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# Is There an Acceptable Answer to Rising Medical Malpractice Premiums?

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*Dr. William P. Gunnar**

## I. INTRODUCTION

Throughout 2003, the 108th Congress debated the impact of a sweeping change to medical malpractice tort law on the American healthcare system: the adjudication of medical malpractice claims, and the medical malpractice insurance industry.[1] A central issue was whether legislative constraints on medical malpractice awards could stabilize or diminish rising physician malpractice premiums without affecting the availability of the tort system to an injured patient or the vitality of the medical malpractice insurance industry. Specifically at issue was The Help Efficient, Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2003.[2] The purpose of this legislation was to decrease the number of claims brought against physicians, slow the rate of rise in pecuniary awards to injured patient-plaintiffs, and decrease physician medical malpractice premiums.[3] The HEALTH Act, modeled after a series of California statutes enacted in 1975, mandated limitations on non-economic damages to injured patients, shortened the statute of limitations for presenting a claim, provided the physician the opportunity to present evidence of collateral source benefits, allowed for periodic payment of future damages, limited attorney's contingency fees, and eliminated joint and several liability. A version of this bill, supported by physicians and the medical malpractice industry and opposed by trial lawyers, passed the Republican led House of

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1. *See* Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003), *available at* http://www.gpoaccess.gov/bills/index.html.

2. *See, e.g.*, Jennifer Razor, *The Ripple Effects of the Medical Liability Crisis*, 88 BULL. AM. C. SURGEONS 8, 17 (2003).

3. *See generally* JOINT ECON. COMM., 108TH CONG., LIABILITY FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE (May 2003) (Vice-Chairman Jim Saxton, R-NJ), *available at* http://www.house.gov/jec/tort.htm [hereinafter Joint Economic Committee Study]

Representatives;[4] however, its counterpart in the Senate, The Patients First Act of 2003, failed to obtain the sixty votes required to pass a motion to proceed.[5]

Sweeping reform of the present medical malpractice tort system mandates investigation into the immediate and future effects such legislation would have on the distinct and justifiable interests of physicians, patients, lawyers, and medical malpractice insurers. Public interest in radical change to the healthcare system is universal. Physicians claim that the cost of medical malpractice insurance threatens public access to health care and that the cost to society for the practice of defensive medicine is exorbitant.[6] Lawyers plead the constitutional rights of the injured patient to a responsible legal system that assigns liability and awards damages appropriately.[7] Finally, medical malpractice insurers maintain that the vitality of the insurance industry protects public interest by assuring an available deep pocket when negligence occurs.[8]

This article seeks to outline the issues surrounding the present "crisis in healthcare" through exploration of the separate interests involved. Part II examines changes in physician reimbursement and overhead and the impact of these changes on availability of physician services. Part III describes issues that impact the legal system, specifically the injured patient and the attorney either representing plaintiff-patient or defendant-physician. Part IV examines the economic forces influencing the medical malpractice insurance industry. Part V describes categories of tort reform previously passed into law or considered by state and federal legislative bodies. Part VI predicts the impact of the HEALTH Act if passed and signed into law. Finally, Part VII proposes alternatives for malpractice reform.

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4. *See* Kathryn M. Pontzer, *AAOS Medical Liability Reform Legislative Activities: A Chronology*, AAOS BULL., Aug. 2003, at 2, *at* http://www.aaos.org/wordhtml/bulletin/aug03/wash.htm.

5. *Id.*; Am. Med. Ass'n (AMA), *Medical Liability Reform*, *at* http://www.ama-assn.org/ama/pub/category/6087.html (last visited Feb. 19, 2004).

6. *See* Am. Coll. of Surgeons, *Why America Needs Medical Liability Reform*, *at* http://www.facs.org/ahp/whyamerica.html (July 8, 2003).

7. See the home page for the American Trial Lawyers Association at http://www.atla.org with links to multiple articles including promotional sites for funding including http://www.atla.org/promotions/advertising/foa.aspx.

8. *See* U.S. GEN. ACCOUNTING OFFICE (GAO), PUB. NO. GAO-03-702, REPORT TO CONGRESSIONAL REQUESTERS, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (June 2003), *available at* http://www.gao.gov/cgi-bin/getrpt?GAO-03-702 [hereinafter GAO REPORT].

## II. THE PHYSICIAN'S POINT OF VIEW

### *A. Reimbursement*

Physicians' incomes have been steadily declining since the late 1980s, fueled in part by the passage of the Omnibus Reconciliation Acts (OBRA) of 1989 and 1990.[9] These statutory reforms of physician reimbursement by Medicare consisted of four initiatives and a mandate: limits on financial liability of Medicare beneficiaries through prohibition on balance billing; a resource-based relative value scale fee schedule to define the work associated with each physician service replacing the reasonable and customary fee-setting charge mechanism; a volume performance standard to address excess services (physician induced demand), expressed through a conversion factor; and a practice/malpractice expense measure to be implemented at a future time when an appropriate methodology could be worked out. The mandate was for five-year re-evaluations of the resource-based relative value scales to be conducted by the American Medical Association (AMA) through a Relative Value Update Committee (RUC).[10]

The relative value portion of the physician fee is proportioned as follows: a physician work component that measures the time, skill, and intensity associated with the service provided (accounting for 54.5% of a service's relative value); a practice-related expense component that measures average practice expenses such as office rents and employee wages and that varies depending on whether the service is performed in a facility or nonfacility setting (accounting for 42.3% of a service's relative value); and a malpractice expense component (accounting for 3.2% of the service's relative value).[11] The RUC is composed of twenty-nine members, twenty-three appointed by major national medical specialty societies and six representatives of Healthcare Advisory Organizations.[12]

The result of the changes legislated by OBRA has been the steady annual

9. The Omnibus Budget Reconciliation Act (OBRA) of 1989, § 6102, Pub. L. 101-239 (repealed 1998).

10. *See* Margaret M. Manning & J. Mark Waxman, *Physician Payment Reform: Implications for the Health Care System*, 9 HEALTHSPAN 3, 3, 7 (1992); Jack M. Matloff, *The Practice of Medicine in the Year 2010: Revisited in 2001*, 72 ANNALS THORACIC SURGERY 1105, 1105 (2001) [hereinafter Matloff, *Practice of Medicine*].

11. *See* JENNIFER O'SULLIVAN, CONG. RESEARCH SERV., MEDICARE: PAYMENTS TO PHYSICIANS (Jan. 1998), *available at* http://countingcalifornia.cdlib.org/crs/pdf/98-75.pdf.

12. *See* Alan M. Scarrow, *Physician Reimbursement Under Medicare,* NEUROSURGICAL FOCUS, Apr. 2002, at 1, 2 (2002), *available at* http://www.aans.org/education/journal/neurosurgical/apr02/12-4-8.pdf; AMA, Update Comm., *RVS Updating Committee and Members*, *at* http://ama-assn.org/ama/pub/category/3108.html.

decrease in physician reimbursement per procedure.[13] Particularly hard hit has been the income of the hospital-based physician specialist. The Centers of Medicare and Medicaid Services (CMS), previously know as the Health Care Financing Administration (HCFA), declared in 1992 that "specialists . . . do virtually all their work in hospitals, and Medicare already reimburses hospitals for overhead."[14] For example, cardiovascular surgeons sustained a 50% decrease in their income per procedure between 1989 and 2002, which, when adjusted to consumer-price index dollars, amounts to a startling 77.5% decrease.[15]

Historically, physicians have offset "discount service" to patients covered by Medicare, Medicaid, or self-pay (no-pay) payment plans with substantially greater reimbursement for services provided to those patients with private insurance or "up-front" fee-for-service. This "cost shifting" was possible until the middle to late 1990s when managed care began to dominate the healthcare industry and enforced "across-the-board" cuts in physician income.[16]

The traditional economic model treated physician services as a retail business—physicians managed their clinical and business practice, while patients chose a physician through referral or reputation.[17] Payment was made directly to the physician either by out-of-pocket payments or through an insurance plan.[18] Demands from the business community to decrease employee healthcare costs gave rise to the managed care industry. Between 1990 and 2000, managed care and managed competition in essence converted physician services from a retail business to a wholesale market. Health maintenance organizations (HMOs) acted as bulk purchasers of physician services through either direct employment of physicians or selective contracting with physician networks. The result dramatically weakened the physician's bargaining power.

The HMO bulk purchasers exercised market clout forcing physicians to be price takers, and soon, physicians were negotiating fee schedules based

13. *See* Matloff, *Practice of Medicine*, *supra* note 10, at 1106; *Medicare Program; Physician Fee Schedule Update for Calendar Year 2003*, 42 C.F.R. §§ 410, 414, 485 (2003).

14. *See* Jack M. Matloff, Meeting of the Joint Government Relations Committee for the Society of Thoracic Surgeons and American Association for Thoracic Surgery (Jan. 4, 1992); Jack M. Matloff, *Special Report of the Joint Committee on Government Relations*, 60 ANNALS THORACIC SURGERY 740, 743 (2001).

15. *See* Matloff, *Practice of Medicine*, *supra* note 10, at 1105.

16. *See* Kevin Grumbach, *Fighting Hand to Hand Over Physician Workforce Policy*, 21 HEALTH AFF. 13, 27 (2002), *available at* http://www.medscape.com/viewarticle/440692_print.

17. *Id.*

18. *Id.*

upon Medicare rates on a take-it-or-leave-it basis.[19] Medicare rates were viewed as a floor for negotiation, but in time, through capitation schemes and physicians' acceptance of lower fees in lieu of market share competition, reimbursement for physician services in many health care plans were established at a fraction of Medicare rates.[20] Many physicians when offered money up front for their practices readily sold their interests to Physician Practice Management corporations (PPMs), exchanging immediate profit taking and private ownership with contractual employment to a larger corporate entity.[21]

Enrollment in HMOs diminished between 1999 and 2000 as the business of managing healthcare systems became less desirable and patients became disenchanted with a system without choices. Many PPMs dissolved, leaving once employed physicians to reorganize with debt, lower reimbursement schedules, and further diminished income. The result has been a return to a similar retail market for physician services of over a decade ago, but with significantly lower fee schedules.[22]

An additional impact on physician income has been the rising number of uninsured or self-pay patients. The Emergency Medical Treatment and Active Labor Act (EMTALA) embodies the essence of the Hippocratic Oath through guarantees for medical care to all, regardless of an ability to pay.[23] EMATLA dictates that hospitals with emergency departments provide emergency care to anyone who requires it and that all patients with similar medical conditions must be treated consistently.[24] In other words, the healthcare system is accessible to all who need it, regardless of an ability to pay for services. The over forty million people in the United States without healthcare insurance receive "full service," hospital-based healthcare "free" and without reimbursement to either hospital or physician when they present to an emergency room.[25] Furthermore, 85% of physicians who serve Medicaid (public aid) patients are reimbursed at a fraction of Medicare rates and often experience long delays in payment receipt.[26]

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19. *Id.*

20. *See* Manning & Waxman, *supra* note 10, at 7.

