

5 HOUS. J. HEALTH L. & POL'Y 111-144 111 R
Copyright © 2005 Alec Shelby Bayer,
Houston Journal of Health Law & Policy
ISSN 1534-7907

**LOOKING BEYOND THE EASY FIX AND
DELVING INTO THE ROOTS OF THE REAL
MEDICAL MALPRACTICE CRISIS**

Alec Shelby Bayer

Introduction	112	R
I. The Medical Malpractice Crisis	114	R
A. Crisis Defined	114	R
B. History Repeats Itself: Past Crises Recur	115	R
C. Views from Different Perspectives	116	R
1. The Doctor's Perspective.....	116	R
2. The Insurance Company's Perspective	117	R
3. The Third Party Perspective	118	R
4. The Attorney's Perspective	118	R
5. The Patient's Perspective	119	R
6. The Federal Government's Perspective	120	R
D. The Real Medical Malpractice Crisis	121	R
II. Caps on Noneconomic Damages.....	122	R
A. Actions from the Hill	122	R
1. Senate.....	122	R
2. House.....	123	R
B. Actions from the Oval Office	125	R
C. Actions from the Lone Star State	125	R
III. Flawed Reform: The Shortcomings of the "Solution".	126	R
A. Horizontal Inequity	127	R
B. Inequity Among Sectors	128	R
C. Inequity Between Government and Constituents	129	R
D. Minimal Effect	130	R
E. Corporate Greed	130	R
F. Avoids the Root of the Problem	131	R
G. Safeguards Are Already in Place.....	131	R
H. If Tort Reform Is the Key, Caps Are Not the Right Fit	133	R
IV. Alternatives.....	136	R

A. Awareness of the Power Retained by Insurance Companies	136	R
B. Improving the Medical System	136	R
C. Different Tort Reform: No Fault Method	139	R
D. Improving Communication Techniques	140	R
E. Judicial Alternatives	141	R
V. Conclusion.....	142	R

INTRODUCTION

There is a medical malpractice crisis in America that affects different people and entities in many ways. Members of Congress have attacked the problem and are trying to solve it.¹ Unfortunately, this problem will not be solved until policymakers correctly identify the source of the problem.

Two analogies illustrate the situation well. First, if the kitchen faucet springs a leak, putting a towel on the floor to soak up the water might appear to solve the problem. Until the faucet is fixed, however, the leak remains, and eventually will cause a much greater problem. Similarly, if an injury results from a car wreck, covering head scratches with a Band-Aid might appear to solve the problem. The process of going to the doctor for tests will take more time and seems unnecessary, but without an accurate diagnosis, the Band-Aid could prove to be a potentially fatal distraction from proper treatment for the injury.

Many state legislatures have put Band-Aids on the medical malpractice crisis,² and President Bush is pushing Congress towards an easy fix: capping noneconomic damages.³ However, the underlying problem is much more complex. Many medical errors are occurring.⁴ While only a small percentage of doctors make repeated

¹ See discussion *infra* Part IIA.

² See Peter Eisler et al., *Special Report: Hype Outpaces Facts in Malpractice Debate; Degree of Crisis Varies Among Specialties and from State to State*, USA TODAY MAG., March 5, 2003, available at 2003 WL 5306396 (noting that President Bush supports a plan modeled after California that caps noneconomic damages at \$250,000). See also Chris Grier, *Joining His Peers, Md. Governor Wants Caps on Malpractice Awards*, BEST'S INS. NEWS, Nov. 13, 2003, available at 2003 WL 59121918 (listing "Arkansas, Florida, Idaho, Montana, Nevada, New Hampshire, Ohio, Texas, Utah and West Virginia [as states which have] enacted some kind of reform legislation.").

³ Eisler et al., *supra* note 2 ("Bush pressed his case for a federal cap on pain and suffering damages . . . in a speech to the American Medical Association.").

⁴ See generally National Medical Malpractice Statistics, MedicalMalpractice.com, at <http://www.medicalmalpractice.com/National-Medical-Malpractice-Facts.cfm> (last visited Nov.

mistakes,⁵ these mistakes give doctors a bad reputation, because horrifying stories of medical errors are made public.⁶ Also, insurance companies are in financial trouble due to failed pricing practices, necessitating higher premiums to make up for lost profits.⁷ However, leaders in Congress ignore all the data and, erroneously and carelessly, choose to blame the crisis on frivolous lawsuits and excessive jury awards.⁸ If Congress institutes a cap on noneconomic damages, jury awards will decrease, but medical errors will continue to occur, and incompetent doctors will remain unnoticed and undisciplined.⁹ Insurance companies would then reap financial benefits by being able to charge high premiums, absent any scrutiny or regulation.¹⁰ According to the Institute of Medicine, “[b]etween 44,000 and 98,000 people die in hospitals annually each year due to preventable medical errors.”¹¹ More than half of the medical malpractice payouts are the consequence of only 5.1% of doctors, and “only 13 percent of doctors with five medical malpractice payouts have been disciplined.”¹² In addition, according to the National Association of Insurance Commissioners, between 1995 and 2000 the

13, 2004) (asserting “[b]etween 44,000 and 98,000 people die in hospitals annually each year due to preventable medical errors. . . .”) [hereinafter *Malpractice Statistics*].

⁵ *Id.* at ¶ 12. See also Daniel Eisenberg & Maggie Sieger, *The Doctor Won't See You Now*, TIME MAG., June 9, 2003, at 46, 58 (stating that five percent of doctors are responsible for a third of all medical malpractice judgment costs).

⁶ See Eisler et al., *supra* note 2.

⁷ See, e.g., S. FLA. BUS. J., *Weiss Ratings: Caps Fail to Contain Malpractice Cost Increases*, June 2, 2003 [hereinafter *Weiss Ratings*]. See also Rachel Zimmerman & Christopher Oster, *Assigning Liability: Insurers' Missteps Helped Provoke Malpractice Crisis*, WALL ST. J., June 24, 2002, available at 2002 WL 3398631.

⁸ Kevin Dobbs, *Malpractice Cap Debate Rages in D.C.*, ARGUS LEADER, July 11, 2003, at A1.

⁹ See Kara M. McCarthy, Note, *Doing Time for Clinical Crime: The Prosecution of Incompetent Physicians as an Additional Mechanism to Assure Quality Health Care*, 28 SETON HALL L. REV. 569, 582 (1997).

[T]he concept that medical malpractice serves as a mechanism for quality control is also increasingly scrutinized. Specifically, malpractice does not adequately monitor physician competence and, [sic] therefore, does not curtail the provision of incompetent medical care. In theory, medical malpractice suits control the quality of health care by forcing physicians to take the necessary safety precautions in an effort to avoid compensating negligently injured patients. The threat of litigation has traditionally provided little incentive for a physician to take precautions against the provision of negligent medical care because insurance companies pay malpractice claims.

Id.

¹⁰ Kevin J. Gfell, *The Constitutional and Economic Implications of a National Cap on Non-economic Damages in Medical Malpractice Actions*, 37 IND. L. REV. 773, 780 (2004).

¹¹ *Malpractice Statistics*, *supra* note 4, at ¶ 13.

¹² *Id.* at ¶ 12.

number of malpractice claims actually decreased,¹³ countering the theory that the increase in malpractice premiums resulted from an epidemic of frivolous lawsuits.

This Comment describes how the government missed the mark by ignoring the underlying problems in favor of politics, and treating the intricate issue with a Band-Aid that has no possibility of healing the current medical malpractice crisis. In Part I, I define the medical malpractice crisis; explain the history of previous crises; describe the current crisis from differing points of view; and then assert my opinion regarding the real crisis. In Part II, I explain actions that have been taken to effectuate a cap on noneconomic damages. Part III analyzes the multitude of shortcomings of noneconomic damage caps as a tort reform. Part IV describes different alternatives suggested by commentators. Finally, in Part V, I conclude by offering a better approach to attacking the crisis.

I. THE MEDICAL MALPRACTICE CRISIS

A. Crisis Defined

The medical malpractice crisis is characterized by exorbitant insurance liability premiums charged to doctors, which consequently affect innocent bystanders.¹⁴ The effects of the crisis are myriad. Currently, some doctors see more patients per day to ensure their ability to pay malpractice premiums.¹⁵ Others have either closed their practices, or have continued to practice while refusing to perform risky surgeries, leaving patients without a doctor in times of genuine need.¹⁶ Doctors in Pennsylvania, Nevada, Florida, West Virginia, and especially New Jersey feel the greatest adverse

¹³ *Id.* at ¶ 14 (stating that the number of claims decreased by four percent).

¹⁴ See generally Eisenberg & Sieger, *supra* note 5, at 49–50 (explaining that insurance premiums have doubled in the last two years, forcing doctors either to move to different states with lower premiums or to refuse to perform high-risk surgeries. This article also notes that medical students are changing their focus to lower-risk specialties).

¹⁵ Alan Feigenbaum, *Special Juries: Deterring Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, 1385 (2003) (explaining that the quality of care and the strength of the patient-doctor relationship are eroding as a consequence of physicians seeing more patients per day).

¹⁶ Eisenberg & Sieger, *supra* note 5, at 50 (explaining that “many women now have to drive an hour or more to reach a hospital with a delivery room, forcing several . . . to give birth in the car en route to the hospital [because] six obstetricians stop[ped] delivering babies” within a 6,000 square mile area in Arizona).

effects of this crisis.¹⁷ Doctors, insurance companies, and legislators, with President Bush's support, attempt to solve the crisis of excessive malpractice premiums.¹⁸ Each player in the crisis, including the patient, is affected differently, and each subscribes to a different theory to explain the cause of the crisis experienced at the state and national levels.¹⁹ After each perspective is understood, the question may be asked: What is the real medical malpractice crisis?

B. History Repeats Itself: Past Crises Recur

The medical malpractice crisis is not a new concept in our country, having experienced similar crises in the 1970s and 1980s.²⁰ From the 1950s through the mid-1980s, the number of medical malpractice claims filed increased by 1000%, and the amount of successful jury awards increased by more than 275%.²¹ More specifically, many state legislators enacted tort reform legislation in response to the large increase in medical malpractice insurance between 1972 and 1983.²²

The extended process "between an injury, the filing of a claim, and the claim's disposition [caused] insurance carriers to use premiums paid in later years to defend claims" from previous years.²³ Consequently, insurance companies suffered a greater loss than anticipated, and were forced to raise premiums in order to show a profit.²⁴ As competition among insurers grew and price slashing of premiums increased, rates no longer adequately covered malpractice claims.²⁵ The rise in liability costs, compounded by declining investment returns, instigated a crisis for insurance companies.²⁶

¹⁷ Feigenbaum, *supra* note 15, at 1385 (noting that large insurance companies became insolvent, forcing physicians to find new carriers).

