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Health Care in Crisis: The Need for Medical Liability Reform

Donald J. Palmisano, M.D., J.D.*

Health care in the United States is currently in a state of crisis, and the need for reform is significant. The American Medical Association (AMA) was established in 1847 in large part to help safeguard and improve medical care and patient safety.¹ Unfortunately, 150 years later, the health care system is seriously jeopardized by the detrimental effects of this nation's broken medical liability system.

Indeed, medical negligence lawsuits are as old as the AMA. At the same time the AMA was taking shape, pioneering physicians were discovering new treatments for previously untreatable conditions—for example, doctors developed methods to heal compound fractures that did not require amputation.² Yet these advancements produced a surprising result: Trial lawyers began using the example of “a limb [that] had healed to a shortened, deformed, or frozen position” as the basis for medical negligence lawsuits.³ As a result of these lawsuits, “some of the best physicians in the country stopped taking such cases.”⁴

Today, lawsuits against skilled physicians are yielding largely the same result: Experienced obstetricians no longer deliver babies; highly-trained neurosurgeons no longer perform life-saving brain and trauma surgery; and orthopedic surgeons no longer perform complex procedures.⁵ Ironically, as physicians grow increasingly skilled at treating the most complex conditions, personal injury lawyers target those same high-risk specialists.⁶ Indeed, the AMA has found that the number of U.S. states with

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1. AM. MED. ASS'N, *CARING FOR THE COUNTRY* 14-15 (1997).

2. James Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 *JAMA* 1733 (2000).

3. *Id.*

4. *Id.*

5. Am. Med. Ass'n, *America's Medical Liability Crisis: A National View* (2004), at <http://www.ama-assn.org/ama/noindex/category/11871.html>.

6. Mohr, *supra* note 2.

“crisis” situations has increased from twelve to twenty since it began its most recent national medical liability crisis in 2002.⁷

The developments prompting the AMA’s concerns have not gone unnoticed, and the resulting policy debates have been contentious. Several state legislatures have gone into extra sessions to try to resolve the crisis.⁸ In Congress, the fight to address the medical liability crisis has been particularly divisive: The House of Representatives has passed medical liability reforms multiple times,⁹ but none has passed the Senate.

The bitterness of this dispute can be traced to personal injury lawyers’ desire to maintain the status quo of a civil justice system where multi-million dollar jury awards benefit a very few, but have negative ripple effects that affect many. The average jury award in 2002 reached \$6.2 million in medical negligence cases.¹⁰ Between 1996 and 2002, the average liability judgment increased 234%, and by 2001-2002, fifty-two percent of

7. Am. Med. Ass’n, *supra* note 5. Those twenty states are Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, and Wyoming. As a result, the AMA has made medical liability reform its top legislative priority. *Id.* In determining whether a state is “in crisis,” “showing problem signs,” or “currently okay,” *id.*, the AMA considers a wide variety of factors and available sources. The primary factor in the AMA analysis is the degree to which patients have lost access to medical care. For example, the AMA is concerned with newspaper and other anecdotal reports showing that a growing number of physicians no longer provide crucial medical services such as delivering babies and providing trauma care. The AMA also considers each state’s legislative, legal, and judicial climates; the affordability and availability of professional liability insurance; and the trends of jury awards and settlements. Other factors include the frequency and severity of lawsuits, the quality and presence of a state’s medical liability laws, and the likelihood of reforms being enacted and/or constitutionally upheld. *See, e.g.*, Am. Med. Ass’n, Statement for the Record of the American Medical Association to the Senate Health, Education, Labor and Pensions Committee and the Senate Judiciary Committee RE: Patient Access Crisis: The Role of Medical Litigation (Feb. 11, 2003) [hereinafter Am. Med. Ass’n Statement], <http://www.ama-assn.org/ama/pub/category/12990.html>.

8. *See, e.g.*, Steve Stanek, *Illinois Legislature Fails Again at Tort Reform*, HEALTH CARE NEWS (Sept. 1, 2004), <http://www.heartland.org/Article.cfm?artId=15515>.

9. *See* HEALTH Act of 2004, H.R. 4280, 108th Cong. (2004); Pregnancy and Trauma Care Access Protection Act of 2004, S. 2207, 108th Cong. (2004); Healthy Mothers and Healthy Babies Access to Care Act of 2003, S.2061, 108th Cong. (2003); Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003); Patients First Act of 2003, S. 11, 108th Cong. (2003).

