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Richard E. Anderson

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Effective Legal Reform and the Malpractice Insurance Crisis

Richard E. Anderson, M.D.*

This Case Study is built around two fundamental questions: First, is there really a malpractice insurance crisis in the United States today? Second, what is the best way to improve the medical liability system? While there is much ongoing debate, this Case Study argues that the answers to both questions are clear. I first review the nature, breadth, and source of the current crisis and then examine ways to ameliorate the problems in both the short and long-term. There is clear evidence that current problems are the result of a dramatic increase in the cost of litigation and that certain legal reforms would significantly alleviate the crisis.

I. THE MALPRACTICE INSURANCE CRISIS

A crisis is defined as “an unstable or crucial time or state of affairs in which a decisive change is impending; especially one with the distinct possibility of a highly undesirable outcome.”¹ The American Medical Association (AMA) has found this definition to be an apt description of the medical malpractice insurance situation in an increasing number of U.S. states:

America’s patients are losing access to care because the nation’s out-of-control legal system is forcing physicians in some areas of the country to retire early, relocate or give up performing high-risk medical procedures. There are now 20 states in a full-blown medical liability crisis—up from 12 in 2002. In crisis states, patients continue to lose access to care. In some states, obstetricians and rural family physicians no longer deliver babies. Meanwhile, high-risk specialists no longer provide trauma care or perform complicated surgical procedures.²

* Fellow of the American College of Physicians, Chairman and Chief Executive Officer of The Doctors Company.

1. MERRIAM WEBSTER’S COLLEGIATE DICTIONARY 275 (10th ed. 1995).

2. Am. Med. Ass’n, *America’s Medical Liability Crisis: A National View* (2004), at

The actions of protesting doctors—from selectively withholding medical services to marching on state capitols to demand legal reform—have also made it clear that we are in the midst of a crisis.³ In turn, multiple state legislatures,⁴ the United States Congress,⁵ and the media⁶ have turned their attention to medical malpractice, frequently concluding that increasing insurance rates represent an urgent concern that must be addressed. Important legislative action has been taken in states as diverse as Texas, Florida, and Idaho.⁷ Many other states are actively debating the issue, but no legislation has resulted.⁸ The fact that so many legislatures are simultaneously and independently discussing the malpractice insurance crisis attests to its urgency.

The current state of medical malpractice insurance has been precipitated by a sharp rise in the cost of malpractice claims—both due to the increasing volume of malpractice litigation and to the growing size of awards. This increase in the cost of claims has resulted in a dramatic rise in the cost of malpractice premiums. In 2002, malpractice insurance rates for physicians nationwide rose approximately twenty percent,⁹ but this average figure obscures a very wide range. States like California that enjoy effective legal reforms have seen rates increase only a few percent per year in this interval,¹⁰ while states lacking such reforms have seen increases in excess of

<http://www.ama-assn.org/ama/noindex/category/11871.html>.

3. Tom Ramstack, *Doctors' Careers on Life Support*, WASH. TIMES, Sept. 1, 2003 at A1.

4. AM. TORT REFORM ASS'N, TORT REFORM RECORD 2-3 (July 2004), http://www.atra.org/files.cgi/7802_Record6-04.pdf

5. Help Efficient, Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2004, H.R. 4280, 108th Cong. (2004); Pregnancy and Trauma Care Access Protection Act of 2004, S. 2207, 108th Cong. (2004).

6. See, e.g., Jessica Bruder, *New Jersey Starts Fund for Malpractice Costs*, N.Y. TIMES, June 8, 2004, at B5. Research searches using the phrase “malpractice crisis” return a multitude of articles, reports, and other resources. See, e.g., U. S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (June 2003), <http://www.gao.gov/new.items/d03702.pdf>; John E. Lemoine, Controlling the Medical Malpractice Crisis: A Letter from the CEO (Jan. 7, 2004), at <http://www.lammico.com/letter/addendum-detail.asp?addendum=17>; Casualty Actuarial Soc’y, *The Medical Malpractice Crises: The Causes and Remedy*, at <http://www.casact.org/media/medmal.htm> (last visited Oct. 12, 2004).

7. See AM. TORT REFORM ASS'N, *supra* note 4, at 2-3.

8. See *id.*

9. *2002 Rate Survey Finds Malpractice Premiums Are Soaring...*, MED. LIABILITY MONITOR, Oct. 2002, at I-IV.