21. *See generally* Jeffrey Stensland & Ira Moscovice, *Why Do Rural Primary Care Physicians Sell Their Practices?*, 18 J. RURAL HEALTH 93, 108 (2002).

22. Grumbach, *supra* note 16, at 13-27.

23. 42 U.S.C. § 1395dd (2000).

24. *Id.*

25. Razor, *supra* note 2, at 9.

26. *See generally* Peter J. Cunningham, Ctr. for Studying Health Sys. Change, Tracking Rep. No. 6, *Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001* (Dec. 2002), *at* http://www.hschange.org/CONTENT/505/ (last visited May 12, 2004).

In summation, overall physician reimbursement has diminished steadily since 1990 influenced primarily by changes in the Medicare fee schedule, negotiation of all other payment plans (including HMO reimbursement to a Medicare based fee schedule), and a significant proportion of uninsured or Medicaid patients receiving what is essentially free healthcare.[27] Physician specialists' income has been particularly hard hit, resulting in more than a 50% pay cut over the past decade.[28] Projections from CMS indicate physician reimbursement will continue to decrease over the immediate upcoming years.[29] Healthcare delivery in the United States is returning to a market based system, albeit modified by business schemes initiated by HMO and PPM entities. Patients prefer to maintain flexibility in choosing a physician and healthcare facility, indicated by their support for traditional physician-patient relations and diminishing interest in managed care delivery systems.

### *B. Overhead*

Physicians have experienced an annual increase in practice overhead to maintain offices, personnel, and malpractice insurance premiums.[30] Medical malpractice coverage is essential to a physician's practice and a recent rise in premium rates has had a considerable impact on overall net income.[31] Hospital bylaws generally require physicians to carry at least $1 million to $3 million in coverage to maintain medical staff privileges.[32] Florida is an exception to the rule and does not require physicians to have liability insurance, but rather mandates physicians post a bond of $250,000 in place of contractual insurance coverage.[33] For the vast majority of physicians, failure to maintain malpractice insurance precludes his or her ability to practice medicine. Foregoing malpractice coverage or "going bare" is neither practical considering the liability exposure, nor possible if the physician desires to continue practicing.

Medical malpractice premiums have risen dramatically over the past

27. Matloff, *Practice of Medicine*, *supra* note 10, at 1105-06

28. *Id.* at 1106.

29. Razor, *supra* note 2, at 10.

30. *See* Am. C. of Emergency Physicians, *Emergency Physician Overhead* (June 2002), *at* http://www.acep.org/1,479,0.html; Fredrickson Healthcare Consulting, *"It's the Revenue, Stupid!": Revenue is the Key to Medical Practice Performance Improvement* (Spring 2001), *at* http://www.fredhealth.com/articles/2.htm.

31. GAO REPORT, *supra* note 8, at 6-12.

32. *Id.* at 6.

33. *See* HCPro, Inc., *Jury Awards Putting Some Docs in the Poor House or Out of Practice*, DOCTOR'S OFF., June 2003, *at* http://www.hcpro.com/ppv.cfm?content_id=33401.

decade with exceptional rate increases in the past two years.[34] *Time Magazine* reported the experience of one Illinois neurosurgeon who, when notified that his malpractice premium had been increased to $468,000, was forced to either move to another state with better rates or quit.[35] This article, reporting data provided by subspecialty societies, identified neurosurgeons as a group to have experienced a 35.6% increase in premium rates between 2001 and 2002.[36] Other subspecialties, including obstetrics and gynecology, emergency medicine, orthopedic surgery, and general surgery reported average rate increases over the same time period ranging from 19.6% to 56.2%.[37]

Malpractice insurance rates imposed upon physicians are non-negotiable. Physicians are unable to shop for competitive malpractice insurance rates because prevailing rates are similar between companies.[38] Moreover, the number of insurance companies extending malpractice coverage to the physician is decreasing.[39] In Illinois, as of 2003, only six medical malpractice insurance providers remain from a field that was once twenty. The physician's dilemma is not which company will contract for his liability, but rather which company will accept to contract for his business. Therefore, physicians are at the mercy of a shrinking pool of insurance companies willing to underwrite medical malpractice.[40] Since practicing without medical malpractice insurance is neither practical nor possible, physicians accept available rates or face the inability to practice and unacceptable liability risk for the upcoming years.[41]

Medical malpractice insurers spread liability risk among physicians by primarily taking into account specialty of practice, practice location, and years in practice.[42] An individual physician's malpractice claims history, accumulated settlement payments, and history of disciplinary actions by the hospital are not particularly influential in determining malpractice premium rates. Since 1990, approximately 54% of malpractice awards and settlements have resulted from just 5% of physicians, according to the

34. GAO REPORT, *supra* note 8, at 6-12.

35. Daniel Eisenberg & Maggie Sieger, *The Doctor Won't See You Now*, TIME, June 9, 2003, at 52-53.

36. *Id.* at 55 (graph).

37. *See id.* at 46.

38. *See* HCPro, Inc., *supra* note 33, at 1.

39. Eisenberg & Sieger, *supra* note 35, at 49.

40. Grace Vandecruze, *Has the Tide Begun to Turn for Medical Malpractice?*, HEALTH LAW., Dec. 2002, at 15.

41. *See id.*

42. Philip K. Howard, *Yes It's a Mess—But Here's How to Fix It*, TIME, June 9, 2003, at 62.

National Practitioner Data Bank.[43] These high risk physicians do not realize a proportionate increase in their malpractice premiums coincident with their claims history. Instead the risk of these individuals is spread among members of similar specialties.

Physicians new to the practice of medicine receive a graduated increase in premium rates over the first five years of practice to reflect exposure, while retiring physicians receive a huge benefit under certain conditions.[44] New physicians have limited claim exposure because they have not built a practice and full liability exposure requires time in practice. On the other hand, retiring physicians, regardless of claim history, receive what can be an enormous financial benefit under certain circumstances. Typically, to maintain medical malpractice coverage beyond the period of claims-made coverage, a retiring physician would be required to purchase a tail policy. A tail policy is usually calculated at two and one-half times the amount of the past year's premium. Hypothetically, a physician planning on retirement who paid $100,000 in his last year of practice would be required to pay $250,000 within a month of retirement to maintain liability coverage for his period of exposure or establish with the insurance provider a payment plan for the same amount over two years. It is customary practice for an insurance company to waive the cost of tail coverage to the physician who has reached fifty-five years of age and paid premiums for a period of five or more years with the same company because tail coverage imposes a large financial burden on the retiring physician. The cost of this policy is then spread among the practicing physicians of similar specialty. If the neurosurgeon exemplified in the *Time Magazine* article had paid $468,000 for his malpractice coverage, and then retired the following year, he would be required to purchase a tail policy costing $1.17 million to cover his future liability, if not waived by specified conditions.

The American Association of Health Plans (AAHP) surveyed AMA members the past two years and found that medical malpractice liability and associated insurance premiums were overwhelmingly the primary legislative concern of physician constituents.[45] During the 2003 spring meeting of the American College of Surgeons 2003, Donald Palmisano,

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43. THE HOUSE COMM. ON THE JUDICIARY, 108TH CONG., DISSENTING VIEWS TO H.R. 5, at 2, *available at* http://www.house.gov/judiciary_democrats/issues/views.html.

44. The bases for the information in this paragraph are multiple conversations between the author and medical malpractice insurance agents in the pursuit of medical malpractice coverage. Between 1993 and 2003 the author was a practicing cardiovascular surgeon and officer of a private practice medical corporation operating in Cook and DuPage counties, Illinois.

45. Genevieve Belfiglio, *Partnering for Malpractice Reform*, HEALTHPLAN, Mar./Apr. 2003, at 1, *available at* www.aahp.org.

M.D., J.D., President-elect of the AMA, addressed the current state of medical malpractice premiums in the United States and emphasized that the most serious consequence of rising overhead and diminishing physician income would be limits placed on public access to necessary healthcare.[46]

Across the nation, physicians have reacted to rising malpractice premium overhead through protest, work slowdown, migration from a region with high malpractice insurance rates to a region with lower premiums, limiting practice to avoid emergency or high risk procedures, or leaving the practice of medicine all together.[47] These activities have not been endorsed by the AMA.[48] Physicians in Florida, New Jersey, Mississippi and West Virginia have closed their offices and postponed non-emergency care in order to hold protest rallies and lobby elected officials.[49] In July 2002, physicians in Las Vegas, Nevada, closed the main trauma center for ten days in response to rate increases from $40,000 to $200,000 in one year.[50] Mississippi towns with populations of 20,000 or less no longer have obstetrical care.[51] Washington State's largest neurosurgical group lost its insurance, leaving hospitals without emergency room coverage.[52] Nine hundred physicians in Pennsylvania closed practices.[53] Family practitioners in Bisbee, Arizona, have closed the maternity ward in response to insurance rate increases of 500%.[54] Florida radiologists are considering avoiding services associated with risk such as reading mammograms.[55] In Illinois, patients with head injuries must be transported forty-five minutes from Joliet to Chicago to obtain emergency care due to absence of emergency neurosurgical coverage.[56] Currently, eighteen states are experiencing critical physician shortages particularly in neurosurgical and obstetrical care as a direct response to the cost of malpractice insurance premiums.[57]

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46. *Cf.* Christine Wiebe, *Doctor Walk-Outs Highlight Need for Malpractice Reform* (Feb. 10, 2003), *at* http://www.medscape.com/viewarticle/449219.

47. *See generally* Eisenberg & Sieger, *supra* note 35, at 46-60.

48. *See generally* Wiebe, *supra* note 46, at 1. *See also* Razor, *supra* note 2, at 11.

