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## Comment

# The Medical Malpractice Crisis: A Problem with No Answer?

### I. INTRODUCTION

In recent years, medical malpractice insurance premiums have skyrocketed for doctors<sup>1</sup> around the country. As a result, many doctors have moved to more general practices,<sup>2</sup> have moved to states in which insurance premiums are cheaper,<sup>3</sup> or have given up practicing medicine altogether.<sup>4</sup> These problems have reached epidemic proportions<sup>5</sup> in many states,<sup>6</sup> precipitating gov-

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1. For purposes of this Comment, the author will refer to doctors' rising insurance premiums when discussing the medical malpractice liability crisis. The liability crisis, however, is not limited to doctors. *See, e.g.*, Emily V. Cornell, *Addressing the Medical Malpractice Insurance Crisis* (NGA Ctr. for Best Practices, Issue Brief, Dec. 5, 2002), available at <http://www.nga.org/cda/files/1102MEDMALPRACTICE.pdf> (describing the medical malpractice problem as one involving "hospital emergency rooms, trauma centers, birthing centers, and nursing homes," in addition to individual doctors).

2. U.S. DEP'T OF HEALTH & HUMAN SERVS., *CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 4* (July 25, 2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.htm> [hereinafter, *CONFRONTING*]; *see also* American Medical Association, *Professional Liability Insurance: Clamoring for Relief* (Apr. 24, 2002). The AMA argues that "liability rates are driving physicians from their practices, leaving patients vulnerable and the entire field of medicine in a state of turmoil." *Id.*

3. *CONFRONTING*, *supra* note 2, at 3.

4. *Id.*

5. *See* Susan Jones, *Medical Malpractice Crisis Prompts New Push for Reform*, CYBERCAST NEWS SERV., Feb. 10, 2004, available at <http://www.cnsnews.com/Nation/archive/200402/NAT20040210a.html> (stating that "[i]t won't matter if Americans have health insurance—if there are no doctors around to treat them").

6. The American Medical Association ("AMA") lists 19 states as being in a "full-blown medical liability crisis." American Medical Association, *19 States Now in Full-blown Medical Liability Crisis*, available at <http://www.ama-assn.org/ama/pub/article/6282-7347.html> (last updated Oct. 6, 2003). The AMA lists these states as Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, and Wyoming. *Id.* Breaking some of the problems down state by state, the AMA describes Arkansas's problem as having "[m]ore than 50 percent of" the state's doctors reporting "that they have been forced to reduce or discontinue one or more medical services . . . due to rapidly increasing medical premiums"; in Illinois, the AMA claims "hospitals and small towns are in jeopardy because of physicians no longer performing certain procedures such as brain surgery and de-

ernment involvement at both the state and federal levels, in what has been deemed a “medical malpractice crisis.”<sup>7</sup> Because medical malpractice law has failed on many levels, experts tend to blame the “medical malpractice crisis”<sup>8</sup> on at least one of three things: 1) too much litigation,<sup>9</sup> 2) the recent downturn in the economy,<sup>10</sup> and 3) unregulated doctors making too many mistakes.<sup>11</sup> Thus, a tripartite relationship exists between trial lawyers, insurance companies, and doctors, in which each group points a finger at the other.<sup>12</sup> Despite the finger-pointing, some commentators argue that the three big players are

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livering babies”; in Kentucky, high-risk specialists “including emergency room physicians and general surgeons” have found “increases in their liability premiums . . . between 87 to 200 percent,” and “[n]early one-quarter of the state’s physicians say medical liability concerns make them consider leaving the state”; in Missouri, doctors’ liability insurance premiums have risen over 60 percent in the course of a year; and in North Carolina, hospitals have seen “professional liability insurance premium increases of 400 to 500 percent” over a three year period. *Id.*

7. See Kathy Kendell, Comment, *Latent Medical Errors and Maine’s Statute of Limitations for Medical Malpractice: A Discussion of the Issues*, 53 ME. L. REV. 589, 599 (2001).

8. The phrase itself takes on different connotations. See David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1639-40 (2002). Hyman describes physicians complaining about a “liability coverage crisis,” where “coverage is too expensive or simply unavailable” and plaintiffs’ lawyers complain about a “malpractice crisis,” where doctors “are routinely committing malpractice, and getting away with it.” *Id.*

9. See, e.g., Steven T. Masada, Comment, *Australia’s “Most Extreme Case”: A New Alternative for U.S. Medical Malpractice Liability Reform*, 13 PAC. RIM L. & POL’Y J. 163, 169 (2004). Masada states that “[w]hile many factors likely contribute to the U.S. medical malpractice crisis, the most prevalent catalysts for increasing insurance premiums relate to a rise in medical malpractice litigation and certain inherent inefficiencies imbedded in the U.S. legal system.” *Id.* (footnote omitted).

10. Comparing the current crisis to those of the 1970s, some commentators describe the crisis as a result of a “souring economy.” See, e.g., Peter Zablotsky, *From a Whimper to a Bang: The Trend Toward Finding Occurrence Based Statutes of Limitations Governing Negligent Misdiagnosis of Diseases with Long Latency Periods Unconstitutional*, 103 DICK. L. REV. 455, 475 n.95 (1999).

11. David S. Casey, Jr., *Perspectives From the Front Lines*, 39 TRIAL 9 (Nov. 2003). Casey writes that “ATLA’s position that the lack of insurance-rate regulation is the cause of doctors’ insurance woes was vindicated by California Insurance Commissioner John Garamendi, who slashed a major medical malpractice insurer’s proposed rate increase.” *Id.* at 9.

12. See Robert E. McAfee, *High Health Care Costs? Blame the Greed of Lawyers*, WASH. POST, Aug. 14, 1994, at C8 (letter to the Editor of the Washington Post by the AMA President) (where the AMA President blames “greedy lawyers” for the medical malpractice crisis). See also Berkeley Rice, *Do Doctors Kill 80,000 Patients a Year?*, MED. ECON., Nov. 21, 1994, at 46 (noting the blame for the medical malpractice crisis is often placed squarely on “killer doctors”).

doing their best within a system that simply does not work.<sup>13</sup> Nevertheless, each of the three takes an extreme position in the debate<sup>14</sup> and little effective change takes place.<sup>15</sup> Compounding the problem is the fact that “statistics on both the extent of litigation and amounts of awards are conflicting and difficult to come by.”<sup>16</sup>

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13. See, e.g., Thomas B. Metzloff, *Understanding the Malpractice Wars*, 106 HARV. L. REV. 1169, 1173 (1993) (reviewing PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* (1991)). Metzloff explains that Paul Weiler assesses the “best available evidence” in concluding that “plaintiffs’ lawyers are, by all accounts, doing their best to identify meritorious claims; that juries are taking their work seriously; and that insurers are trying to charge reasonable insurance rates based upon their best estimates of future claims.” *Id.*

14. See Medical Malpractice Referral Network, *Medical Malpractice “Crisis” Contrived*, available at [http://www.medical-malpractice-lawyers-attorneys.com/medical\\_malpractice\\_crisis.html](http://www.medical-malpractice-lawyers-attorneys.com/medical_malpractice_crisis.html) (last visited Oct. 8, 2004). On this website, Dr. Sidney Wolfe, director of Public Citizen’s Health Research Group, argues that “[t]here are serious ethical questions about doctors striking and preventing patients from getting medical care.” *Id.* Joan Claybrook, president of Public Citizen, states that “[d]octors are falsely demonizing America’s legal system rather than saving tens of thousands of lives and litigation costs by preventing careless or unnecessary medical errors, such as operating on the wrong part of the body.” *Id.* While the statements contain grains of truth, they are examples of one-sided finger-pointing by all three of the big players. This author’s opinion is that doctors strike because they are demoralized by their increasing premiums, not because they do not care about the welfare of their patients.

15. See MIMI MARCHEV, NAT’L ACAD. FOR STATE HEALTH POLICY, *THE MEDICAL MALPRACTICE INSURANCE CRISIS: OPPORTUNITY FOR STATE ACTION*, (2002). Marchev explains that “[c]onflicts among insurance companies, the medical profession, and trial lawyers are inherent to the debate over how to solve the crisis and often create a chilling effect on efforts to improve patient safety.” *Id.* at 1. Marchev continues:

Insurers and doctors blame “predatory” trial attorneys, “frivolous” law suits, and “out of control” juries for the spike in insurance premiums. In turn, consumer groups accuse insurance companies of “price gouging,” while plaintiffs’ attorneys point to an exorbitant rate of medical errors and the need to deter malpractice and provide compensation to injured patients. This animosity and defensiveness create a closed environment and impede state efforts to address broader issues of patient safety.

*Id.*

16. *Id.* at 5. Marchev cites research by Jury Verdict Research group, a firm often cited by the insurance companies, which claims “that the median jury award in medical malpractice cases rose from \$500,000 in 1995 to \$1,000,000 in the year 2000.” *Id.* (citing Jury Verdict Research, Horsham, Pa. at <http://www.juryverdictresearch.com> (last visited Apr. 5, 2005)). The author finds such well-rounded numbers invalid on their face. Marchev contrasts Jury Verdict Research’s statistics with those of a Bureau of Justice Statistics survey, which cites \$285,576 as the median award for 1996, “about half the amount cited by Jury Verdict Research for that same year.” *Id.* (citing MARIKA F.X. LITRAS ET AL., *TORT TRIALS AND VERDICTS IN LARGE COUNTIES*, 1996

Problems with the availability and affordability of liability insurance have been the impetus for much of the reform efforts throughout the country,<sup>17</sup> but the problems in medical malpractice law are much further-reaching than doctors' rising insurance premiums.<sup>18</sup> While these skyrocketing premiums indicate that medical malpractice law has failed to protect doctors, the law has also failed to protect patients.<sup>19</sup> Medical malpractice law neither deters future negligence by doctors<sup>20</sup> nor adequately compensates those who are injured by physician negligence.<sup>21</sup> Currently, laws across the country do not work, and their failure presses us to re-examine the purposes of the legislative reforms that continue to be enacted.