10. In fact, since 1976, when the Medical Injury Compensation Reform Act (MICRA) of 1975, chs. 1-2, 1975 Cal. Stat. 2d Ex. Sess. 3949, went into effect, California’s rates have

one hundred percent for specialists in high-risk areas of medicine.¹¹ As a result, high-risk physicians in states lacking legal reforms face annual malpractice insurance premiums in excess of \$100,000 and in some cases in excess of \$200,000 per year, per doctor.¹² In the states most directly affected by rising premiums—for example, Mississippi, West Virginia, Nevada, and Pennsylvania—some physicians have found themselves uninsurable at any price or have turned to state-run plans, which are even more expensive than coverage available in the marketplace, as the insurer of last resort.¹³

A. *The Underlying Problem: Malpractice Litigation*

1. *Frequency of Litigation*

Even the now commonplace phrase “high-risk specialists” is indicative of this crisis. We used to speak of high-risk patients, referring to individuals with higher than normal risk of unfavorable outcomes, such as neurosurgical patients with spinal cord tumors. Now, we refer to entire medical specialties as high-risk, meaning that they face a much higher than normal risk of litigation. In fact, neurosurgeons practicing in the United States today face, on average, a malpractice claim every two years.¹⁴ For obstetricians, orthopedists, general surgeons, emergency room doctors, and other high-risk specialists, the figure is one claim every three years.¹⁵

More than three quarters of all such claims close without any payment to the plaintiff, but they are extremely costly to defend, averaging nearly \$23,000 per claim.¹⁶ If a case must go all the way through a jury trial before

increased by less than three percent per year. See RICHARD E. ANDERSON, *MEDICAL MALPRACTICE: A PHYSICIAN'S SOURCEBOOK* 214 (2004); see also *infra* notes 40-53 and accompanying text (discussing MICRA).

11. *Trends in 2002 Rates for Physicians' Medical Professional Liability Insurance*, MED. LIABILITY MONITOR, Oct. 2002 (special report), at 1-16.

12. *E.g.*, *id.* at 4.

13. NGA CTR. FOR BEST PRACTICES, *ADDRESSING THE MEDICAL MALPRACTICE INSURANCE CRISIS* 3-4 (2002).

14. Richard E. Anderson, *Defending the Practice of Medicine*, 164 *ARCHIVES INTERNAL MED.* 1173, 1174 (2004).

15. *Id.*

16. *Harming Patient Access to Care: Implications of Excessive Litigation: Hearing Before the Subcomm. on Health of the House Comm. on Energy & Commerce*, 107th Cong. 84 (2002) [hereinafter *Hearing*] (statement of Richard E. Anderson, M.D., F.A.C.P., Chairman/CEO of The Doctors Co., for the Physician Insurers Ass'n of Am.).

a defense verdict, the average expense exceeds \$85,000.¹⁷ These costly victories are important drivers of medical malpractice premium rates.

There are more than 125,000 pending malpractice claims against America's 700,000 licensed physicians today.¹⁸ Thus, if you are reading this Case Study on a weekday, roughly six hundred more malpractice claims will be filed today. This large number of claims is even more striking when you consider that many licensed physicians are in research, academia, the military, or are retired and are thus not at risk of being sued.

2. *Fallacy of the Bad Doctor*

Faced with this onslaught of litigation, physicians feel that they are under siege.¹⁹ There might be less widespread concern about malpractice claims if they were primarily brought against negligent doctors. The frequency data cited above make clear that virtually all physicians face the prospect of litigation, though most are ultimately vindicated. There is little victory in vindication, however, given the costs, long duration of malpractice claims,²⁰ and the personal attacks on professional identity that are at the core of the malpractice allegations.

In any given year, two percent of claims are responsible for about half of the compensation provided to plaintiffs,²¹ leading some to argue that removing the two percent of doctors responsible for these large claims would eliminate the crisis. However, the two percent of physicians who have to make these payments differ every year. Were this fact not true, other doctors would not risk practicing with them, nor tolerate their negative impact on the profession, and insurance companies certainly would not offer them coverage. In truth, the problem with our current medical liability system is not the presence of a few bad doctors, it is that

17. *Id.* at 86.