¹⁸ See Eisler et al., *supra* note 2 (arguing that these players blame the crisis on frivolous lawsuits and multimillion dollar judgments).

¹⁹ See generally Eisenberg & Sieger, *supra* note 5, at 47–52.

²⁰ Feigenbaum, *supra* note 15, at 1363.

²¹ Michael Foster, *No-Fault Medical Injury Compensation: Hoofbeats or Pipe Dreams?*, 68 ST. JOHN'S L. REV. 727, 729–30 (1994) (explaining that claim frequency and claim severity are the major factors that affect premium prices. The author also notes that claim frequency increased drastically, which had a great effect on premiums).

²² Matthew W. Light, *Who's the Boss?: Statutory Damage Caps, Courts, and State Constitutional Law*, 58 WASH. & LEE L. REV. 315, 317 (2001).

²³ Foster, *supra* note 21, at 730 (explaining the longer "tail" of medical malpractice insurance which distinguishes medical malpractice insurance from other types).

²⁴ *Id.*

²⁵ Zimmerman & Oster, *supra* note 7.

²⁶ *Id.*

Bad business and accounting practices necessitated higher premiums, which have, in turn, begotten the tort reform movement once again.²⁷

C. Views from Different Perspectives

1. *The Doctor's Perspective*

Doctors hold attorneys accountable for rising insurance premiums, which they believe are caused by frivolous lawsuits and multi-million-dollar judgments.²⁸ Medical costs have increased significantly.²⁹ Doctors claim that the fear of litigation has caused them to practice “defensive medicine.”³⁰ Defensive medicine is evidenced by overly cautious behavior, such as ordering unnecessary tests, and has been attributed to “five to fifteen billion dollars of unnecessary medical costs per year.”³¹

Thinking that “every patient that walks into the physician’s office is . . . a potential legal adversary,”³² many doctors view lawyers who represent the victims of malpractice as the “bad guys” who are hindering the practice of medicine by causing the medical malpractice insurance crisis in America.³³ On the other hand, doctors are questioning insurance carriers’ business and accounting practices, and wondering if physicians are paying for insurers’ business mistakes.³⁴

²⁷ See, e.g., Foster, *supra* note 21, at 729; Zimmerman & Oster, *supra* note 7.

²⁸ See, e.g., Eisler et al., *supra* note 2; Eisenberg & Sieger, *supra* note 5, at 50.

²⁹ See generally Eisler et al., *supra* note 2 (quoting the executive director of the Kansas Medical Society, “Medical costs are going up 15%–20% a year, and they tend to drive up medical malpractice awards and settlements.”).

³⁰ Feigenbaum, *supra* note 15, at 1370.

³¹ *Id.* at 1371. See also Barbara A. Brill, Comment, *An Experiment in Patient Injury Compensation: Is Utah the Place?*, 1996 UTAH L. REV. 987, 996 (1996) (explaining that “positive defensiveness” occurs when doctors order extra tests that might not be needed in order to avoid the risks of liability. “Negative defensiveness” or “resistive defensiveness” refers to situations where doctors opt not to use new procedures or opt to turn away indigent patients).

³² Feigenbaum, *supra* note 15, at 1372.

³³ Catherine T. Struve, *Doctors, the Adversary System, and Procedural Reform in Medical Liability Litigation*, 72 FORDHAM L. REV. 943, 952 (2004) (stating that “[p]hysicians reacted strongly to the upswing in malpractice suits. Medical writers asserted that many, if not most, suits were meritless.”).

³⁴ Zimmerman & Oster, *supra* note 7 (arguing that the insurance companies must take some responsibility for the crisis).

2. *The Insurance Company's Perspective*

Medical malpractice insurance carriers also blame plaintiffs' attorneys for the crisis, and cite a rise in lawsuits and jury awards.³⁵ However, the chief executive of a leading malpractice insurer in California said, "I don't like to hear insurance-company executives say it's the tort system—it's self inflicted."³⁶ Insurance companies are under attack, with much attention focused on their pricing and accounting practices.³⁷ From 1995–2000, smaller carriers entered the market, competition swelled, and price wars commenced, which caused the carriers to knowingly charge rates inadequate to cover malpractice claims.³⁸ Because insurers' investment income relies heavily on the equity investment market, falling bond interest rates and stock prices negatively affected their income.³⁹ The effects of charging inadequate rates to stay competitive, coupled with bad market decisions, forced insurance companies to raise premiums.⁴⁰ Unlike many other industries which are heavily regulated, such as telecommunications and pharmaceuticals,⁴¹ insurance carriers are not federally regulated. This allows insurance carriers to offer plans to doctors without having to go through an arduous approval process.⁴²

³⁵ Eisenberg & Sieger, *supra* note 5, at 55.

³⁶ Zimmerman & Oster, *supra* note 7.

³⁷ *Id.*

³⁸ *Id.*

³⁹ Eisler at al., *supra* note 2 (offering information from the Physician Insurers Association of America that "investment income contributed 47% to its companies' revenue in 1995, but only 31% in 2001.").

⁴⁰ Thomas P. Hagen, *This May Sting a Little—A Solution to the Medical Malpractice Crisis Requires Insurers, Doctors, Patients, and Lawyers to Take Their Medicine*, 26 SUFFOLK U. L. REV. 147, 151 (1992)

Insurance premiums, which had remained artificially low throughout a decade of increasing payouts, suddenly soared, no longer cushioned by investment income. As a result of these combined factors, in the critical years of 1974 and 1975, those insurers unable or unwilling to increase rates sufficiently to operate profitably began refusing to underwrite medical liability.

Id.

⁴¹ Regulation Through Litigation: Trial Lawyers, Inc. Supplants Elected Officials and Regulators as a Fourth Branch of Government, at <http://www.triallawyersinc.com/html/print08.html> (last visited Jan. 7, 2004).

⁴² Cf. William S. Boyd School of Law & Center for Democratic Culture, *The Law and Politics of Tort Reform*, 4 NEV. L.J. 377, 412 (2003).

3. *The Third Party's Perspective*

According to Weiss Ratings, as reported in *The South Florida Business Journal*, six factors contributed to the proliferation of excessive medical malpractice insurance premiums.⁴³ First, in the last twelve years, “[m]edical costs have risen 75%.”⁴⁴ Second, insurers are raising premiums to recover from lost profits in 1999.⁴⁵ Third, medical malpractice insurers failed to adequately reserve profits and as a consequence lost approximately \$4.6 billion from 1997 through 2001.⁴⁶ To make up for losses over the last six years, insurance companies must set aside profits now, which requires them to raise premiums.⁴⁷ Fourth, investment income declined, which is “particularly critical . . . since the claims payouts can span several years.”⁴⁸ Fifth, medical malpractice insurers are under pressure to increase rates, despite the caps, to re-establish security in the market.⁴⁹ Lastly, the number of malpractice insurance carriers decreased significantly, which has allowed the few who remain to set higher prices.⁵⁰ These points confirm the complexity of the issue, and support the opinion that the crisis was not caused by any one simple factor and cannot be “fixed” with one simple solution.

4. *The Attorney's Perspective*

Many argue that frivolous lawsuits are to blame for rising medical malpractice insurance premiums. However, frivolous lawsuits are not the proceedings that effectuate exorbitant jury awards. According to an article in *USA Today*, plaintiffs prevail in only 20%

⁴³ *Weiss Ratings*, *supra* note 7.

⁴⁴ *Id.* See generally Feigenbaum, *supra* note 15 (offering the theory that medical costs are rising because of physicians' increased practice of defensive medicine: the practice of performing excessive and unnecessary tests to avoid liability).

⁴⁵ *Weiss Ratings*, *supra* note 7. See also Zimmerman & Oster, *supra* note 7 (asserting that past pricing practices play an equal role with malpractice litigation in causing the increase in insurance premiums).

⁴⁶ *Weiss Ratings*, *supra* note 7 (explaining “the only way to shore up reserves is to increase premiums . . .”).

⁴⁷ *Id.*

⁴⁸ *Id.* See, e.g., Malpractice Statistics, *supra* note 4, ¶ 14.

⁴⁹ *Weiss Ratings*, *supra* note 7 (contending that “34.4% of the nation's medical malpractice insurers are vulnerable to financial difficulties, [but only] 23.9% of property and casualty insurance industry [are vulnerable to such financial difficulties].”).

⁵⁰ *Id.*

of the cases that are tried, which is less than 2% of total claims.⁵¹ The number of malpractice verdicts and settlements has risen about 400%, which leads to the conclusion that patients “don’t win often, but when they do, they win big.”⁵² With these statistics in mind, how can people disregard the number of medical errors and lackadaisical business practices of insurance companies and simply blame the frivolous law suits as cause of the current medical malpractice crisis?

5. *The Patient’s Perspective*

Patients are feeling abandoned as more doctors leave their practice or opt to no longer perform high-risk procedures.⁵³ Medical students and specialists, like obstetricians, neurologists, and pulmonologists, are switching to “safer” specialties, such as dermatology and ophthalmology.⁵⁴ Alternatively, some doctors have moved their practices to other states that charge lower insurance premiums.⁵⁵ Therefore, patients in need of certain specialists are forced to either find other doctors or go across state lines to follow their doctors.⁵⁶

Caps provide a ceiling of compensation for plaintiffs while providing a ceiling of liability for doctors. Arguably, doctors will be less deterred from making medical errors because of the protection offered by such ceilings.⁵⁷ Consequently, patients will be adversely affected because they will hardly be compensated fully for extreme injuries, regardless of how tangible their damages might be.⁵⁸

⁵¹ Eisler et al., *supra* note 2 (stating “2/3 of patients who file a claim don’t get a dime About 61% of cases are dismissed or dropped; 32% are settled, with average payouts of \$300,000, and only 7% go to trial.”).

