatives immediately accountable through the democratic process.

Legislatures should also amend damage caps to restrict the meaning of "health care providers" to individual practitioners and hospitals. Given the historical background in which states increasingly regulated medical liability, a narrow definition best fits the original policy purposes of the malpractice reform movement without unnecessarily abridging the common law. Statutes that cap certain forms of damages for non-hospital corporate entities allow those entities to unfairly benefit from laws intended to protect hospitals and individual practitioners from an unforeseen insurance crisis. Damage caps, as well as the other procedural restrictions in malpractice reform laws, significantly harm plaintiffs seeking to recover for medical malpractice.[153] Despite the ongoing debate regarding the efficacy of damage caps on malpractice insurance and health care accessibility, caps directly reduce the availability and profitability of medical malpractice claims.[154] Even assuming that caps achieve the intended effect of maintaining the affordability and availability of health care, protecting entities like Walgreens and Quest Diagnostics from large jury awards does little to reduce the high malpractice premiums on individual physicians and hospitals that prompted damage caps in the first place. To validate the original policy purposes of malpractice reform, an ideal damage cap would confine "health care providers" to individual medical

[148]Neb. Rev. Stat. Ann. § 44-2801(1) (1976); Colo. Rev. Stat. Ann. § 13-64-102 (2003); Wis. Stat. Ann. § 893.55(1d)(a) (2008); Utah Code Ann. § 78B-3-402(1) (West 2008).

[149]*See* Phillips, 647 S.E.2d at 928.

[150]Daniels & Martin, *supra* note 62, at 1072-1073.

[151]Ctr. for Just. & Democracy, *supra* note 9.

[152]*Id.*

[153]Daniels & Martin, *supra* note 62, at 1072-1073.

[154]*See id.*; Shreve et al., *supra* note 4, at 5.

practitioners and hospitals. Thus, even if damage caps prove ineffective in regulating malpractice insurance prices, a narrower scope for qualifying health care providers enables plaintiffs to sufficiently recover against defendants for their real harm.

IV. Conclusion

Renewed attention on malpractice damage caps demonstrates state legislatures are capable of substantively modifying malpractice regulations without plunging medical systems into another malpractice insurance crisis.[155] Legislatures and courts should seriously consider whether limiting large non-hospital corporate entities' malpractice liability for harmed plaintiffs is consistent with the underlying policy purposes of malpractice reform. If, as this Note argues, that effect is inconsistent with the original legislative intent, courts should narrowly construe statutory definitions of "health care providers." Additionally, legislators should closely scrutinize the impacts of malpractice caps at the state level when considering any proposals to enact federal malpractice caps. As long as states continue to impose damage caps on medical malpractice plaintiffs, the laws should at least remain consistent with the original policy purposes unless they demonstrate clear legislative intent otherwise.

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[155] *See* Melody Gutierrez, *California Gets New Rules Covering Medical Malpractice Payments. Here's What Will Change*, Los Angeles Times (May 23, 2022, 11:45 AM), https://www.latimes.com/california/story/2022-05-23/california-new-rules-medical-malpractice-payments-changes [https://perma.cc/AQ6Z-G8QP].

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