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A Patient Perspective: Focusing on Compensating Harm

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*Introduction by Valerie Witmer**

I. INTRODUCTION

Susan J. Schwartz joined the law firm of Corboy & Demetrio following graduation from Loyola University Chicago School of Law and became a partner in 1994. Ms. Schwartz is a zealous plaintiffs' advocate whose practice is centered on representing patients or their families in complex medical malpractice cases. She has been markedly successful in procuring large settlements for those who have been harmed as a direct result of medical professional negligence, and in many cases, her efforts have secured damage awards in excess of $1 million.

Ms. Schwartz is an active member of several bar associations and serves on the board of managers of the Illinois Trial Lawyers Association. She has also served on the faculty of the National Institute for Trial Advocacy. Ms. Schwartz's accomplishments as a medical malpractice attorney and patient advocate have earned her frequent invitations to lecture locally and nationally at seminars, continuing legal education programs, and conferences on topics of trial practice techniques, alternative methods of dispute resolution, and the analysis of medical legal claims.

At the Loyola University Chicago School of Law's Annual Health Law and Policy Colloquium, Ms. Schwartz spoke passionately about the patient perspective on the medical malpractice crisis. Her remarks elucidated the need to preserve the tort system in order to give patients a voice against negligent healthcare providers and revealed the failure of non-economic damage caps to enhance the availability and quality of healthcare. This article will expand upon the reasons the tort system is not to blame for the medical malpractice crisis. Further, this article will explore why tort reform is not a viable solution to the crisis and why the tort system must be preserved as a forum for patient advocates, like Susan Schwartz, to ensure that medical professional negligence-induced injuries do not go

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uncompensated.

II. ARGUMENTS AGAINST TORT REFORM

A. The Tort System Is Not the Leading Cause of the Medical Malpractice Crisis

The tort system has come under attack in recent years as another medical malpractice crisis has reared its head, but the system can and must be defended. While critics of the tort system have identified out-of-control litigation as the primary culprit, there are several much more likely suspects that must be investigated as potential causes of the crisis. These factors include: (1) the accounting system utilized by malpractice insurers to set premium rates; (2) malpractice insurers' declining investment income; (3) increasing reinsurance rates for medical malpractice insurers; (4) falling profits in the malpractice insurance industry; and (5) malpractice insurers' exemption from antitrust laws.[1] Although these factors were outside the scope of Ms. Schwartz's remarks, they are cited by patient advocates, like Ms. Schwartz, in defending against assertions that the tort system is primarily to blame for the malpractice crisis. Therefore, these factors and their contributions to premium rate increases will be explored hereinafter.

The unique accounting method used by malpractice insurers to set premium rates contributes to periodic rate hikes and is consequently a noteworthy suspect in the medical malpractice crisis.[2] Insurance companies use an accounting system called Statutory Accounting Principles (SAP).[3] Under SAP, insurers set their rates according to their anticipated costs for a given year.[4] The largest component of malpractice insurers' anticipated costs is incurred losses[5], which in theory, represent expected future payments on claims reported in the current year.[6] The argument set forth by critics of the tort system—that increased frequency and severity of malpractice claims is responsible for driving up malpractice insurance

1. *Patient Access Crisis: The Role of Medical Litigation, House Comm. on the Judiciary*, 108th Cong. 2-3 (2003) (statement of Jay Angoff, Counsel, Roger G. Brown & Associates) [hereinafter Angoff Testimony]. *See also* U.S. GEN. ACCOUNTING OFFICE (GAO), PUB. NO. GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 4 (June 2003), *available at* http://www.gao.gov [hereinafter GAO, INCREASED PREMIUM RATES].

2. Angoff Testimony, *supra* note 1, at 2.

3. *Id.*

4. GAO, INCREASED PREMIUM RATES, *supra* note 1, at 16.

5. *Id.*

6. *Id.* at 20.

rates[7]—breaks down when one recognizes that insurance companies have incentives to overstate their incurred losses.[8]

First, insurers may overstate their incurred losses in order to justify increasing premium rates and generate higher profits.[9] Second, since increasing incurred losses translates into lower income for the insurer, there are tax benefits associated with overstating incurred losses.[10] Finally, insurers today have inflated their incurred losses because they are trying to recover lost investment income, not because they have been making more or larger payouts on malpractice claims.[11] In light of these incentives for insurers to artificially inflate incurred losses, it is apparent that incurred losses do not accurately reflect expected future payments on reported claims. Thus it becomes equally clear that increases in incurred losses, if and when they occur, are not commensurate with increased frequency and severity of malpractice claims. Therefore, increased litigation of malpractice claims is not the culprit in this scenario; rather the incentives created by the SAP accounting principles may be one possible cause behind rising malpractice insurance premiums.