Any future success the law may find will be realized only if the reforms put in place ensure that care is both "cost effective and safe,"<sup>22</sup> because the failure of past reforms is due in part to the fact that they focus almost entirely

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(U.S. Dep't of Justice, Bureau of Justice Statistics Bulletin No. NCJ 179769, Aug. 2000).

17. See, e.g., Kenneth D. Kranz, *Tort Reform 1997-98: Profits vs. People*, 25 FLA. ST. U. L. REV. 161 (1998). Kranz explains:

In response to a perceived medical malpractice insurance crisis, the 1985 Legislature attempted to offer relief in what was known as the Comprehensive Medical Malpractice Reform Act of 1985 (1985 Act). Before the ink dried on the 1985 Act, the Legislature enacted the much more comprehensive Tort Reform and Insurance Act of 1986 (1986 Act). The 1986 Act was conceived as an effort to relieve the general liability insurance affordability and availability "crisis" perceived to exist throughout much of the business community.

*Id.* at 162-63 (footnotes omitted).

18. See Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?*, 140 U. PA. L. REV. 1147, 1183-84 (1992) (citing CAL. MED. ASS'N & CAL. HOSP. ASS'N, REPORT ON THE MEDICAL INS. FEASIBILITY STUDY 101 (Don H. Mills ed., 1977)). The study found that less than 10 percent of negligently injured patients sued. *Id.* Even for the most severely injured plaintiffs, the study concluded that less than 1 in 6 filed suit. *Id.* See also *id.* (citing LEON S. POCINKI ET AL, THE INCIDENCE OF IATROGENIC INJURIES 50 (1973)) (finding that only 6 percent of negligently injured patients files suit); *id.* (citing HARVARD MEDICAL PRACTICE STUDY GROUP, PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 7-1 (Report of the Harvard Medical Practice Study to the State of New York, 1990)) (where the Harvard Medical Practice Study found that in New York "eight times as many patients suffer an injury from medical negligence as there are malpractice claims," and "there are about sixteen times as many patients who suffer an injury from negligence as there are persons who receive compensation through the tort system").

19. See HARVARD MED. PRACTICE STUDY GROUP, *supra* note 18.

20. See *id.*

21. See *id.*

22. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1595 (2002).

on being cost effective and neglect current problems in patient care. Reform efforts need to do more than protect doctors from being run out of their professions by skyrocketing premiums. Reforms also need to protect patients, both by deterring doctors' negligent conduct and by adequately compensating victims who have been harmed by negligent medical care. Experts who have conducted empirical studies suggest reforms such as no-fault insurance,<sup>23</sup> but these suggestions have thus far received little support.<sup>24</sup> History shows that if anything is going to get done, it will get done along political lines.<sup>25</sup> This will require give and take from each of the three big players.<sup>26</sup>

This Comment will look at the changes that have been made in the way of tort reform and will analyze the problems that past tort reform efforts have ignored. The purpose of this Comment is not to suggest an easy, one-size-fits-all solution to the medical malpractice problems we face but rather to expose some of the problems that past efforts have missed, in the hope that state legislatures will learn from their past mistakes. This Comment will also suggest alternative remedies to get the health care system on its way to becoming a system where fewer medical mistakes are made, injured plaintiffs are adequately compensated, and doctors can most effectively and efficiently operate.<sup>27</sup>

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23. See Jeffrey O'Connell, *A Proposed Remedy for Mississippi's Medical Malpractice Miseries*, 22 MISS. C. L. REV. 1 (2002). See also Hyman, *supra* note 8; Mello & Brennan, *supra* note 22; Larry I. Palmer, *Patient Safety, Risk Reduction, and the Law*, 36 HOUS. L. REV. 1609 (1999); David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the Untied States*, 27 AM. J. L. & MED. 225 (2001).

24. *But see* FLA. STAT. ANN. § 766.301-.316 (West 2001); VA. CODE ANN. §§ 38.2-5000 to -5021 (Michie 2002).

25. Hyman, *supra* note 8. See also Paul C. Weiler, *The Case for No-fault Medical Liability*, 52 MD. L. REV. 908, 909-10 (1993). Weiler comments that the "legislative preoccupation with medical malpractice seems curious" given that the "total cost of malpractice insurance . . . is only a tiny fraction of the nation's \$130 billion in tort liability expenditures." *Id.* at 909. But, Weiler further explains that "[t]here is, of course, a political explanation for this legislative preoccupation. The principal targets of malpractice litigation are not faceless corporations, such as product manufacturers, but real, live doctors." *Id.* at 910. Weiler continues, saying that "a malpractice suit challenges the professional performance, reputation, and identity of a doctor" and "both legislatures and voters can more readily empathize with the plight of their family doctor than, for example, drug manufacturers [so] statutory relief has regularly been forthcoming." *Id.*

26. See Thomas P. Hagen, Note, "*This May Sting a Little*"—*A Solution to the Medical Malpractice Crisis Requires Insurers, Doctors, Patients, and Lawyers to Take Their Medicine*, 26 SUFFOLK U. L. REV. 147, 161 (1992). Hagen explains that in order for a system which protects both doctors and patients to be implemented, there must be "careful study and contemplation of all points of view." *Id.*

27. Evidence suggests that the medical malpractice crisis leads doctors to practice "defensive medicine," whereby doctors are so afraid of legal exposure that they order and prescribe more treatment than they feel is necessary. *Id.* at 148 & n.4.

Again, this will take action by each of the big three.<sup>28</sup> For insurance companies, these changes include experience-rating doctors' insurance premiums,<sup>29</sup> so that the problems caused by a few of the doctors are not borne by the whole profession. Statistics suggest that a small number of doctors are at the root of substandard care problems. These problem doctors should absorb costs commensurate with their neglect. Reform should also involve planning for the insurance cycle by setting back rainy day reserves so that malpractice premiums reflect insurance industry costs more and the state of the economy less.<sup>30</sup> For doctors and insurance companies, reform should include distributing insurance rates across the medical specialties so that specialists are not squeezed out of the profession. For plaintiffs' attorneys, reform should include submission of claims to screening panels (or pre-suit certification of cases) in order to stop the administrative costs imposed by frivolous suits.<sup>31</sup>

Because successful reform must account for both the doctor and patient crises in medicine, these proposals take a comprehensive look at the concerns voiced by all three players.<sup>32</sup> In order to properly analyze their probability of success, one must first understand the history behind the current crisis.

## II. OVERVIEW OF THE MEDICAL MALPRACTICE CRISIS

### A. History

Although medical malpractice litigation began in the mid-1800s,<sup>33</sup> medical malpractice cases were rare until the 1970s.<sup>34</sup> Prior to 1960, only

28. See MARCHEV, *supra* note 15, at 21 (explaining that a "comprehensive approach to the medical malpractice insurance crisis that addresses tort and insurance reform in conjunction with reporting requirements and other strategies aimed at reducing medical errors may be the most effective course of action for states").

29. See, e.g., Gary M. Fournier & Melayne Morgan McInnes, *The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation*, 68 J. RISK & INS. 255 (2001).

30. If insurance companies are going to continue increasing premiums in years in which they turn significant profits, this practice should be offset with regulations requiring that they set back rainy day reserves.

31. See, e.g., Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181 (1990).

32. See Hagen, *supra* note 26, at 161 (explaining that "reform must strike a balance that ensures the highest quality health care, the lowest possible malpractice insurance rates, and an efficient and discriminating tort system that compensates victims while deterring tortfeasors from reckless conduct and frivolous plaintiffs and attorneys from spurious claims").

33. See Rima J. Oken, Note, *Curing Healthcare Providers' Failure to Administer Opioids in the Treatment of Severe Pain*, 23 CARDOZO L. REV. 1917, 1968 n.252 (2002).

34. *Id.*

about one in seven doctors could expect to be sued in his entire career.<sup>35</sup> Now about one in seven doctors is sued each year.<sup>36</sup> Most experts agree that the first wave of medical malpractice insurance problems began in the 1970s.<sup>37</sup> One commentator describes this first wave of problems as an “availability crisis,”<sup>38</sup> in which insurers became unwilling to underwrite medical liability insurance,<sup>39</sup> because they were experiencing depressed investment income as a result of a “souring economy”<sup>40</sup> and a large “oil crisis.”<sup>41</sup> Insurers dropped out of the market,<sup>42</sup> and doctors around the country began to see their malpractice premiums soar.<sup>43</sup> To deal with the availability crisis of the 1970s,<sup>44</sup> most state legislatures enacted tort reforms in the mid-1970s, seeking both to reduce the frequency of suits<sup>45</sup> and to curtail the severity of the awards.<sup>46</sup> One such state was California, which enacted the Medical Injury Compensation Reform Act (MICRA)<sup>47</sup> in 1975.<sup>48</sup>

35. *Id.*

36. *Id.*

37. See Kendell, *supra* note 7, at 601 (explaining that it “is undisputed . . . that by the early 1970s doctors in many areas of the country began to experience significant increases in their malpractice premiums”).

38. See Hagen, *supra* note 26, at 150.

39. *Id.*

40. *Id.*

41. *Id.* at 151.

42. See IAIN HAY, MONEY, MEDICINE, AND MALPRACTICE IN AMERICAN SOCIETY 89 (1992). During the late 1970s, the number of medical malpractice insurers dropped from over one hundred to around twelve nationally. *Id.*

43. See Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499, 502-03 (1989). The premiums doctors paid during the 1970s tripled. *Id.*

44. See Allen Redlich, *Ending the Never-ending Medical Malpractice Crisis*, 38 ME. L. REV. 283, 316-24 (1986) (discussing the tort reform actions taken in forty-nine states in the mid-1970s).

45. Hagen, *supra* note 26, at 157. Hagen explains that states tried to reduce the frequency of suits “by making it difficult or impossible for a plaintiff to bring any malpractice suit, by encouraging settlement, and by deterring frivolous claims.” *Id.* (footnotes omitted).

46. *Id.* at 157-58. States attempted to reduce the size of awards “by establishing caps, revising the treatment of collateral source compensation, and encouraging periodic payment of awards.” *Id.* (footnotes omitted).