49. *Id. See also* Eisenberg & Sieger, *supra* note 35, at 50-52. According to the Joint Economic Committee Study, malpractice insurance premiums in 2002 averaged $201,376 for Ob/Gyns, while the average was $176,268 for general surgeons. *See* Joint Economic Committee Study, *supra* note 3, at 15.

50. Symposium, *Medical Malpractice: Innovative Practice Applications*, 6 DEPAUL J. HEALTH CARE L. 309, 311 (2003) [hereinafter Medical Malpractice Symposium].

51. *Id.* at 311.

52. Eisenberg & Sieger, *supra* note 35, at 55 (graph).

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. Eisenberg & Sieger, *supra* note 35, at 55; Kaveh G. Shojania et al., *MedGenMed's Selection of the Top 10 Medical/Health Stories of 2002* (Dec.19, 2002) *at*

Physicians may also elect to no longer care for patients who receive their health care benefits through government programs.[58] A study by the Center for Studying Health System Change reports a growing problem of Medicare and Medicaid patients being denied access to physician care.[59] When physicians opt-out of Medicare and Medicaid programs or any restrictive health insurance plan, under certain conditions, they have the right to return to fee-for-service billing.[60] Once having elected not to participate in Medicare and Medicaid, a physician is essentially limited to a "boutique practice," frequently without hospital privileges.[61]

The impact of physician shortages will be noticeable for years to come.[62] In 2001 and 2002, surgical program directors noted a worrisome reduction in the number of United States medical students applying for general surgical training.[63] In 2001, there were sixty-nine unfilled first-year surgical residency positions.[64] Moreover, the attrition rate for general surgical residents is between twenty to 30% for the five year training period, and sometimes longer if independent research time is required. Estimates indicate that by 2005, only 5% of medical school graduates will choose a career in general surgery.[65] Factors which have forced applicants to nonsurgical fields are the rigorous training period, long work hours associated with diminished reimbursement, proportionately higher

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http://www.medscape.com/viewarticle/446310. *See also The Medical Liability Insurance Crisis: A Review of the Situation in Pennsylvania: AMA Statement to the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives*, 108th Cong. (Feb. 10, 2003) (statement of Donald J. Palmisano, President, AMA), *available at* http://www.ama-assn.org/ama/pub/article/6281-7329.html [hereinafter Palmisano Testimony]. The AMA argues that the liability system has created a crisis in health care. The AMA also lists another twenty-six states and the District of Columbia showing signs of a serious medical liability problem. Press Release, AMA, 18 States Now in Full-Blown Medical Liability Crisis (Mar. 3, 2003), *at* http://www.ama-assn.org/ama/pub/article/1616-7340.htm.

58. Thomas W. Greeson & Heather L. Gunas, *Medicate Private Contracting: Section 4507 and the Importance of Private Contracts*, 10 HEALTH MATRIX 35, 41 (2000).

59. *Growing Physician Access Problems Complicate Medicare Payment Debate*, ISSUE BRIEFS, NO. 55 (Sally Trude & Paul B. Ginsburg, Ctr. for Studying Health Sys., Washington, D.C.), Sept. 2002, at 1.

60. Greeson & Gunas, *supra* note 58, at 41.

61. 42 C.F.R. § 405.415(k) (2003). Private contracts between physician and patient may not be entered at times of emergency or urgent care services. 42 C.F.R. § 440.440(b) (2003). A non-participating physician may provide emergency or urgent services to a Medicare beneficiary if the physician has no prior contract with the patient and a Medicare fee schedule is accepted.

62. Steven G. Friedman, *Anyone in the O.R.?*, N.Y. TIMES, June 10, 2003, at A29.

63. Author conversations with surgical program directors in the Chicago area.

64. Friedman, *supra* note 62, at A29.

65. *Id.*

malpractice rates, and lifestyle considerations.[66] The average debt carried by a graduating medical student is now $109,457, while more than 25% carry a burden over $150,000.[67] A plastic surgeon responded to a December 2002 article entitled, *Shrinking Applicant Pool for Surgery Residency Programs*, with the following comments:

> My recollection of the general surgery residency training experience is clouded by the customary severe sleep deprivation during that time in my life. But what I do remember is that the experience was far from pleasant. General surgery residency training involved inhumane work hours with little sleep. The potential for lethal mistakes, peer ridicule, and massive doses of caffeine served to keep me barely awake during this time in my life. In addition, all of us were under constant stress to learn an enormous quantity of information for our yearly in-service exams, despite being overseen by "academic surgeons," many of whom taught very little and criticized very much. General surgery residency all but made it impossible to have a healthy relationship, and friendships suffered as well. All of the negatives at the time were offset by the belief that when we finished we would be rewarded by our hard work and sacrifice. It turns out that with managed care, the carrot at the end of the dark tunnel isn't as big or as tasty as we were led to believe. Is it really a surprise, then, that presumably smart men and women are shying away from a training experience that is arduous, lifestyle-crippling, at times humiliating, almost always stressful, and not that helpful in eventually gaining a healthy income? [68]

Increasing numbers of foreign medical school applicants are filling available residency slots. The *Chicago Tribune* reported that, in 1999, 80.3% of obstetrics and gynecology residencies were filled by United States medical school graduates,12.8% were filled by foreign medical schools or independent applicants, and 6.9% remained unfilled.[69] In 2003, 68.3% of the positions were filled by United States medical school graduates, 22.9% by foreign medical school graduates or independent applicants, and 8.8% remained unfilled.[70]

As a result, rising physician overhead and, specifically, dramatic

66. Albert B. Lowenfels, *Recruitment and Retention of Residents: Lessons Learned and Prescription for the Future* (2003), *at* http://www.medscape.com/viewarticle/453456.

67. AMA, *Medical Student Debt* (Feb. 17, 2004), *at* http://www.ama-assn.org/ama/pub/printcat/5349.html.

68. Susan L. Smith, *We Hear You—Responses from Shrinking Applicant Pool for Surgery Residency Programs* (Feb. 14, 2003), *at* http://www.medscape.com/viewarticle/449176.

69. Bruce Japsen, *Obstetrics Practices Thin as Costs Rise*, CHI. TRIB., June 15, 2003, at C1.

70. *Id.*

increases in medical malpractice insurance premiums have come to the attention of the national media and federal government. Public access to healthcare is of considerable concern as increasing numbers of physicians move to states with lower malpractice premium rates, limit their practice to lower risk procedures, or quit altogether. Of future concern to the delivery of healthcare is the negative effect financial expectations and lifestyle considerations have on influencing physician applicants to residency positions; particularly, United States medical school graduates' choices regarding post-graduate training in the fields of obstetrics and gynecology, general surgery, and surgical subspecialties, particularly neurosurgery, thoracic surgery, and cardiovascular surgery.

### *C. The Impact of Litigation*

Medical malpractice lawsuits have produced feelings in physicians of being singled out and placed in a negative public light. For example, a Harvard study demonstrated that physician perception of the risk of being sued is three times the actual risk, with physician specialists experiencing the greatest vulnerability to litigation.[71] Family practitioners report that the seven most common reasons for patients to sue are: failure to diagnose or delay in diagnosis; negligent maternity care practice; negligent fracture or trauma care; failure to consult in a timely fashion; negligent drug treatment; negligent procedures; and failure to obtain informed consent.[72] Physicians have come to believe that every patient is a potential lawsuit associated with ridicule, public disclosure of events and circumstances surrounding the patient's care, comparison with a colleague's "expert opinion" as to the standard of care, and time away from practice.[73]

In order to avoid liability, physicians take precautionary measures and practice defensive medicine. This risk-management style of medical practice can be characterized by the four Cs: compassion, communication, competence, and charting.[74] Unfortunately, the practice of defensive medicine has resulted in a dramatic increase in the cost of medical care to both the individual patient and society as a whole. A 1993 study revealed that defensive medicine accounted for five to fifteen billion dollars of

71. *See Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York, in* THE REPORT OF THE HARVARD MEDICAL PRACTICE STUDY TO THE STATE OF NEW YORK 9-58 to 9-59 (1990). *See also* Alan Feigenbaum, *Special Juries: Deterring Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, 1372 (2003).

72. Richard G. Roberts, *Seven Reasons Family Doctors Get Sued and How to Reduce Your Risk*, FAM. PRAC. MGMT., Mar. 2003, at 31-32.

73. Feigenbaum, *supra* note 71, at 1372.

74. Roberts, *supra* note 72, at 32.

unnecessary medical costs per year, primarily through ordering of diagnostic tests for legal, rather than medical, purposes.[75] Current estimates of healthcare savings—if physicians could practice without provider liability—are as high as $69 billion to $124 billion.[76]

## III. THE LAWYER'S POINT OF VIEW

### *A. The Injured Patient*

*U.S. News and World Report* reported the findings of the Physician Insurers Association of America in 2002: in a sample of 5524 malpractice cases, 0.9% resulted in jury verdicts for the plaintiff, 27.4% were settled before trial, 67.7% were dropped or dismissed, and 4% ended in a verdict for the defendant.[77] In other words, when a malpractice case goes to trial, the injured party has only a 20% chance of a verdict returned in his favor. The total number of cases resulting in a jury verdict for the plaintiff has remained stable over recent years at around 400 cases annually, as reported to the federal National Practitioner Data Bank (NPDB).[78] Between 1995 and 2000, the median national jury award in malpractice cases doubled from $500,000 to $1 million.[79] However, the NPDB reported the sum of all jury awards against physicians increased only 20% from $143 million in 1993 to $172 million in 2002.[80] Seven of the top twenty verdicts in 2001 and 2002 occurred in medical malpractice suits amounting to total payouts of $3.0 billion.[81] Enormous jury verdicts such as the $140 million awarded to a brain damaged four year-old are levied against the physicians and the facility, which can be either a hospital or nursing home.[82] The overwhelming majority of all claims are levied against the deep pocket—either the hospital or related health care facility—and not the physician.[83] Interestingly, and perhaps unfairly, the burden of the overall cost for

75. Neville M. Bilimoria, *New Medicine for Medical Malpractice: The Empirical Truth About Legislative Initiatives for Medical Malpractice Reform—Part I*, 27 J. HEALTH L. 268 (1994).

76. Joint Economic Committee Study, *supra* note 3, at 13.

77. Christopher H. Schmitt, *A Medical Mistake*, U.S. NEWS & WORLD REP., June 30, 2003, at 24-27.

78. *Id.* at 24.

