

5-2006

## Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law

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### Recommended Citation

Kyle Miller, Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law, 59 *Vanderbilt Law Review* 1457 (2019)

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# Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law

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## I. INTRODUCTION

Medical malpractice litigation is not a modern invention. Rather, it has been part of the American legal system since before the

Revolution,<sup>1</sup> and the most recent medical malpractice insurance crisis is not the first this country has known. However, losses to insurers during the earlier medical malpractice insurance crises pale in comparison to the ailments of this most recent crisis.<sup>2</sup> Though this most recent medical malpractice insurance crisis seems to be coming to a close,<sup>3</sup> by examining the causes of this crisis and enacting changes at present, this country may be able to avoid future crises. Of course, the first step in avoiding repetition is identifying the cause—a task that to date has eluded consensus.

There are three groups of professions involved in the debate over the causes of the medical malpractice insurance crises—physicians, insurers, and plaintiffs' attorneys. Though blame, to some degree, rests with all three of the principal actors, this Note does not focus on the source of the crisis. Instead, it primarily focuses on changes directly pertinent to the legal profession which may be able to prevent future crises.

The problem with current efforts to reform medical malpractice laws is that the effects of certain reforms do not comport with both the goal of reform and the objectives of tort law. Specifically, the goal of medical malpractice reform is to stabilize and/or reduce medical malpractice insurance premiums. However, that goal should not offend the twin objectives of tort law—deterrence and redress.<sup>4</sup> Once the current medical malpractice debate is viewed through the lens of this conflict, the fatal flaws of the popular methods of medical malpractice reform (caps on damages and arbitration/screening panels) are exposed, while other methods of medical malpractice reform (increased regulation of the medical profession, regulation of the insurance market, imposition of certificates of merit at the pretrial stage, and alterations in the manner through which the standard of

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1. See Stephen J. Nolan, *Referred Pain: Is the Tort System to Blame for Medical Malpractice Claims*, 37 MD. B. J. 38, 40 (2004) (noting that, like most aspects of common law, "the concept of holding individual physicians accountable for medical mistakes originated in England and was imported by the colonies").

2. See ROBERT P. HARTWIG, TRENDS IN MEDICAL MALPRACTICE INSURANCE: BEHIND THE CHAOS 6 (2003), available at [http://server.iii.org/yy\\_obj\\_data/binary/695301\\_1\\_0/medmal.pdf](http://server.iii.org/yy_obj_data/binary/695301_1_0/medmal.pdf) (indicating that underwriting losses reached an all time high in 2001, with insurers losing more than \$50 million; the medical malpractice insurance crises of the 1970s and 1980s experienced peak losses of only \$4 million and \$25 million, respectively).

3. See Michelle M. Mello, *Managing Malpractice Crises*, 33 J.L. MED. & ETHICS 414, 414 (2005) (noting industry reports that claim the medical malpractice insurance crisis may be coming to a close).

4. See Allen Kachalia et al., *Physician Responses to the Malpractice Crisis: From Defense to Offense*, 33 J.L. MED. & ETHICS 416, 417 (2005) (stating, "[t]he medical malpractice system has two primary goals: to compensate injured patients and to deter physicians from careless behavior").

care is defined) surface as more ideal solutions to achieve both the goal of medical malpractice reform and the objectives of tort law.

This Note argues that two of the most popular proposed solutions to the medical malpractice insurance crisis, damage caps and arbitration/screening panels, are ineffective at lowering medical malpractice premiums. Furthermore, such proposed solutions distort the twin objectives of tort law, deterrence and redress. Part II of this Note analyzes several factors that led to the most recent medical malpractice insurance crisis, highlights the concerns of the professions involved, and identifies the optimal goal to be achieved by medical malpractice reform. Part III identifies and analyzes the previous “solutions” to medical malpractice insurance crises, highlighting both the strengths and weaknesses of these approaches. Part IV proposes a solution to the medical malpractice insurance crisis through the adoption of certificates of merit and the use of court appointed experts to define the standard of care for both the judge and the jury.