Another suspect in the crisis is malpractice insurers' declining investment income. Medical malpractice insurers make money not by collecting more premium income than they pay out in claims,[12] but by investing their premium income in bonds and other conservative instruments.[13] Investment income is particularly important for malpractice insurers who invest their premiums for approximately six years between the time a claim occurs and the time that claim is paid.[14] When investment returns are high, insurers can continue to operate profitably even when losses on malpractice claims exceed income from premiums[15] because their "investment income more than makes up for any difference between [their] premiums and [their] payouts."[16]

The investment income on which malpractice insurers so heavily rely has a direct impact on premium rates. State insurance regulations require that medical malpractice insurers reduce their premium rates in consideration of

7. Health Coalition on Liability & Access, *Issue Briefing 2003*, *at* http://www.hcla.org/2003 briefingbook/2003BriefingBook.pdf.

8. Angoff Testimony, *supra* note 1, at 2-3.

9. *Id.* at 3.

10. *Id.*

11. *Id.*

12. *Id.* at 2.

13. GAO, INCREASED PREMIUM RATES, *supra* note 1, at 24.

14. Angoff Testimony, *supra* note 1, at 2.

15. GAO, INCREASED PREMIUM RATES, *supra* note 1, at 26.

16. Angoff Testimony, *supra* note 1, at 2.

expected investment income.[17] Consequently, when insurers expect their investment income to be high, they will reduce their premium rates accordingly and when insurers anticipate low investment income, premium rates escalate to cover a larger portion of insurers' costs.[18] The latter scenario has prevailed in recent years.

While some bonds have performed better than the stock market as a whole, annual yields on the bonds that comprise approximately eighty percent of malpractice insurers' investment income have declined steadily since 2000 and fallen overall since 1995.[19] The United States General Accounting Office (GAO) examined the average investment returns of the fifteen largest medical malpractice insurers of 2001 and found that "the average return fell from about 5.6 percent in 2000 to an estimated 4.0 percent in 2002."[20] Although none of these insurers experienced net investment losses during this period, the decrease in investment income required a proportional increase in premium income, in the form of a rate hike, in order for the insurers to maintain their level of income.[21] In light of malpractice insurers' reliance on income from investment assets, it is clear that poor market performance has driven premium rate hikes.

Escalating reinsurance rates may also help to drive premium rates up. Increasing reinsurance rates have raised malpractice insurers' aggregate costs, and malpractice insurers have passed those costs along to insureds in the form of higher premiums.[22] Just like the people and entities they insure, insurance companies often purchase reinsurance to cover losses they cannot afford to pay.[23] Critics of the litigation system contend that reinsurance rates are rising because it is becoming more risky and expensive to provide reinsurance to the medical malpractice market.[24] However, this argument ignores the reality that reinsurance rates increased across the board as a direct result of the September 11, 2001, terrorist attacks.[25] In light of the malpractice insurance industry's dependence on market performance,[26] it should come as no surprise that reinsurance premiums are also affected by events shaping the world economy. As Jay Angoff pointed out in his

17. GAO, PUB. NO. GAO-03-836, MEDICAL MALPRACTICE INSURANCE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 25 (Aug. 2003), *available at* http://www.gao.gov [hereinafter GAO, ACCESS TO HEALTH CARE],.
18. *Id.*
19. GAO, INCREASED PREMIUM RATES, *supra* note 1, at 24-25.
20. *Id.* at 25.
21. *Id.* at 26.
22. *Id.* at 4-5.
23. Angoff Testimony, *supra* note 1, at 2.
24. GAO, INCREASED PREMIUM RATES, *supra* note 1, at 32.
25. *Id.*
26. *Id.* at 24.

testimony before the Senate Judiciary Committee, "[t]he re-insurance market is an international market, affected by international events, and the cost of re-insurance for commercial lines . . . increased far more [after the September 11th attacks], due to fears related to terrorism (and completely unrelated to medical malpractice)."[27] This begs the conclusion, once again, that litigation of medical malpractice claims is not primarily to blame for premium rate hikes.