79. *See* Medical Malpractice Symposium, *supra* note 50, at 310.

80. *See* Schmitt, *supra* note 77, at 24.

81. Robert P. Hartwig, Presentation at the American Academy of Orthopaedic Surgeons, *Trends in Medical Malpractice Insurance: Behind the Chaos*, Apr. 25, 2003 (data is from LAWS. WKLY. U.S.A., Jan. 2003).

82. Schmitt, *supra* note 77, at 24; Vandecruze, *supra* note 40, at 15.

83. Medical Malpractice Symposium, *supra* note 50, at 283.

medical malpractice insurance is shouldered by the physician. In 2001, the total premium for medical malpractice insurance exceeded $21 billion and was paid for by the following parties: 60% by physicians, 28% by hospitals, and 12% by other entities.[84]

Over recent years, the amounts paid in settlement to the plaintiff has risen dramatically while the number of annual lawsuits has remained stable.[85] Between 1995 and 2000, the median settlement amount in the U.S. rose from $350,000 to $500,000.[86] Factors that compel a pre-trial settlement include the 80% risk of a jury verdict for the defendant and the potential for an enormous jury verdict for the plaintiff.[87]

An essential element of the United States tort system is a requirement that the injured party be returned to whole, best achieved through a pecuniary award.[88] Awards to the injured patient include the cost of past and future economic damages as well as any non-economic damages such as pain and suffering. Influential to the valuation of damage awards is the cost to deliver healthcare: healthcare spending in the United States rose 10% in 2001 and 9.6% in 2002, compared to a 2002 increase in U.S. consumer prices of 2.4%.[89] In 2002, spending on inpatient hospital care grew by 6.8% and the costs of outpatient hospital care rose by 14.6%.[90] The cost of healthcare and anticipated future increases are reflected in medical malpractice settlement and jury awards. In other words, past and future economic damages related to the sustained injury include accumulated medical expenses and estimated costs of future medical care. When viewed in this light, the rise in payments by defendant-physicians to injured patient-plaintiffs is reasonably proportional to the overall rising cost of healthcare.

### *B. The Plaintiff's Attorney*

The contingency fee system has been beneficial to both plaintiff-patient and lawyer.[91] In comparison to a retainer and fee-for-service payment

84. GAO REPORT, *supra* note 8, at 4 (citing TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2002 UPDATE-TRENDS AND FINDINGS ON THE COSTS OF THE U.S. TORT SYSTEM 16 App.5, (2003).

85. *See* Eisenberg & Sieger, *supra* note 35, at 51.

86. Medical Malpractice Symposium, *supra* note 41, at 310.

87. Schmitt, *supra* note 77, at 24.

88. VICTOR E. SCHWARTZ ET AL., PROSSER, WADE AND SCHWARTZ'S TORTS 518-65 (10th ed. 2000).

89. Kim Dixon, *U.S. Health Costs Rose 9.6% in 2002—Study*, REUTERS, June 11, 2003, *available at* http://www.forbes.cin/home/newswire/2003/06/11/rtr996684.html.

90. *Id. See also* Bruce Japsen, *Health Cost Rise Slows but Patients Pay More*, CHI. TRIB., June 12, 2003, §1, at 1.

91. Feigenbaum, *supra* note 71, at 1382-83. *See also* Eric Helland & Alexander

method, the patient represented by counsel working on contingency is not required to pay any money for legal representation and thus suffers no economic loss regardless of the outcome of the case. The plaintiff attorney is typically compensated one-third of the amount awarded to the injured patient at the time of settlement or jury award. The contingency fee system, supported by the Model Code of Professional Responsibility and the Model Rules of Professional Conduct, both of which are authored by the American Bar Association, provides access to the American legal system to all injured patients, guarantees Rule 11 protection against frivolous lawsuits, and discourages lawyers from pursuing cases which have little or no merit.[92] Plaintiff attorneys absorb the cost of litigating malpractice claims[93] with the knowledge that only 28% of malpractice lawsuits result in an award to their client, either through settlements or jury verdict award. The attorney's cost of bringing the case of an injured plaintiff to trial can average in the range of $35,000 to $50,000.[94] Adverse to the physician's sense that the large dollar amounts of select medical malpractice jury awards compel a plaintiff's attorney to bring baseless claims, the prevailing forces demand that the plaintiff's attorney select his cases wisely on the merits of the claim and likelihood of compensation to an injured client. Only in settlement negotiations by representative parties or jury verdict adjudicated under the full power of the court will the plaintiff's attorney find compensation for his preparation and performance.

### *C. The Defense Attorney*

Medical malpractice insurance providers contract legal representation of their physician clients.[95] The defense attorney is paid on an hourly fee-for-service basis negotiated and agreed to by their insurance provider client. The physician is provided a defense attorney under this agreement with whom he discusses the claim, relevant evidence, and potential expert

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Tabarrok, *Contingency Fees, Settlement Delay, and Low-Quality Litigation: Empirical Evidence from Two Datasets*, 19 J.L. ECON. & ORG. 517 (examining whether legal quality is lower under contingency or hourly fees and finding contingency fees increase legal quality and decrease the time to settlement).

92. Feigenbaum, *supra* note 71, at 1382-83.

93. Schmitt, *supra* note 58, at 24.

94. Medical Malpractice Symposium , *supra* note 50, at 311.

95. The author has provided medical expert testimony in the past ten years for both plaintiff and defense. The commentary in this paragraph is the product of this experience. Insurance companies regulate the fees the defense attorney may contract to pay medical experts on behalf of the defendant-physician client. In my opinion the reimbursement rate paid to medical experts by the insurance carrier for medical expert testimony to defend the physician client is approximately one-third to one-half the rates paid by the plaintiff attorneys for similar services.

witnesses for his defense. The defense attorney performs his duties to the physician under guidelines imposed by the insurance provider client to limit costs.[96] These limitations influence the choice and fees paid to medical experts and settlement if the plaintiff's allegations have sufficient merit. Although the choice of whether to sign off on a negotiated settlement or send the case to trial remains the physician's ultimate decision, the insurance provider has influence and must approve any settlement offer. Therefore, physicians have to answer all claims of negligence; they do so through representation of defense counsel, who is under contract with the insurance provider directing payment for his services. It is unclear how often the relationship between insurance provider and defense attorney ignores the issue of physician fault and offers a settlement just to avoid the costs of further litigation or the potentially large jury award.

A July 2002 report prepared by the U.S. Department of Health and Human Services (HHS) identified that the cost to defend a medical malpractice claim averaged over $24,000.[97] The AMA has concluded that considerable economic resources are diverted from patient care to "fruitless legal wrangling," citing that the overwhelming majority of claims are ultimately dismissed.[98]

The defense attorney's platform upon which he bases representation to a medical malpractice claim is the applicable and nationally uniform standard of care, as represented by expert testimony.[99] This standard of care is taught through medical training and tested by National Board Exams. Few restrictions prevent a patient-plaintiff from both bringing a malpractice claim and prevailing; however, this depends on whether he can show by a preponderance of the evidence that the physician-defendant negligently breached the applicable standard of care during performance of his duties. Physicians have taken offense to what they believe are baseless claims and have in the past brought countersuits in response.[100]

Countersuits against the patient-plaintiff and representative attorney have been pursued under several theories including primarily malicious

96. I was recently requested to provide expert medical testimony on behalf of a defendant-physician in a case of alleged medical malpractice. Following my review of the medical record I was instructed to meet with the defense attorney and a representative of the physician's medical malpractice insurance carrier to discuss my findings and, in this case, appropriate platform for what was an eventual pre-trial settlement.

97. U.S. DEP'T HEALTH & HUMAN SERVS. (HHS), CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 8 (July 25, 2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.htm.

98. Palmisano Testimony, *supra* note 57.

99. SCHWARTZ ET AL., *supra* note 88, at 168-70.

100. Feigenbaum, *supra* note 71, at 1373-77.

prosecution, abuse of process, and defamation.[101] In most situations, these defense positions have been unsuccessful since courts are reluctant to discourage plaintiffs from utilizing the judicial system for meritorious claims.[102] Specifically, the burden of proof required of the physician in each of these counterclaims is difficult to establish. Malicious prosecution requires a favorable termination of the initial lawsuit in the physician-defendants favor,[103] a high burden of proof for probable cause,[104] and proof of malice defined as improper motive or wanton purpose.[105] A counterclaim for abuse of power requires proof that the attorney representing the patient-plaintiff brought suit against the physician-defendant with an ulterior purpose or motive. This is a difficult burden, requiring an inquiry into the subjective mind of the party bringing the suit.[106] Defamation claims typically fail because attorneys have an absolute privilege to publish defamatory statements made during the course of judicial proceedings as long as the statements have some relation to the proceeding.[107] Moreover, the cost of "defending one's character" would be placed on the physician-defendant since counterclaims unrelated to the actual defense of the negligence allegation would fall outside the contractual obligation with the medical malpractice insurance provider.[108]

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101. Linda A Sharp, *Medical-Malpractice Countersuits*, 61 A.L.R.5th 307, at 1A (1998).

102. *See, e.g.*, *Physician's Countersuits*, 35 AM. JUR. TRIALS 225, § 4 (2003).

103. Lackner v. LaCroix, 602 P.2d 393, 394 (Cal. 1979) (stating the dismissal of the malicious-prosecution action was based upon the determination that the underlying action did not meet the element of termination in favor of the physician).

104. Williams v. Coombs, 224 Cal. Rptr. 865, 874 (3d Dist. 1986) (concluding that "the objective standard should be measured by whether a prudent attorney, after such investigation of facts and research of the law as circumstances reasonably warrant, would have considered the action to be tenable on the theory advanced").

105. Morowitz v. Marvel, 423 A.2d 196, 198 (D.C. 1980) (stating that a showing by the plaintiff's physician of "special injury" is required, and not, as in this case, just the injuries "incident to any litigation").

106. Bull v. McCuskey, 615 P.2d 957, 960 (Nev. 1980) (one of the few cases in which a court affirmed judgment against an attorney when the attorney filed suit without reviewing medical records or obtaining medical expert opinion). The court held that it was permissible for the jury to believe that the attorney used process for the ulterior purpose of coercing a nuisance settlement since the attorney offered to settle the case for $750. *Id.*

107. Wright v. Yurko, 446 So. 2d 1162, 1164 (Fla. Dist. Ct. App. 1984) (defamation claim brought by physician against plaintiff's attorney and plaintiff's medical expert failed when the court held that defamation committed in the course of judicial proceedings is not actionable and that the parties and witnesses have absolute immunity).