47. Medical Injury Compensation Reform Act of 1975, ch. 1, 1975 Cal. Stat. 3969 (codified at CAL. BUS. & PROF. CODE § 6146 (West 2003); CAL. CIV. CODE §§ 3333.1-.2 (West 1997); CAL. CIV. PROC. CODE §§ 340.5, 364, 365, 1295 (West 1982); CAL. CIV. PROC. CODE § 667.7 (West 1987)).

48. See Grace Vandecruze, *Has the Tide Begun to Turn for Medical Malpractice?*, 15 HEALTH LAW. 15, 15 (2002). Since enacting MICRA in 1975, California’s malpractice premiums have risen 167 percent, compared to a 505 percent increase in the rest of the United States, according to the American Medical Association. *Id.*; see also CONFRONTING, *supra* note 2, at 17 (“California has more than 25 years of experi-



A second wave of medical liability problems developed in the 1980s. One commentator describes this crisis as one not of “availability” like the 1970s<sup>49</sup> but rather one of “affordability.”<sup>50</sup> During this second wave of problems, there was a renewal of reform efforts much like the efforts of the 1970s.<sup>51</sup>

Despite the tort reforms of the 1970s and 1980s, a crisis in medical liability has returned again, and this time the federal government is considering getting involved. If the problems of the 1970s and 1980s can be categorized as problems of “availability” and “affordability,” respectively, this third wave of problems encompasses those encountered in both of the first two waves.

The availability crisis peaked in 2002, when St. Paul Fire and Marine Insurance Co., which was the nation’s largest malpractice carrier<sup>52</sup> reportedly insuring somewhere between 9 percent and 10 percent of doctors nationwide,<sup>53</sup> left the medical liability insurance arena altogether.<sup>54</sup> Additionally, PHICO and Frontier Insurance Group pulled out of the malpractice market,<sup>55</sup> and MIXX stopped providing malpractice coverage in every state except New Jersey.<sup>56</sup> These departures left doctors with few insurance options.<sup>57</sup>

In this third wave, affordability problems have coincided with this availability crisis. In 2002, for example, the state of Nevada faced problems in malpractice affordability on such a grand scale that the University of Nevada Medical Center closed its trauma center for ten days.<sup>58</sup> Surgeons quit working

ence with this reform. It has been a success. Doctors are not leaving California. Insurance premiums have risen much more slowly than in the rest of the country without any effect on the quality of care received by residents of California.”) MICRA has become the model followed by many states when enacting malpractice reforms and is the model under which the current administration considers enacting federal legislation.

49. Hagen, *supra* note 26, at 152.

50. *Id.*

51. *Id.* at 154.

52. CONFRONTING, *supra* note 2, at 14.

53. *Id.*

54. *Id.* St. Paul’s exit from the marketplace left an estimated 750 hospitals and 42,000 doctors without coverage. *Medical Liability Insurance: Looming Crisis?*, TRENDWATCH, (Advancing Health in America), June 2002, at 1 [hereinafter TRENDWATCH].

55. CONFRONTING, *supra* note 2, at 14.

56. *Id.*

57. William Poe, *Malpractice Malaise*, ST. LOUIS COM. MAG., Oct. 2003. A financial risk manager for one insurance agency explains that St. Paul’s departure from the market makes it so “[t]here are very limited carriers now for medical malpractice insurance, and their appetite is very narrow.” *Id.*

58. William Booth, *Las Vegas Trauma Center Closes as Doctors Quit: Surgeons Cite Rising Costs of Malpractice Insurance, Lawsuits—a Growing National Problem*, WASH. POST, July 4, 2002, at A2.

because they could not afford insurance premiums<sup>59</sup> that had risen from \$40,000 to \$200,000 per year for some doctors.<sup>60</sup> To illustrate the severity of this problem, one need only consider that a surgeon—who faces one of the greatest risks of being sued and thus the greatest burden of rising malpractice premiums—has little incentive to continue practicing medicine at \$300,000 per year when he must pay \$200,000<sup>61</sup> for malpractice insurance. This problem of affordability is not limited to the state of Nevada. It has spread throughout the country,<sup>62</sup> driving some doctors<sup>63</sup> out of their professions and making emergency care unavailable in some areas of the country.<sup>64</sup>

These problems of affordability and availability of liability insurance for doctors are real, and they have driven most recent tort reform efforts throughout the country. These reforms have come by way of tort law changes aimed at decreasing plaintiffs' recoveries and reducing the number of lawsuits filed

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59. CONFRONTING, *supra* note 2, at 2.

60. *Id.*

61. This \$200,000 figure is a reality for many doctors. See Joelle Babula, *Medical Malpractice Crisis: Insurance Costs Driving Doctors Away*, LAS VEGAS REVIEW-JOURNAL, Jan. 23, 2002 (labeling obstetricians as the doctors who "are bearing the brunt of the rate jumps," and citing as an example a physician whose rates jumped from \$46,000 to \$225,000 between 2001 and 2002).

62. See MARCHEV, *supra* note 15, at 4. Marchev explains that "malpractice insurance premiums vary widely throughout the United States with doctors paying vastly different amounts depending on their specialty [and] geographic location." *Id.* Marchev then explains that "an obstetrician practicing in Florida can pay as much as \$200,000 for an annual malpractice premium, whereas the same specialist would pay \$73,000 in New Jersey and \$25,000 in Maine." *Id.* (citing *Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance*, MED. LIABILITY MONITOR, Oct. 2001).

63. See CONFRONTING, *supra* note 2. Predominantly, our surgeons and OB/GYNs are hit hardest with rising malpractice premiums. *Id.* at 9.

64. In Pennsylvania, many doctors left their practices, when they could no longer afford malpractice premiums. See *id.* at 9 (noting a Chester County poll in January 2001, in which 65 percent of doctors said they were seriously considering moving their practices to another state) (citing *Doctors and Patients are at Risk*, PHILADELPHIA INQUIRER, Jan. 19, 2001); see also *id.* (stating that in three health care facilities in one area of Philadelphia, all twelve orthopedic surgeons left their practices when insurance premiums doubled to \$106,000 a year in 2001) (citing *Rising Costs of Insurance Sends Doctors Scurrying*, PHILADELPHIA INQUIRER, Dec. 21, 2000); *id.* (stating that in Mississippi, many of the state's smaller communities no longer have doctors who will deliver babies) (citing *Exodus of Doctors Causing Crisis for Moms-to-be in Mississippi*, ASSOCIATED PRESS, July 11, 2002); *id.* at 4 (stating that in New Jersey, 65 percent of the hospitals report that doctors are leaving because premiums have increased so rapidly, at 250 percent over a three year period) (citing Press Release, American College of Obstetricians and Gynecologists, Red Alert Facts: The Professional Liability Insurance Crisis (May 2002)); *id.* at 12 (stating that the cost of healthcare liability insurance has been increasing at an average of 30 percent in Florida).

against doctors. The medical malpractice crisis, however, reaches much further than these burdens that doctors have faced. Medical malpractice law has failed to protect doctors, but it has equally failed to protect patients.<sup>65</sup> The law neither deters negligent conduct by doctors<sup>66</sup> nor appropriately compensates those who have been injured by doctors' negligent care.<sup>67</sup>

### B. The Wrong Claims

One of the major goals of tort law is deterrence.<sup>68</sup> In medical malpractice law, the goal is that doctors will reduce or eliminate their unsafe medical practices if they know they will be held accountable for wrongdoing to patients. Medical malpractice law has done a poor job of meeting this goal.

Many of malpractice law's problems stem from what Professor Phillip Peters describes as "too many claims and too few claims."<sup>69</sup> On one hand, too many meritless suits are being filed.<sup>70</sup> On the other hand, many negligently

65. See INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al., eds., 1999). Between 44,000 and 98,000 Americans die in hospitals each year as a result of preventable medical errors. *Id.* at 1. See also Michael J. Berens, *Infection Epidemic Carves Deadly Path*, CHICAGO TRIB. July 21, 2002, at C1. Berens reports that about 75,000 Americans die each year because of infections they acquired during their hospital stay—infections that "were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses." *Id.*

66. HARVARD MED. PRACTICE STUDY GROUP, *supra* note 18. This study found that only 1 in 8 medical errors committed in hospitals results in a malpractice claim. *Id.*

67. *Id.*

68. See Daniel W. Shuman, *The Psychology of Deterrence in Tort Law*, 42 U. KAN. L. REV. 115, 115 (1993) ("Tort law seeks to reduce injury by deterring unsafe behavior and [this] goal informs tort standards for behavior."). See also Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain & Suffering"*, 83 NW. U. L. REV. 908, 934 (1989).

69. Philip G. Peters, Jr., *The Medical Malpractice Crisis*, Lecture at Gannet Hall, University of Missouri-Columbia (Oct. 6, 2003). See also David A. Hyman, *Medical Malpractice and System Reform: Of Babies and Bathwater*, HEALTH AFF., Jan./Feb. 2000, at 258, 258 (reviewing STEPHEN L. FIELDING, *THE PRACTICE OF UNCERTAINTY: VOICES OF PHYSICIANS AND PATIENTS IN MEDICAL MALPRACTICE CLAIMS* (1999)) (explaining the crisis by saying that "[d]epending on one's perspective, there is too much medical malpractice litigation or not enough; contingent fee arrangements create an obscene form of bounty hunting or are absolutely necessary to ensure justice; physicians should not be second-guessed by those too dumb to avoid jury service or the jury system works just fine; and legislators who enact tort reform are protecting fat-cat doctors or have prudently restrained a tort system run amok").

70. See, e.g., Alan Feigenbaum, *Special Juries: Deterring Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, 1378 (2003) (stating that doctors have been unable to remedy the onslaught of "meritless medical malpractice lawsuits").

injured patients do not bring suit and are not compensated for their injuries.<sup>71</sup> Several studies have found that as little as one in thirty patients who are negligently injured by medical mistakes files suit against the doctor responsible.<sup>72</sup> Such low figures are due in part to attorneys' unwillingness to take malpractice claims.<sup>73</sup> Medical malpractice lawsuits are difficult to win<sup>74</sup> because jurors are typically pro-doctor.<sup>75</sup> Additionally, unless the patient has suffered big damages, the cost<sup>76</sup> and the difficulty of bringing a medical malpractice suit makes it unfeasible for a plaintiffs' attorney to proceed with the

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71. See, e.g., Thomas R. McLean, *Crossing the Quality Chasm: Autonomous Physician Extenders Will Necessitate a Shift to Enterprise Liability Coverage for Health Care Delivery*, 12 HEALTH MATRIX 239 (2002). McLean says that "the current system allows for otherwise worthy patients who have been injured by negligent physician extender care to go uncompensated." *Id.* at 269-70.