The declining profitability of the malpractice insurance industry, due to factors unrelated to medical malpractice litigation, may cause insurers to raise their rates. Beginning in the late 1990s, selling malpractice insurance became a considerably less profitable enterprise, despite premium rate hikes.[28] Those who blame falling profits on increasing frequency and severity of malpractice claims are not telling the complete story. The phenomena described above—insurers' declining investment income and escalating reinsurance rates—have contributed significantly to insurers' declining profitability, resulting in a negative rate of return for some insurers.[29] In addition, during the 1990s, competition in the malpractice insurance market was fierce, and high investment returns allowed insurers to offer low premium rates in order to attract business.[30] In retrospect, some of those insurers reduced their rates too much, rendering them unprofitable, and in some cases, insolvent.[31] Confronted with plummeting profits, some large insurers pulled out of the business, thus reducing the price competition that existed through much of the 1990s.[32] In the absence of price competition, the remaining insurers were able to further increase premium rates to cover a larger portion of anticipated losses.[33] Clearly, there are factors other than malpractice claims at work in this scenario, which are largely responsible for spikes in premium rates.

Finally, the insurance industry's limited exemption from federal antitrust laws could potentially allow insurers to collectively raise premium rates without fear of prosecution if and when they are so inclined. Unlike most other industries, the insurance industry is exempt from federal regulation pursuant to the McCarran-Ferguson Act, which states in relevant part:

(a) State regulation

27. Angoff Testimony, *supra* note 1, at 2.
28. GAO, INCREASED PREMIUM RATES, *supra* note 1, at 28.
29. *Id.*
30. *Id.* at 4.
31. *Id.*
32. *Id.* at 28.
33. *Id.* at 31.

> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) Federal regulation
>
> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . .[34]

The McCarran-Ferguson Act was intended primarily to preserve state regulation of the insurance industry.[35] Secondarily, the Act was meant to provide insurance companies with limited exemption from the Sherman Act, the Clayton Act, and the Federal Trade Commission Act for certain cooperative practices determined to constitute the "business of insurance."[36] Despite the fact that Congress did not intend the McCarran-Ferguson Act to give insurance companies a blanket exemption from federal antitrust laws, uncertainty as to what constitutes the "business of insurance" has allowed insurance companies to collectively raise premium rates—an activity which would otherwise be prohibited under the federal antitrust laws.[37]

When market conditions are bleak, as they are today, insurers have obvious incentives to agree amongst each other to raise premium rates to compensate for lost investment income.[38] Since insurers enjoy limited exemption from federal antitrust laws, they can do so without fear of prosecution.[39] While there is no indication of the extent to which this concerted behavior is occurring today, evidence from the last medical malpractice insurance crisis "supports the conclusion that insurance companies . . . have collectively raised prices."[40] Such cooperative practices are another potential cause of the medical malpractice crisis, having nothing to do with medical malpractice claims.

In light of the preceding arguments, it is apparent that the tort system is not the leading cause of the medical malpractice crisis. Considering the

34. Angoff Testimony, *supra* note 1, at 3; McCarran-Ferguson Act, 15 U.S.C. § 1011 (2000).

35. Eric Peter Gillett, *The Business of Insurance: Exemption, Exemption, Who Has the Antitrust Exemption*, 17 PAC. L.J. 261, 265 (1985).

36. *See* 15 U.S.C. § 1012(b) (2000); Jonathan R. Macey & Geoffrey P. Miller, *The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role of Insurance Regulation*, 68 N.Y.U. L. REV. 13, 14-15 (1993).

37. Gillett, *supra* note 35, at 265; Angoff Testimony, *supra* note 1, at 3.

38. Angoff Testimony, *supra* note 1, at 3.

39. *Id.*

40. *Id.*

slough of factors, other than the litigation of malpractice claims, that have contributed significantly to the problems facing the medical malpractice insurance industry, the solution does not necessarily lie in tort reform.