18. See Health Care Liab. Alliance, Health Care Lawsuits, Claim Payments on Upswing (Apr. 27, 1995) (on file with author). The 125,000 figure is based on data from 1995 because the number of pending claims has not been tracked since then. The figure of 125,000 represents a conservative estimate of current suits, since the number of physicians practicing has increased significantly, WAYS AND MEANS COMM., HOUSE OF REPS., GREEN BOOK 2003 app. C, C27-28 (2003), and the frequency of litigation has certainly not decreased significantly since 1995, The Doctors Co., Annual Claims Per Mature Internal Medical Equivalent Doctor 1976-2002 (on file with author).

19. See ANDERSON, *supra* note 10, at ix-xv.

20. On average, "it takes 5 ½ years for an insurer to close a malpractice claim after the date of the incident." *Hearing, supra* note 16, at 87.

21. See ANDERSON, *supra* note 10, at 210.

every year a large number of physicians face meritless claims.²²

Why are the doctors involved in large claims different every year? The Harvard Medical Practice Study gives us the answer: There is no relationship between the presence or absence of medical negligence and the outcome of malpractice litigation. The only variable that predicts the outcome of claims is the degree of injury. A severely injured plaintiff is likely to be compensated in court whether or not the doctor was at fault.²³

3. Increasing Size of Claim Awards

While the volume of malpractice litigation alone is sufficient to qualify as a crisis, the cost of the average claim is rising at unprecedented rates. Between 1997 and 2000, the median malpractice award doubled to one million dollars.²⁴ The average (modal) jury verdict in malpractice trials was 3.5 million dollars in 2000.²⁵ In states without legal reforms, the outer limit of liability has skyrocketed to amounts never before seen in medical negligence cases.²⁶ Just under one billion dollars in medical malpractice compensation was paid out in New York and Pennsylvania (combined) in 2000,²⁷ and the total cost of medical malpractice litigation now exceeds twenty-four billion dollars annually and continues to grow.²⁸

22. Steve Ellman, *ABA Blasts Fla. Ballot Measure Limiting Attorney Fees*, MIAMI DAILY BUS. REV. (Oct. 18, 2004); see also Medical Malpractice Lawyers, Medical Malpractice Lawsuit, at <http://www.medmalattorney.us.com/lawsuit.html> (last visited Dec. 4, 2004). While the costs incurred by the medical profession are widespread, few injured patients benefit from the payments. It is worth noting that contingency fee lawyers take home up to forty percent of the awards won by plaintiffs.

23. See Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1963-67 (1996) (comparing outcomes based on independent assessments of the merit of plaintiffs' claims).

24. Press Release, Jury Verdict Research, Medical Malpractice Verdict and Settlement Study Released (Mar. 22, 2002) (on file with author).

25. Jury Verdict Research, Ins. Info. Inst., Trends in Malpractice Insurance: Behind the Chaos (on file with author).

26. A jury in Texas awarded a \$268 million verdict in a case involving the death of a single patient. *Model's Jury Award Top Verdict*, LAWYERS WEEKLY USA, Jan. 8, 2001, at 1. Pennsylvania has had multiple awards in excess of \$50 million. Christopher Guadagnino, *Malpractice Awards Surge in PA*, PHYSICIAN'S NEWS DIG., Jan. 2001, <http://www.physiciansnews.com/cover/101.html>.

27. PA. MED. SOC'Y, MEDICAL MALPRACTICE SEVERITY, 2000 (2002).

28. TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2003 UPDATE 13 (2003).

B. Impact on Malpractice Insurance Companies

The rising cost of claims has meant that malpractice insurers will have paid close to \$1.60 for every dollar of premium collected between 2001 and 2003.²⁹ The cost of claims represents nearly eighty percent of an insurer's expenses³⁰ and the nonpartisan United States General Accounting Office (GAO) affirms that "losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term. Such losses are by far the largest component of insurer costs, and in the long run, premium rates are set at a level designed to cover anticipated costs."³¹

At the same time, falling interest rates between 2000 and 2002 lowered investment returns on premiums and reserves, reducing the subsidization of rates. The decline in investment income, however, accounted for only 7.2% of premium increases according to the GAO, underscoring the magnitude of rising claims costs.³² Moreover, even in a better economic environment, investment income can only be expected, at best, to bridge a small gap between insurance rates and expenses.