⁵² *Id.*

⁵³ Eisenberg & Sieger, *supra* note 5, at 48 (relating stories of pregnant women who drive across borders to see their physician, or go through the trouble of finding a new physician in the middle of the pregnancy).

⁵⁴ *Id.* at 50.

⁵⁵ Judy Bowman, *Lawsuits Threaten Health Care*, KAN. CITY STAR, Dec. 24, 2003, available at 2003 WL 67755891.

⁵⁶ *Id.* See Eisenberg & Sieger, *supra* note 5, at 48.

⁵⁷ *Doctors and Tort Reform*, WASH. POST, Feb. 16, 2003, available at 2003 WL 13332467 (reasoning that caps protect doctors against frivolous lawsuits, but “[demand] nothing of them in exchange” to reduce the increasing problem of medical errors).

⁵⁸ See Sylvia A. Law, *A Consumer Perspective on Medical Malpractice*, 49 LAW & CONTEMP. PROBS. 305, 306 (1986).

6. *The Federal Government's Perspective*

It seems likely that President Bush believes the crisis was instigated by high jury awards and frivolous lawsuits, because he is trying to pass a bill which limits “noneconomic patient damages to \$250,000, shortens the statute of limitations for filing complaints and allows judges to review lawyers’ contingency fees.”⁵⁹ However, the President faces opposition in Congress.⁶⁰ First, pending United States Senate and House of Representatives bills addressing the medical malpractice crisis do not cap noneconomic damages.⁶¹ This will be discussed in further detail in Part II. Second, ten Democratic members of Congress sent a letter to the General Accounting Office (GAO) because they believed that the insurance companies were at the root of the crisis.⁶² The letter asked the GAO to investigate how past investment and undercharging practices affect present premium rates.⁶³ Although the President seems to believe the crisis can be fixed with a national cap on noneconomic medical malpractice damage awards, other members of Congress reject a national cap, asserting two arguments:⁶⁴ First, a cap will not decrease insurance premium rates,⁶⁵ and second, a cap will not fully compensate an innocent victim of negligent medical malpractice errors.⁶⁶

⁵⁹ Jeanne Cummings, *Doctors’ Activism Revives Malpractice Bill*, WALL ST. J., Jan. 13, 2003, at A4, available at 2003 WL-WSJ 3956321.

⁶⁰ *Id.* (discussing how Democrats in Congress argue that caps will not decrease premium rates, and will have a negative effect on victims of medical malpractice). See also Christopher Oster, *Lawmakers Seek GAO Examination of Insurers’ Rates*, WALL ST. J., July 3, 2002, at D3, available at 2002 WL-WSJ 3399714 (explaining that congressional Democrats believe that the insurance industry created the crisis).

⁶¹ See *infra* Part II.A.1-2.

⁶² Oster, *supra* note 60.

⁶³ *Id.*

⁶⁴ Cummings, *supra* note 59.

⁶⁵ *Id.* (noting that members of Congress who oppose noneconomic damage caps assert that caps will not decrease premium rates, and will have adverse consequences on innocent victims of medical errors).

⁶⁶ See also Eisler et al., *supra* note 2 (explaining that members of Congress hesitate to pass legislation which caps noneconomic damages because of the public’s emotional response to medical misconduct cases that show a clear sign of medical carelessness, specifically citing two cases: Santillan, a girl who died from a heart and lung transplant of the wrong blood type, and McDougal, a woman who “received an unnecessary double mastectomy because her biopsy results were mixed up with those of another woman, who was mistakenly told she was cancer-free.”).

D. The Real Crisis

The real crisis is that the government is oversimplifying a complex problem: It acknowledges that insurance premiums are too high, blames the crisis on exorbitant jury awards, and consequently, proclaims that noneconomic caps on damages will solve the nation's crisis. However, this viewpoint ignores many other factors such as medical error rates, judicial safeguards, and the lack of correlation between caps on noneconomic damages and lower insurance premiums.

The medical malpractice crisis is characterized by the undeniable rise in insurance premiums, as well as the number of medical malpractice verdicts and settlements of over \$1 million.⁶⁷ Some state legislatures have capped non-economic damages, but physicians did not experience the intended outcome of lower premiums.⁶⁸ Doctors continue to leave their practices because their insurance premiums are too high, and caps are not effectuating lower premiums.⁶⁹ It is time to discover the true causes of the excessive increase in medical malpractice insurance premiums, and concentrate our efforts on creating realistic plans that address the root of the crisis.

The amount of insurance premiums that physicians are charged is determined according to the frequency of malpractice committed by the individual or group of physicians, the specific insurance company's plan, and the average size of damage amount awarded.⁷⁰ Thus, the frequency and severity of claims are the main factors determining the amount of insurance premiums. Naturally, if medical errors occur less frequently and the injuries are less severe, then premiums should decrease.⁷¹ According to *Pediatrics* magazine, "medical errors occur in more than one in ten cases involving children with complex medical problems."⁷² The Institute of Medicine reported "44,000–98,000 patients die annually as the result

⁶⁷ See, e.g., Eisler et al., *supra* note 2; Eisenberg & Sieger, *supra* note 5, at 49; Zimmerman & Oster, *supra* note 7.

⁶⁸ David Morrison, *In Search of Savings: Caps on Jury Verdicts Are Not a Solution to Health Care Crisis*, 7 LOY. CONSUMER L. REP. 141–42 (1995) (stating, "Both the Ohio and Texas courts cited data confirming that caps had little or no effect on insurance rates.").

⁶⁹ *Id.*; Bowman, *supra* note 55.

⁷⁰ 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, 53 (1991).

⁷¹ *But see* Zimmerman & Oster, *supra* note 7 (claiming that insurance companies charged inadequate premiums to cover claims to compete in price wars in the 1990s. Now they are forced to charge high premiums to make up for lost profits).

⁷² Eisler et al., *supra* note 2.

of medical errors.”⁷³ More important than focusing on medical error statistics, though, is realizing that to solve this crisis, we must understand the *causes* of the medical errors.⁷⁴

Too many medical errors are occurring. According to the Harvard Medical Practice Study, most injured people with “legitimate claims appeared not to file them . . . and not too many, but too few suits were brought for the negligent injuries inflicted on patients.”⁷⁵ If fewer errors occur, it naturally follows that fewer claims will be brought against doctors. In addition, the reduced incidence of irreparable harm to patients will correlate to lower jury compensations for losses. Presumably, if fewer suits are brought and jury awards are lower, then the required amount of insurance liability for doctors should decrease. If doctors required less liability, and insurers did not take advantage of doctors by overcharging to increase their own profits, insurance premiums would decrease, allowing physicians to maintain their practices with affordable insurance.

In sum, if the root of the problem is attacked by improving the reporting of errors so repeatedly negligent doctors are punished and other physicians are not, and by insurers opening their books to elucidate the rationale of their prices, a natural byproduct is the possibility of “solving” the problem more effectively for all the players involved in this crisis.

II. CAPS ON NONECONOMIC DAMAGES

A. Actions from the Hill

1. *United States Senate*

The Better Health Act of 2003 acknowledges many problems with the current system and supplies accompanying solutions. The

⁷³ *Malpractice Statistics*, *supra* note 4, at ¶ 13.

⁷⁴ Lucian L. Leape, M.D., *Special Article: How Many Medical Error Deaths Are There Really?*, at <http://www.gasnet.org/societies/apsf/newsletter/2001/fall/03errors.html> (last visited Feb. 9, 2004). See also John P. Marren et al., *The Hospital Board at Risk and the Need to Restructure the Relationship with the Medical Staff: Bylaws, Peer Review and Related Solutions*, 12 *ANNALS HEALTH L.* 179, 190 (2003) (arguing that the current medical system is seriously flawed because it emphasizes the blame method for handling errors and de-emphasizes affective peer review).

⁷⁵ An “Epidemic” of Medical Malpractice? *A Commentary on the Harvard Medical Practice Study*, at <http://www.thedoctors.com/advocacy/ourcause/harvardstudy/commentary.asp> (last visited Dec. 24, 2003) (arguing that most people with potentially legitimate claims failed to file a malpractice suit against the physicians or hospitals) [hereinafter *Epidemic*].

bill provides sanctions for attorneys who bring frivolous claims⁷⁶ in addition to reforming medical malpractice insurance.⁷⁷ Most importantly, the bill acknowledges the risk of ignoring the high rate of medical errors by providing a section for “reducing medical malpractice by preventing medical errors.”⁷⁸ This makes the Senate’s awareness of the need to attack the root of the problem apparent. On July 8, 2003, the bill was sent to the Finance Committee.⁷⁹

On November 17, 2003, the Senate placed an amended Patient Safety and Quality Improvement Act on the Senate legislative calendar.⁸⁰ The Findings and Purpose Section demonstrates the Senate’s stance concerning a viable solution. The findings state that medical errors constitute the “eighth leading cause of death in the United States.”⁸¹ Most importantly, the Senate notes that “the research on patient safety unequivocally calls for a learning environment, rather than a punitive environment, in order to improve patient safety.”⁸² This acknowledgment speaks to the most pertinent aspect of the crisis. Too many medical errors are occurring,⁸³ and the Senate recognizes the necessity of creating a learning environment which moves away from the “shame and blame” approach our medical system currently practices. Correspondingly, the bill encourages more voluntary reporting to improve patient safety.⁸⁴ By analyzing the research, the United States Senate created a reasonable solution to the actual underlying problem of this crisis.

2. *United States House of Representatives*

On March 12, 2003, House Bill 1219, the Medical Malpractice and Insurance Reform Act of 2003, also addressed the crisis. This bill requires insurance companies to

⁷⁶ Better Health Act of 2003, S. 1374, 108th Cong. § 302 (2003).

⁷⁷ § 401–04.

⁷⁸ § 601–03.

⁷⁹ *Id.* at II.

⁸⁰ Patient Safety and Quality Improvement Act, S. 720, 108th Cong. (2003).

⁸¹ Patient Safety and Quality Improvement Act, H.R. 663 § 2(a)(1), 108th Cong. (2003) (quoting S. 720 § 2(a)(1) which was introduced in the Senate on March 26, 2003). See also <http://thomas.loc.gov/cgi-bin/bdquery/z?d108:SN00720:@@L&summ2=m&> (noting “[t]he Senate incorporated S. 720 in H.R. 663 as an amendment [on July 22, 2004] and passed H.R. 663 in lieu of S. 720.”).