10. JURY VERDICT RESEARCH, CURRENT AWARD TRENDS IN PERSONAL INJURY 18 (43d ed. 2004).

all awards for medical negligence cases were for one million dollars or more.¹¹ Physicians and patients seek reform because these excesses have caused significant disruption and skyrocketing costs to the health care system.

This Case Study argues that California's Medical Injury Compensation Reform Act (MICRA) of 1975¹² is a model of the type of reform needed to guide deliberations and action in Congress and in the states without reform.

I. HEALTH CARE IN CRISIS

In medicine, it is necessary to diagnose the problem before one can correctly treat the patient; the same holds true in the medical liability reform debate. When people think about the medical liability crisis, they may think first of the staggering jury verdicts leveled against defendant physicians.¹³ Indeed, current trends in jury awards illustrate why the medical liability crisis has taken such deep hold: The median medical liability award in medical liability cases jumped 114% from 1996 to 2002, topping one million dollars.¹⁴

It is also important to note the significant costs that trials inflict on physicians, even when they are not found liable, as is often the case. Nearly seventy percent of medical liability claims in 2002 were closed without payment to the plaintiff.¹⁵ In fact, plaintiffs lost the majority of their cases that went to a jury: Of the 4.9% of claims decided by jury verdict, the defendant won 82.4% of the time.¹⁶ However, physicians who prevail at trial still have large fees—on average, more than \$77,000 per claim—to pay for their defenses.¹⁷ Yet, as significant as these costs are, the most dramatic consequences of the medical liability crisis are not the direct effects on physicians, but the indirect effects on patients and the health care system as a whole.

11. *Id.* at 18, 43.

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

13. *E.g.*, Walter Olsen, *Curing Health Care; Delivering Justice*, WALL ST. J., Feb. 27, 2003, at A12 (“Most juries, it seems, decide such [medical negligence] cases in favor of the defense. But those that find for the plaintiff return awards that not infrequently top \$10 million.”).

14. JURY VERDICT RESEARCH, *supra* note 10, at 18.

15. PHYSICIAN INSURERS ASS'N OF AM., PIAA CLAIM TREND ANALYSIS exhibits 1-2 (2003).

16. *Id.* exhibits 1-2, 6a.

17. *Id.* exhibits 6a-4. In cases where the claim was dropped or dismissed, costs to defendants averaged almost \$16,307. *Id.* exhibits 6b-4.

The importance of these indirect effects is reflected in the criteria that the AMA uses to determine whether a state is in a “state of crisis” as a result of its medical liability environment. While the AMA considers a wide variety of factors, the most important of these is the magnitude of patients losing access to care.¹⁸ The largely indiscriminate nature of the system—where anyone can file a lawsuit for any reason regardless of whether there is evidence that negligence occurred—has engendered a fear of liability in physicians that is harmful to individual patients and to the health care system as a whole. Fear of liability influences both the specialties that physicians pursue, as well as the ways in which they practice medicine. Medical residents, for example, appear to be growing increasingly concerned about liability issues.¹⁹ Sixty-two percent of medical residents reported that liability issues were their top concern in 2003—surpassing any other concern, and representing an enormous increase from 2001, when only fifteen percent of residents said liability was a concern.²⁰ The AMA is concerned that medical residents’ growing concerns may cause them to avoid choosing high-risk specialties or practicing in a crisis state.

These fears extend to our nation’s medical students as well. Approximately half of the respondents to a recent AMA survey indicated that the current medical liability environment was a factor in their specialty choice.²¹ There are many reasons medical students and residents choose their future specialty, but it is a troubling sign that our nation’s vicious litigation system may exacerbate a potential shortage of high-risk specialists. In addition, thirty-nine percent said the medical liability environment was a factor in their decisions about whether they would like to complete residency training in a given state.²² Finally, sixty-one percent of students reported that they are extremely concerned that the current medical liability environment is decreasing physicians’ ability to provide quality medical care.²³ These fears become no less salient once physicians

18. See Am Med. Ass’n, *supra* note 7. We use the term “magnitude” to indicate that we consider not only the number of patients that are affected, but also the extent to which they are affected.