II. SOLUTIONS TO THE CRISIS

Some of the factors that have produced this litigation crisis are cultural and can be changed only over long periods of time. One of these is monetary desensitization: From awards on games shows³³ and the salaries of sports figures³⁴ and corporate executives³⁵ to attorneys' fees³⁶ and the

29. See CONNING RESEARCH & CONSULTING INC., *MEDICAL MALPRACTICE: ANATOMY OF A CRISIS* 2003, at 22 (2003); see also JAMES D. HURLEY, *A NEW CRISIS FOR THE MED MAL MARKET?*, 4 *EMPHASIS* (Tillinghast) 2 (2002), http://www.towersperrin.com/tillinghast/publications/publications/emphasis/Emphasis_2002_4/Hurley.pdf. This statistic reflects all medical malpractice insurers, including physician-owned medical practice insurers (termed mutuals and reciprocals). These insurers cover more than sixty percent of the country's doctors, see *Hearing, supra* note 14, at 86, and do not face shareholder pressure for profit.

30. U. S. GEN. ACCOUNTING OFFICE, *supra* note 6, at 16.

31. *Id.* at 43.

32. *Id.* at 27.

33. For example, *Who Wants To Be a Millionaire?* has replaced the *\$64,000 Question*.

34. The shortstop for a last place team signed a ten-year \$252 million contract. See Murray Chass, *Rodriguez Strikes It Rich in Texas*, N.Y. TIMES, Dec. 12, 2000, at D1.

35. In recent years, we have seen billionaires created after two or three years of hard work in the technology industry. MicroSolutions and Broadcast.com founder, Mark Cuban, and eBay founder, Pierre Omidyar, are just two examples. *The Forbes 400, The Richest People in America*, FORBES, Oct. 11, 2004 (Special Issue), at 186, 254.

federal budget,³⁷ we have seen dramatic increases in the amounts of money at stake in society. Hearing about people earning hundreds of millions of dollars or deals totaling billions of dollars is now surprisingly commonplace. In this environment, it is not surprising that a jury that would have awarded one million dollars a few years ago now responds with a ten million dollar verdict, even though actual economic damages in medical malpractice claims have not changed to nearly that extent. This monetary desensitization, in general, and the size of jury verdicts, in particular, has greatly exceeded the inflation rate for the economy as a whole.³⁸ More broadly, Phillip Howard, founder of the legal reform group Common Good, notes:

Fear of litigation has undermined our freedom to make sensible decisions. Doctors, teachers, ministers, even little league coaches, find their daily decisions hampered by legal fear. Our system of justice, long America's greatest pride, is now considered a tool for extortion, not balance. What's missing is the essential idea of law. Law is supposed to set the boundaries of legal action, so that people know where they stand. Law should make us feel comfortable doing what's reasonable and nervous doing what's wrong. Today Americans are nervous doing almost anything.³⁹

Changing this mindset will be difficult and will take a considerable amount of time to happen. Fortunately, we do not have to wait for such a cultural shift to occur on its own; there are several strategies available that will help create meaningful change in the short-term.

A. MICRA and Effective Tort Reform

There is more than a quarter century of experience and an abundance of evidence that the four principal reforms embodied in California's

36. Attorneys regularly now demand billion dollar fees in areas such as tobacco, asbestos, and other mass tort litigation. *See, e.g.*, CTR. FOR LEGAL POL'Y AT THE MANHATTAN INST., TRIAL LAWYERS, INC.: A REPORT ON THE LAWSUIT INDUSTRY IN AMERICA 2003, at 6-7, 10-11 (2003); Lester Brickman, *Want To Be a Billionaire? Sue a Tobacco Company*, at <http://www.calahouston.org/billion.html> (last visited Oct. 13, 2004).

37. The federal budget is now expressed in trillions of dollars.

38. The average annual inflation rate in the United States between 1990 and 2000 was 2.7%. *See* North America: Economy: Inflation, at http://www.nationmaster.com/graph-T/eco_inf_199/NAM (last visited Oct. 13, 2004).

39. *Why We Have Come Together*, Common Good, <http://cgood.org/about> (last visited July 9, 2004).

Medical Injury Compensation Reform Act (MICRA) statutes prevent the kind of malpractice insurance crisis we are experiencing today.⁴⁰

MICRA was passed by the California legislature in 1975 under circumstances similar to those described in current headlines. A tidal wave of malpractice litigation in the state drove up insurance rates by several hundred percent, but eventually most insurers in California concluded that the practice of medicine was not an insurable risk and simply refused to provide coverage under any circumstances.⁴¹ Local doctors went on strike, and physicians marched on Sacramento. The legislature responded with MICRA, and California has had a stable insurance environment ever since.