⁸² H.R. 663 § 2(a)(8).

⁸³ See, e.g., H.R. 663 § 2(a)(1); *Malpractice Statistics*, *supra* note 4, at ¶ 1.

⁸⁴ H.R. 663 § 2(b)(1).

implement a plan to annually dedicate at least fifty percent of such annual savings [achieved as a result of this bill] to reduce the amount of premiums that the company charges physicians for medical malpractice liability coverage.⁸⁵

This clearly shows the House's acknowledgment that insurers should maintain proper business practices and be held accountable to the public for the high premiums they are charging physicians. The bill also provides sanctions for lawyers who bring frivolous claims.⁸⁶ On March 12, 2003, the bill was sent to the House Judiciary Committee and to the House Committee on Energy and Commerce.⁸⁷

The Medical Malpractice Reform Act of 2003, House Bill 1124, was introduced on March 6, 2003.⁸⁸ This bill offers tort reform, but does not cap noneconomic damages.⁸⁹ Rather, it provides a statute of limitations and requires a certificate of merit to discourage frivolous suits from being filed.⁹⁰ Additionally, it limits punitive damages to circumstances of "gross negligence; reckless indifference to life; . . . voluntary intoxication or impairment by a physician, sexual abuse or misconduct, assault and battery, or falsification of records."⁹¹ Under the bill, insurance companies are required to reduce premiums in proportion to the amount saved as a consequence of the Act, and to report that reduction within a year after the Act's enactment.⁹² On March 6, 2003, this bill was sent to the Committees on the Judiciary and Energy and Commerce.⁹³

The Patient Safety and Quality Improvement Act was referred to the Senate after the House accepted its terms as H.R. 663.⁹⁴ The bill encourages a learning environment, which is characterized as a system conducive to voluntary reporting.⁹⁵ Congress has realized the need to address the real issue of improving the medical system. Lawsuits and insurance companies' business practices are tertiary

⁸⁵ Medical Malpractice and Insurance Reform Act of 2003, H.R. 1219, 108th Cong. § 106 (a)(2) (2003) (offering a section entitled *Reduction in Premiums Paid by Physicians for Medical Malpractice Insurance Coverage*).

⁸⁶ H.R. 1219 § 103 (2003).

⁸⁷ H.R. 1219.

⁸⁸ Medical Malpractice Reform Act of 2003, H.R. 1124, 108th Cong.(2003).

⁸⁹ *See id.*

⁹⁰ H.R. 1124 § 203.

⁹¹ H.R. 1124 § 201-05.

⁹² H.R. 1124 § 204.

⁹³ H.R. 1124 (2003).

⁹⁴ H.R. 663, *supra* note 81.

⁹⁵ H.R. 663 § 2(b)(1).

concerns until the medical system is improved so that doctors may learn from voluntary reporting to improve long term patient safety.

B. Actions from the Oval Office

President George W. Bush supported California's legislation, which caps noneconomic damages and encourages a similar federal version.⁹⁶ California similarly experienced a medical malpractice insurance crisis in the 1970s that caused increasing health care costs; doctors leaving the state; and doctors limiting their practices.⁹⁷ Consequently, patients found necessary medical care unavailable.⁹⁸ In response to the crisis, California's legislature enacted the Medical Injury Compensation Reform Act ("MICRA"), which capped noneconomic damages at \$250,000 with the intent of lowering insurance rates, which in turn would trigger lower medical costs so indigents could receive much needed medical care.⁹⁹

The goals of MICRA are laudable. However, California remains in a crisis since the enactment of noneconomic damage caps in 1975, more than twenty-eight years ago.¹⁰⁰ After MICRA was enacted, malpractice claims rose; as a result, malpractice insurance premiums rose.¹⁰¹ Because health care costs are still high, "caps on medical malpractice have not achieved what the Legislature hoped."¹⁰²

C. Actions from the Lone Star State

The Texas legislature addressed rising medical malpractice insurance premiums by enacting a tort reform bill on September 1, 2003,¹⁰³ which limited jury awards for noneconomic damages to \$750,000.¹⁰⁴ The state constitution afforded citizens the right to a

⁹⁶ Cummings, *supra* note 59 (stating that "the president is calling for passage of a bill that limits some noneconomic patient damages to \$250,000, shortens the statute of limitations for filing complaints and allows judges to review lawyers' contingency fees.").

⁹⁷ Mark A. Finkelstein, Note, *California Civil Section 3333.2 Revisited: Has It Done Its Job?*, 67 S. CAL. L. REV. 1609, 1610-11 (1994).

⁹⁸ *Id.* at 1611.

⁹⁹ *Id.* at 1609-14 (citing Geri O'Brien, *Medical Malpractice—\$250,000 Cap on Pain & Suffering—Ca. Civ. Code S. 3333.2—Does the Statute Meet Its Constitutional Burden and Legislative Goals?*, 8 WHITTIER L. REV. 601, 618 (1986)).

¹⁰⁰ Finkelstein, *supra* note 97, at 1618.

¹⁰¹ *Id.* (citing data from 1975 through 1989).

¹⁰² *Id.*

¹⁰³ TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.301-.303 (Vernon 2004).

¹⁰⁴ News Release, Office of Jeff Wentworth, Study Proposition 12 Carefully (Aug. 28, 2003).

court decision in particularized cases.¹⁰⁵ A majority of Texans voted in favor of Proposition 12, which amended their constitutional rights by giving legislators—rather than jurors or judges—the right to determine the amount of noneconomic damage awards.¹⁰⁶ Proposition 12 passed on September 13, 2003.¹⁰⁷ As a result, “the legislature by statute may determine the limit of liability for all damages and losses, however, characterized, other than economic damages.”¹⁰⁸ Noneconomic damages compensate a plaintiff for “physical pain and suffering, mental or emotional pain or anguish, loss of consortium, disfigurement, physical impairment, loss of companionship and society, inconvenience, loss of enjoyment of life, [and] injury to reputation.”¹⁰⁹ Economic damages, which award actual economic loss, such as medical bills or lost wages, are not limited by the new amendment.¹¹⁰ Significantly, the amendment allows limits on “other actions,” which arguably gives the insurance industry too much power over citizens’ constitutional rights.¹¹¹

III. FLAWED REFORM: THE SHORTCOMINGS OF THE “SOLUTION”

Some see caps as the solution to the crisis.¹¹² Undoubtedly, caps on noneconomic damages have lowered jury awards. Whether or not this is a positive or negative effect of the cap depends on one’s perspective. After enacting MICRA in California, noneconomic damages were reduced by 74%, and the total judgments decreased by 25%.¹¹³

However, the data offer conflicting results concerning the caps’ effectiveness in reducing medical malpractice premiums,

¹⁰⁵ *False Pretenses: Proposition 12’s Health Care Promises Turn to Dust*, HOUS. CHRON., Nov. 23, 2003, at 2, available at 2003 WL 68823054.

¹⁰⁶ *Id.*

¹⁰⁷ Janet Elliott, *To Amend? The Propositions Lawsuit Caps Win in a Squeaker*, HOUS. CHRON., Sept. 14, 2003, available at 2003 WL 57442781 (stating that the constitutional amendment passed 51% to 49%).

¹⁰⁸ TEX. CONST. art. III, § 66(b).

¹⁰⁹ TEX. CIV. PRAC. & REM. CODE ANN. § 41.001(12) (Vernon 2004).

¹¹⁰ TEX. CONST. art. III, § 66(a).

¹¹¹ James Pinkerton, *South Texas Doctors Find Themselves at Center of Debate on Malpractice Caps*, HOUS. CHRON., Aug. 26, 2003, available at 2003 WL 56766473.

¹¹² See generally Barry Furrow & David Hyman, *Federal Efforts and State Approaches to the Crisis*, in 13 ANNALS HEALTH L. 521, 524 (2004).

¹¹³ J. Clark Kelso & Kari C. Kelso, *Jury Verdicts in Medical Malpractice Cases and the MICRA Cap*, INST. FOR LEGIS. PRAC., Aug. 5, 1999, at 17–18.

which is their supposed purpose.¹¹⁴ According to the U.S. Department of Health and Human Services, states that enacted caps on noneconomic damages have significantly lowered insurance premiums.¹¹⁵ On the other hand, Weiss Ratings reported that states with noneconomic damage caps experienced higher premium increases, while states without caps maintained insurance rates.¹¹⁶ If the goal of the legislature is to reduce medical malpractice premiums, research indicates that caps on noneconomic damage recovery are not necessarily the proper solution.¹¹⁷

Noneconomic damage caps distract people from understanding the real causes underlying the crisis. The following material suggests many shortcomings of tort reform's noneconomic damage caps as a response to the medical malpractice insurance crisis.

A. Horizontal Inequity

Horizontal inequity is a valid concern when caps are utilized in awarding jury amounts in medical malpractice cases. Horizontal inequity occurs when two people in similar situations are treated differently.¹¹⁸ Suppose, for example, that a man goes to a hospital to have a tumor on one of his lungs removed, and the surgeon removes the wrong (healthy) lung. He lives the rest of his life with one unhealthy lung and is permanently connected to an oxygen tank.¹¹⁹ This man will be able to recover his medical expenses and any lost wages incurred from the medical error (economic loss). He will experience significant pain and suffering while carrying around an oxygen tank to breathe, and he must live the remainder of his life

¹¹⁴ See, e.g., Ronald G. Spaeth et al., *Quality Assurance and Hospital Structure: How the Physician-Hospital Relationship Affects Quality Measures*, 12 ANNALS HEALTH L. 235, 246 (2003); *Weiss Ratings*, *supra* note 7.

¹¹⁵ Spaeth et al., *supra* note 114 (citing U.S. Dep't of Health & Human Services, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System 1-2* (July 25, 2002), at <http://aspe.hhs.gov/daltcp/reports/litrefm.htm>) (last visited Feb. 9, 2004).

¹¹⁶ *Weiss Ratings*, *supra* note 7 (stating that "among the 19 states with caps, only two, or 10.5 percent, experienced flat or declining medical malpractice premiums. By contrast, states without caps were better able to contain premium rate increases, with six, or 18.7 percent, experiencing stable or declining trends.").

¹¹⁷ See *id.*

¹¹⁸ Finkelstein, *supra* note 97, at 1620.