B. Even if the Tort System Is a Contributing Factor in the Medical Malpractice Crisis, Damage Caps Are Not a Viable Solution

Even if, as critics contend, the tort system is a contributing factor in the malpractice crisis, caps on non-economic damages are not the answer for a variety of reasons. First, damage caps deny patients the right to be fully compensated for medical professional negligence-induced injuries and impose an unfair burden on the most catastrophically injured patients.[41] Legislation that arbitrarily limits the amount injured patients can recover will systematically deny full recovery to patients who require more than the statutory amount to be made whole. Second, damage caps will not solve the malpractice problem because they will not reduce the occurrence of medical professional negligence that generates malpractice claims. Finally, damage caps promise to have a negative impact on the availability and quality of healthcare. Removing the threat of large damage awards will enable negligent physicians to continue to practice medicine without fear of a substantial penalty and without an incentive to minimize the risk of injury to their patients. Each of these issues will be addressed in turn. However, as an initial matter, in order to appreciate the shortcomings of damage caps, it is necessary to understand the measures proposed by tort reform advocates.

Recent tort reform efforts have been aimed, in large part, at limiting the monetary damages patients can recover in actions against negligent healthcare providers.[42] One of the most sought-after tort reforms by physicians and hospitals is a ceiling on the amount a patient may recover for non-economic damages in any given case.[43] Non-economic damages represent compensation for human losses.[44] Such non-monetary losses include, *inter alia*, pain and suffering, emotional distress, and loss of

41. William R. Padget, *Damage Limitations in Medical Malpractice Actions: Necessary Legislation or Unconstitutional Deprivation?*, 55 S.C. L. Rev. 215, 224-25 (2003); Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 Nw. U. L. Rev. 908, 909-10 (1989).

42. U.S. CONG., OFFICE OF TECHNOLOGY ASSESSMENT, PUB. NO. OTA-BP-H-1 19, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS 1-2 (Sept. 1993), *available at* http://www.wws.princeton.edu/~ota/ns20/year_f.html.

43. David Karp, *The Misdirected Search for Malpractice Reform*, MED. ECON., Oct. 13, 1997, *at* http://me.pdr.net/me/content/journals/m/data/1997/maa/maa202.html.

44. Symposium, *Anatomy of a Malpractice Case From a Litigator's Perspective*, 6 DEPAUL J. HEALTH CARE L. 279, 295 (2003).

enjoyment of life.[45] In the last two years, lawmakers have proposed federal legislation that includes placing caps on non-economic damages. Congress is currently considering a bill that would, in relevant part, impose a $250,000 cap on non-economic damages.[46] The previous Congress considered at least two similar bills containing nearly identical provisions regarding non-economic damages.[47]

Tort reform proponents believe that out-of-control non-economic damage awards are responsible for premium rate hikes, the threat of large damage awards forces physicians to practice defensive medicine which in turn increases the cost of health care, and caps on non-economic damages are an appropriate solution to the medical malpractice crisis.[48] However, there is another side to the story which must not be ignored. As discussed in Part II, *supra*, litigation of medical malpractice claims is not the leading cause of the malpractice crisis, and as such, tort reform should not be focused on as the only appropriate solution to the problem. Physicians' misguided belief that they need to practice defensive medicine in order to avoid being sued and the detrimental effects of non-economic damage caps will be explored in the remainder of this section.

Many physicians contend that the threat of malpractice litigation with potentially large damage awards forces them to practice defensive medicine (i.e., provide extraordinary or unnecessary tests or treatment) in order to avoid being sued.[49] However, physicians do not need to practice defensive medicine in order to avert lawsuits. Rather, they must simply provide medical care at the level accepted as reasonable by the medical profession.[50] A series of claims studies conducted by the Physician Insurers Association of America (PIAA) revealed that physicians got into legal trouble because they failed to provide routine medical care reasonably required by the medical profession.[51] For example, many of the physicians who were adjudged guilty of negligence "[o]mitted routine exams or tests," "[d]idn't take adequate medical and family histories," "[d]idn't communicate effectively with patients or other physicians, "[d]idn't follow the patient appropriately," and "[d]idn't meaningfully document their care and

45. Health Coalition on Liability & Access, *supra* note 7, at 1.

46. Padget, *supra* note 41, at 218; Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. § 4(b) (2003).

47. Help, Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002, H.R. 4600, 107th Cong. § 4(b) (2002); Common Sense Medical Malpractice Reform Act of 2001, S. 1370, 107th Cong. § 6(a) (2001).