108. Medical malpractice insurance carriers limit coverage of physicians to claims-made.

## IV. THE INSURANCE INDUSTRY

In 2001 medical malpractice insurers paid out $1.53 in claims and expenses for each $1 in premiums collected.[109] To hedge losses, these companies either: make decisions which impact physician clients; continue with double digit increases in premiums to meet budget deficits; refrain from contracting with physicians in regions with the greatest risk; or eliminate malpractice coverage all together.[110] For example: SCPIE Holdings, California's second largest malpractice insurer, pulled out of Texas and Georgia markets due to projected losses; St. Paul Companies of Minnesota, providing malpractice coverage for 42,000 physicians, elected not to renew policies; PHICO insurance company in Vermont dissolved and left hundreds uninsured; and Princeton Insurance Company abandoned 1000 physicians in Pennsylvania.[111]

As the traditional, so-called third-party insurers exited the medical malpractice market over the past decade, alternative medical malpractice insurers have emerged to now comprise 70% of the medical malpractice market.[112] Alternative insurance methods are created by professionals, with the focus on conservative management and maximizing the potential for successful market retention.[113] Unfortunately, alternative medical insurers have been unable to reverse or stabilize the trends of rising medical malpractice premium rates.[114]

Some insurers of the malpractice market attempted to compensate for poor underwriting performance in the late 1990s by generating strong investment income. Downturns in the U.S. capital markets, interest rate cuts by the Federal Reserve, and low bond yields resulted in severe underperformance of investment portfolios.[115] Physicians and trial lawyers

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109. *See* Eisenberg & Sieger, *supra* note 35, at 50. The Joint Economic Committee Study reported that in 2001 malpractice insurers paid out $1.34 in claims and costs for every $1.00 it received in revenue (including investment income). *See* Joint Economic Committee Study, *supra* note 3, at 5. No matter which number is correct, the available data supports the fact that medical malpractice has become an unprofitable insurance product line. *Id.*

110. Joint Economic Committee Study, *supra* note 3, at 3-7.

111. *See* Shojania et al., *supra* note 57, at 10.

112. GAO REPORT, *supra* note 8, at 5.

113. *Id.* at 5 (stating that common alternative insurance mechanisms include self-insurance (where a firm or group of firms assume all or much of their risk exposure themselves), captive insurers (which are wholly-owned subsidiaries of the firms they insure) and risk retention groups (a group of firms or individuals that come together to form a limited-purpose insurer).

114. In Illinois, the ISMIE Mutual Insurance Company, owned by physician policyholders and managed by physicians imposed a thirty-five percent premium rate in 2003. Low overall reserve funds forced a moratorium on new business. Further details can be found on the website http://www.ismie.com.

115. *See* Eisenberg & Sieger, *supra* note 35, at 51.

have blamed the current malpractice crisis on investment losses and poor investment strategy of the insurance companies as the primary factor affecting malpractice premiums, which rose by approximately 40% or $1.4 billion between 2001 and 2002.[116]

In a June 2003 report, the U.S. General Accounting Office (GAO) analyzed the causes for recent rises in medical malpractice insurance rates. The GAO implicated multiple factors, including a rapid increase in insurers' losses related to medical malpractice claims,[117] a decrease in insurers' investment returns forcing insurers to offset claims losses with insurance premiums, the lack of competitive pressure in the medical malpractice insurance market due to the number of insurers that have left the market voluntarily or through insolvency, and a rise in reinsurance rates that have increased medical malpractice insurers' overhead.[118]

An Overview of the Property and Casualty Insurance Industry (PCI) by A.M. Best reveals that between 1991 and 2002, 2001 was the first year with a net loss of $6.9 billion in income, associated with a payment of approximately $50 billion in claims and expenses.[119] Medical malpractice underwriting alone accounted for 6% or $3 billion of the total loss to claims and expenses.[120] Investment income of medical malpractice reserves in 2001 totaled $1.1 billion and, in combination with collected premiums, were unable to offset the overall loss.[121] Investment strategy of the entire PCI as of December 31, 2001, shows 66% bonds, 21% common stock, 6% cash and short term securities, and 7% other.[122] The GAO analyzed the average investment returns of the fifteen largest medical malpractice insurers of 2001 and found the average return fell from about 5.6% in 2000 to an estimated 4.0% in 2002.[123] This reporting suggests that the traditional medical malpractice insurance industry pools premiums with the substantially larger PCI, and that overall investment losses in the past decade have indeed affected malpractice premium rates.

116. *See* Vandecruze, *supra* note 40, at 15; Medical Malpractice Symposium, *supra* note 50, at 309.

117. Breakdowns in portions attributable to economic and non-economic damages were not available.

118. GAO REPORT, *supra* note 8, at 4-5

119. *See* Harwig, *supra* note 81.

120. *Id.* at 70.

121. *Id.*

122. *Id.*

123. GAO REPORT, *supra* note 8, at 25.

## V. MEDICAL MALPRACTICE STATUTES

### *A. First Generation*

Beginning in the 1970s and continuing throughout the 1980s, nearly every state adopted at least one statute affecting tort and insurance law with the intention to limit the frequency and severity of malpractice claims.[124] The purpose of such legislation was to improve healthcare by providing more acceptable premium costs for medical malpractice insurance, thereby guaranteeing physician access.[125] These first generation statutes modified the tort system by legislative purpose in at least one of the following ways: curtailing the size of recoveries; curtailing the claim frequency; limiting the plaintiff's ability to win; improving the judicial process; or reforming insurance.[126]

#### 1. Statutes That Limit Recovery

Statutes that limit the size and severity of recoveries include damage caps, periodic payment of damages, collateral source offsets, and changes in the rules regarding joint and several liability. In 1975, the California legislature enacted a series of five statutes known as the Medical Injury Compensation Reform Act (MICRA).[127] MICRA permitted future damage awards in excess of $50,000 to be paid in periodic payments;[128] limited attorney fees in medical malpractice litigation;[129] eliminated the "collateral source rule" allowing the defendant to show evidence of collateral benefit received by the plaintiff either through excessive medical care or third party payment of medical expenses;[130] and imposed a $250,000 cap on the

124. *See* Eleanor D. Kinney, *Malpractice Reforms in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99, 100 (1995).

125. *See id.* at 101-02 App.A (providing a detailed list of first generation tort reform by state). In 1994, twenty states had damage caps, thirty-three states had collateral source rules, twenty states had screening panels, fourteen states had binding arbitration for malpractice, and thirteen states had patient compensation funds. *Id.* at App.A. Appendix C contains specific reference to individual state statutes. *Id.* at App.C.

126. *See* Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499, 514-17, 521-22 (1989).

127. *See* CAL. CIV. CODE § 3333.1(a), (b) (West 2003); CAL. CIV. CODE § 667.7 (West 2003); CAL. BUS. & PROF. CODE § 6146 (West 2003); CAL. CIV. CODE § 3333.2 (West 2003). *See also* Jonathan J. Lewis, *Putting MICRA Under the Microscope: The Case for Repealing California Civil Code Section 3333.1(a)*, 29 W. ST. U. L. REV. 173, 177-178 (2001).

128. CAL CIV. CODE § 667.7(a).

129. CAL. BUS. & PROF. CODE § 6146(a).

130. CAL. CIV. CODE § 3333.1.

amount that a medical malpractice plaintiff could receive for non-economic damages.[131] In 1984 and 1985, MICRA came under judicial challenge for violation of the equal protection and due process clauses of the Fourteenth Amendment.[132] The California Supreme Court applied a rational test to each MICRA provision and determined that each statute was rationally related to the legitimate governmental purpose of easing the insurance crisis in California and, therefore, was constitutional.[133] Attempts to raise the dollar amount of the damage cap in 1997, and again in 1999, were unsuccessful, leaving MICRA to remain in full effect.[134] Overall, thirteen states have upheld caps on pain and suffering damages.[135]

In contrast, the Illinois State Legislature enacted the Civil Justice Reform Amendment of 1995 which included a limitation of compensatory damages for non-economic damages to $500,000 in wrongful death and personal injury actions and eliminated joint and several liability.[136] Two years later, the Illinois Supreme Court held that the cap on damages was unconstitutional based upon the remittitur doctrine and the concept that a legislative damage cap violates separation of powers.[137] The remittitur

131. CAL. CIV. CODE § 3333.2(b).

132. *See* Fein v. Permanente Med. Group, 695 P.2d 665 (Cal. 1985) (holding that Cal. Civ. Code § 3333.1(a) is constitutional); Roa v. Lodi Med. Group, Inc., 695 P.2d 164 (Cal. 1985) (holding that Cal. Bus. & Prof. Code § 6146 is constitutional); Barme v. Wood, 689 P.2d 446 (Cal. 1984) (holding that Cal. Civ. Code § 333.1(b) is constitutional); Am. Bank & Trust Co. v. Cmty. Hosp. of Los Gatos-Saratoga, Inc., 683 P.2d 670 (1984) (holding that Cal. Civ. Proc. Code § 667.7 is constitutional).

133. *See Fein*, 695 P.2d at 680; *Roa*, 695 P.2d at 165; *Barme*, 689 P.2d at 450; *Am. Bank & Trust Co.*, 683 P.2d at 679.

134. *See* Martin Ramey, Comment, *Putting the Cart Before the Horse: The Need to Re-Examine Damage Caps in California's Elder Abuse Act*, 39 SAN DIEGO L. REV. 599, 629-31 (2002)

135. The states which have upheld damage caps on pain and suffering are California, Idaho, Indiana, Kansas, Louisiana, Massachusetts, Maryland, Missouri, Montana, Nebraska, Oregon, Virginia, and West Virginia. *See* David Fink, Notes & Comments, Best v. Taylor Machine Works, *the Remittitur Doctrine, and the Implications for Tort Reform*, 94 NW. U. L. REV. 227, 229 (1999); Matthew W. Light, Note, *Who's the Boss?: Statutory Damage Caps, Courts, and State Constitutional Law*, 58 WASH. & LEE L. REV. 315, 319, 321 (2001) (examining constitutional challenges to damage caps in six states: three states in which caps were struck down (Illinois, Ohio, and Oregon) and three states in which caps survived (Kansas, Maryland, and Virginia)).