¹¹⁹ *Patient Stories*, at <http://www.centerjd.org/stories/Flagg%20Obit.html> (last visited Oct. 8, 2004) (telling the story of Richard Dustin Flagg, who died on September 8, 2003, because of medical malpractice complications).

with one diseased lung. These damages (noneconomic) will be capped.

Now, suppose that this same man with a tumor on one lung is in his car, on the way to the hospital to have it removed, when another car negligently crashes into *his* car. The accident causes the man to lose his only good lung. Since the other driver was negligent and caused the car wreck, this man, in this situation, can receive full economic damages and unlimited noneconomic damages for his pain and suffering.¹²⁰

In both examples, the man has to live with one bad lung for the rest of his life. A doctor's negligence caused the problem in the first scenario, whereas a layperson's negligence caused the problem in the second. However, the victim will be compensated very differently for the same bad lung depending on the circumstances. As one legal scholar wrote, "this unfairness and arbitrariness must be considered a cost of having these caps."¹²¹ Therefore, noneconomic caps privilege physicians while discriminating against all other negligent individuals.¹²²

B. Inequity Among Sectors

Arguably, an elite group may be more heavily, and unfairly, burdened. Caps only limit noneconomic damages, while economic damages are awarded in full. Thus it follows that "children, retirees, and stay-at-home parents would be most affected because they have no income, making it particularly tough to prove any damages from loss of income" because they were not necessarily paid for their work, despite the fact that they were stripped of their livelihoods.¹²³ Thomas Koenig and Michael Rustad performed a study that showed "women stand to lose more when 'nonprivileged' types of damages

¹²⁰ Finkelstein, *supra* note 97, at 1620 (offering an example of a man with a bad kidney in the hospital versus the man with the bad kidney who gets into a car wreck on the way to the hospital).

¹²¹ *Id.* (emphasizing that many things are unfair in life, but society should not create and endorse a system which clearly benefits some and punishes others for no reasons beyond who caused the injury).

¹²² Jacqueline Ross, Note, *Will States Protect Us, Equally, From Damage Caps in Medical Malpractice Legislation?*, 30 IND. L. REV. 575, 591 (1997).

¹²³ Eisler, *supra* note 2. See also Lisa M. Ruda, *Caps on Noneconomic Damages and the Female Plaintiff: Heeding the Warning Signs*, 44 CASE W. RES. L. REV. 197, 231 (1993) (contending that "caps on noneconomic damages . . . have a harsher effect on a female plaintiff who brings a claim that is already economically undervalued. Damages awarded to females are consistently lower than those awarded to males in the same age group.").

are curtailed.”¹²⁴ Noneconomic damage awards are particularly significant for women, because those awards tend to compensate for the low value placed on claims by people whose only economic damages are medical bills.¹²⁵

If a housewife becomes paralyzed due to medical errors, she would be awarded economic damages, which would only include the medical bills. But the pain and suffering she will experience because she is no longer able to clean her house, cook for her family, run her errands, and drive the children to school and to activities will be capped. Her entire way of life has been eviscerated, and a cap provides no compensation for this.

C. Inequity Between Government and Constituents

Legislation that limits an amount a jury can award in particularized cases destroys the theory behind the separation of powers.¹²⁶ The *Fort Worth Star-Telegram* asserted that caps “would gut the idea of checks and balances among the branches of government and pulverize the separation of powers guaranteed in the Texas Constitution.”¹²⁷ This leads to the following questions: Are jurors’ rights denied when the amount they are allowed to reward is capped in certain situations by the government? Are victims’ rights denied when the government, regardless of the specific circumstances, universally caps the amount they are awarded?

¹²⁴ Martha Chamallas, *The Disappearing Consumer, Cognitive Bias and Tort Law*, 6 ROGER WILLIAMS U. L. REV. 9, 28 (2000).

¹²⁵ *Id.* (citing Martha Chamallas, *Questioning the Use of Race-Specific and Gender-Specific Economic Data in Tort Litigation: A Constitutional Argument*, 63 FORDHAM L. REV. 73, 81–89 (1994)). *But see* Thomas Koenig & Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 WASH. L. REV. 1, 82 (1995) (claiming in footnote 334 “[c]omplete data is not available because the verdict reports of some courts do not separately report non-economic damages.”).

¹²⁶ *See generally* Thomas R. Phillips, *The Constitutional Right to a Remedy*, 78 N.Y.U. L. REV. 1309, 1310–12 (2003) (arguing that forty states’ constitutions provide for the right to a remedy, one of the most important rights people hold. The author also notes that the federal constitution does not mirror the states’ pattern in recognizing the right to a remedy. Additionally, this article cites to a Texas case, which criticized caps on noneconomic damages. *Lucas v. U.S.*, 757 S.W.2d 687 (Tex. 1998), held that limiting medical malpractice damages violated the Texas Constitution). *But see Lucas*, 757 S.W.2d at 701, a concurring opinion which argues that the legislature and the courts should respect the separation of powers doctrine and courts should give deference to legislative findings that there is a medical malpractice crisis).

¹²⁷ *Study Proposition 12 Carefully*, *supra* note 104 (quoting Editorial, *Keeping Courts Open*, FORT WORTH STAR-TELEGRAM, Aug. 24, 2003, at 2).

D. Minimal Effect

A National Association of Insurance Commissioners report insinuates that caps will not affect medical malpractice premiums.¹²⁸ Arguably, insurance rates fluctuate according to the economy and insurers' investments.¹²⁹ Naturally, if insurers' pricing and accounting practices are major factors, caps will have a minimal effect on the amount carriers charge doctors for malpractice premiums.¹³⁰ According to the Congressional Budget Office, caps will decrease premiums by less than 0.5%.¹³¹ Notably, noneconomic caps would minimally affect insurance premiums because economic damages, such as medical bills and lost wages, have increased; that amount has no ceiling.¹³² Additionally, caps only apply to litigated cases,¹³³ and, "[l]ess than two [percent] of malpractice claims result in a winning verdict at trial, according to insurance industry estimates."¹³⁴ Finally, since the onset of each of the medical malpractice crises, many states have reformed tort laws, which have proven futile.¹³⁵

E. Corporate Greed

By not making the insurance companies accountable for high premiums being charged to doctors and limiting a distressed plaintiff's potential award, the caps protect big companies and punish innocent victims.¹³⁶

Caps on damages and other tort "reforms" really mean less accountability and more profits for . . . [corporations] especially in the current climate of corporate greed and corruption . . . at the expense of patients, families, consumers, children, seniors, and taxpayers.¹³⁷

This "big business" protection is not the right solution to the medical malpractice liability crisis.

¹²⁸ Mitchell S. Berger, *Following the Doctor's Orders—Caps on Noneconomic Damages in Medical Malpractice Cases*, 22 RUTGERS L.J. 173, 187–88 (1990).

¹²⁹ Cummings, *supra* note 59.

¹³⁰ Zimmerman & Oster, *supra* note 7.

¹³¹ Eisler et al., *supra* note 2.

¹³² *Id.*

¹³³ Max B. Baker, *Sides Differ Widely on Effects of Texas Liability Cap*, TEX. KNIGHT RIDDER/TRIB. BUS. NEWS, Aug. 31, 2003.

¹³⁴ Eisler et al., *supra* note 2.

¹³⁵ Cleckley & Hariharan, *supra* note 70, at 30–33.

¹³⁶ Mary Alexander, *Corporate Greed*, 38 TRIAL 10 (2002).

¹³⁷ *Id.*

F. Avoids the Root of the Problem

The main problem with caps is that this “solution” avoids the real root of the medical malpractice epidemic: Many medical errors are preventable, mistakes are seldom analyzed, and preventive measures are neither taught nor learned in the existing medical system.¹³⁸ For example, “[i]n 2000, the Institute of Medicine published a report suggesting that a majority of doctors’ mistakes were products of flawed systems that did not provide the checks and balances necessary to prevent errors by physicians. Many are preventable.”¹³⁹ Also contributing to the problem is that members of medical staffs fail to coordinate responsibly, which causes many avoidable errors.¹⁴⁰ Even if caps effectuated lower insurance premiums for doctors, medical errors would continue.¹⁴¹ The medical system relies on a “shame and blame” method, which consists of “accusations of incompetence, unprofessionalism, and unworthiness to treat patients.”¹⁴² A doctor has little incentive to report errors when he or she will face punishment and chastisement as the consequences.¹⁴³ Another concern that doctors confront, which leads to more secrecy and less reporting of errors, is further liability in potential litigation.¹⁴⁴ Doctors may be hesitant to report medical errors, because doing so would make damaging information available to plaintiffs’ attorneys.¹⁴⁵

G. Safeguards Already in Place

Safeguards are already in place to stem both frivolous lawsuits and disproportionately high jury awards. The Federal Rules of Civil Procedure afford many provisions that prevent the court docket from being burdened by frivolous claims. For example, Rule 11 mandates, “the claims, defenses, and other legal contentions therein are warranted by existing law or by a non-frivolous argu-

¹³⁸ Bryan A. Liang, *A System of Medical Error Disclosure*, QUALITY & SAFETY IN HEALTH CARE, Mar. 2002, at 64–68 [hereinafter Liang, *Medical Error Disclosure*]. See also Dan Shapiro, *Beyond the Blame: A No-Fault Approach to Malpractice*, N.Y. TIMES, Sept. 23, 2003, § F, at 6.

¹³⁹ Shapiro, *supra* note 138.

¹⁴⁰ Law, *supra* note 58, at 313.

¹⁴¹ Stephan J. Nolan, *Referred Pain—Is the Tort System to Blame for Medical Malpractice Claims?*, 37 MD. B. J. 38, 45 (2004).

¹⁴² Liang, *Medical Error Disclosure*, *supra* note 138, at 64.

¹⁴³ *Id.* (explaining that this method is not helpful in reducing errors or improving quality).

¹⁴⁴ Bryan A. Liang, *Error in Medicine: Legal Impediments to U.S. Reform*, 24 J. HEALTH POL. POL’Y & L. 27, 39 (1999) [hereinafter Liang, *Error in Medicine*].