48. GAO, INCREASED PREMIUM RATES, *supra* note 1, at 1; GAO, ACCESS TO HEALTH CARE, *supra* note 17, at 1.

49. GAO, ACCESS TO HEALTH CARE, *supra* note 17, at 1.

50. Karp, *supra* note 43.

51. *Id.*

treatment."[52] These physicians were not sued for their failure to provide extraordinary or unnecessary tests or treatment.[53] The suits were brought and the physicians lost because they failed to follow accepted medical practices.[54]

The results of the PIAA studies suggest that defensive medicine is not what is needed to prevent malpractice claims.[55] According to liability experts, the solution lies in loss prevention.[56] Physicians must identify "those conditions that pose the greatest risk of medical injury to their patients and the greatest liability risks to themselves," and "promulgate, disseminate, and then follow guidelines acceptable to them for diagnosing and treating those conditions."[57] They must carefully and thoroughly document the care they provide in order to protect patients from injury.[58] Further, they must nurture doctor-patient relationships by communicating with their patients in a clear and effective manner about their diagnosis and treatment.[59] In short, physicians must practice good medicine. Only then will the malpractice crisis begin to subside.

Non-economic damage caps are not a viable solution to the medical malpractice crisis because they deprive patients of their right to full, fair and reasonable compensation for their injuries and unfairly burden the most catastrophically injured patients.[60] Patients who are harmed as a direct result of medical professional negligence are entitled to full, fair, and reasonable compensation for the extent and duration of their injuries, which will not be possible if a cap is placed on non-economic damages.[61] Despite criticisms by tort reform advocates that non-economic damage awards are unpredictable, pain and suffering, emotional distress, loss of enjoyment of life, and other intangible losses are undeniably legitimate elements of damages and must be fully compensated in order to make the injured patient whole.[62] Therefore, legislation which arbitrarily restricts the amount of non-economic damages patients can recover will deprive patients of the

52. *Id.*
53. *Id.*
54. *Id.*
55. *Id.*
56. Karp, *supra* note 43.
57. *Id.*
58. *Id.*
59. *Id.*
60. Symposium, *Presentation: Tort Reform 2003*, 6 DEPAUL J. HEALTH CARE L. 309, 309 (2003).
61. *Medical Liability Issues Testimony: Hearing Before the Subcommittee on Health, Comm. on House Energy and Commerce*, 108th Cong. (2003) (statement of Donald J. Palmisano, President, American Medical Association).
62. Bovbjerg et al., *supra* note 41, at 911.

right to be fully compensated for their injuries and will impose an unfair burden on the most catastrophically injured patients.

The tort system exists to ensure that patients receive full redress for injuries inflicted by negligent defendants.[63] Non-economic damage caps "creat[e] two classes of medical malpractice victims, those with serious injuries whose recovery is limited by the caps and those with minor injuries who receive full compensation."[64] If a jury determines that a patient is entitled to $1 million in non-economic damages, but the legislature imposes a $250,000 ceiling on the amount she can recover, that patient is not receiving full redress for her injuries.[65] As the foregoing example demonstrates, a cap on non-economic damages will affect only those patients for whom an award in excess of the cap is necessary to provide full, fair, and reasonable compensation.[66]

As Ms. Schwartz points out in the transcript that follows, the detrimental effects of non-economic damage caps will be felt most by housewives and elderly patients whose economic damages are limited, and children who have an entire lifetime of suffering ahead of them as a result of medical professional negligence. The housewife who went into the hospital for appendicitis and developed a complication, caused by negligence, resulting in brain damage which requires her to have round-the-clock care will not have economic damages from loss of wages. Similarly, the elderly patient who lost both her legs as a result of medical neglect will have nominal monetary losses from lost wages because she is retired. Furthermore, her losses from future medical expenses will be limited because following the amputation, she will need little continuing care. Neither of these patients suffered huge economic losses, but that does not mean that their lives were not catastrophically affected. These patients suffered, and will continue to suffer from tremendous pain and suffering, emotional distress, and loss of enjoyment of life. A $250,000 non-economic damage award is grossly inadequate to compensate them for such suffering.