72. See Michael J. Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM & MARY L. REV. 693, 703 (1994) (reviewing PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* (1993)).

73. See Saks, *supra* note 18, at 1190. Professor Saks explains that even victims who want to bring a claim "cannot realistically do so unless a lawyer agrees to handle their case, and lawyers usually do not accept a case unless they see an acceptable probability of economic success for themselves in doing so." *Id.* Saks further comments that attorneys turn away cases for many reasons, which include the following: the plaintiff is seen as too unsympathetic for the potential jury, the evidence is ambiguous, or the attorney may lack needed experts or expertise. *Id.* at 1191.

74. See *id.*

75. See Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 932 (2002). Professor Peters explains that while "[c]onventional wisdom assumes that juries will sympathize with injured plaintiffs and will penalize wealthy physician defendants[,] . . . jurors sympathize more with the physicians who are sued than with the patients who sue them." *Id.* Peters cites a study conducted by Ellen L. Leggett, in which Leggett found that two-thirds of potential jurors believe plaintiffs' lawyers have coerced plaintiffs into suing. *Id.* Peters also cites a study of North Carolina juries conducted by Neil Vidmar, in which Vidmar notes that comments such as "too many people sue their doctors" and "it is just going to raise the health insurance rates for the rest of us" are commonly elicited from jurors. *Id.* Peters also suggests the role of cognitive dissonance in juror attitudes, suggesting that "the need to trust physicians with one's own life certainly gives each of us a powerful motive to assume that physicians are rarely careless." *Id.* at 932-33.

76. See Weiler, *supra* note 25, at 916. Weiler explains that doctors adopt many defensive mechanisms, such as "ordering extra laboratory tests, performing more elaborate procedures . . . , keeping more detailed medical records and spending more time with patients," as a result of their perceptions about being sued. *Id.* Weiler posits that defensive medicine costs twice as much annually as direct malpractice premiums. *Id.* at 916-17 (citing Roger A. Reynolds et al., *The Cost of Medical Professional Liability*, 257 J. AM. MED. ASS'N 2776 (1987)).

suit. For all of these reasons, many patients who are negligently injured by doctors go uncompensated.<sup>77</sup>

On the other hand, there are too many meritless suits filed. One Harvard study found that 83 percent of claims filed by plaintiffs did not involve negligence.<sup>78</sup> Those frivolous suits impose a heavy cost on the system, driving up doctors' insurance premiums<sup>79</sup> and fueling doctors' claims of a liability insurance crisis.<sup>80</sup> Because there is little correlation between actual negligence and lawsuits filed against physicians, doctors are not deterred from making the same mistakes in the future.<sup>81</sup> Instead, doctors view the malpractice system as a lottery.<sup>82</sup>

Compounding the inability of malpractice law to deter future mistakes are doctors' misperceptions about their malpractice risks.<sup>83</sup> In a survey of 739 New York physicians, doctors estimated that 60 percent of negligent injuries led to claims.<sup>84</sup> But the empirical data indicated that only 13 percent of negligent injuries led to claims.<sup>85</sup> Furthermore, doctors estimated their annual rate of being sued at more than three times its actual rate.<sup>86</sup> Doctors are "demoralized,"<sup>87</sup> viewing the current system as a lottery<sup>88</sup> in which their professional reputations are up for grabs.<sup>89</sup> These misperceptions—and indeed the realities

77. See Saks, *supra* note 72.

78. See HARVARD MED. PRACTICE STUDY GROUP, *supra* note 18. For analysis, see PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993). See also Tim Cramm et al., *Ascertaining Customary Care in Medical Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699 (2002).

79. Reasoning that litigation costs create doctors' out-of-control insurance premiums, the AMA in Washington urges Congress to pass "MICRA-like reforms." See J. Edward Hill, *The Sleeping Giant: America's Physicians, Activism and the Medical Liability Crisis*, Address at Society of Laparoscopic Surgeons Annual Meeting (Sept. 30, 2004), available at <http://www.ama-assn.org/ama/pub/category/print/13882.html>.

80. *Id.*

81. Shuman, *supra* note 68, at 120. Shuman explains that the "[d]eterrence theory assumes that . . . people are cognizant of the likelihood of tort sanctions for proscribed behavior and choose safer alternatives to avoid those sanctions." *Id.* at 116.

82. See Feigenbaum, *supra* note 70, at 1372.

83. See Mello & Brennan, *supra* note 22, at 1609.

84. *Id.*

85. *Id.*

86. *Id.* Doctors estimated that almost 20 percent of their colleagues were sued each year. *Id.* In actuality, less than 7 percent were sued each year. *Id.*

87. Peters, *supra* note 69.

88. Feigenbaum, *supra* note 70, at 1372. Feigenbaum comments that the perceived number of medical malpractice lawsuits by doctors leads to feelings by doctors that they "have been targeted." *Id.*

89. *Id.* Feigenbaum explains that "every patient that walks into the physician's office is seen as a potential legal adversary." *Id.*

of being sued<sup>90</sup> as well—lead doctors to practice defensive medicine,<sup>91</sup> further increasing the country's health care costs and fueling the inefficient medical malpractice litigation train.

### III. CHANGES IN MALPRACTICE LAW

The purpose behind reforms that legislatures have taken around the country has predominantly been to reduce the premiums that doctors pay so that doctors are not driven from their profession.<sup>92</sup> These reforms can be broken down into two major categories: 1) those intended to curtail the amount of the awards that injured patients can receive, and 2) those intended to weed out frivolous lawsuits. In the area of curtailing payments, states have put caps on compensatory damages, have abrogated the collateral source rule, have installed periodic payment standards, have made it more difficult for plaintiffs to receive punitive damages, and have enacted statutes of repose.<sup>93</sup> In the area of weeding out frivolous lawsuits, states have enacted screening panel requirements, have enacted certification or affidavit requirements, have approved safe harbors, have placed restrictions on permissible expert witnesses, and have installed sliding scale contingent fees.<sup>94</sup>

Despite these many legislative changes throughout the 1970s, 1980s, and up to the present, the medical malpractice crisis persists. This Comment examines some of the most important of these reforms, including non-economic damage caps, abrogation of the collateral source rule, limitations on contingent fees, and implementation of screening panels. It concludes that the benefits of non-economic damage caps and abrogation of the collateral source rule, the two biggest reforms aimed at curtailing payments, are outweighed by the harms caused to injured plaintiffs. Further, sliding scale contingent fees, aimed at protecting a plaintiff by preserving more of a plaintiff's recovery for himself, do just the opposite, making legitimate lawsuits unworthy of a plain-

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90. See Oken, *supra* note 33, at 1968 n.252. One in seven doctors is sued for malpractice each year. *Id.*

91. Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1298 (1994). Frankel says that "[d]efensive medicine"—tests and procedures provided primarily to minimize the chance of future litigation—may cost the country an additional \$15 billion each year." *Id.* (citing Robert Pear, *Clinton May Seek Lid on Doctor Fees and Liability Suits*, N.Y. TIMES, Mar. 9, 1993, at A1, A14).

92. There have been some limited efforts to improve medical quality, like implementing peer review requirements, increasing disciplinary board powers, implementing reporting requirements, and implementing requirements for continuing medical education.

93. MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 475 tbl. 1, 476-78 (6th ed. 2003).

94. *Id.*

tiff attorney's risk. All of these reforms produce a system where the injured patient is not protected.

Instead of these current reforms which put the injured patients' interests last, tort reform should come in the form of screening panels which could prevent frivolous lawsuits and the costs they entail. Within the screening panel system, attorneys who continue to bring frivolous lawsuits should be prevented from bringing future malpractice claims.

Beyond these tort reform measures aimed directly at trial lawyers, this Comment looks at reforms in the medical profession and insurance industry—proposals that have received little support in an atmosphere in which state legislatures have primarily looked to curtail awards and prevent frivolous suits. But states should create systems in which problem doctors are held accountable and systems in which doctors take care of their own, spreading insurance premiums for the high-risk medical specialties throughout the medical profession. Finally, this Comment argues for changes in insurance industry regulations. It calls for the industry to set back rainy day reserves to account for the insurance cycle and calls for the industry to rate the experience of doctors when setting malpractice liability insurance premiums.

#### IV. CHANGES IN MALPRACTICE LAW: THE LEGAL PROFESSION

##### *A. Reforms to Curtail Payments*

##### 1. Limitations on Non-economic Damage Awards

The biggest "reforms" that have taken place around the country have been in direct response to doctors' claims that insurance premiums are out of control. The most commonly adopted reform is a limitation on non-economic damages, such as pain and suffering.<sup>95</sup> Proponents of caps argue that non-economic damages are too imprecise by their very nature.<sup>96</sup> They argue that

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95. See Elizabeth Stewart Poisson, Comment, *Addressing the Impropriety of Statutory Caps on Pain and Suffering Awards in the Medical Liability System*, 82 N.C. L. REV. 759 (2004). Poisson addresses legislators' common use of "pain and suffering" interchangeably with "non-economic damages." *Id.* at 761 n.7. She explains that these non-economic damages include "'damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.'" *Id.* (quoting Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002, H.R. 4600, 107th Cong. § 9(15)).