¹⁴⁵ *Id.*

ment . . .¹⁴⁶ [and] the allegations and other factual contentions have evidentiary support or, if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation or discovery.”¹⁴⁷ If a frivolous claim is brought, and the allegations are not likely to have evidentiary support, then sanctions will be imposed against the attorneys.¹⁴⁸ The threat of sanctions is thought to deter attorneys from bringing frivolous claims.¹⁴⁹ Indeed, Rule 11 has been effective in discouraging the filing of frivolous claims.¹⁵⁰ The thinking behind the 1993 revision of Rule 11 is that it could deter the filing of frivolous claims, and maintain the practice of zealous, creative advocacy.¹⁵¹

Rule 11 motions are often made in conjunction with motions for summary judgment.¹⁵² If the plaintiff fails to provide evidence in discovery, the defendant may file a motion for summary judgment, which also serves as an effective deterrent to filing frivolous claims.¹⁵³ Summary judgment is granted if “there is no genuine issue as to any material fact, and the moving party is entitled to a judgment as a matter of law.”¹⁵⁴ The use of summary judgment has been successful in preventing meritless litigation by precluding frivolous claims from moving beyond the discovery stage.¹⁵⁵

Aside from the Federal Rules of Civil Procedure, many states, including Texas, require a “certificate of merit” supplied by medical experts to establish a good faith claim and thereby reduce the number of frivolous lawsuits.¹⁵⁶ In addition, lawyers are deterred from

¹⁴⁶ FED. R. CIV. P. 11(b)(2).

¹⁴⁷ FED. R. CIV. P. 11(b)(3).

¹⁴⁸ FED. R. CIV. P. 11(c).

¹⁴⁹ Arthur R. Miller, *The Pre-Trial Rush to Judgment: Are the “Litigation Explosion,” “Liability Crisis,” and Efficiency Clichés Eroding Our Day in Court and Jury Trial Commitments?*, 78 N.Y.U. L. REV. 982, 1009 (2003).

¹⁵⁰ Martin B. Louis, *Intercepting and Discouraging Doubtful Litigation: A Golden Anniversary View of Pleading, Summary Judgment, and Rule 11 Sanctions Under the Federal Rules of Civil Procedure*, 67 N.C.L. REV. 1023, 1053–54 (1989) (citing that “federal courts have rendered more than a thousand decisions” under Rule 11).

¹⁵¹ Karen Kessler Cain, *Frivolous Litigation, Discretionary Sanctioning and a Safe Harbor: The 1993 Revision of Rule 11*, 43 U. KAN. L. REV. 207, 215–16 (1994).

¹⁵² Miller, *supra* note 149, at 1009.

¹⁵³ David M. Kopstein, *An Unwise Reform Measure*, 39 TRIAL 26, 28 (2003).

¹⁵⁴ FED. R. CIV. P. 56(c) (stating in the Advisory Committee notes, “Summary judgment procedure is a method for promptly disposing of actions in which there is no genuine issue as to any material fact.”).

¹⁵⁵ Christopher M. Fairman, *The Myth of Notice Pleading*, 45 ARIZ. L. REV. 987, 994 (2003).

¹⁵⁶ Kopstein, *supra* note 153, at 26 (describing that a “certificate of merit” is a generic term which describes a variety of certifications used to legitimate claims).

filing frivolous claims by the ABA's Model Rules of Professional Conduct.¹⁵⁷ A lawyer is prohibited from asserting a claim "unless there is a basis in law and fact for doing so that is not frivolous."¹⁵⁸ Although the model rules do not provide statutory authority disciplined by law, "they [do] offer guidance for lawyer behavior and a basis for lawyer discipline."¹⁵⁹

The Federal Rules of Civil Procedure also provide safeguards against exorbitant jury awards.¹⁶⁰ If the damage award is not proportional to the conduct, the district court may order a new trial or remittitur, which requires the plaintiff to agree to a lower judgment award.¹⁶¹ In one medical malpractice case, an award of \$22,500 plus medical and hospital expenses was deemed excessive and remittitur was ordered.¹⁶² According to the Rustad and Koenig Study II, "judges frequently vacate, remit, or reverse punitive damage awards in medical malpractice cases."¹⁶³ Therefore, the use of remittitur has the same potential to curtail the medical malpractice crisis if high jury awards were the sole cause of the crisis.¹⁶⁴

H. If Tort Reform Is the Key, Caps Are Not the Right Fit.

Current research indicates that medical errors are too common.¹⁶⁵ The litigation system only hinders efforts to improve the

¹⁵⁷ MODEL RULES OF PROF'L CONDUCT R. 3.1 (2004).

¹⁵⁸ *Id.* (stating in comment 2 that lawyers are required to "inform themselves about the facts of their clients' cases and the applicable law and determine that they can make good faith arguments in support of their clients' positions The action is frivolous if the lawyer is unable to make a good faith argument on the merits of the action taken.").

¹⁵⁹ Elizabeth Gepford McCulley, *School of Sharks? Bar Fitness Requirements of Good Moral Character and the Role of Law Schools*, 14 GEO. J. LEGAL ETHICS 839, 842 (2001).

¹⁶⁰ FED. R. CIV. P. 59 dec. 9.

¹⁶¹ FED. R. CIV. P. 59 dec. 126 (stating, "Court may order new trial or remittitur when manifest weight of evidence shows that amount of punitive damages assessed is out of all reasonable proportion to the malice, outrage, or wantonness of the tortious conduct.").

¹⁶² FED. R. CIV. P. 59 dec. 127 (citing *Lee v. Miles*, 317 F.Supp. 1404 (1970)).

¹⁶³ Michael L. Rustad, *Unraveling Punitive Damages: Current Data and Further Inquiry*, 1998 WIS. L. REV. 15, 44 (1998). See also Lisa M. White, *A Wrong Turn on the Road to Tort Reform: The Supreme Courts Adoption of De Novo Review in Cooper Indus. v. Leatherman Tool Group, Inc.*, 68 BROOK. L. REV. 885, 918 (2003).

¹⁶⁴ William R. Padget, *Damage Limitations in Medical Malpractice Actions: Necessary Legislation or Unconstitutional Deprivation*, 55 S.C. L. REV. 215, 228 (2003) (arguing that a state legislature by enacting guidelines on remittitur and the awarding of new trials could reduce the instances of a "liability crisis" when damage awards were "blatantly excessive").

¹⁶⁵ See, e.g., *Malpractice Statistics*, *supra* note 4, at ¶ 1; Bryan A. Liang, *The Effectiveness of Physician Risk Management: Potential Problems for Patient Safety*, 5 RISK DECISION & POL'Y 183 (2000).

health care system.¹⁶⁶ Fear of litigation induces physicians to hide errors, thereby preventing other physicians from analyzing the contributing circumstances of the error and determining what preventative measures should be taken if the same situation presents itself in the future.¹⁶⁷ Peer review has the potential to be very effective in evaluating and improving patient care.¹⁶⁸ Unfortunately, absent state reform legislation, peer review is discouraged for fear of litigation or chastisement.¹⁶⁹ Admittedly, tort reform is necessary, but the question of which reforms can solve the problem remains.

Caps fail to provide hopeful outcomes when analyzed against the true purposes of tort reform. The twin goals of tort reform are deterrence and compensation.¹⁷⁰ Capping noneconomic damages limits the amount of liability a physician is responsible for, which in turn abates the deterrence effect.¹⁷¹ If a doctor's careful scrutiny in dealing with patients has no affect on premium rates, there is less incentive to try harder than other physicians to reduce medical errors.¹⁷² The potential liability cap will be considered when deciding what treatments to prescribe or authorize,¹⁷³ which seems counterproductive to one of the tort system's primary goals: to deter negligent and injurious behavior. The California State Assembly Committee reported that with a cap on noneconomic damages in place, "there is little economic incentive for bad doctors to improve

¹⁶⁶ See, e.g., Bryan A. Liang & Steven D. Small, *Communicating about Care: Addressing Federal-State Issues in Peer Review & Mediation To Promote Patient Safety*, 3 HOUS. J. HEALTH L. & POL'Y 219, 220-21 (2003).

¹⁶⁷ *Id.*

¹⁶⁸ Lisa M. Nijm, *Pitfalls of Peer Review*, 24 J. LEGAL MED. 541, 542 (Dec. 2003) (noting that "[p]eer review serves as one of medicine's most effective risk management and quality improvement tools.").

¹⁶⁹ *Id.* at 541-42 ("State legislatures have attempted to encourage good faith peer review by passing various statutes that provide civil tort immunity to peer review participants, that grant a peer review information privilege in certain judicial proceedings, and that require confidentiality on the part of all peer review participants.").

¹⁷⁰ David Rosenberg, Essay, *Mass Tort Class Actions: What Defendants Have and Plaintiffs Don't*, 37 HARV. J. ON LEGIS. 393, 395 (2000).

¹⁷¹ Elliot Klayman & Seth Klayman, Article, *Punitive Damages: Toward Torah-Based Tort Reform*, 23 CARDOZO L. REV. 221, 249 (2001). See Cleckley & Hariharan, *supra* note 70, at 60.

¹⁷² Berger, *supra* note 128.

¹⁷³ Thomas C. Galligan, Jr., Essay, *Deterrence: The Legitimate Function of the Public Tort*, 58 WASH. & LEE L. REV. 1019, 1037-38 (2001) (describing the under-deterrence effect of caps, and suggesting that codes of professional ethics might serve as a deterrent to doctors, but ethics concerns will have no effect on insurers or health maintenance organizations who authorize treatments).

their quality of care, as there is little or no consequence for their improper behavior.”¹⁷⁴

If doctors cannot recognize the behaviors and practices from which they are supposed to be deterred, the tort system as it stands is not effective. The Harvard Medical Practice Study¹⁷⁵ published in 1991 provided many helpful findings. First, it defined an “adverse event” as “an injury that was caused by medical management.”¹⁷⁶ Alarminglly,

[i]n the duplicate review of a subsample of 318 records, . . . a second team of physicians did not identify the same group of adverse events as did the first team, but they did find about the same incidence of adverse events and adverse events due to negligence. By their own admission, their methodology fails to consistently identify the same incidents as adverse events.¹⁷⁷

Secondly, physicians did not report behavioral pattern changes as a result of a malpractice lawsuit.¹⁷⁸ If doctors cannot recognize behavior that could be judged as negligent, they cannot appropriately be deterred from behaving similarly with another patient. The system is flawed, and noneconomic caps ignore this lingering issue, which remains a problem in hospitals.