There are four major components to MICRA: First, it provides for a \$250,000 cap on non-economic damages.⁴² This provision is the single most important provision of MICRA. It is critical to note that there is no limit on total awards for actual damages, but capping awards for pain and suffering removes the potential for medical malpractice plaintiffs to be awarded incalculable windfalls. Second, MICRA allows defendants to introduce into evidence additional sources of compensation for injury that have already been paid; this is known as collateral source reform.⁴³ For example, if an injured patient has already had lost wages or medical costs covered by disability or medical insurance, the recovery need not be duplicated. Third, MICRA provides for periodic payments, allowing damage awards to be paid over the time frame they are intended to cover.⁴⁴ This sensible reform permits the insurance system to pay large awards without facing insolvency by taking advantage of the time value of money and assures funds will be available for the patient when needed. Finally, MICRA limits contingency fees by using a sliding scale.⁴⁵ For example, an attorney may keep forty percent of the first \$50,000 of an award, but is limited to \$221,000 (plus expenses) of a one million dollar judgment, meaning an additional \$179,000 actually reaches the injured patient as compared to a state with a straight forty percent contingency fee. Not only is this provision of direct benefit to the injured patient, but it also makes it more difficult

40. Medical Injury Compensation Reform Act (MICRA) of 1975, chs. 1-2, 1975 Cal. Stat. 2d Ex. Sess. 3949.

41. Approximately eighty percent of the malpractice claims filed in California during the twentieth century (up to 1975) were filed between 1970 and 1975. Barry Keene, *California's Medical Malpractice Crisis*, HEALTH CARE LIABILITY ALLIANCE 1 (2003).

42. CAL. CIV. CODE ANN. §3333.2 (West 1997 & Supp. 2004).

43. *Id.* § 3333.1.

44. CAL. CIV. PROC. CODE ANN. § 667.7 (West 1997 & Supp. 2004).

45. CAL. BUS. & PROF. CODE ANN. § 6146 (West 1997 & Supp. 2004).

for attorneys to finance large numbers of non-meritorious cases with the few that they win.⁴⁶

MICRA has reduced California's malpractice premiums by forty percent in constant dollars since 1975. Uncorrected for inflation, this statistic translates into increases in insurance premiums of less than three percent per year,⁴⁷ less than one-third the rate at which premiums have risen nationally.⁴⁸

It is reliably estimated by entities as diverse as the U.S. Congressional Budget Office,⁴⁹ the U.S. Department of Health and Human Services,⁵⁰ Milliman and Robertson,⁵¹ the Florida Governor's Select Task Force on Healthcare Professional Liability Insurance,⁵² and the American Academy of Actuaries⁵³ that passage of reforms similar to MICRA in states currently lacking such statutes would result in premium savings of twenty-five to thirty percent annually.

Not only is there convincing evidence that these reforms are effective when enacted, we have, unfortunately, compelling evidence of the damage that occurs when these reforms are withdrawn. The state of Ohio enacted MICRA-like statutes in 1975.⁵⁴ Malpractice insurance rates in the state fell steadily from 1975 until the law was challenged in 1982, and the Ohio Supreme Court found the statutes to be unconstitutional.⁵⁵ Thereafter, malpractice insurance rates resumed their climb.⁵⁶ Not surprisingly, Ohio is

46. More than three quarters of claims close without payment. *See supra* note 16 and accompanying text.

47. ANDERSON, *supra* note 10, at 214.

48. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 19 (July 2002).

49. CONG. BUDGET OFFICE, COST ESTIMATE FOR H.R. 4600 HEALTH ACT OF 2002, at 1 (Sept. 25, 2002) (ordered reported by the House Committee on Energy and Commerce).

50. *Supra* note 48, at 18.

51. R.S. BIONDI & K. QUINTILIAN, MILLIMAN & ROBERTSON, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY PROJECTED EFFECT ON NEW YORK PROFESSIONAL LIABILITY COSTS OF CAPPING NONECONOMIC DAMAGES 2-4 (1995).

52. UNIV. OF CENTRAL FLA. GOVERNOR'S SELECT TASK FORCE ON HEALTHCARE PROFESSIONAL LIABILITY INSURANCE (2003) [hereinafter GOVERNOR'S TASK FORCE].