96. *Id.* at 772. Poisson explains that proponents of caps argue that "pain and suffering awards by their nature are too intangible to allow jurors to make any legitimate pecuniary evaluation and, therefore, require standardization through fixed statutory caps." *Id.*

non-economic caps are essential to prevent windfalls to plaintiffs<sup>97</sup> and to lower insurance costs for doctors.<sup>98</sup> They further argue that there is a tendency of pain and suffering awards “to take on an unfairly punitive nature.”<sup>99</sup> Legislators routinely adopt these limitations on non-economic awards because they subscribe to doctors’ arguments about the variability of non-economic awards—variability that doctors argue is perpetuated by courts that are “content to say that pain and suffering damages should amount to “fair compensation” or a “reasonable amount,” without any more definite guide” to juries.<sup>100</sup> So, state legislatures enact caps to prevent the awards from getting out of control, citing examples in which juries have returned excessive pain and suffering awards.

A cap adopted in many states sets the maximum for non-economic damages at \$250,000.<sup>101</sup> This is the level at which California originally set its cap under MICRA.<sup>102</sup> States enacting a \$250,000 limit<sup>103</sup> cite California’s (alleged) success under MICRA;<sup>104</sup> however, California’s limit was enacted in 1975.<sup>105</sup> Adjusted for inflation, this cap would now have to be more than \$800,000 to compensate an injured plaintiff to the same extent as a plaintiff

97. *Id.*

98. *Id.*

99. *Id.*

100. Bovbjerg et al., *supra* note 68, at 912 (quoting DON B. DOBBS, HANDBOOK ON THE LAW OF REMEDIES 545 (1973)).

101. *See, e.g.*, GOVERNOR’S SELECT TASK FORCE ON HEALTHCARE PROF’L LIAB. INS., FINAL REPORT 212, 218-21 (2003) (explaining the belief that the \$250,000 figure will work in Florida because it worked well in other states, including California).

102. *See* CAL. CIV. CODE § 3333.2 (West 1997) (defining damages for non-economic losses to include damages that “compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage”).

103. *See* Paul C. Weiler, *Fixing the Tail: The Place of Malpractice in Health Care Reform*, 47 RUTGERS L. REV. 1157, 1173 (1995).

104. The extreme positions taken by the different players in the malpractice system is illustrated in conflicting evidence regarding MICRA’s success. One commentator explains that MICRA “has done little to help consumers because it has led to a negligible reduction of health insurance rates in California.” Jonathan J. Lewis, Recent Development, *Putting MICRA Under the Microscope: The Case for Repealing California Civil Code Section 3333.1(A)*, 29 W. ST. U. L. REV. 173, 185 (2001). Lewis describes the problems with MICRA, including “victims of medical malpractice hav[ing] a difficult time obtaining representation.” *Id.* at 191.

105. *See* Weiler, *supra* note 103, at 1180. Weiler describes legislatures’ use of the 1975 dollar figure in these terms:

We all know what doctors would (rightly) say about a federal health care “reform” . . . that capped for the future all physician income at a fixed number reflecting the top California medical earnings back in the mid-1970s. It is hard to see, then, how doctors can legitimately ask for exactly that kind of legal treatment for their (negligently-injured) patients.

*Id.*



was compensated in 1975.<sup>106</sup> States, such as Missouri,<sup>107</sup> which had already enacted statutes limiting a plaintiff's recovery for non-economic damages,<sup>108</sup> have now reduced the statutory cap<sup>109</sup> to an amount closer to California's 1975 ceiling.

On the national level, President George W. Bush has supported medical malpractice reforms<sup>110</sup> that are very similar to those enacted in California<sup>111</sup> and used the medical malpractice crisis as part of his platform for reelection. Federal legislation has been introduced, which, like California's MICRA,<sup>112</sup> would limit non-economic recovery to \$250,000<sup>113</sup> in medical malpractice cases. Currently, no federal bills have been passed placing caps on pain and suffering awards. For such caps to be enacted on the national level, the President and Congress will first have federalism hurdles to jump. Nevertheless, the federal government's interest in the medical malpractice arena demonstrates the extent of the current crisis, or at least the country's current perception of the crisis.

In addition to attacks on these procedural hurdles, the caps themselves also receive heavy and well-deserved criticism. One of the biggest problems

106. See Poisson, *supra* note 95, at 773 n.70 (citing Bureau of Labor Statistics, United States Dept. of Labor, Inflation Calculator, at <http://data.bls.gov/cgi-bin/cpicalc.pl>).

107. In Missouri, the state legislature's enactment of a non-economic cap was drastically undercut by the Missouri Court of Appeals for the Eastern District decision in *Scott v. SSM Healthcare St. Louis*, 70 S.W.3d 560 (Mo. Ct. App. 2002). In *Scott*, the court held that Missouri's statutory cap under Missouri Revised Statute Section 538.210 allowed the plaintiff to recover the cap amount for each occurrence of negligence alleged against the hospital. *Id.* at 571. The plaintiff was allowed two recoveries of the \$528,000 cap, totaling \$1,056,000, because his injuries were the result of two acts of malpractice. *Id.* at 564. The reasoning of the *Scott* court was a blatant end-run around the Missouri legislature's cap. The decision rightfully scared insurers in Missouri and led insurers to increase liability premiums. While Missouri's recent enactment of a \$350,000 cap, H.B. 393, 93d. Gen. Assem., 1st Reg. Sess. (Mo. 2005) (effective Aug. 28, 2005), seems unwise to this author, the *Scott* decision defied logic and has fortunately been superseded by H.B. 393.

108. MO. REV. STAT. § 538.210 (2000) (amended by H.B. 393, 93d. Gen. Assem., 1st Reg. Sess. (Mo. 2005) (effective Aug. 28, 2005)).

109. H.B. 1304, Gen. Assem., 2d. Reg. Sess. (Mo. 2004).

110. See Jones, *supra* note 5 (quoting President Bush from a January 2004, trip to Arkansas as saying, "We've got too many darn lawsuits, too many frivolous and junk lawsuits that are affecting people.").

111. See generally Richard A. Oppel Jr., *Bush Enters Fray Over Malpractice*, N.Y. TIMES, Jan. 17, 2003, at A24 (explaining that President Bush is considering a plan to reduce non-economic damage recoveries to the California maximum of \$250,000); Richard W. Stevenson, *President Asks Congress for Measures Against Frivolous Suits*, N.Y. TIMES, Jan. 17, 2003, at A24.

112. CAL. CIV. CODE § 3333.2 (West 1997).

113. See Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2002, H.R. 4600, 107th Cong.

with non-economic caps is that they adversely affect those most severely injured.<sup>114</sup> Whereas people who are not severely injured often find themselves adequately compensated with or without caps—because their recoveries are often less than the statutory cap<sup>115</sup>—those who are most severely injured see their recoveries undercut.<sup>116</sup> One commentator explains that a major flaw of cap statutes is that they are “separating patients into one general class, whether they have valid or baseless claims, foster[ing] a medical malpractice scheme where those that do have valid claims are arbitrarily penalized.”<sup>117</sup> In other words, the recoveries of those most severely injured are the most reduced. This is a large price to pay when little empirical evidence exists that these non-economic caps have any real, lasting impact on the availability and affordability of liability insurance for doctors.<sup>118</sup>

Additionally, the caps that legislatures choose may be even more arbitrary than the non-economic damages that juries award. Juries have the benefit of a judge’s guidance, a case’s facts, and specialized jury instructions.<sup>119</sup>

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114. See Weiler *supra* note 103, at 1180. Weiler explains that a “legislative cap exerts its influence almost exclusively upon the damages awarded to the most severely injured victims—those left quadriplegic or blind, for example—while leaving untouched the victims of much less severe injuries—such as a permanent limp or scar.” *Id.* Weiler further explains that

empirical research about personal injury litigation has consistently demonstrated that victims of severe injuries recover a much smaller proportion of their losses . . . than do more modest injury victims. The addition of a cap to the malpractice system simply aggravates this inequitable treatment by forcing those few patients who are already worst-off to bear the lion’s share of the burden of tort reform and cost containment.

*Id.*

115. For less severely injured plaintiffs, recoveries are probably already below the statutory cap.

116. See Poisson, *supra* note 95, at 784. Poisson cites to *Ballinas v. N.Y. City Health & Hosps. Corp.*, No. 7709194 (N.Y. Sup. Ct. 2001), where an injured boy received one of the nation’s largest non-economic awards at \$72 million. Poisson, *supra* note, at 784 (citing Amy Johnson Conner, *Med-Mal Lawyer Breaks Personal Record with \$107 Million Verdict*, LAW. WKLY. USA, Jan. 7, 2002, at B19). The doctors in this case negligently caused him to contract meningitis, which caused his cerebral palsy. *Id.* As a result, the boy is confined to a wheelchair and must have 24 hour care. *Id.* Poisson explains that the boy’s pain and suffering award, while extremely large, and possibly excessive, would not be adequately compensated under a \$250,000 cap. *Id.* \$250,000 would not adequately compensate a boy for the 60+ years of torment that will accompany a condition in which his body is entirely crippled and his mind untouched. *Id.*

117. See Feigenbaum, *supra* note 70, 1382.

118. See Edward C. Martin, *Limiting Damages for Pain and Suffering: Arguments Pro and Con*, 10 AM. J. TRIAL ADVOC. 317, 337-38 (1986). Martin reasons that placing caps on non-economic damages is “minimal at best,” because severely injured plaintiffs comprise a minority of plaintiffs in medical malpractice cases. *Id.* at 337.

119. See Poisson, *supra* note 95, at 780.

Legislators, removed from the courtroom and the actual troubles a particular plaintiff will face as a result of physician negligence<sup>120</sup> are instead forced to make decisions based on partisan sources.<sup>121</sup> The arbitrariness in state legislatures' cap determinations is shown by the fact that the \$250,000 cap being adopted in many states—and being considered by the federal government—imitates a cap adopted over twenty-five years ago in California.

While caps at some level serve to rein in juries, the current proposals and limits of \$250,000 do not adequately compensate the most severely injured plaintiffs. Simply put, two hundred fifty thousand dollars is insufficient to remedy the pain and suffering endured by a patient who will spend the rest of his life with a debilitating injury.