The second goal of the tort system is to compensate victims to the full extent, including tangible and intangible injuries. Many studies have shown that medical malpractice victims, especially the seriously injured, are not fully compensated.¹⁷⁹ Not only are capped awards undercompensating seriously injured victims, but the patients who are successful in their medical malpractice actions are still responsible for attorney and court fees, and they must wait, on

¹⁷⁴ Jonathan J. Lewis, *Putting MICRA Under the Microscope: The Case for Repealing California Code Section*, 29 W. ST. U. L. REV. 173, 190 (2001).

¹⁷⁵ Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991).

¹⁷⁶ *Id.* at 370.

¹⁷⁷ *Epidemic*, *supra* note 75.

¹⁷⁸ Thomas Koenig, *The Law Arises Out of Fact, Even for a “Poet Laureate,”* 28 SUFFOLK U. L. REV. 1021, n.106 (1994) (quoting Harvard Medical Practice Study, Medical Injury, Malpractice Litigation & Lawyers, Malpractice Patient Compensation in New York (Executive Summary) 1990, at 10).

¹⁷⁹ Lewis, *supra* note 174, at 189–90 (stating “[o]nly 26.6% of medical malpractice victims receive some compensation for their injuries”). See also *Epidemic*, *supra* note 75 (stating that “not too many, but rather too few suits were brought for the negligent injuries inflicted on patients. [M]ost persons with potentially legitimate claims appeared not to file them.”). See Betsy J. Grey, Article, *The New Federalism Jurisprudence and National Tort Reform*, 59 WASH. & LEE L. REV. 475, 529 (2002).

average, three to five years to receive the award.¹⁸⁰ Therefore, most victims choose not to sue, and the ones who do will be awarded an inadequate amount up to five years later.

IV. ALTERNATIVES

Many alternative solutions which avoid caps on noneconomic damages have been offered to “solve” the medical malpractice crisis, which is evidenced by shockingly high insurance premiums.

A. Awareness of the Power Retained by Insurance Companies

The insurers’ role in this medical malpractice crisis deserves much scrutiny.¹⁸¹

To date, no one knows whether the insurance companies are overcharging. They have repeatedly refused to make their books available, and their premium costs are not subject to regulation by the Department of Insurance. With these facts—or lack of facts—in mind, it seems even more incredible that substantial revisions of our existing compensatory system are being proposed without any plausible scheme for insurance regulation and without dispassionate development of those facts that triggered the alleged crisis.¹⁸²

Additionally, insurance companies made unfortunate investment decisions in the past that necessitated larger premiums to cover their costs.¹⁸³ Lack of insurance regulation, compounded by the fact that insurers need to make up for lost profits,¹⁸⁴ suggests that the high premium crisis has more to do with insurers’ practices than with frivolous lawsuits and exorbitant jury awards.

B. Improving the Medical System

The current medical system is heavily criticized. Too many medical errors are occurring, and the majority of these errors come

¹⁸⁰ Brill, *supra* note 31, at 988 (describing how the current tort system is flawed by offering evidence that victims of malpractice are unquestionably under-compensated for their injuries).

¹⁸¹ Berger, *supra* note 128, at 178.

¹⁸² *Id.* at n.34 (citing Aitken, *Medical Malpractice: The Alleged “Crisis” in Perspective*, 637 INS. L.J. 90, 91 (1976)).

¹⁸³ U.S. GEN. ACCT. OFFICE, *MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE* 13 (2003), available at <http://www.gao.gov/new.items/d03836.pdf> (last visited Feb. 18, 2005).

¹⁸⁴ *Malpractice Statistics*, *supra* note 4, at ¶ 14 (stating “insurance companies are raising rates because of poor returns on their investments, not because of increased litigation or jury awards, according to J. Robert Hunter, director of insurance for the Consumer Federation of America.”).

from a small percentage of doctors. Negligent behavior is not being reported, demonstrating that this system is not conducive to evaluating and preventing medical errors.¹⁸⁵ The studies and reports of these problems are numerous and many scholars have offered solutions.

Reducing medical malpractice, without concentrating on the few “repeat offenders,” is a main focus for many commentators. One popular “fix” is asking those in the medical profession to assume more responsibility by becoming a more self-policing group.¹⁸⁶ That would reduce the effect higher insurance rates have on the majority of doctors who are now “forced to subsidize the higher insurance costs of a few incompetents.”¹⁸⁷ Other solutions include mandatory reporting of errors, establishing disciplinary procedures, and better staffing at hospitals, which can provide another checkpoint to prevent lackadaisical mistakes.¹⁸⁸

As an example, Dr. Michael McEnany resigned as chief of cardiovascular surgery after many peers challenged his competency. The Medical Center struck a resignation deal with the doctor and agreed not to file a report with the medical board of California, which allowed the doctor to continue practicing in another state, where he continued to injure patients.¹⁸⁹ This example illustrates that malpractice premiums increase universally because careless doctors who repeatedly make blatantly negligent errors are not being reported or disciplined,¹⁹⁰ even though

hospitals are required to report to their state medical board . . . any revocation, suspension or restriction of a doctor’s clinical privileges for more than 30 days . . . 55% of all nonfederal hospitals . . . had not reported a single disciplinary action against a doctor . . . [This

¹⁸⁵ See, e.g., Eisenberg, *supra* note 5 (offering a story of a doctor who repeatedly made egregious errors); *Malpractice Statistics*, *supra* note 4 (offering statistics of medical errors and statistics for certain causes of those errors); Liang, *Medical Error Disclosure*, *supra* note 138 (offering more communication-based approaches to move away from the shame and blame method which does not encourage physicians to openly talk about mistakes so they can learn from them).

¹⁸⁶ Eisler et al., *supra* note 2. See also Eisenberg & Sieger, *supra* note 5, at 58 (quoting Dr. John Walsh, “doctors haven’t sold themselves as a self-policing group.” The article also notes that many in the medical profession acknowledge the need to become a more self-policing group).

¹⁸⁷ See Leslie Berestein, *An Undisciplined Doctor*, TIME, June 2003, available at <http://time-proxy.yaga.com/time/magazine>; Eisenberg & Sieger, *supra* note 5, at 58.

¹⁸⁸ Eisler et al., *supra* note 2.

¹⁸⁹ Berestein, *supra* note 187.

¹⁹⁰ Eisler et al., *supra* note 2.

has resulted in] one third of malpractice awards and settlements . . . from just 5% of doctors.¹⁹¹

Therefore, we must find a solution to combat the problem whereby a small number of doctors are responsible for the majority of total payments in medical malpractice cases. One solution is to entice physicians not to make mistakes by charging higher premiums to physicians who show a pattern of incompetence.¹⁹² This will punish incompetent doctors for the necessary high premiums, instead of punishing innocent victims of medical malpractice by capping their deserved reward, or punishing innocent doctors who practice competently and effectively.¹⁹³ Another solution is to allow the state licensing boards or professional medical societies to regulate the medical system or focus on professionally regulating the hospital staff.¹⁹⁴

Several theories have been offered to motivate physicians to report medical errors.¹⁹⁵ No-fault judgments and open communication are popular theories, which are discussed in detail in the following sections.¹⁹⁶ These methods attack the root of the problem, namely too many medical errors in the system.¹⁹⁷ Capping noneconomic damages, on the other hand, sidesteps the problem, and it only helps insurance companies to circumvent the system by charging high premiums to recover lost profits and hurts genuinely innocent bystanders of medical malpractice occurrences.¹⁹⁸ Although it seems as if major problems in the medical system go uncontested, the solutions vary. Caps on noneconomic damages simply sidestep the problems in the medical arena and focus on the litigation that ensues.¹⁹⁹

¹⁹¹ See, e.g., Eisenberg & Sieger, *supra* note 5, at 58 (citing the Federal Government's National Practitioner Data Bank as the source of the statistic); Berestein, *supra* note 187.

¹⁹² David J. Nye et al., *Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495, 1158-59 (1988).

¹⁹³ *Id.* See also Cleckley & Hariharan, *supra* note 70, at 61 (emphasizing that innocent doctors need not be financially burdened, but not at the expense of innocent victims of medical malpractice. Rather, incompetent doctors should pay higher premiums for their behavior so innocent doctors and patients are no longer punished).

¹⁹⁴ Nye et al., *supra* note 192, at 1559-60 (emphasizing that discipline is necessary to ensure better quality health care).

¹⁹⁵ See discussion *infra* Part III.F.

¹⁹⁶ See discussion *infra* Parts IV.C, IV.D.

¹⁹⁷ See generally Gail A. Robinson, Comment, *Midwifery and Malpractice Insurance: A Profession Fights for Survival*, 134 U. PA. L. REV. 1001, 1021 (1986).

¹⁹⁸ Cummings, *supra* note 59.

¹⁹⁹ Law, *supra* note 58, at 315.

C. Different Tort Reform: No-Fault Method

A no-fault system approach, similar to automobile no-fault insurance, offers a tactic to improving quality care and frequency of reporting.²⁰⁰ The approach allows doctors to learn from honest mistakes, and also provides for more investigation to discover which doctors are consistently negligent.²⁰¹ Patients would be compensated for any injury due to medical treatment, regardless of negligence.²⁰² Doctors and patients would pay into a “local injured-patient compensation fund” which would replace the need for liability insurance, and physicians would voluntarily report all mistakes without the fear of looming litigation; the voluntary reporting would be awarded with a no-fault judgment.²⁰³ Boards would investigate medical errors, and would discover doctors who showed patterns of substandard practice.²⁰⁴ This technique would allow doctors to learn from their mistakes and other doctors’ mistakes, which ultimately promotes a better quality of medical care.²⁰⁵

Many benefits can be gained from such a community-and learning-centered approach, but this approach has drawbacks. First, the ultimate goal of everyone involved would have to be improving the medical system.²⁰⁶ Even though potential victims might benefit from better quality health care down the road, present victims will probably be more inclined to demand greater compensation for their losses rather than allow the medical system to treat them as guinea pigs.²⁰⁷ Another problem is defining a “compensable” event.²⁰⁸ It is necessary to determine whether the injury was caused

²⁰⁰ Robinson, *supra* note 197, at 1021. See Shapiro, *supra* note 138.

²⁰¹ See generally Shapiro, *supra* note 138 (arguing that a no-fault system would provide a better system for everyone because doctors will learn from their mistakes, which will increase the quality of care).

²⁰² Robinson, *supra* note 197, at 1021 (explaining the term “iatrogenic injury” as any caused by medical treatment).