19. Daniel Merenstein, *Winners and Losers*, 291 JAMA 15 (2004).

20. MERITT, HAWKINS & ASSOC., SUMMARY REPORT: 2003 SURVEY OF FINAL YEAR MED. RESIDENTS 5 (2003).

21. DIV. OF MKT. RESEARCH & ANALYSIS, AM. MED. ASS’N, AMA SURVEY: MEDICAL STUDENTS’ OPINIONS OF THE CURRENT MEDICAL LIABILITY ENVIRONMENT 1 (Nov. 2003). Forty-eight percent of students in their third or fourth year of medical school indicated that the liability situation was a factor in their specialty choice. *Id.*

22. *Id.*

23. *Id.*

start practicing. On the one hand, liability fears can discourage innovation in medical practice: Fifty-nine percent of physicians believe that the fear of liability discourages open discussion and thinking about ways to reduce health care errors.²⁴ On the other hand, it can encourage the performance of unnecessary and costly tests.²⁵ This practice of “defensive medicine” takes many forms, including ordering tests and performing procedures that may not be clinically indicated; referring patients to emergency departments, safety net hospitals, and academic health centers; declining to take calls in the emergency department and declining elective referrals from emergency departments and safety net clinics, especially for uninsured patients. All of these forms of “defensive medicine” are driven by liability concerns.²⁶ Defensive medicine is one of the most difficult components of the medical liability debate to quantify, but it is perhaps one of the most costly—the costs of defensive medicine are estimated to be between \$70 billion and \$126 billion per year.²⁷

The costs of the liability crisis affect the U.S. health care system in a number of ways. Most disturbingly, as physicians’ liability insurance premiums increase dramatically, physicians restrict services, retire early, or relocate to another geographic area where the liability system is more stable. For example, forty-five percent of hospitals reported that the professional liability crisis has resulted in the loss of physicians and/or reduced coverage in emergency departments.²⁸ In turn, patients may be forced to wait longer to see a specialist (such as to receive a mammogram) or travel longer distances to receive care (such as when a pregnant woman in a rural community loses her doctor); cases of resulting patient deaths have been reported.²⁹

24. HARRISINTERACTIVE INC., COMMON GOOD, COMMON GOOD FEAR OF LITIGATION STUDY: THE IMPACT ON MEDICINE 65 (2002), <http://cgood.org/assets/attachments/57.pdf>.

25. Richard Anderson, Commentary, *Billions for Defense: The Pervasive Nature of Defensive Medicine*, 159 ARCH. INTERNAL MED., 2399, 2399 (1999) (“Malpractice litigation is the primary cause of defensive medicine.”).

26. ROBERT BERENSON ET AL., MEDICAL MALPRACTICE LIABILITY CRISIS MEETS MARKETS: STRESS IN UNEXPECTED PLACES (Ctr. for Studying Health System Change, Issue Brief No. 68, Sept. 2003), <http://www.hschange.org/CONTENT/605/?words=malpractice>.

27. OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING & EVALUATION, U.S. DEP’T OF HEALTH & HUMAN SERVS., ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 11 (2003).

28. AM. HOSP. ASS’N, PROFESSIONAL LIABILITY INSURANCE: A GROWING CRISIS: RESULTS OF THE AHA SURVEY OF HOSPITALS ON PROFESSIONAL LIABILITY EXPERIENCE 2 (2003).

29. See Health Coalition on Liab. & Access, *Who Is Being Hurt: Patient Profiles*, at <http://www.hcla.org/who.html> (last visited Oct. 18, 2004).

II. CAUSES OF THE CRISIS

Perhaps medical malpractice claims would be less problematic if such claims were the result of real negligence on the part of physicians and others in the medical community. Yet, the data indicate otherwise: One study found that “a substantial majority of medical negligence claims filed are not based on actual provider carelessness.”³⁰ In fact, the study found that negligence had occurred in only one-sixth of the filed claims³¹ and that “in its initial filing stage the tort system is even more error-prone than the medical care system.”³² Another study, conducted in 1996, found that the only significant predictor of payment to medical liability plaintiffs in the form of a jury verdict or a settlement was disability and *not* the presence of an adverse event due to negligence.³³ In other words, the severity of a patient’s disability determined the jury award, not the actions of the physician.³⁴ These data suggest that it is not physician negligence, but the zealotry of personal injury attorneys, that is prompting the medical liability crisis.