136. *See* Kirk W. Dillard, *Illinois' Landmark Tort Reform: The Sponsor's Policy Explanation*, 27 LOY. U. CHI. L.J. 805, 808-13 (1996) (discussing the section of Public Act 89-7 pertaining to the limitation on compensatory damages, 735 ILCS 5/2-1115.1, and the section causing abolition of joint and several liability, 735 ILCS 5/2-1117).

137. *See* Best v. Taylor Mach. Works, 689 N.E.2d 1057, 1080 (Ill. 1997). Vernon Best was severely injured while operating a forklift and alleged that he had and will incur non-economic damages in excess of $500,000. *Id.* at 1064. The Illinois Supreme Court held that the provisions of Public Act 89-7 that violate the Illinois Constitution are the limitation on compensatory damages, section 3.5(a) of the Joint Tortfeasor Contribution Act, the abolition

doctrine exists in virtually every jurisdiction nationwide and dictates that a judge can order a remit or reduction in excessive damages if the plaintiff consents or a new trial if the plaintiff does not agree with the reduction. The Illinois Supreme Court held that remittitur was an inherent power of the judicial branch and, as such, the cap on damages was a "legislative" remittitur that violated the separation of powers provision of the state constitution.[138] Prior to this decision in Illinois, seven state supreme courts had struck down non-economic damage caps relying on analysis of equal protection or state constitutional provisions for the right to trial by jury; the states included Alabama, Florida, Ohio, New Hampshire, North Dakota, Texas, and Washington.[139] Until the Illinois Supreme Court decision, no other state had used the remittitur doctrine and separation of power analysis to challenge the constitutionality of tort reform.[140]

### 2. Statutes That Reduce Claim Frequency

Tort reform aimed at reducing claim frequency includes a number of alternative dispute resolution (ADR) methods including, but not limited to, pretrial arbitration, shortening the statute of limitations, certificate of merit, and attorney fee limits.[141]

### 3. Statutes Aimed at Diminishing the Likelihood of the Plaintiff Succeeding

All of the following have been legislated with the purpose to either make winning on a claim more difficult for the plaintiff or to limit the award upon settlement or jury verdict: expert witness requirements; informed consent limits; professional standard of care; *res ipsa loquitor* restrictions; and statute of frauds for medical promises.[142]

### 4. Statutes Intended to Improve the Judicial Process

The following legislative directives have mandated mediation: notice of

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of joint and several liability, and the discovery statutes which mandate the unlimited disclosure of plaintiffs' medical information and records. *Id.* at 1083. The Court further held that because these unconstitutional provisions may not be severed from the remainder of the act, Public Act 89-7 as a whole is invalid. *Id.* at 1104.

138. *See* Philip H. Corboy et al., *Illinois Courts: Vital Developers of Tort Law As Constitutional Vanguards, Statutory Interpreters, and Common Law Adjudicators*, 30 LOY. U. CHI. L.J. 183, 217 (1999).

139. Fink, *supra* note 135, at 229.

140. *See id.* at 265.

141. *See* Bovbjerg, *supra* note 126, at 499-556 (1989).

142. *See* Kinney, *supra* note 124, at 101-02.

intent to sue, required pre-calender conference, and preferred scheduling.[143]

5. Insurance Reforms

First generation insurance reform enhanced "availability of affordable malpractice for providers as well as reliable sources of compensation for claimants." Included in this list are patient compensation funds, joint underwriting associations, limits on insurance cancellation, and requirements for insurers to report the disposition of claims to insurance regulators.[144]

*B. Second Generation Reforms*

Second generation malpractice reform proposals were developed in the late 1980s and early 1990s by scholars and others, including The Robert Wood Johnson Foundation's Medical Malpractice Program and the Agency for Health Care Policy and Research. These reform measures were infrequently implemented and geared toward improving the adjudication and compensation system from the prospective of the claimants and providers.[145] The following are the seven major second generation reforms: use of medical practice guidelines to set the standard of care; scheduling of damages; mandated use of ADR in lieu of trial; administrative, fault-based systems; no-fault approaches; enterprise liability; and private contract to implement malpractice reform.[146]

1. Use of Medical Practice Guidelines to Set the Standard of Care

Medical practice guidelines have been developed by the Institute of Medicine and other specialty societies in order to standardize the delivery of healthcare for specific clinical circumstances. Despite acknowledgement that physician clinical decisions are often an imperfect science, medical practice guidelines have been useful in directing uniform conduct for specific clinical situations as represented by experts in the field. In the past, inconsistencies in the definition and application of the standard of care have contributed substantially to the practice of defensive medicine. Theoretically, medical practice guidelines can aid in adjudication and settlement of malpractice claims by providing proxy of what an expert might testify as to the standard of care; shield the physician from liability when practicing within the guidelines; diminish the number of unnecessary

143. *Id.* at 102.
144. *Id.* at 101-02.
145. *Id.* at 101-04.
146. *Id.* at 103.

tests and the practice of defensive medicine; form the platform upon which ADR methods or administrative fault-based systems may adjudicate a claim; and define and update compensable events in limited no-fault systems.[147]

### 2. Scheduling of Damages

The scheduling of damages would rationalize awards for specified injuries by establishing preset compensation for a specific injury. Prevalent in workers compensation, awards for specific claims are more predictable and fair. Moreover, juries are provided information of specified awards based upon past experience.[148]

### 3. Mandated ADR in Lieu of Trial

ADRs generally produce decisions comparable to jury verdicts. An ADR decision may be subject to judicial review and reversal if determined to be influenced by either corruption, fraud, undue influence or the presentation of new evidence unavailable at the time of the ADR proceeding.[149]

### 4. Administrative Fault-Based Systems

The AMA and the Physicians Insurers Association of America (PIAA) each published proposals in the late 1980s that were designed to segregate the adjudication and compensation of medical malpractice claims from the tort system altogether. The AMA proposal established a state administrative board consisting of consumers, lawyers, and some physicians, and provided for oversight of physician activity through standard of care guidelines and called for scheduling damages.[150] Similarly, the PIAA proposal established a state administrative agency to determine negligence, the potential for a common law court to determine fault and not damages, and a schedule of non-economic compensation for specific injuries.[151] Both proposals provided for judicial review of agency decisions.[152]

147. *Id.* at 103-05.
148. Kinney, *supra* note 124, at 105.
149. *Id.*
150. *Id.* at 106.
151. *Id.*
152. *Id.*

### 5. No-Fault Approaches

A range of proposals for no-fault schemes have surfaced over the past three decades. In its purist form, any claimant with a medical injury resulting from medical care would be compensated regardless of fault.[153] Damages would be scheduled and limited.[154] Limited no-fault early compensation schemes have, at their core, expedited payment for specific medical injuries which arise from events that do not ordinarily occur given good medical care is provided.[155] Physicians and healthcare facility under a no-fault system would agree to acknowledge liability in selected claims.[156]

### 6. Enterprise Liability

The enterprise liability theory in the healthcare field would extrapolate enterprise liability prevalent in industry to hospital, healthcare facility, or healthcare plan.[157] The intent is to eliminate medical liability from the physician and health care practitioner, and place it under the umbrella enterprise; in doing so, it would simplify and expedite the process of malpractice adjudication and compensation.[158]

### 7. Private Contract to Implement Malpractice Reform

Malpractice reform theoretically may be implemented on a contractual basis. Contracts for the delivery of healthcare could define a relevant standard of care for services provided, specify reasonable outcome expectations, establish provider's malpractice liability, and mandate ADR as arbitrator for claims of negligence.[159]

## *C. Impact of Tort Reform*

Franklin Cleckley and Govind Hariharan reported in 1991 that the enacted reforms had had no significant impact on medical malpractice premium rates.[160] In 2003, Harvey Rosenfield of the Foundation for Taxpayer and Consumer Rights testified before the House Energy and Commerce Committee Subcommittee on Oversight and Investigations and

153. *Id.*
154. Kinney, *supra* note 124, at 106-07.
155. *Id.* at 107.
156. *Id.* at 106-07.
157. *Id.* at 108-09
158. *Id.*
159. *Id.* at 109.
160. *See* Franklin D. Cleckley & Govind Hariharan, *A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live with Inefficient Doctors?*, 94 W. VA. L. REV. 11, 30 (1991).

reported that, by 1988, twelve years after the passage of MICRA, California medical malpractice premiums had reached an all-time high, 190% higher than 1976 when the statutes were enacted.[161] A recent report by Weiss Ratings, an independent insurance-rating agency in Palm Beach Gardens, supported the conclusion that statutes capping damages are not associated with lower malpractice insurance premiums; more likely, the opposite is true.[162] Weiss Ratings identified that in states without caps on non-economic damages, the median annual premiums for standard medical malpractice coverage rose 36% between 1991 and 2002 compared to a 48% increase in states with such caps during the same time period.[163]

In 1986, Patricia Danzon examined the frequency and impact on medical malpractice claims from 1975 to 1984 for states enacting tort reform measures.[164] Danzon's study revealed that, under first generation reforms, shorter statutes of limitation reduced claim frequency by 8%, abolished or modified collateral source rules, reduced claim severity up to 18%, and reduced claim frequency by 14.0%.[165] In addition, damage caps reduced claim severity by 23%.[166] However, none of the other measures, including screening panels and limits on contingency fees, had any significant impact on claim frequency or severity.[167] Some evidence suggested that voluntary arbitration may increase the frequency of claims filed and paid, and that states that permit voluntary binding arbitration have had a lower average claim severity.[168]

To determine why first generation medical malpractice reform did not result in lower medical malpractice premiums, one can look to the medical malpractice insurance industry. Clearly, physician malpractice insurance premiums have continued to disproportionately rise in states with damage caps, despite the fact that claims payments grew only 38%; in contrast, states without damage caps realized a 71% increase in claims payments.[169]

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161. *See The Medical Insurance Crisis: A Review of the Situation in Pennsylvania: Hearing Before the Subcomm. on Oversight and Investigations of the Comm. on Energy and Commerce, House of Representatives*, 108th Cong. 130 (2003) (testimony of Harvey Rosenfield, President, Foundation for Consumer and Taxpayer Rights) [hereinafter Rosenfield Testimony].