## II. MEDICAL MALPRACTICE INSURANCE CRISES—WHERE ARE WE, HOW DID WE GET HERE, AND WHERE SHOULD WE BE GOING?

### *A. Defining Medical Malpractice*

To fully understand how the structure of medical malpractice litigation can evolve into a more just and predictable system, one must first appreciate the basic differences between traditional negligence and medical malpractice. While in traditional negligence the duty not to act negligently applies among all persons regardless of their relationship to one another, the idea behind medical malpractice liability is that by undertaking the voluntary role of physician, the doctor creates a special relationship between herself and the patient.<sup>5</sup> As a result of this voluntary undertaking, the physician is required to exercise the duty of providing medical services within the applicable standard of care.<sup>6</sup> Because the duty flowing from the physician to the

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5. See 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 287 (2004) (iterating that “[a]n essential element of a tort cause of action for medical malpractice is the existence of a health-care provider-patient relationship giving rise to a duty of care”).

6. See *id.* (stating that it is an essential element of a medical malpractice claim for the plaintiff to prove the physician breached the “standard of medical care”). The requirement to provide the appropriate standard of care is based on three separate duties:

(1) a duty to possess the requisite knowledge and skill such as is possessed by the average member of the medical profession; (2) a duty to exercise ordinary and reasonable care in the application of such knowledge and skill; and (3) a duty to use best judgment in such application.

patient is grounded in the special nature of their relationship, traditional negligence standards are inapplicable. Instead, for a medical malpractice plaintiff to recover, he must use expert testimony to demonstrate the appropriate standard of care and that the defendant-physician deviated from that standard.<sup>7</sup>

The doctrine of medical malpractice presupposes that the standard of care is an objective standard.<sup>8</sup> Unfortunately, the reality of medical malpractice litigation is that both judge and jury are often presented with competing standards of care by the parties' respective experts.<sup>9</sup> The practical effect of these dueling experts is that the judge and/or jury must define for themselves the appropriate standard of care—a task that the law incorrectly assumes would be resolved by medical experts.

### B. *Is There a Medical Malpractice Crisis?*

As demonstrated below, some critics argue there is, in actuality, no crisis.<sup>10</sup> These critics contend that rising premiums are a direct result of the cyclical nature of the insurance industry rather than increases in litigation.<sup>11</sup> However, much of the determination as to whether there is a medical malpractice crisis depends on how the current controversy regarding medical malpractice insurance and litigation is perceived and defined. Statistically, there is probably not a medical malpractice *litigation* crisis.<sup>12</sup> While the majority viewpoint

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*Id.*

7. See *id.* at § 307:

[A] plaintiff claiming medical malpractice has not only the burden of proving that the treatment complained of was negligent and that such negligence was the proximate cause of the injury, but also the burden of establishing by expert medical testimony that the act or omission of the accused physician fell below the community standard of care.

8. See Joseph H. King, Jr., *Reconciling the Exercise of Judgment and the Objective Standard of Care in Medical Malpractice*, 52 OKLA. L. REV. 49, 50 (1999) (stating that the notion there is an objective standard of care has been generally accepted, whether applied through a national or local standard).

9. See Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 654–55 (2001) (noting the burden on the parties to prove the standard of care).

10. See Stephanie Mencimer, *Malpractice Makes Perfect: How the GOP Milks a Phony Doctors' Insurance Crisis*, WASH. MONTHLY, Oct. 2003, at 23 (asserting that the current crisis is a Republican driven farce).

11. Mitchell J. Nathanson, *It's the Economy (and the Combined Ratio) Stupid: Examining the Medical Malpractice Crisis Myth and the Factors Critical to Reform*, 108 PENN. ST. L. REV. 1077, 1078 (2004) (asserting medical malpractice insurance "crises . . . have more to do with fluctuations in the bond market than anything associated with medical malpractice litigation").

12. See Peter M. Villari, *Whose Crisis Is It?*, PA. LAW., Mar./Apr. 2003, at 16, 18 (stating that the National Association of Insurance Commissioners reported a 4% decrease nationally in

has been that premiums for medical malpractice insurance rise as a direct result of increased litigation and increased payouts,<sup>13</sup> the more likely reality is that dramatic spikes in medical malpractice insurance premiums are more directly related to the nation's economy than any other factor.<sup>14</sup> And while the minority viewpoint is that the frequency of medical malpractice lawsuits and payouts there from have absolutely no effect on medical malpractice insurance premiums, the reality is that litigation, at a minimum, has some residual effect on the cost of medical malpractice insurance.<sup>15</sup>