53. AM. ACAD. OF ACTUARIES, MEDICAL MALPRACTICE TORT REFORM: LESSONS FROM THE STATES 1-4 (Issue Brief, Fall 1996).

54. OHIO REV. CODE ANN. § 2307.43 (Anderson 1994) (repealed 1997).

55. *See* *Morris v. Savoy*, 576 N.E.2d 765 (Ohio 1991).

56. *Medical Malpractice Reform in California, Ohio and New York*, CONTINGENCIES (Am. Acad. of Actuaries), Sept./Oct. 1995, at 22.

one of the states the AMA has declared to be in “crisis” and is again debating the need for legal reforms.

Similarly, Oregon capped non-economic damages in 1987.⁵⁷ In 1998, the Oregon Supreme Court nullified the law.⁵⁸ By 2001, the cost of malpractice claims in the state had increased from a base \$15 million in 1998 to \$60 million, an increase of 400%, and has continued to rise since.⁵⁹

Moreover, just as the California experience has illustrated the effectiveness of MICRA, the experiences of other states have shown us how much less effective other types of reforms have been. For example, New York, Texas, and Florida have all at various times passed more limited reform measures that predictably did not affect the malpractice crisis.⁶⁰ In every case, legal reform opponents were able to substitute these measures for MICRA-based statutes knowing that they would be less effective. Those who would block necessary modification in the law will argue that tort reform sometimes fails to reduce malpractice premiums.⁶¹ Invariably, these critics cite the experiences of states that have passed peripheral or minor reforms rather than the fundamental protections embodied in MICRA. In 1996, Texas passed a package of reforms that included none of the MICRA provisions and, as could have been easily predicted, resulted in no change in malpractice insurance rates. This failure merely proves that minor reforms will often prove ineffective. In 2003, the state passed a \$250,000 limit on non-economic damages, and premium rates have already stabilized and started to head downward.⁶²

57. OR. REV. STAT. § 31.710 (2003); *see also* Press Release, Am. Med. Ass’n, AMA Joins Oregon Doctors To Protect Patient Access to Care (Aug. 10, 2004), <http://www.ama-assn.org/ama/pub/category/13939.html>.

58. *Lakin v. Senco Prods., Inc.*, 987 P.2d 463 (Or. 1997).

59. James T. Dorigan, Jr., Northwest Physicians Mutual Ins. Co., Oregon Medical Malpractice 1996-2001, Presentation to Lane County Medical Society (Sept. 10, 2002) (on file with author).

60. *See* ANDERSON, *supra* note 10, at 215; *see also* FLA. STAT. ANN. § 95.11(4)(b) (Harrison 1996 & Supp. 2000); N.Y. C.P.L.R. 214(a), 3021-a, 5031 (McKinney 1992 & Supp. 2004); TEX. CIV. PRAC. & REM. CODE ANN. §§ 33.011, 33.015, 41.008 (Vernon 1997 & Supp. 2004-2005); TEX. REV. CIV. STAT. ANN. art. 4590, §§ 10.01, 14.01 (Vernon 1997 & Supp. 2004-2005).

61. *Medical Malpractice Reform in California, Ohio and New York*, *supra* note 56, at 23.

62. Damon Adams, *Texas Tort Reform Vote Signals Lower Liability Rates*, AMNEWS, Oct. 6, 2003, <http://www.ama-assn.org/amednews/2003/10/06/gv111006.htm>.

CONCLUSION

America's physicians face an unprecedented tide of litigation.⁶³ The direct costs of this crisis exceed twenty-four billion dollars per year, but the indirect costs are much higher: The U.S. Department of Health and Human Services conservatively estimates that the cost of defensive medicine may approach \$100 billion per year.⁶⁴ The Pew Charitable Trusts project on medical liability in Pennsylvania reported that nearly forty percent of the doctors surveyed were dissatisfied with the practice of medicine.⁶⁵ These doctors are more likely to engage in "riskier prescribing practices . . . to leave clinical practice or relocate, disrupting continuity of care."⁶⁶ In particular, "[p]hysicians dissatisfied with liability risks and costs may also take specific steps to reduce their exposure, such as restricting scope of practice, avoiding high-risk patients, and engaging in 'defensive medicine.'"⁶⁷ More than ninety percent of specialists said that "the malpractice system limits doctors' ability to provide the highest-quality medical care."⁶⁸

Our medical system has been described as being on the verge of "meltdown,"⁶⁹ the AMA has declared that twenty states face medical liability crisis,⁷⁰ and physicians have started to talk about a coming "medical apocalypse."⁷¹ In many cases, legal standards of care have replaced medical standards, and the practice of defensive medicine has become the norm.⁷²

The most serious and immediate effect of the malpractice crisis is its impact on access to care. The Florida Governor's Select Task Force on Healthcare Professional Liability Insurance concluded:

The concern over litigation and the cost and lack of medical malpractice insurance have caused doctors to discontinue high-risk procedures, turn away high-risk patients, close practices, and move out of the state. In

63. See *supra* note 18 and accompanying text.

64. See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 48, at 7.

65. Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, 23 HEALTH AFF. 42, 45 (2004).