## 2. Abrogation of the Collateral Source Rule

Under traditional common law tort doctrine, payments that a plaintiff receives from a collateral source—such as treatment expenses paid by the injured plaintiff's health care provider and lost earnings paid by sick pay or disability benefits<sup>122</sup>—do not reduce the plaintiff's recovery from the defendant. Some states, however, have abrogated the collateral source rule<sup>123</sup> by enacting legislation that either makes mandatory an offset for payment from collateral sources<sup>124</sup> or permits the jury to consider the collateral source payment when determining a plaintiff's award.<sup>125</sup> States have enacted such legislation with the intent to reduce doctors' liability insurance premiums. These collateral source reforms, however, ignore that plaintiffs must use these collateral source payments to offset the litigation costs they owe their attorneys.<sup>126</sup> While doctors are insured for the legal costs they incur in defending themselves against lawsuits,<sup>127</sup> patients are not insured for the legal costs they incur in recovering the tort remedies they deserve.<sup>128</sup> As one commentator explains, the financial costs to the injured patient for legal representation are “just as much the byproduct of negligent medical injury as are expenditures

120. *Id.*

121. *Id.*

122. *See* Weiler, *supra* note 103, at 1175.

123. One commentator lists Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Indiana, Illinois, Iowa, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, Nebraska, New Jersey, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Washington, and Wisconsin as among the states enacting legislation abolishing the collateral source rule. *See* MARCHEV, *supra* note 15, at 10 tbl. 2.

124. *See* Weiler, *supra* note 103, 1173 n.31. These are “mandatory collateral source offsets.”

125. *Id.* These are “permissive collateral source offsets.”

126. *Id.*

127. *Id.*

128. *Id.*

on additional doctor and hospital treatment.”<sup>129</sup> But the tort system does not make the doctor liable for such costs—costs that are partially offset by the collateral source rule.<sup>130</sup>

Additionally, the collateral source rule ensures that the wrongdoer—the doctor (and the doctor’s insurer)—pays for the wrong.<sup>131</sup> Abrogating this rule eliminates some of the wrongdoer’s responsibility and places it on the victim. It removes from the victim a source of payment for attorney’s fees, which are the product of the doctor’s negligent act, and it places that burden onto the negligently injured plaintiff.

The collateral source rule serves important judicial purposes. While eliminating the rule curtails some of the problems of the malfunctioning malpractice system, these benefits are not only minimal but also come at a heavy cost to the injured patient.

## *B. Reforms to Prevent Frivolous Lawsuits*

### 1. Sliding Scale Contingent Fee Systems

Many states have enacted sliding scale contingent fee systems for plaintiffs’ lawyers,<sup>132</sup> predominantly for two major reasons. First, too little of an injured plaintiff’s recovery actually goes back into the patient’s pocket. Proponents of limiting attorney contingent fee arrangements argue that by limiting fees, more of the actual recovery is channeled back to the victims. Second, there are too many frivolous lawsuits. In enacting sliding scale contingent fee systems, state legislatures argue that frivolous suits are reduced because fewer attorneys file suit merely in the hopes of hitting the jackpot.

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129. *Id.*

130. *Id.* Weiler notes that instead of protecting the patient’s litigation expenses with the collateral source rule, legislatures respond to the patient’s lost legal costs by arguing that “caps should be imposed upon the size of the contingent fee that patients can be charged by their lawyers.” *Id.* The author will address the effects of sliding scale contingent fee arrangements later in this article.

131. See Lewis, *supra* note 104, at 196. Lewis explains that the collateral source rule encourages people to obtain insurance and promotes the practice of third parties providing aid to the injured[. . .] helps ensure that plaintiffs are able to obtain representation[. . .] [and] protects against arbitrariness with respect to medical malpractice tort claimants and all other tort claimants by ensuring that the law in all tort cases is applied evenly.

*Id.* at 196-97.

132. See MARCHEV, *supra* note 15, at 10 tbl. 2. Marchev lists California, Connecticut, Delaware, Florida, Illinois, Indiana, Maine, Massachusetts, Michigan, New Jersey, New York, Oklahoma, Tennessee, Utah, Wisconsin and Wyoming as among the states which have limited attorney contingency fees under tort reform statutes. *Id.*

While these arguments correctly address two major problems in our current malpractice law, contingent fee reforms often miss their mark. Instead of protecting patients, such laws leave injured patients with no remedy at all.<sup>133</sup> Instead of preventing only the frivolous suits, such laws just as often prevent legitimate suits. When a plaintiff's attorney takes a case on a contingency fee basis and receives a percentage of the plaintiff's recovery,<sup>134</sup> the attorney recovers only *if the plaintiff wins the lawsuit*. Such an attorney fronts huge amounts of money to cover litigation costs at the risk that the defendant doctor will prevail and the attorney will go uncompensated for her hours of work. Increasing this financial risk to the plaintiffs' attorneys is the fact that medical negligence cases are difficult to win, because most juries are pro-doctor.<sup>135</sup> Plaintiffs' lawyers use the large fees obtained in winning cases to offset the financial losses incurred in losing cases, thereby securing their availability to injured plaintiffs. Reducing attorneys' contingency fees makes these attorneys much less likely to take malpractice cases and undercuts injured patients' available remedies.

Under most states' professional ethics codes, attorneys are required to give clients the choice of paying by the hour or choosing a contingency fee arrangement. Clients choose to pay on the contingency fee basis because it poses no financial risk to them and because they cannot afford to pay an attorney by the hour. The attorneys bear the financial risk.<sup>136</sup> This allows pa-

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133. While this author supports contingent fees systems as the only means of providing many injured plaintiffs with a remedy, other commentators have disagreed. *See, e.g.,* Lester Brickman, *The Market for Contingent Fee-financed Tort Litigation: Is it Price-competitive?*, 25 CARDOZO L. REV. 65, 71-72 (2003). Brickman makes several assertions regarding the unfairness in the contingent fee system, including the following:

[T]hat contingent fee lawyers charging standard contingent fees are routinely overcharging some claimants because, in many instances, the representation involves no meaningful risk of no or low recovery and therefore the substantial risk premium in these instances yields unearned and unethical windfall fees; . . . that these windfall fees often amount to effective rates of thousands of dollars an hour; . . . that the gross overcharging of tort claimants is not only in the interest of plaintiff lawyers but also benefits defendant lawyers[;] . . . that contingent fee lawyers engage in concerted efforts to hide their effective hourly rates from public view; [and] that the efforts at concealment of both effective hourly rates and risk levels incommensurate with risk premiums being routinely charged plays an important if not critical role in the tort reform wars currently being waged.

*Id.* at 71-73.

134. Oftentimes, this fee is one-third of the plaintiff's total recovery, after subtracting the costs of litigation.

135. *See* Peters, *supra* note 75.

136. One commentator suggests that plaintiffs' attorneys' actual risk is exaggerated. *See* Brickman, *supra* note 133, at 72. Brickman argues that "contrary to the claims of many tort lawyers, the actual risk level of most contingent fee lawyers'

tients who are injured by physician negligence to bring lawsuits. Cutting back on contingency fees awarded to plaintiffs' attorneys undercuts the attorneys' incentive to take such cases. Without the attorneys taking the cases, injured plaintiffs have no line of recourse for their injuries.

Instead of protecting injured patients' recoveries, contingent fee limitations often prevent them. Although such fee limitations decrease the number of frivolous lawsuits that plaintiffs' attorneys will file, they also undercut patients' already limited abilities<sup>137</sup> to proceed with meritorious claims. Preventing frivolous lawsuits can be better accomplished, without the resulting detriment to injured plaintiffs, through other measures, including screening panels.

## 2. Screening Panels

One reform that many states have enacted are screening panels, whereby a panel, often comprised of a lawyer, a physician,<sup>138</sup> and a judge,<sup>139</sup> determines the merits of a claim before it is filed in court. These panels are designed to eliminate meritless claims and their associated costs, to encourage settlement of meritorious claims, and to decrease malpractice insurance costs for doctors.<sup>140</sup>

Although the panels have shown some success in reducing frivolous claims, there have been accompanying problems. In some states, a panel's decision does not bind the plaintiff.<sup>141</sup> In these states, plaintiffs can merely use the screening panel as a testing ground for their lawsuit and beef up their case for trial if the first go-round proves unsuccessful.<sup>142</sup>

In such states, these problems are essentially undercutting the entire purpose of the screening panel system. Nevertheless, these problems can be drastically reduced by holding plaintiffs' lawyers accountable for filing frivolous suits. In order to prevent frivolous lawsuits, there needs to be some punishment for attorneys who continually file frivolous claims. Attorneys who

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portfolios of cases does not justify the substantial risk premiums they uniformly charge." *Id.*

137. *See Saks, supra* note 72.

138. In Massachusetts, the judge selects a doctor from a list of doctors which the Massachusetts Medical Society submits to him. *See MASS. GEN. LAWS* ch. 231, § 60B (2002). The physician must practice in the medical field in which the plaintiff's injury occurred, and must practice outside the county where the defendant doctor practices or lives. *Id.*

139. *See Feigenbaum, supra* note 70, at 1379.

140. *Id.*

141. *Id.* at 1380.

142. *See, e.g., N.M. STAT. ANN.* §§ 41-5-14 to -20 (Michie 1996) (in which the panel's report is not admissible at a later trial); *see also MONT. CODE ANN.* § 27-6-701 (2003) (in which the panel's findings are neither binding nor admissible at a later trial).

continue to file frivolous claims should no longer be allowed to file medical malpractice lawsuits.<sup>143</sup> Without such a provision in the screening panel statutes, plaintiffs' attorneys will continue using the screening panels as a testing ground for their suits.

Opponents of screening panels argue that they do not work. However, evidence suggests that any problems with panels are the result of both gaps in the statutes<sup>144</sup> and poor timing in their passage. Many screening panel statutes were enacted and overturned in a time when alternative forms of dispute resolution were much less popular. Despite the arguments that screening panels are not working, one commentator argues that they should be enacted in every state,<sup>145</sup> but with more uniformity across the states.<sup>146</sup>

## V. CHANGES IN MALPRACTICE LAW: THE MEDICAL PROFESSION

The doctors who are at risk of being run out of their profession by skyrocketing insurance premiums are specialists, such as surgeons and OB-GYNs.<sup>147</sup> General practitioners, on the other hand, are not being driven from the medical profession. In fact, surgeons and OB-GYNs are being driven into general practice because the liability insurance premiums of a general practitioner are affordable. This is a scary problem in many areas of the country, where high-risk, injured and sick patients need immediate care and no emergency or specialized care can be found.