162. Jyoti Thottam, *He Sets Your Doctor's Bill*, TIME, June 9, 2003, at 51.

163. *Id.*

164. Patricia M. Danzon, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims*, 48 OHIO ST. L.J. 413, 413, 417 (1987).

165. *Id.*

166. *Id.*

167. *Id.*

168. See Kinney, *supra* note 124, at 120 (citing PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY (1985)).

169. *Id.*

In 1999, the California State Assembly Committee on the Judiciary reported that, under the statutory requirements of MICRA, California medical malpractice insurers earned over $763 million in 1997 while paying out less than $300 million to claimants.[170] The Committee found that medical malpractice insurance companies have had a 20.6% average rate of return over the previous decade, a rate higher than the 13% rate of return for property and casualty insurance and the 6.8% rate of return for private automobile insurers.[171] The Weiss Ratings also concluded that medical malpractice insurers were profiting from the benefit of claim limitations imposed by the damage caps, offsetting past debt and not passing a benefit of lower premiums on to the physician.[172]

Rosenfeld testified that the only legislative method shown to decrease medical malpractice insurance premiums has been reform of the medical malpractice insurance industry.[173] In 1988, responding to the continued escalation of physician malpractice insurance premiums in the mid 1980s, California voters passed Proposition 103. Proposition 103 rolled back insurance rates by 20% for all property and casualty policyholders, including medical malpractice; statutorily froze premiums rates for one year; refunded billions of dollars to policyholders; created "prior approval" regulation of insurers allowing the insurance commissioner to reject or alter rate increase requests; allowed consumers to challenge insurers' rate increase proposals; abolished the insurance industry's exemption from state and federal anti-trust laws; and made the Insurance Commissioner an elected position.[174] Upon enactment, this California law mandated an immediate 20% rollback in premium rates and a subsequent one year freeze on the lowered rate.[175] By 1992, three of the California's largest malpractice insurers, Norcal Mutual, SCPIE, and The Doctors Company, refunded $69.1 million to physicians; by 1995, the total was $135 million in refunds from all insurance providers.[176] Following election of the state's insurance commissioner, the premium rate freeze remained in effect for four years following the rollback. This legislation, passed in November 1987, has effectively maintained aggregate malpractice premium rates in California below the national figures since 1991.[177]

170. Lewis, *supra* note 127, at 187.
171. *See id.* at 187.
172. Thottam, *supra* note 162, at 51.
173. *See* Rosenfield Testimony, *supra* note 161, at 133.
174. *Id.*
175. *Id.*
176. *Id.*
177. *Id.*

### *D. Federal Statutes for Malpractice Reform*

Physicians have historically supported and continue to support first generation malpractice reform measures. Second generation malpractice reforms have not been legislated at the federal level. In 1993, President Clinton's Health Reform Task Force, led by Hillary Clinton and coordinating the efforts of some 500 experts, considered the second generation malpractice reform of enterprise liability in which physician liability was covered under the larger umbrella policy of the health plan. This proposal was abandoned by the Task Force following organized opposition from the healthcare provider community and lack of organized consumer interest. The majority of physicians still find most second generation reform measures unpalatable due to a well engrained impression that these types of reform measures disrupt the physician-patient relationship.[178]

Physicians prefer fault-based systems that identify negligence and assign fault, thereby reflecting physician's medical training, sense of duty, and expectations of professionalism. Although the AMA has in the past considered the second generation reform of ADR and administrative, fault-based systems, proposals that restrict patient-plaintiffs from using standard of care guidelines offensively,[179] current efforts of this organization and other physician groups focus support to Republican sponsored first generation reform measures presently before the United States 108th Congress.[180]

The HEALTH Act of 2003 was modeled after MICRA. The legislation called for a cap for unqualified non-economic damages to $250,000; a limit of the statute of limitations to three years; a provision that allows the defendant to present to the jury plaintiff's receipt of any collateral source benefits; elimination of joint and several liability; a damage award schedule that establishes past and current economic expenses to be paid at time of judgment, but provides payment of future damages of $50,000 or more to be paid over time; and guidelines for punitive damages if the state legislature has failed to act.[181] On March 13, 2003, a House of Representatives version of the bill passed by a vote of 229-196-1. On July 9, 2003, the Motion to Proceed on this proposed legislation failed in the Senate by a margin of 49-48.

178. *See* Kinney, *supra* note 124, at 123.
179. *Id.* at 123.
180. *See* Palmisano Testimony, *supra* note 57, at 55-56.
181. *See* Razor, *supra* note 2, at 12.

## VI. PROJECTED IMPACT OF THE HEALTH ACT OF 2003

If enacted, the HEALTH ACT of 2003 will have a marginal impact on physician overhead, a significant negative impact on injured patients and lawyers representing either patient-plaintiff or physician-defendant, and a significant positive impact on the medical malpractice insurance industry. This legislation will primarily promote a decrease in the number of claims brought by injured patients and a decrease in the amounts paid in damage awards. Physician's medical malpractice premiums will continue to rise as they have in California following the enactment of MICRA in 1975. Truly injured patients will be limited in the amount that can be recovered for non-economic damages, such as pain and suffering. Plaintiff's attorney contingency fees will be cut by a cap on the overall award allowable to their client and defense attorneys will have fewer malpractice claims to adjudicate. The windfall of this tort reform, similar to what occurred in California following MICRA, will be realized by the medical malpractice insurance industry. Without insurance reform designed to exchange insurance company profits for lower malpractice premiums, the benefits of tort reform that lowers medical malpractice claim frequency and severity will never be realized.

Furthermore, once enacted, the HEALTH Act or similar law mandating first generation reform measures will come under considerable constitutional attack. To date, individual state statutes effecting tort reform have been customized reflecting constituent input, population density, workforce, resources and healthcare needs. Unfortunately, the variable political culture of states has made first generation tort reform acceptable in one state, while unconstitutional in another. For example, in Illinois damage caps were deemed unconstitutional on the basis of the remittitur doctrine and separation of powers.[182] These arguments are particularly powerful. and if the HEALTH Act were to become law, a similar challenge would undoubtedly ensue. Most likely, a law embracing the first generation tort reforms contained in the HEALTH Act of 2003 would be ruled unconstitutional by the U.S. Supreme Court.

Therefore, the HEALTH Act of 2003 will not substantially influence physician overhead without complimentary controls on the malpractice insurance industry. Moreover, this first generation tort reform will most likely not withstand certain constitutional challenges. New alternatives for tort reform at the federal level are needed to bring substantially lower malpractice insurance rates.

182. *See* Best v. Taylor Mach. Works, 689 N.E.2d 1057, 1080 (Ill. 1997).

## VII. ALTERNATIVES FOR MALPRACTICE REFORM

Proposals for future tort reform must acknowledge and satisfy the interests of physicians, the constitutional rights of the injured patient, and the stability of the medical malpractice insurance industry. Failure of future legislative proposals to address each of these concerns will lead to the initiative's inevitable death for lack of public support, insurmountable lobby efforts, and constitutional challenge. Past legislative efforts are instructive: first generation tort reform addresses physician and insurance industry interests, but not the interest of the injured patient, and proposals for second generation tort reform may satisfy the constitutional rights of the patient, but not address completely the physician's interest. Therefore, to bring effective change, tort reform legislation should incorporate new ideas with lessons learned from past experience.

The purposes of future tort reform must be to facilitate the delivery of low cost, efficient, and quality health care to the public; to ensure the presence of an expeditious, cost-conscious legislative system that adjudicates meritorious medical malpractice claims fairly and equitably to all parties; to discourage the filing of medical malpractice claims that are without merit; and to encourage a competitive market environment for medical malpractice insurers that exchanges profits for lower premium rates and provides performance incentives. With these purposes in mind, four general categories for future tort reform measures are here proposed: decrease the cost of healthcare; streamline adjudication of claims; insure quality of care; and reform the insurance industry.

### *A. Decrease the Cost of Healthcare*

The annual increases in the overall cost of healthcare are reflected in the rise in settlement and jury verdict awards to patients injured through malpractice. Damage award calculations account for past and future medical expenses. Customary charges for hospital and physician services are utilized in this calculation instead of a "reasonable expectation of reimbursement" standard. If Medicare-based reimbursement rates were the standards for hospital charges, the calculation of medical expenses would be significantly lowered and considerable savings would be realized. Damage awards would then more appropriately reflect "true charges" and future expenses. A similar argument has been proposed by health activists, requesting "realistic charges" for the uninsured patient; such "self-pay" patients receive substantially higher requests for payments from physicians and health care facilities compared to the discounted rates for services

reimbursed by HMOs and other insurers.[183]

The cost of defensive medicine is astoundingly high and getting more expensive every year as the cost of health care rises. The perceived risk of liability by the physician produces intentional but extraneous physician, hospital, and technology related fees. The AMA and representative physician specialties must evaluate available medical guidelines with the emphasis of outlining "standards of care and expectations of outcome." The following are examples of such guideline recommendations: a normal chest radiograph is acceptable to rule out pneumonia precluding the need for a CAT scan of the chest; a treadmill test, and not a cardiac angiogram, is acceptable to evaluate chest pain unaccompanied by electrocardiographic changes under certain circumstances; and vaginal delivery may be acceptable for breech births, precluding the need for a cesarean section. Physicians must know that when operating within the standard of care, they are protected from the litigious patient who brings suit for an unfortunate outcome, whether that unfortunate outcome was fully anticipated or not.

Moreover, medical guidelines must reflect the "art" *and* the "science" of patient care. Interpretation of the guidelines should be broadly defined to accommodate patient-to-patient variability and the complexity of often multiple and interacting co-morbid conditions. Plaintiff lawyers advising clients on the merits of a claim would understand this broadly defined standard of care and be less likely to bring suit. The overall impact would be to decrease the approximately 72% of claims which cost substantial sums to adjudicate, but ultimately end up in dismissal.

Therefore, tort reform can lower the cost of healthcare through two separate and distinct methods: mandate that economic damages, past and future, reflect the current Medicare-based reimbursement schedule when Medicare reimbursement rates are expected, and decrease the practice of defensive medicine through the use of established and well recognized guidelines for the standard of medical care that emphasize "most probable" requirements for clinical care. Guidelines should be interpreted broadly by the legal system and accommodate the complexity and imperfect world of patient care. The result of this reform would be to lower the severity of settlement and jury verdict awards, decrease the number of claims without merit, and lower the overall cost of healthcare in general.