Some have offered alternative explanations for the crisis to avoid criticism of plaintiffs and their attorneys, but these explanations do not hold up under scrutiny. Some claim that physicians are victims of insurance companies that made bad business decisions and are now trying to recoup their losses.³⁵ However, investment yields of medical liability insurers have been stable and positive since 1998.³⁶ Moreover, a report by

30. PAUL C. WIELER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION & PATIENT COMPENSATION 140 (1993).

31. *Id.* at 139.

32. *Id.* at 140.

33. Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963 (1996).

34. *Id.* at 1965.

35. JACKSON WILLIAMS, PUBLIC CITIZEN, MEDICAL MALPRACTICE BRIEFING BOOK: CHALLENGING THE MISLEADING CLAIMS OF THE DOCTORS’ LOBBY 24 (2004), <http://www.citizen.org/documents/MedMalBriefingBook08-09-04.pdf>. Opponents of medical liability reform often suggest that the insurance industry is to blame for indiscriminately increasing physicians’ premiums. See, e.g., Press Release, Ams. for Ins. Reform, Insurers Continue To Price-Gouge Doctors Despite Dropping Medical Malpractice Payouts (Oct. 12, 2004), <http://www.insurance-reform.org/pr/041012.html>.

36. Those returns have ranged from 4.5%-5.4% and include income from interest, dividends, and real estate income. See AM BEST, BEST’S AGGREGATES & AVERAGES - PROPERTY/CASUALTY, QUANTITATIVE ANALYSIS REPORT, MEDICAL MALPRACTICE PREDOMINATING 335 (2003).

the U.S. General Accounting Office sheds light on the cause of recent escalation in physicians' medical liability insurance premiums and found that "[i]ncreased losses on claims are the primary contributor to higher medical malpractice premium rates"³⁷ and "[i]nsurers are not charging and profiting from excessively high premium rates."³⁸ The facts simply do not justify placing blame on the insurance industry for an out-of-control legal system.

III. ENDING THE CRISIS

Numerous studies of the medical liability crisis in states that have implemented reforms have revealed the value of such efforts. To begin, reforms have been linked with an overall decrease in medical expenditures: "[M]alpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications."³⁹ Importantly, reforms are also credited with reducing physicians' premiums. For example, one study found that in states with direct reforms, including caps on non-economic damages, premiums declined by 8.4% within three years.⁴⁰ According to another report, capping medical liability awards reduced premiums for general surgeons by an average of thirteen percent in the year following enactment of the reform and by an average of thirty-four percent over the long term.⁴¹ Premiums for general practitioners and obstetricians were affected similarly.⁴²

Comparative data provide support. If we consider similar major metropolitan markets and the premiums charged to physicians, we observe vast differences between states which limit non-economic damages,⁴³ such

37. U.S. GEN. ACCOUNTING OFFICE, MED. MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 15 (2003), <http://www.gao.gov/new.items/d03702.pdf>.

38. *Id.* at 32.

39. DANIEL P. KESSLER & MARK B. MCCLELLAN, DO DOCTORS PRACTICE DEFENSIVE MEDICINE? 2 (Nat'l Bur. of Econ. Analysis, Working Paper No. 5466, 1996), <http://www.nber.org/papers/w5466.pdf>.

40. Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS. 81, 98 (1997).

41. Stephen Zuckerman et al., *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167 (1990).

42. *Id.*

43. Twenty-two states currently have some type of a cap on non-economic damages, and

as California, and states which do not provide such limits:

Table 1: Professional Liability Insurance:
Manual rates (in U.S. dollars) for \$1M/\$3M policies⁴⁴

	2000	2001	2002	2003
Ob-gyn				
Florida (Miami-Dade)	147,621	166,368	201,376	249,196
Illinois (Chicago)	78,880	88,928	102,640	139,696
Pennsylvania (Philadelphia)	37,556	45,938	100,045	134,335
Ohio (Cleveland)	56,166	72,541	100,691	119,482
California (Los Angeles)	52,874	52,874	54,563	60,259
General Surgery				
Florida (Miami-Dade)	110,068	124,046	174,268	226,542
Illinois (Chicago)	52,364	59,016	68,080	92,576
Pennsylvania (Philadelphia)	33,684	35,793	82,157	108,038
Ohio (Cleveland)	39,676	51,274	70,948	84,056
California (Los Angeles)	32,507	32,507	36,740	45,421
Internal Medicine				
Florida (Miami-Dade)	32,744	38,378	56,153	65,697
Illinois (Chicago)	19,604	22,060	26,404	35,756
Pennsylvania (Philadelphia)	7,390	7,853	18,429	24,546
Ohio (Cleveland)	12,192	15,828	21,375	25,013
California (Los Angeles)	10,097	10,097	11,164	12,493