Changes must be implemented in two ways to prevent this flight by medical specialists. First, it may be time for the government to subsidize these specialties.<sup>148</sup> The problem has reached epidemic proportions, with

143. Proposal of many Republicans and of John Edwards, Democratic candidate for Vice-President, during his 2004 campaign for the Democratic nomination for President. See John Edwards, Editorial, *Let's Keep Doctor's in Business*, WASH. POST, May 20, 2003, at A19.

144. Screening panels do not work if plaintiffs' lawyers can use them as a testing ground for their lawsuit.

145. See Macchiaroli, *supra* note 31, at 187.

146. *Id.* Macchiaroli attributes screening panels' varied success to the fact that their "requirements and procedures vary considerably." *Id.*

147. See TRENDWATCH, *supra* note 54 (stating that the "[h]igh-risk specialties, like obstetrics/gynecology and neurosurgery are most affected"); see also Patricia J. Fowler, *Medical Liability Insurance: Another Costly Crisis*, MICHIGAN'S OPPORTUNITIES AND CHALLENGES: MSU FACULTY PERSPECTIVES (Mich. State Univ. Extension), available at <http://www.msue.msu.edu/msue/iac/transition/papers/mediab.pdf> (last visited Apr. 10, 2005) (explaining that rising liability insurance premiums have produced a shortage of physicians in the high-risk specialties like obstetrics and emergency medicine).

148. See Cornell, *supra* note 1, at 3 (citing AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, RADICAL, INNOVATIVE STATE LEGISLATIVE REMEDIES (ACOG State Legislative Fact Sheet, 2002)). Arizona, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, North Carolina, Texas and Washington tried some form of subsidy pro-

some areas of the country losing their surgeons and OBGYNs.<sup>149</sup> Second, doctors should take care of their own, spreading these increasing costs throughout the profession. If the doctors who are involved in general practices and the low-risk specialties would shoulder some of the insurance costs of their high-risk colleagues,<sup>150</sup> liability insurance would be affordable for all doctors.<sup>151</sup> Doctors would not be forced into less risky practices, and patients needing specialized and emergency care would be able to find it.

## VI. CHANGES IN MALPRACTICE LAW: THE INSURANCE INDUSTRY

### *A. Rainy Day Reserves Accounting for the Insurance Cycle*

Efforts to reduce doctor's malpractice premiums often ignore the one player that actually sets those premiums—the insurance industry. Accordingly, many commentators have correlated doctors' rising liability insurance premiums to the state of the economy and the insurance cycle.<sup>152</sup> Citing studies which show that there is little correlation between tort reforms and the liability insurance premiums imposed on doctors,<sup>153</sup> these commentators ar-

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gram during the 1980s. *Id.* Most states quickly cut these programs when the insurance cycle steadied. *Id.* See also MARCHEV, *supra* note 15, at 7. Marchev explains that "rising malpractice premiums understandably cause great anxiety and concern on the part of physicians and may cause them to avoid high risk patients and procedures, notably in the field of obstetrics." *Id.* (citing R.A. Rosenblatt et al., *Tort Reform and the Obstetrics Crisis: The Case of the WAMI States*, 154 W. J. MED. 693, 693-99 (1991)).

149. See TRENDWATCH, *supra* note 54.

150. See Jones, *supra* note 5. A coalition of the most at-risk doctors, named Doctors for Medical Liability Reform (DMLR), is campaigning for Congress to impose statutory caps on damages. *Id.* DMLR consists of over 230,000 of our country's "neurosurgeons, orthopedic surgeons, obstetricians and gynecologists, cardiologists, thoracic surgeons, emergency [room] physicians, spine specialists, urologists and dermatologists." *Id.*

151. Ironically, doctors currently shoulder the responsibility of other doctors, but they shoulder the responsibility of those doctors who make the most mistakes (rather than those whose specialty makes them most at risk), because insurance companies do not experience-rate physicians.

152. See, e.g., MARCHEV, *supra* note 15, at 1. Marchev states, "While an increase in litigation and higher damage awards are often blamed for rising premiums, insurance companies may be equally culpable due to their pricing policies of the 1990s." *Id.*

153. See, e.g., Frank A. Sloan, *State Responses to Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment*, 9 J. HEALTH POL., POL'Y & L. 629 (1985) (in which Sloan studied the tort reforms of the 1970s, in which more than a dozen states enacting tort reforms limiting liability, and found that such reforms had little or no effect on liability insurance premiums for doctors).



gue that insurance industry reforms are the only way to prevent recurring availability and affordability crises.<sup>154</sup>

Liability insurance prices are artificially low during a booming economy. Because insurers make most of their money from investment returns,<sup>155</sup> they compete for premiums during good financial times.<sup>156</sup> When the economy shifts, insurers must hike prices to maintain their previous levels of profitability, levels which are unregulated in the law.<sup>157</sup> Because of the difficulty in predicting a receding economy and because each is averse to being among the first companies to raise its insurance rates, the premium hike comes even later than the economy warrants. The subsequent hike is then even larger than the economy justifies because the insurers must make up for losses they have already begun to incur. According to these commentators, the doctors who are at the greatest risk of being sued then face liability insurance rates that they cannot bear.

For stability in medical malpractice law, insurance rates should not directly reflect the rise and fall of the economy, but rather should reflect the specific costs to insurers for insuring physicians. Without some regulation of insurance industry profits, medical malpractice problems may never be solved.

### *B. Experience-rating Doctors*

Currently, doctors' insurance premiums are not experience-rated.<sup>158</sup> Today, malpractice premiums reflect geographic and specialty differences among doctors rather than an individual doctor's risk of being sued. While experience-rating is the standard procedure in most insurance contexts, it is almost never found in the medical malpractice setting.<sup>159</sup> The consequence is that "good" doctors pay for "bad" doctors' mistakes. Good doctors face

154. See FOUND. FOR TAXPAYER & CONSUMER RIGHTS, HOW INSURANCE REFORM LOWERED DOCTOR'S MEDICAL MALPRACTICE RATES IN CALIFORNIA AND HOW MALPRACTICE CAPS FAILED (Mar. 7, 2003).

155. See MARCHEV, *supra* note 15, at 6.

156. See *id.*

157. *Id.* Marchev explains how "the medical malpractice market remained stable through the economic boom years of the 1990s. During this period, medical liability insurance was one of the most profitable lines in the industry, and new companies entered the market enticing customers with bargain rates." *Id.* (citing NAT'L ASS'N OF INS. COMM'RS, REPORT ON PROFITABILITY 1997 (1999)). Marchev continues, "This price war for new customers prompted many insurers to sell malpractice coverage at rates too low to cover the costs of subsequent claims." *Id.* (citing Rachel Zimmerman & Christopher Oster, *Insurers' Missteps Helped Provoke Malpractice "Crisis"*, WALL ST. J., June 24, 2002, at A1).

158. Experience-rating refers to adjusting a doctor's insurance premiums based on the doctor's claims history. Fournier & McInnes, *supra* note 29, at 255.

159. *Id.*

higher premiums and are sometimes driven out of their specialties because of the skyrocketing premiums resulting from bad doctors' mistakes.

Holding accountable those doctors who cause the majority of the problems serves the purpose not only of reducing low risk doctors' subsidization of high risk doctors,<sup>160</sup> but of encouraging high risk doctors to take steps to reduce risk.<sup>161</sup> Thus, the good doctors pay premiums they can afford. The bad doctors cannot afford their premiums and are weeded out of the profession. As the bad doctors are weeded out, there are fewer patients negligently injured, and there are fewer lawsuits.

The results of holding accountable those doctors who are causing the majority of the problems seems obvious. The doctor wins with lower insurance premiums, and the patient wins with better care. This is one of the most obvious reforms that should be implemented, but it is a reform that often gets overlooked by state legislatures.

## VII. ANOTHER POSSIBLE REFORM: NO-FAULT INSURANCE

In response to many of the problems associated with the medical malpractice crisis—too many victims of malpractice going uncompensated, too much of a patient's recovery being swallowed up by litigation costs, and doctors being demoralized and stigmatized by medical malpractice lawsuits—many academics have proposed a no-fault system<sup>162</sup> to replace our current malpractice system.<sup>163</sup> Under a no-fault approach, patients who are injured as a result of medical treatment receive compensation for their injuries without a determination of whether the doctor negligently caused the injury. Under such a system, the savings are derived predominantly by eliminating the ex-

160. *Id.* (stating that “[a]djusting insurance premiums through experience rating has” the benefit that “cross-subsidization of high-risk subscribers by those of low risk is reduced”).

161. *Id.* (stating that “high-risk subscribers are given incentives to find cost-effective ways to reduce risk”).

162. *See, e.g.,* Weiler, *supra* note 25; *see also* Hyman, *supra* note 8, at 1639; Studdert & Brennan, *supra* note 23, 225.

163. *See* Weiler, *supra* note 25. Weiler proposes a no-fault approach, saying that [c]ontrary to doctors' impressions, injured patients do not sue at the drop of a hat . . . . There are far fewer suits than serious injuries; when claims are made, juries tend to sympathize more with doctors than with patients; and even successful plaintiffs obtain, on average, lower awards than they are supposedly entitled to receive.

*Id.* at 918 (footnote omitted). He further explains that “[m]ost of the claims brought are the wrong ones, inflicting a good deal of stress on innocent doctors and . . . tort damages are distributed in a highly erratic fashion, with a few lucky plaintiffs collecting huge awards, while most of the seriously injured receive much less than their actual economic losses.” *Id.* at 918-19 (footnotes omitted).

pensive litigation system<sup>164</sup> under which the largest costs are incurred.<sup>165</sup> The savings can then be funneled toward treatment of patients' injuries. Thus, more injured plaintiffs receive compensation for their injuries, eliminating the current system's problem of leaving so many injured patients uncompensated.<sup>166</sup> Plaintiffs do not have to undergo the extensive, exhaustive process of litigation and thus receive "faster, more efficient compensation."<sup>167</sup> Additionally, doctors are not stigmatized because there is no determination of negligence against them.<sup>168</sup>

Most no-fault theories further suggest an enterprise liability system whereby the hospital is responsible for the no-fault premiums. Under this theory, hospitals will enact guidelines to ensure patient safety because the hospitals will pay for the costs of negligent care.