On the flipside, a five-year-old girl who suffered paralyzing injuries at birth due to medical negligence during her delivery will have massive economic damages. Her future medical expenses for continuing care will be astronomical, and she will have significant lost future earnings. However, despite a large economic damage award, a cap on non-economic damages will deprive her of full recovery for the injuries she suffered at the

63. Padget, *supra* note 41, at 222-23.

64. *Id.* at 222 (internal quotations omitted).

65. *Id.*

66. 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, 213 (1999).

hands of a negligent physician. This young girl faces an entire lifetime of pain and suffering, for which $250,000 will not begin to make her whole.

Victims of medical malpractice must have a voice against negligent healthcare providers. The tort system is the only forum in which patients can exercise their fundamental right to be made whole when they are harmed as a result of medical professional negligence. Non-economic damage caps threaten to undermine the goal of the tort system by depriving patients of their right to be fully compensated for their injuries and placing an unfair burden on the most catastrophically injured patients. In light of these detrimental effects, damage caps are not an acceptable solution to the malpractice problem.

Moreover, caps on non-economic damages will not remedy the malpractice problem for the very simple reason that they do not reduce the occurrence of medical professional negligence-induced injuries that land medical malpractice cases in court.[67] In fact, they may have the opposite effect. The tort system deters medical professional negligence by imposing complete liability on physicians and their insurers.[68] Removing the threat of large malpractice claims may have the opposite effect of permitting physicians to engage in negligent conduct knowing that they are shielded from complete liability.[69]

Medical malpractice law gives physicians and other healthcare providers broad latitude to make medical judgments.[70] Physicians are not expected to be perfect or to achieve a positive outcome in every case.[71] They are only expected to have "the skill possessed by the average member of the profession in good standing . . . 'giv[ing] the medical profession . . . the privilege, which is usually emphatically denied to other groups [of tort defendants], of setting their own legal standards of conduct, merely by adopting their own practices.'"[72] This standard of care eases the burden placed on defendant physicians by shielding them from liability so long as they provide care at a level accepted as reasonable by the medical profession, regardless of their ability to successfully treat or cure a patient.[73]

The non-economic damage caps sought by physicians and healthcare providers will only benefit those providers who lose, in spite of the relaxed

67. Karp, *supra* note 43.

68. Padget, *supra* note 41, at 227-28.

69. 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, 60 (1991).

70. Karp, *supra* note 43.

71. *Id.*

72. U.S. CONG., OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 42, at 11.

73. Karp, *supra* note 43.

standard of care.[74] Physicians who provide sub-standard care and are adjudged guilty of negligence will no longer have to pay a substantial sum to the patients they harm.[75] Absent the threat of a substantial payout, incompetent doctors will be allowed to continue to practice medicine without an adequate incentive to take precautions against unreasonable risks of harm to their patients.[76] In other words, caps on non-economic damages "don't prevent malpractice litigation; they only alleviate the pain of being sued as losing a case."[77]

III. CONCLUSION

The tort system is not the leading cause of the medical malpractice crisis and therefore, tort reform should not be focused on as the only appropriate solution. Several factors, having nothing to do with medical malpractice, have contributed to the premium rate hikes at the root of the malpractice problem, which include: the accounting principles by which malpractice insurers determine premium rates; malpractice insurers' declining investment income; escalating reinsurance rates; falling profits throughout the malpractice insurance industry; and malpractice insurers' exemption from antitrust laws. In light of this line-up of likely suspects, casting malpractice litigation as the primary culprit in the medical malpractice crisis is a questionable endeavor.

Even if the tort system were a contributing factor to the crisis, the answer to the malpractice problem does not lie in capping the amount of non-economic damages an injured patient can recover. Non-economic damage caps promise to cause a host of detrimental effects, which include: depriving injured patients of their fundamental right to be made whole; placing an unfair burden on the most catastrophically injured patients by systematically denying them full recovery for their losses; and allowing incompetent physicians to continue to practice medicine and harm patients without fear of a substantial payout. In the transcript that follows, Ms. Schwartz passionately explains that from the patient's perspective, caps on non-economic damages are not the answer to the medical malpractice crisis so long as medical professionals continue to engage in the negligent conduct that lands medical malpractice claims in court.

74. *Id.*
75. *Id.*
76. Cleckley & Hariharan, *supra* note 69, at 60.
77. Karp, *supra* note 43.