six states have a cap on total damages. For a full discussion and comparison of different state laws, see AM. MED. ASS'N, *MEDICAL LIABILITY REFORM—NOW!* (2004), <http://www.ama-assn.org/amal/pub/upload/mm/450/mlrnowjune112004.pdf>.

44. While California has a “hard” damages cap, the other states do not. The October issues of *Medical Liability Monitor* for the years 2000 through 2003 provide these manual rates for professional liability insurance. *Medical Liability Monitor*, an independent Chicago-based publication, completed comprehensive rate reports of insurers in all fifty states. This table does not include all the rates reported for the geographic areas selected above, nor the premiums paid by physicians in other areas of the country, which may be higher or lower. These rates reflect the manual rates for one of the state’s marketshare leaders. The MLM notes that these rates do not reflect credits, surcharges, or other factors that may reduce or increase the actual rates charged to physicians. The AMA alone is responsible for the accuracy of the above information taken from the MLM and believes the rates listed above are a reasonable benchmark to demonstrate professional liability insurance trends for select specialties in certain geographic areas.

The AMA supports California's reforms, as set forth in MICRA, as a model for federal and state legislation: MICRA has successfully moderated physicians' professional liability insurance premium increases, while preserving patients' access to the courts.⁴⁵ This is not to say MICRA is the only legislative solution, but its efficacy is now time-tested.

With its \$250,000 cap on non-economic damages (it does not limit economic damages), joint and several liability reform, a sliding-scale contingency fee schedule, and other reforms, MICRA has resulted in stable and moderate increases in premiums in California: Between 1976 and 2002, premiums in California rose 235%, while premiums in the rest of the United States rose 750%.⁴⁶ According to Phil Hinderberger of Norcal Mutual, a major California insurer, before MICRA was passed "California physicians paid almost 25 percent of all medical liability premiums paid in the [United States] at a time when they represented only about 10 percent of all practicing physicians in the [United States]. Today, California physicians pay about [ten] percent of all medical liability premiums paid in the [United States] which represents a fair share."⁴⁷ Because of MICRA, premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois, and Nevada.⁴⁸ Moreover, in California, claims are settled in one-third less time than in states without caps on non-economic damages⁴⁹—not only decreasing the cost of litigation, but also resulting in injured patients being compensated far faster. An important element of MICRA's success is that it has been upheld by the California State Supreme Court.⁵⁰ Other states have not been so lucky. Illinois, Ohio, Oregon, and Washington have had reforms overturned by the courts,⁵¹ while the state

45. AMA policy is decided by its House of Delegates, which has determined that MICRA-type reforms should be the basis for federal legislative support. AMA policy also supports a state's right to determine whether other types of medical liability reforms may be more appropriate for that state.

46. NAT'L ASS'N OF INS. COMM'RS, PROFITABILITY BY LINE BY STATE, 1976-2002, at 116-17 (2002).

47. Posting of Phil Hinderberger, phil-hinderberger@norcalmutual.org, to asmac@unity.ama-assn.org (Jan. 20, 2003) (copy on file with author).

48. See *supra* note 44 and accompanying table.

49. *Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the Subcomm. on Health of the Comm. on Energy and Commerce*, 107th Cong. 88 (2002) (statement of Richard E. Anderson, Chairman of the Doctors' Co. for the Physician Ins. Ass'n of Am.).

50. Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985); Fein v. Permanente Med. Group, 695 P.2d 665 (Cal. 1985).