Regardless of which school of thought is more correct on the question of a malpractice *litigation* crisis, it is clear that there is, in fact, a medical malpractice *insurance* crisis underway. Since late 1999, medical malpractice insurance premiums have increased at an unprecedented rate.<sup>16</sup> In 2003, many states experienced 25 percent increases in medical malpractice insurance premiums.<sup>17</sup> Internists in Virginia, for example, witnessed a 139 percent increase in medical malpractice insurance premiums in 2003.<sup>18</sup> The problem is compounded by the fact that suppliers of medical malpractice insurance have vanished from the market.<sup>19</sup> Over the past ten years,

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medical malpractice filings since 1995); *see also* Kathy Kendall, Comment, *Latent Medical Errors and Maine's Statute of Limitation for Medical Malpractice: A Discussion of the Issues*, 53 ME. L. REV. 589, 600 (2001) (noting that though statistically in the 1970s there was a sizeable escalation in the number of medical malpractice suits filed annually in the United States, there has not been a direct statistical correlation drawn between the *frequency* of medical malpractice filings and increases in premiums).

13. *See* Amanda R. Lang, Note, *A New Approach to Tort Reform: An Argument for the Establishment of Specialized Medical Courts*, 39 GA. L. REV. 293, 295 (conclusively stating "the resulting wave of medical malpractice litigation led to an increased number of jury awards and an increase in medical malpractice insurance premiums") (citing Fulton Haight, *Doctor, Heal Thyself: Strong Medicine for Professional Woes*, LEGAL TIMES, May 8, 1989, at 25).

14. *See* Nathanson, *supra* note 11, at 1081 (stating that recent studies do not support the intuitive sense of the majority viewpoint—that increased litigation and jury awards result in increased medical malpractice premiums; rather, the recent studies suggest that the spike in premiums is directly related to the economy).

15. *See id.* (arguing that while the minority viewpoint may be correct that premium increases are not fueled primarily by litigation, the minority viewpoint incorrectly blames recent premium increases entirely on insurers' investments).

16. In some states, particular specialties experienced a 165% increase in premiums between 1999 and 2002. U.S. GEN. ACCOUNTING OFFICE (GAO), MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 10 (2003).

17. Christina O. Jackiw, *The Current Medical Liability Insurance Crisis: An Overview of the Problem, Its Catalysts, and Solutions*, 13 ANNALS HEALTH L. 505, 506 (2004).

18. *Id.*

19. *See* WEISS RATINGS, INC., MEDICAL MALPRACTICE CAPS: THE IMPACT OF NON-ECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS, AND AVAILABILITY OF COVERAGE 4 (2003) [hereinafter "WEISS"] (estimating the number of medical malpractice insurers decreased from 274 in 1997 to 247 in 2002); *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND

twenty of Florida's forty medical malpractice insurance carriers withdrew entirely from the market.<sup>20</sup> In New Jersey, three medical malpractice insurance carriers, representing 55 percent of the physicians within the state, discontinued coverage.<sup>21</sup> Not only did increased rates affect doctors, but decreased coverage and policy cancellations affected them as well.<sup>22</sup> Because many physicians will not practice without coverage,<sup>23</sup> the lack of coverage translates into decreased services for patients.

As of 2006, the American Medical Association ("AMA") categorized twenty-two states as being in a "medical liability crisis"<sup>24</sup> and an additional twenty states as being on the verge of crisis.<sup>25</sup> Though the AMA neither defined what constitutes a "crisis state," nor identified the "problem signs" that lead to crisis,<sup>26</sup> it stated, "[i]n 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."<sup>27</sup>

If, in fact, increases in premiums, decreases in coverage, or declines in the number of insurance carriers do discourage doctors from practicing in particular markets, then patients will potentially lose access to medical services. However, until it is proven (which empirically it seems not to have been thus far), that medical malpractice litigation is the sole or major contributing factor to the

LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 14 (2002) [hereinafter "HHS"] (highlighting the withdrawal of St. Paul's, MIXX, PHICO, Frontier Insurance Group, and Doctors Insurance Reciprocal from the medical malpractice insurance market).