66. *Id.* at 43.

67. *Id.*

68. *Id.* at 49.

69. Earl R. Washburn, *The Coming Medical Apocalypse*, PHYSICIAN EXEC., Jan.-Feb. 1999, at 34, 36.

70. See Am. Med. Ass'n, *supra* note 2.

71. See Washburn, *supra* note 69, at 34.

72. See Anderson, *supra* note 14, at 1177.

some communities, doctors have ceased or discontinued delivering babies and discontinued hospital care.⁷³

The U.S. Department of Health and Human Services Agency for Healthcare Research and Quality found that in 2000 the number of physicians per capita was twelve percent higher in states with caps on non-economic damages than in states lacking these reforms.⁷⁴ The General Accounting Office has found localized health care access problems in five states experiencing rapid increases in malpractice insurance premiums,⁷⁵ and there are innumerable specific instances of this effect.⁷⁶

In sharp contradistinction, analysis of the effect of MICRA on health care access in California found that the enactment of MICRA was important to ensuring that high-cost and low-income groups have access to health care.⁷⁷ Moreover, MICRA played an important role in lowering the cost of health care in California.⁷⁸ Finally, the resulting reduction in “malpractice pressure” is expected to result in a greater number of physicians practicing in the state.⁷⁹

For more than twenty-five years, the nation has accumulated direct experience with the effect of tort reform on medical malpractice insurance premiums and access to health care. The four major reforms embodied in MICRA, including, most importantly, a \$250,000 limitation on non-economic damages, promote a stable insurance market, preserve access to care, and still provide full compensation for actual damages. We also know that lesser reforms are ineffective and divert attention from the necessary enactment of substantive legislation needed to effect real change.

Once this tort hemorrhaging has been stanching, we need to look ahead to more profound reform. Phillip Howard has proposed specialized

73. See GOVERNOR’S TASK FORCE, *supra* note 52, at vi.

74. FRED J. H. & WILLIAM E., U.S. DEP’T OF HEALTH & HUMAN SERVS., THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS 1 (July 2003).

75. U. S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE (Aug. 2003). Examples of typical local health care access issues include decreased availability of Pap smears, reluctance to test HIV vaccines, and the absence of even a single neurosurgeon in large areas of West Virginia.

76. HEALTH CARE LIAB. ALLIANCE, FACT SHEET: THE HEALTH CARE LIABILITY SYSTEM BARS ACCESS TO HEALTH CARE (1997) (on file with author).

77. WILLIAM G. HAMM, LECC, AN ANALYSIS OF HARVEY ROSENFELD’S REPORT: “CALIFORNIA’S MICRA” 12 (1997).

78. *Id.* at 18.

79. *Id.* at 23.

health courts, staffed by specially trained judges with the power to hire neutral experts.⁸⁰ The goal would be to advance patient safety and increase the reliability and predictability of legal rulings on the provision of health care. Though such a proposal seems a long way from today's "shame and blame" courts, similar systems are already in place for such specialized areas as taxes, worker's compensation, and vaccine liability.⁸¹ There can be little doubt that our flawed system of medical liability is in crisis. Solutions that will provide immediate relief are available, and more profound long-term change is also needed. The alternative is simply unacceptable.

80. Philip K. Howard, Op-Ed, *A Case for Medical Justice*, PHILA. INQUIRER, May 16, 2004, <http://cgood.org/learn-reading-cgpubs-opeds-26.html>.

81. *Id.* Senate Majority Leader Dr. William Frist has endorsed the concept. *See* Senator Bill Frist, Summary of Key Health Policy Proposals, Address to National Press Club (July 12, 2004), http://frist.senate.gov/index.cfm?FuseAction=Speeches.Detail&Speech_id=97&Month=7&Year=2004).