51. Best v. Taylor Mach. Works, 689 N.E. 2d 1057 (Ill. 1997); State *ex rel.* Ohio Acad. of

constitutions in Arizona, Kentucky, and Pennsylvania prohibit caps on non-economic damages.⁵²

Another important element of MICRA compared to other states that have enacted a cap is the quality of the cap. For example, a state with a “hard” cap on non-economic damages should not be compared to a state with a “soft” cap on non-economic damages. A hard cap, like the \$250,000 cap found in California’s MICRA is not subject to exceptions, does not adjust over time, and applies irrespective of the number of defendants or plaintiffs. By contrast, a soft cap may be subject to numerous exceptions; increase annually with inflation, other economic indicators, or based on a set schedule; or apply individually to every defendant or plaintiff, thereby allowing several caps for a single claim. Missouri illustrates the problems presented by soft caps: The cap in Missouri increases with inflation. Originally set at \$350,000 in 1986, the cap reached \$565,000 as of February 1, 2004.⁵³ Missouri’s cap was also considerably weakened by the courts in a 2002 decision, *Scott v. SSM Healthcare*, in which the court held that the cap can be applied separately for each act of medical liability.⁵⁴ Therefore, if there are two separate and distinct “occurrences” of liability that contribute to a single injury the court can apply a separate cap for each occurrence even if they are applied to a single defendant. Where there are exceptions to the caps, there is not the same predictability afforded to physicians and insurers under MICRA.

Indeed, while the need for reform is clear, achieving it has not been as easy as one might hope. Florida has only been able to pass untested reforms, including a \$500,000 cap on non-economic damages that is subject to broad exceptions which will certainly be the subject of judicial interpretation for years to come.⁵⁵ In Iowa and Missouri, after bitter debate, the legislatures finally passed reforms,⁵⁶ including hard caps on non-economic damages, but the governors vetoed them.⁵⁷ State legislatures in

Trial Lawyers v. Sheward, 715 N.E. 2d 1062 (Ohio 1999); *Lakin v. Senco Prods., Inc.*, 987 P.2d 463 (Or. 1999); *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989).

52. ARIZ. CONST. art. II, § 31; KY. CONST. § 54; PA. CONST. art. III, § 18.

53. MO. REV. STAT. § 538.210 (2004).

54. *Scott v. SSM Healthcare*, 70 S.W.3d 560, 569, 571 (Mo. Ct. App. 2002); see also *Cook v. Newman*, 142 S.W.3d 880 (Mo. Ct. App. 2004).

55. FLA. STAT. ch. 766.118 (2004).

56. H.F. 2440, 80th Gen. Assem., Reg. Sess. (Iowa 2004); H.B. 1304, 92d Gen. Assem., Reg. Sess. (Mo. 2004).

57. See Iowa Med. Soc’y, *Governor Vetoes Tort Reform Bill*, IMS ADVOCATE, May 21, 2004, at 1; MISSOURI STATE MED. ASS’N, 2004 LEGISLATIVE REV. 1 (2004), <http://msma.org/docs/Legislative%20Review.pdf>.

Pennsylvania,⁵⁸ Massachusetts,⁵⁹ North Carolina,⁶⁰ Virginia,⁶¹ Connecticut,⁶² and Washington⁶³—to name a few—were unable to enact proven reforms in 2004.

MICRA-type legislation has also been pursued on the federal level. However, the battles in Congress have largely mirrored those of the states and have been characterized by intense partisanship. Multiple acts have passed in the Republican-dominated House of Representatives, but have repeatedly stalled in the Senate.⁶⁴

Despite the obvious challenges, there have been some signs of promising change: Patients and policy makers worked together in Texas in late 2003 to enact reforms that have lowered liability insurance premiums.⁶⁵ In September 2003, Texas voters cemented the reforms with enactment of Proposition 12, a “constitutional amendment concerning civil lawsuits against doctors and health care providers, and other actions, authorizing the legislature to determine limitations on non-economic damages.”⁶⁶ Reforms recently enacted in West Virginia and Mississippi have potential, but their future will not truly be known until the laws pass likely

58. Tanya Albert, *Pennsylvania Physicians' Efforts on Liability Reform Hit a Roadblock: In Wyoming, Legislators Discuss Tort Reform in a July Special Session*, AMNEWS, July 26, 2004, at <http://www.ama-assn.org/amednews/2004/07/26/gvsb0726.htm>.

59. Tom Walsh, *Lawmakers Pass Limited Medical Liability Bill, MMS Vows To Continue Push for More Adequate Reform* (July 28, 2004), at <http://www.massmed.org/vitalsigns/aug04/top1.html>.