While no-fault theories address problems in care by doctors, problems in compensation to injured patients, and problems in rising premiums for doctors, they are for the most part academic theories<sup>169</sup> that ignore the reality of

164. See Studdert & Brennan, *supra* note 23, at 229. Studdert and Brennan explain that "no fault programs absorb dramatically lower administrative costs than their tort counterparts." *Id.* at 230 (referencing Robert G. Elgie et al., *Medical Injuries and Malpractice: Is it Time for 'No-Fault'?*, 1 HEALTH L. J. 97, 113-15 (1993)). See also Weiler, *supra*, note 25, at 926. Weiler determines that malpractice litigation is costly for several reasons.

First, it is hard for patients to detect and document provider fault. This process often requires extensive discovery before the essential facts are uncovered and the claim can then be either paid or dropped. Second, doctors have strong personal and professional incentives to fight hard against any such admission or finding of carelessness on their part.

*Id.* Weiler then explains that medical malpractice cases take much longer even than motor vehicle cases, because doctors insist on going to trial and malpractice lawsuits "often involve multiple actors, each of whom spend duplicate resources in protracted disputes involving not only the patient-plaintiff, but also each other." *Id.* at 927.

165. Weiler, *supra* note 25, at 921-22. Weiler explains that proving whether an injury was the result of physician negligence "requires more monetary expenditures than does payment to the few patients who successfully litigate that issue." *Id.*

166. See Saks, *supra* note 72.

167. Studdert & Brennan, *supra* note 23, at 229.

168. See MARCHEV, *supra* note 15, at 14. Marchev explains that a "no-fault system would compensate patients for injuries without the need to determine blame or negligence on the part of doctors or other medical providers. Injured patients would be compensated according to a pre-determined schedule of damages." *Id.*

169. No-fault theories are academic theories, in the context of comprehensive medical malpractice reform. However, Virginia and Florida have implemented no-fault with severe neurological birth injuries, in an attempt to remove from the tort system these cases in which causation is very difficult to prove. VA. CODE ANN. §§ 38.2-5000 to -5021 (Michie 2002); FLA. STAT ANN. ch. 766.301-316 (West 2001). Also, the National Childhood Vaccine Injury Act of 1986 authorizes no-fault to handle victims of vaccine-related accidents. Omnibus Health Act of 1986, title II, Pub. L. No. 99-660, 100 Stat. 3743, 3755 (codified as amended at 42 U.S.C. §§ 300aa-1

the political process in which reforms must take place.<sup>170</sup> Currently, there is no support for a no-fault system—not from the medical profession, not from the plaintiffs’ bar, and not from the insurance industry.<sup>171</sup> With no lobby outside of academia, no-fault proposals currently have no real chance of action in state legislatures.<sup>172</sup>

## VIII. CONCLUSION

When we are sick or injured, we look to doctors to heal us. When death looms, we ask doctors to save us. The nature of the medical profession places

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to -34). For critical analysis of Florida’s no-fault program, see Sandy Martin, Comment, *NICA-Florida Birth-related Neurological Injury Compensation Act: Four Reasons Why This Malpractice Reform Must be Eliminated*, 26 NOVA L. REV. 609 (2002). Martin cites the Florida legislature as providing the no-fault approach to birthing injuries “to provide [a] compensation [plan], on a no-fault basis, for a limited class of catastrophic injury that result[ed] in unusually high costs for custodial care and rehabilitation.” *Id.* at 613 (quoting FLA. STAT. ch. 766.301(2) (2001)) (alterations in original). Martin attacks the legislative purpose, saying:

The statute has had two severe structural difficulties that undermined the faith one might have developed in the program. First, predelivery notice was written in to Florida’s version of limited obstetrical no-fault in the hopes that NICA could survive a due process attack. Erstwhile, it puts the provider’s family and livelihood on the line, directly contradicting one of the main legislative intents. Second, the narrow, restrictive definition of birth-related injury also threatens the very beneficiaries it was ostensibly designed to assist. The exceptions to coverage poke so many holes in NICA’s availability that the coverage ends up resembling Swiss cheese. It invites litigation where some of the primary benefits of a partial no-fault system viz a viz NICA is to avoid litigation and speed up solutions.

*Id.* at 644. Thus, according to Martin, even Florida’s statute, aimed at curing a specific harm in the area of OBGYN’s, has failed in its stated purpose.

170. See Palmer, *supra* note 23, at 1623. Professor Palmer argues that “no-fault analysis . . . is not useful to the patient safety debate” because the theory “los[es] sight of the fact that compensation might be important to others, such as potential consumers of health care and the plaintiff’s trial bar” and “the evidence available from studies of limited no-fault systems for medical accidents indicates that the complete elimination of litigation of claims is nearly impossible.” *Id.* See also MARCHEV, *supra* note 15, at 14 (where Marchev identifies the competing medical and legal factions as the root causes for preventing other reforms, such as no-fault liability, from being implemented). Marchv explains,

The national debate about the malpractice insurance crisis has been framed largely as a controversy between doctors and lawyers and has centered on the battle over tort reform. This has left little room for consideration of other reforms directed at making the legal system more efficient and more responsive to injured patients.

*Id.*

171. See Peters, *supra* note 69.

172. *Id.*

a huge responsibility on doctors. They are only human, and even the best make mistakes. The medical malpractice system is supposed to protect patients who are injured because of these mistakes, but it has been doing a poor job of protecting those patients. And while doing a poor job of protecting patients, it is doing an equally poor job of protecting doctors.

It is time for change in our malpractice law. State legislatures have recognized this but have limited reforms to tort law, enacting legislation aimed at limiting the size of jury awards and reducing the number of lawsuits filed.<sup>173</sup> These are short-sighted solutions which account for problems caused by only one of the three big actors<sup>174</sup> and which further perpetuate the law's failure to protect patients. While no-fault proposals address the problems in medicine, in the litigation system, and in the insurance industry, these proposals have little practical value outside of academic circles.

This Comment has proposed that action be taken by all three major players in the medical malpractice crisis. The first step may be to limit the number of frivolous lawsuits because frivolous suits not only impose direct costs on the system<sup>175</sup> but also perpetuate a system in which physician negligence does not correlate to physician accountability.<sup>176</sup> Limiting frivolous suits can be accomplished through a screening panel system in which trial lawyers are held accountable for the claims they file.<sup>177</sup> Holding these attorneys accountable and preventing them from merely using screening panels to test their cases and strengthen them for trial<sup>178</sup> is essential to making the system work.

With the number of frivolous lawsuits reduced,<sup>179</sup> experience-rating doctors' insurance premiums is the next step. It will serve to ensure that claims against doctors more accurately reflect patients' risk under a specific doctor's care. Thus, those doctors who are continually making mistakes will indeed be the doctors who are paying for them. Experience-rating will then serve to lower the insurance costs to low-risk physicians and will encourage high-risk physicians to adopt measures to limit risk to their patients.

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173. In other words, the AMA has been successful in its campaign that our doctors are not protected.

174. Only problems caused by the plaintiffs' bar are taken into account in many of the reforms enacted by state legislatures.

175. The direct costs include the administrative costs associated with defending a lawsuit.

176. This leads doctors to become demoralized and greatly reduces doctors' incentive to take measures to limit risk.

177. This can be accomplished through limitations on the number of "frivolous lawsuits" that an attorney can file, through determinations by the screening panel. For example, if a lawyer files three frivolous suits, that attorney can no longer file malpractice claims.

178. See Feigenbaum, *supra* note 70, at 1380.

179. As it will be reduced in this screening panel system in which attorneys are held accountable.

But experience-rating alone will not fix all liability insurance problems. The system should spread specialists' premiums throughout the medical profession or the government should subsidize medical specialties which inherently face greater malpractice risk. In other words, rather than having a system which subsidizes the bad doctors,<sup>180</sup> the government should subsidize the good doctors in high risk specialties.<sup>181</sup> Combined with experience-rating, specialist subsidization will ensure that the good doctors are not driven from their specialties.

Finally, it is time for regulation of insurance industry profits, time for the insurance industry to take its share of the blame and take steps to ensure that the above measures are not undercut during times of economic downturn. The evidence suggests that insurance companies continue to inflate rates during prosperous times and hit doctors with heavy premium hikes during times of economic downturn. Insurers need to adopt measures preventing premiums from reflecting the economy by putting back rainy day reserves during prosperous times. Otherwise, the insurance cycle will return once again, bringing about a fourth insurance crisis.

The fact is that the medical malpractice system is not working for doctors or for patients.<sup>182</sup> The reforms proposed in this Comment are not novel ideas, but when combined they put responsibility on all three of the big players in the liability crisis. While their enactment would not be a magical solution to all of the problems, these proposals do reflect the need for some unity among the three big players. Effective reform will take place only if each of the players spends a little less time pointing a finger at the others and a little more time looking in the mirror.

The reality is that if positive change is to take place, it will probably get done along political lines. Even if the plaintiffs' bar, the medical profession, and the insurance industry will not voluntarily accept some of the responsibility, state legislatures need to see that responsibility lies with all three actors. Legislators need to listen to the lobbies from all groups and develop a comprehensive program addressing each group's concerns. Our malpractice problems are not simply litigation problems,<sup>183</sup> poor medical care problems,<sup>184</sup> or insurance industry problems.<sup>185</sup> Only by recognizing its multiple causes will we resolve the medical malpractice crisis.

CHANDLER GREGG

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180. The bad doctors are subsidized when there is no experience-rating. Experience-rating will eliminate the subsidization of these poor performing physicians.

181. See TRENDWATCH, *supra* note 54.

182. See Mello & Brennan, *supra* note 22.

183. Masada, *supra* note 9; see also McAfee, *supra* note 12.

184. Rice, *supra* note 12.

185. See Casey, Jr., *supra* note 11.