20. Jackiw, *supra* note 17 at 507.

21. *Id.*

22. *Id.*

23. *But see* Kachalia, *supra* note 4, at 419–22 (noting that certain physicians respond to increasing medical malpractice premiums by "going bare"—practicing medicine with insufficient coverage).

24. The crisis states are: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, West Virginia, and Wyoming. Am. Med. Ass'n, America's Medical Liability Crisis: A National View, <http://www.amaassn.org/ama/noindex/category/11871.html> (last visited May 31, 2006) [hereinafter "AMA Map"].

25. Those states "showing potential problem signs" are: Alabama, Arizona, Delaware, Idaho, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, South Carolina, South Dakota, Utah, Vermont, and Virginia. *Id.*

26. *See* AM. TRIAL LAWS. ASS'N, THE AMERICAN MEDICAL ASSOCIATIONS CRISIS STATES (on file with author) (stating "[t]he AMA's criteria are political—NOT real" and noting the AMA's failure to define what constitutes a "crisis" state).

27. AMA Map, *supra* note 24.

increased premiums, decreased coverage, or discontinued policies, the current “crisis” is more aptly defined as being a medical malpractice insurance crisis. The first step in avoiding repetition of these medical malpractice insurance crises is to determine their origins.

### C. *Who’s to Blame?*

Three groups of professionals—the plaintiffs’ bar, the physicians, and the insurers—constitute the driving forces in identifying the causes of medical malpractice insurance crises. Predictably, each group of professionals has strong opinions regarding the origins of these crises. Often, the strange bedfellows of medicine and insurance are aligned in attacking the plaintiffs’ bar, labeling these attorneys the culprits of medical malpractice insurance crises,<sup>28</sup> while the plaintiffs’ bar asserts its self-appointed role as defender of patients’ rights and focuses on the deficiencies within the medical and insurance professions that may be the root of such crises.<sup>29</sup>

#### 1. Blame the Plaintiffs’ Bar

The majority viewpoint among lawyers and the general public alike is that the lawyers, and in particular the personal injury plaintiffs’ lawyers, are to blame for the most recent medical malpractice insurance crisis.<sup>30</sup> At the 2004 White House Economic Conference, President George W. Bush announced that reform of the medical malpractice system was a priority, claiming that malpractice litigation is “driving really fine, competent people out of the practice of medicine.”<sup>31</sup> Similarly, the Department of Health and Human Services stated that the current medical malpractice litigation system “permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients who happen to win the litigation lottery.”<sup>32</sup>

Increases in jury awards support this allegation against plaintiffs’ attorneys. The AMA points to the fact that the median

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28. See *infra* notes 33–38 (discussing the criticisms levied by the medical and insurance industries against the plaintiffs’ bar).

29. See *infra* notes 41–42 (highlighting the arguments raised by the American Trial Lawyers’ Association).

30. See Nathanson, *supra* note 11, at 1080 (defining the majority viewpoint as a belief that an increase in litigation led to an increase in cost thus forcing insurers either to raise rates or leave the medical malpractice insurance market altogether).

31. Jonathan Weisman, *Lawsuit Reform a Bush Priority; President Seeks to Limit Class-Action, Malpractice Cases*, WASH. POST, Dec. 16, 2004, at A6.

32. HHS, *supra* note 19, at 9.

medical malpractice jury award in 1997 was \$157,000; just six years later, the median award was \$300,000.<sup>33</sup> Additionally, the average jury award rose from \$347,134 in 1997 to \$430,727 in 2002.<sup>34</sup> Similarly, the *median* medical malpractice settlement increased from approximately \$100,000 in 1997 to approximately \$200,000 in 2002.<sup>35</sup> Over the same period of time, the *average* settlement grew from \$212,861 to \$322,544.<sup>36</sup> The National Practitioners Data Base noted that the sum of all jury awards against physicians increased by 20 percent from 1993 to 2002, rising from \$147 million to \$172 million.<sup>37</sup> It should be noted that while the payouts on medical malpractice suits have increased, the actual number of suits filed have remained relatively stable over the same period of time.<sup>38</sup>

In response to the accusation that lawyers are to blame for the medical malpractice insurance premium hikes, opponents of medical malpractice reform point to the fact that medical malpractice