²⁰³ Shapiro, *supra* note 138.

²⁰⁴ *Id.* (emphasizing that doctors who showed repeatedly negligent behavior “would eventually be caught while doctors who were honestly doing their best would have a way to apologize and promote healing by telling the truth about their involvement with the mistake.”).

²⁰⁵ *Id.* (arguing that the quality of medical care would be enhanced if the medical care system provided for bad doctors to be disciplined, while good doctors would be able to learn from their mistakes).

²⁰⁶ Liang, *Medical Error Disclosure*, *supra* note 138, at 67.

²⁰⁷ See generally Shapiro, *supra* note 138 (noting that compensation will be more modest in a no-fault judgment system).

²⁰⁸ Robinson, *supra* note 197, at 1022.

from medical treatment or from the original condition which instigated the hospital visit.²⁰⁹ A negative consequence of this approach could be the turning away of high-risk patients for fear of liability for all injuries.²¹⁰ In addition, the deterrence aspect of tort reform is absent from this approach²¹¹ because patients are compensated, even absent negligent behavior.

D. Improving Communication Techniques

Arguably, we live in a society in which people need a culprit to blame when things go awry.²¹² This system of thinking impedes learning and growing in practicing medicine by disconnecting communications between patients, doctors, and supervisors.²¹³ If doctors are not willing to talk about what went wrong for fear of humiliation or a lawsuit, then no one can take steps to ensure that the same mistakes do not happen again.²¹⁴ The fear of litigation holds doctors back from self-reviews and peer reviews to address problems and mistakes.²¹⁵

Another proposal suggests that an “error disclosure team” should meet with the patient or family to discuss what happened and what measures are being taken in response.²¹⁶ Open communication between the medical team and the patient is highly encouraged because patients are much less likely to sue if they have a good relationship with a physician who has always kept the lines of communication open and honest.²¹⁷

²⁰⁹ *Id.* at 1023 (explaining that proof of medical negligence is not required for compensation; however, injury from treatment is a required element of the cause of action. If the injury in which the plaintiff is suing was caused by an illness or accident that was not aggravated by medical treatment, then the injury would not be compensable).

²¹⁰ Foster, *supra* note 21, at 754 (offering a theory that if a high-risk patient comes in the door with an extreme medical case, doctors may be deterred from helping for fear that the patient will sue and try to prove that medical treatment, rather than a natural development of the injury over time, caused the exacerbation of the medical case).

²¹¹ Robinson, *supra* note 197, at 1024.

²¹² Liang, *Medical Error Disclosure*, *supra* note 138, at 64 (describing this as the “shame and blame” method, which has “led to decades of ignoring the systems nature of health care and an epidemic of deaths due to medical error”). See also Marren et al., *supra* note 74, at 191 (emphasizing possible solutions to improve the quality of health care: (1) move away from the blaming culture which we have created; & (2) more emphasis on peer review).

²¹³ Liang, *Medical Error Disclosure*, *supra* note 138, at 64.

²¹⁴ *Id.*

²¹⁵ Spaeth et. al, *supra* note 114, at 241.

²¹⁶ Liang, *Medical Error Disclosure*, *supra* note 138, at 66.

²¹⁷ *Id.* at 67 (citing Wendy Levinson, et al., *Physician–Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997)).

In addition to the many policies and procedures that a hospital may choose to implement, mandatory alternative dispute resolution is another avenue for alleviating the fear of litigation and encouraging disclosure of medical errors.²¹⁸ Mediation for example, would provide an optimal outlet for patients to vent their dissatisfaction with the medical system, and would provide various settlement solutions, while allowing doctors the opportunity to sympathize with patients and understand what went wrong and how it could have been prevented.²¹⁹ Litigation, in contrast, provides little compensation for a patient's suffering, and provides no instructive criticism for doctors that they could use for later improvement.²²⁰

E. Judicial Alternatives

To decrease the court docket and to eliminate frivolous claims, some state legislatures have enacted screening panels consisting of a physician, an attorney, and a judge.²²¹ Although the panels were successful in achieving the suggested goals, they pose important constitutional problems if they deny the patient's right to a jury trial.²²² Valid constitutional challenges do not make panels the optimal solution for reducing frivolous claims and lightening court dockets.²²³

The use of special juries is another judicial alternative to tort reform involving caps on noneconomic damages in medical malpractice suits.²²⁴ This argument asserts that if "legal concepts are beyond the practical abilities and limitations of the common jury, . . . the educational threshold for service . . . should be a bachelor's degree from an accredited college or university."²²⁵ Requiring a

²¹⁸ Liang, *Medical Error Disclosure*, *supra* note 138, at 67.

²¹⁹ *Id.*

²²⁰ Shapiro, *supra* note 138.

²²¹ Feigenbaum, *supra* note 15, at 1379.

²²² *Id.* at 1380 (mentioning other problems as well, which include the fact that the "panel's decision is not binding . . . [and] the panel's composition can be challenged on the ground that persons outside the judicial profession, such as physicians or attorneys, are making legal determinations.").

²²³ *Id.*

²²⁴ *Id.* at 1411.

²²⁵ Feigenbaum, *supra* note 15, at 1412 (arguing that the selection process would be cost effective and would consist of jurors who are more capable of handling complex cases. On the other hand, the author notes that the argument is flawed in that students with a B.A. in Music would not be more capable of handling a complex medical malpractice case than a person who obtained a medical or osteopathic degree, who, under this system would not be qualified to sit on the special jury, but would have studied the information relevant to

college degree as a prerequisite to sitting on a jury could even survive a constitutional challenge because “college graduates are comprised of individuals from all facets of society, both economically and racially.”²²⁶ The creation of special juries has the potential to deter meritless lawsuits,²²⁷ but such juries will not decrease medical malpractice insurance premiums.

V. CONCLUSION

The real medical malpractice crisis will reach a crescendo if our government ignores the underlying causes of the crisis. The effects are detrimental to all if the quality of medical care declines, or fails to improve, and insurers reap even more power than they currently hold. Although pending legislation does not appear to cap noneconomic damages, President Bush is pushing for a program that mirrors California’s \$250,000 cap, which has not effectuated lower insurance premiums. There are many flaws with the theory that noneconomic caps will solve the crisis by lowering insurance premiums. Numerous alternatives have been offered; each has desirable and undesirable effects.

Lingering issues are being ignored, which could be fatal. If the medical system is not improved, then we all stand to lose. Doctors should be able to learn from their mistakes so they do not let them occur again. The health care environment should be conducive to reporting errors so physicians can learn from mistakes. Further, negligent doctors who repeatedly make mistakes should be reported and disciplined. This will protect the reputation of the majority of doctors who are exceedingly competent in their practice of medicine, and who are also human beings capable of making mistakes.²²⁸ Also, insurers should be responsible for defending themselves and their practices to the public. If insurance companies are raising their rates because they need to make up for lost profits, why are innocent victims of medical malpractice being punished by not being awarded what they are due in court?

the case) (citing *The Case for Special Juries in Complex Civil Litigation*, 89 YALE L.J. 1155, 1172 (1980) (explaining factors the court must consider before creating a special jury)).

²²⁶ *Id.* at 1413.

²²⁷ *Id.* at 1420.

²²⁸ *See generally id.* at 1362–63 (explaining that patients’ expectations of perfection are not realistic, while referencing a study stating that medical treatment “is still more art than science”).

Many bills proposed in Congress address the medical malpractice crisis and deal with individual factors.²²⁹ Ideally, a federal statute would be enacted which addresses every factor of the crisis and prepares a working strategy to ensure proper follow-up procedures. First, peer review should be encouraged; thus, voluntary reporting should be promoted and protected from liability.²³⁰ This will improve patient safety. Second, the hospital (or the insurer) is currently required to report negligent doctors to the National Practitioner Data Bank.²³¹ Failure to do so allows negligent doctors to remain practicing medicine at the expense of the public health.²³² Stricter penalties need to be set and enforced for failure to report. This will ensure that the small percentage of negligent doctors who are responsible for one-third of all medical malpractice payouts do not continue practicing and do not continue making errors which draw them back to the courtroom. Finally, insurance rates should be regulated.²³³ This has been proved to reduce malpractice premiums.²³⁴ In comparison, noneconomic damages caps have not effectuated lower rates. A federal statute which handles these three issues would truly make an impact by improving the medical system's learning environment, patient safety, and establishing fair medical malpractice insurance premiums.

If the head of the household would take the time to determine the source of the leak in the kitchen rather than simply placing a towel on the floor, the causes would be known and eventually resolved. If the government would take the time to analyze the roots of the crisis, eventually this country could see a reduction in medical errors, an increase in reporting errors, and higher scrutiny to

²²⁹ See discussion *supra* Part II.A.

²³⁰ See generally Nijm, *supra* note 168 (contending that “[p]eer review serves as one of medicine’s most effective risk management and quality improvement tools. It provides a safe forum in which medical professionals can review the quality of care and work to reduce medical errors.”).

²³¹ Philip L. Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals*, 38 U.S.F. L. REV. 301, 303 (2004) (explaining that the Health Care Quality Improvement Act, enacted by Congress in 1986, requires such reports).

²³² See generally Berestein, *supra* note 187 (illustrating a story where a negligent doctor was able to continue practicing and harming patients because he was never reported).

²³³ See Richard H. Honaker, *Tort Reform*, 26 WYO. LAW. 4, 8 (Apr. 2003) (clarifying that “[m]alpractice premiums in California increased by 190% during the first 12 years following enactment of its \$250,000 non-economic damages cap. Rates only began to level off in California after voters passed Proposition 103, which removed the insurance industry’s anti-trust exemption and allowed the California insurance commissioner to regulate rates.”).

²³⁴ *Id.*

wards insurance companies' practices. Consequently, innocent victims, such as injured plaintiffs and competent doctors, would no longer pay for doctors' and insurers' careless business practices, which have had an effect on all of us.

For the truly adventurous looking for a challenge, you can look for issues that are not considered easy and try to fix those. It must be warned, though, that it is quite possible that a bug that has been left open has been left into that state because of the difficulty compared to the benefit of the fix. It could also still be open because no consensus has been reached on how to fix the issue (although having a patch that proposes a fix can turn the tides of the discussion to help bring it to a close). Regardless of why the issue is open, you can also always provide useful comments if you do a