60. Dan Kane, *Special Interests Get Their Way: The 2004 Legislative Session, Set to End Today, Shows that Well-Financed Interests Get Legislators' Attention*, NEWS & OBSERVER (Raleigh, N.C.), July 18, 2004, at A1.

61. Virginia S.B. 601 did not include a cap on non-economic damages, leading the Medical Society of Virginia to make passing a cap on of its top priorities for 2005. Med. Soc'y of Va., *MSV's 2005 Legislative Agenda*, at <http://www.msv.org/public/articles/index.cfm?cat=225>).

62. Conn. State Med. Soc'y, *Important Update on Medical Liability Insurance Reform: Governor Vetoes HB 5669* (May 11, 2004), at <http://csms.org/content/showpage.asp?page=lu6>.

63. Carol M. Ostrom, *Initiative Would Seek Malpractice-Suit Caps*, SEATTLE TIMES, June 15, 2004, at B2.

64. *See supra* note 9.

65. TEX. CIV. PRAC. & REM. § 74.301 (2004); Senator John Cornyn, *Address to Senate on One-Year Anniversary of Prop. 12 Passage* (Sept. 13, 2004), <http://www.cornyn.senate.gov/record.cfm?id=226028&ref=home>.

66. Tex. Sec'y of State, *Proposed Constitutional Amendments* (Sept. 13, 2003), <http://www.sos.state.tx.us/elections/voter/2003sepconsamend.shtml>.

constitutional challenges.⁶⁷

Several states have enacted a number of reforms over the years that may be viable enhancements to MICRA-type reforms, such as pre-trial screening panels, arbitration, mediation, alternative dispute resolution, binding arbitration, and private judging. An alternative judicial system for medical liability cases has also been studied. While these reforms do not diminish the need for MICRA reforms at the state and federal level, if properly structured in collaboration with MICRA, they may further help curb skyrocketing medical liability premiums. Realistically these reforms could only be implemented at the state level and should be initiated as target pilot projects in select states to determine their efficacy.

CONCLUSION

We are all frustrated by the inability of policy makers to enact proven reforms. Physicians are frustrated because they are being forced to give up providing care for their patients due to the excesses of the legal system and liability insurance costs.⁶⁸ Patients are frustrated because they are losing access to care, frustrated when they are forced to find a new doctor, frustrated when they are forced to drive longer distances, and frustrated when they incur additional costs. Patients also are keenly aware of the impact of lawsuits on health care costs: Over seventy percent agree that medical liability litigation is driving up health care costs⁶⁹ and favor a law that would guarantee full payment for lost wages and medical expenses, but would limit non-economic damages.⁷⁰

That the system is out of balance is more than evident to anyone willing to look. Without action based on proven reforms and demonstrable data, the crisis will continue to spread. There are available solutions, but

67. See MISS. CODE ANN. § 11-1-60 (2004); W. VA. CODE § 55-7B-8 (2004). The AMA will closely watch the experience of West Virginia following its reforms because while the state has a base cap of \$250,000 on non-economic damages—with certain exceptions that could increase the cap to \$500,000 depending on the severity of the injury—the law also provides for annual adjustments up to \$375,000 (and \$750,000 depending on the injury severity).

68. DIV. OF MKT. RESEARCH & ANALYSIS, AM. MED. ASS'N, NATIONAL PHYSICIAN SURVEY ON PROFESSIONAL MEDICAL LIABILITY 3 (Apr. 2003).

69. HEALTH COALITION ON LIAB. & ACCESS, THE MEDICAL LIABILITY CRISIS: A FEDERAL PROBLEM THAT REQUIRES A FEDERAL SOLUTION (2003), <http://www.hcla.org/factsheets/2003-221-federalissue.pdf>.

70. Press Release, Health Coalition on Liab. & Access, Americans Say Health Care Access Threatened by Liability Crisis (Apr. 7, 2004), <http://www.hcla.org/pressreleases/2004-HCLAPollRelease.pdf>.

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they will require policy makers willing to stand up for patients and change the status quo in the crisis states. California's MICRA provides a prime example of the type of reforms that are necessary if we are to fix the medical liability crisis that currently pervades the United States health care system. We must be relentless in our quest to fix our broken system. Failure to do so will cause irreparable harm not only to physicians, but also to the patients who depend on their care.