### *B. Streamline Adjudication of Claims*

Tort reform that effectively limits the number of claims without merit, speeds the adjudication of claims with merit, and standardizes awards for

183. *See* Lucette Lagnado, *Taming Hospital Billing; Lawmakers Push Legislation to Curb Aggressive Collection Against Uninsured Patients*, WALL ST. J., June 10, 2003, at B1.

non-economic damages will ensure that injured patients receive compensation in a timely, appropriate, and uniform manner. National uniformity would protect the legal system from regional inequities.

A separate federal administrative branch of the judicial system specialized to handle medical malpractice could uniformly protect the constitutional rights of the injured patient and pass judgment in a specialized forum. Specialized judges should rule on fact and law. The goal of specialized medical courts would be to lower judicial costs by limiting judicial review of inconsistent judgments; accelerate the adjudication of meritorious claims; discourage the pursuit of allegations without merit; eliminate jury verdict inconsistencies in awards for non-economic damages;, and standardize awards for meritorious claims utilizing schedules.

### *C. Limit Practices of Physicians and Healthcare Facilities That Perform Poorly*

Five percent of physicians are responsible for 30% of the total amounts awarded in settlement awards and jury verdicts.[184] Simply, physician societies must agree to police bad behavior through mandated education, recertification, and programs of peer supervision. If rehabilitation is not possible, physicians cited for recurrent or particularly egregious acts of medical negligence must practice under limitations or not be allowed to practice at all. Similar performance standards should be in place and enforced against any facility receiving federal dollars.

Reporting of any revocation, suspension, or restriction of a physician's clinical privileges to state medical boards and the NPDB must be enforced. *Time Magazine* reported that in 2001, only 55% of all non-federal hospitals registered with the NPDB reported a single disciplinary action against a physician, implying under-reporting of negligent acts.[185]

Also, physician societies must scrutinize the testimony of medical expert witnesses. In Illinois, as in most jurisdictions, jurors are instructed that physicians must use "the skill and care ordinarily used by a reasonable well-qualified [physician]... under the circumstances similar to those shown by the evidence. A failure to do so is professional negligence."[186] The basis for this charge is the testimony of the medical experts, who are instructed to testify on the basis of their personal knowledge, skill,

184. Leslie Berenstein, *Why Wasn't He Stopped Sooner?*, TIME, June 9, 2003, at 57.

185. *Id.*

186. ILLINOIS PATTERN JURY INSTRUCTIONS-CIVIL 105.01 (2000). *See* William Meadow, *Operationalizing the Standard of Medical Care: Uses and Limitations of Epidemiology to Guide Expert Testimony in Medical Negligence Allegations*, 37 WAKE FOREST L. REV. 675, 675-76 (2002).

experience, training, or education.[187] Federal courts allow considerable leeway for medical experts to present opinion testimony, requiring only that the testimony is based upon sufficient facts or data, the testimony is the product of reliable principles and methods, and the witness has applied the principles and methods reliably to the facts of the case.[188] Unfortunately, a medical expert's opinion may be flawed by limited experience, overgeneralization, inadequate recollection of anecdotal experience, and failure to apply medical practices as described and published in peer-reviewed journals.[189]

In 2002, the U.S. Supreme Court upheld a Seventh Circuit ruling that a professional society could discipline one of its members on the basis of his courtroom testimony in a professional negligence action.[190] In *Austin*, Dr. Austin alleged that the American Association of Neurological Surgeons (AANS), at a disciplinary hearing before the Professional Conduct Committee of the AANS, inappropriately challenged his expert testimony on behalf of the plaintiff-patient in a previous trial.[191] Dr. Austin also claimed that he was inappropriately suspended from the AANS for violation of ethics standards as "revenge" for having testified against an AANS member defendant.[192] The district court granted summary judgment in favor of the Association, and the Seventh Circuit affirmed, finding that Dr. Austin's testimony was "irresponsible . . . and violated a number of sensible-seeming provisions of the Association's ethical code."[193]

The Illinois Medical Society, AMA, and American College of Surgeons filed an *amicus curiae* brief in *Austin* supporting a medical society's right to discipline members after a due process hearing. In their opinion, expert testimony constitutes the practice of medicine and expert opinion needs to be subject to peer review. The Seventh Circuit's opinion was supportive of the AMA's and specialty medical societies' policies that promote and enforce ethical and responsible expert testimony as purposeful means to keep untruthful or misleading testimony out of the courtroom.[194]

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187. FED. R. EVID. 702.

188. *Id.*

189. *See* Meadows, *supra* note 157, at 678.

190. Austin v. Am. Ass'n of Neurological Surgeons, 253 F.3d 967, 971, 974 (7th Cir. 2001).

191. *Id.* at 968.

192. *Id.*

193. *Id.* at 971 ("These include provisions requiring that a member appearing as an expert witness should testify 'prudently,' must 'identify personal opinions not generally accepted by other neurosurgeons,' and should 'provide the court with accurate and documentable opinions on the matters at hand.'").

194. *See* Michael D. Brophy, *Ruling May Signal New Chapter in Expert Testimony of Medical Society Members*, MED. MALPRACTICE L. & STRATEGY, May 2002, at 1.

Therefore, physician societies must report negligent behavior and discipline physician members when appropriate. Negligence should be extended to the testimony of the medical expert. Medical expert testimony which is misleading, misrepresents standards of care, and provides inaccuracies or untruths must be subject to rebuttal and potential sanctions for the declarant. The impact of "policing" physician conduct will improve the quality of healthcare by eliminating "bad actors," decrease the number of claims which end up in dismissal by discouraging inappropriate testimony from medical experts, facilitate the settlement of meritorious claims by discouraging inappropriate testimony from medical experts, and decrease medical insurance premiums as a result of decreased number and severity of claims.

### *D. Insurance Reform*

Successful tort reform will be impossible without federal controls on medical malpractice insurers. For the most part, state insurance regulators impose few restrictions on the medical malpractice insurance industry and, by failing to do so, allow the insurance market to determine market rates for malpractice premium rates.[195] The behavior of medical malpractice insurers in California following the enactment of MICRA in 1975 provides substantial evidence that, when tort reform decreases the number and severity of claims, profit taking is favored over lowering physician malpractice premiums. The insurance industry was the biggest benefactor of California's first generation tort reform. The medical malpractice insurance industry's endorsement and support of the HEALTH Act of 2003 is undoubtedly backed by expectations of future profits generated by unchallenged premium rates and decreased claim payments.

Much can be learned from California's experience with tort reform. Only after the California legislature imposed substantial reforms of the insurance industry in 1988 with Proposition 103 did physician malpractice premium rates stabilize. Therefore, imposing MICRA-type change on a federal level, as is proposed in the HEALTH Act of 2003, demands additional legislation to limit the free-market behavior of the medical malpractice insurance industry through exchange of insurance profits for decreased premium rates. A list of potential federal legislative regulations of the insurance industry might include the following: mandates that the insurance surplus reserve amounts are returned to the healthcare system through rebates and lowered premium rates; requirements that reserves are invested conservatively thereby eliminating the likelihood for investment

195. GAO REPORT, *supra* note 8, at 8.

loses effecting premium rates; separation of medical malpractice premium reserves from the larger property and casualty insurance category; and rewards for quality performance.

## VIII. CONCLUSION

All Americans will be impacted by the rising cost of medical malpractice insurance if the free-market is allowed to prevail. Rising insurance premiums will put many currently practicing physicians out of business and discourage the best and the brightest from a career in medicine, particularly in the specialty fields of neurosurgery, obstetrics and gynecology, and cardiovascular surgery. On the other hand, medicine is an imperfect science and mistakes will be made and patients injured, requiring the full force of a legal system empowered to adjudicate a meritorious claim. A healthy insurance industry is necessary to reimburse the patient for judicially determined economic and appropriate non-economic damages. Therefore, an acceptable answer to rising medical malpractice insurance rates must consider all parties and yet decrease the cost of health care, increase the quality of health care, maintain access to health care, ensure an efficient and equitable legal system to adjudicate medical malpractice claims, and encourage a stable and competitive market for medical malpractice insurers.

The experience of tort reform in California is reflective of what will likely occur on a federal level if changes to healthcare are mandated. California's MICRA enactments of 1975, among other things, limited an award for non-economic damages to $250,000 and limited attorney's fees. Simply, the interest of physicians' malpractice overhead was placed ahead of the interests of injured patients and attorneys. The result was less than satisfactory. California's medical malpractice insurance premiums have continued to rise even though the California legislature subsequently enacted insurance reform, and even as Proposition 103 required the medical malpractice insurance industry to rollback medical malpractice premiums for a one year period. Furthermore, non-economic damages awarded to injured patients in California are capped and attorney's fees limited.

Before Congress in 2003 was The HEALTH Act, patterned after the first generation tort reform measures imposed by California's MICRA of 1975. This legislation is supported by physician groups and the insurance industry, albeit for different reasons. Opposition by the American Trial Lawyers Association, representing the interests of the plaintiff attorney, defense attorney. and the injured patient is substantial. If such legislation were to be enacted, constitutional challenges would be immediate and most likely effective as they have been in Illinois under the concepts of the

remittitur doctrine and separation of powers.

So, can tort reform be acceptable to all parties? Within this commentary, suggestions for future legislation have been proposed which consider universal interest. Modification of physician and hospital charges to reflect realistic Medicare-based reimbursement schedules would decrease the overall cost of health care and decrease the severity of malpractice awards. Physician society review of physician conduct with the purpose to minimize negligence, discourage inappropriate medical expert testimony, and promote a standard of care would decrease the number of malpractice claims by eliminating poorly performing physicians. A judicial system in which medical malpractice claims can be ruled by a specialized judge will streamline the adjudication of claims, control costs, and insure uniformity of decision, while maintaining the constitutional rights of all parties. Separation of medical malpractice premiums from a larger property and casualty reserve, and uniformity of a conservative investment strategy for insurance reserves guarantees that excess insurance reserves will be returned to physicians. Incentives which encourage competition amongst malpractice insurers should decrease medical malpractice insurance rates and eliminate regional discrepancies in the availability of medical insurers and the premium rates they charge. Lasting change will reflect the legitimate interests of the patients, physicians, lawyers, and malpractice insurers.