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33. AM. MED. ASS'N, MEDICAL LIABILITY REFORM – NOW! 3 (2004), available at <http://ama-assn.org/go/mlrnow.pdf> [hereinafter “AMA”] (citing PHYSICIAN INSURERS ASS'N OF AM., PIAA CLAIM TREND ANALYSIS: 2003, at ex. 6a-2 (2004)); NAT'L PRACTITIONERS DATA BASE, 2003 ANNUAL REPORT 23 (2004) [hereinafter “NPDB”] (stating the median medical malpractice payment—settlements included—in 2003 was \$160,000). *But see* HHS, *supra* note 19, at 9 (estimating the average medical malpractice jury award in 1999 was \$800,000); Insurance Information Institute (III), Hot Topics & Issues Updates: Medical Malpractice, <http://www.iii.org/media/hottopics/insurance/medicalmal> (last visited May 31, 2006) [hereinafter “III, Hot Topics”] (estimating the median medical malpractice jury award at \$1 million). One of the surprising facts in the current medical malpractice debate is the lack of concrete evidence with regards to the average jury award, the average noneconomic damage award, the average punitive damage award, and, most importantly, the frequency of suits. This author has chosen to cite directly the American Medical Associations' statistics. The reasoning behind that decision is that while the AMA openly lobbies for noneconomic damage caps, the estimations it projects are counter-intuitive to its position. The fact that the AMA cites this lower average and median inferentially may be an indication of its validity.

34. AMA, *supra* note 33, at 3.

35. *Id.*

36. *Id.*; see also III, *Hot Topics*, *supra* note 33 (stating that the average *claim*—does not separate settlements from jury awards—reached \$178,000 in 2004, up from \$100,000 in 1996).

37. Christopher H. Schmitt, *A Medical Mistake*, U.S. NEWS & WORLD REP., June 30, 2003, at 24. To be clear, in the anomalously large jury awards, generally more people and/or entities are held accountable, not just the physician. See William P. Gunnar, *Is There an Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 477 (2004) (noting that large awards are generally levied against both the physician and the facility where the incident took place and stating the overwhelming majority of claims are levied against the “deep pockets” of the facility).

38. Gunnar, *supra* note 37, at 477 (stating that in recent years the total number of medical malpractice suits filed nationally remained stable). Note that, despite best efforts, this author was unable to identify a comprehensive frequency breakdown by state. As will be discussed later in this Note, this author theorizes that in the wake of medical malpractice caps, in order to maintain profitability, plaintiffs' malpractice attorneys will increase the number of filings in order to create a greater frequency of small verdicts in order to compensate for their lost income due to the caps.

judgments are rising at a rate consistent with the rate of medical inflation.<sup>39</sup> However, that comparison does not necessarily take into account the effect that medical malpractice litigation has on medical inflation (i.e. medical inflation may, in part, be a by-product of increases in the cost of medical malpractice insurance) or the effect of defensive medicine<sup>40</sup> (i.e. medical inflation may, in part, be the result of the additional cost of needless procedures done solely for the purpose of litigation prevention).

## 2. Blame the Doctors

Opponents of medical malpractice reform often point to the culpability of doctors<sup>41</sup> and the lack of severe disciplinary actions in the medical community against physicians who commit malpractice as being the true impetus for increases in medical malpractice insurance.<sup>42</sup> The Institute of Medicine estimated that in 2000, medical error was responsible for between 44,000 and 98,000 deaths in the United States.<sup>43</sup> In 1997, medical error was among the top ten leading causes of death in the United States.<sup>44</sup> Of course, not all

39. AMS. FOR INS. REFORM, MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 2004, at 5 (2004), available at <http://www.insurance-reform.org/StableLosses04.pdf> [hereinafter "AIR"] (stating that since 1975 medical malpractice payouts closely track medical inflation).

40. In a national study by Harris Interactive, Inc., 79% of physicians indicated they perform defensive medicine on a regular basis. See HARRIS INTERACTIVE, INC., MOST DOCTORS REPORT FEAR OF MALPRACTICE LIABILITY HAS HARMED THEIR ABILITY TO PROVIDE QUALITY CARE: CAUSED THEM TO ORDER UNNECESSARY TESTS, PROVIDE UNNECESSARY TREATMENT AND MAKE UNNECESSARY REFERRALS (2002), available at [http://www.harrisinteractive.com/harris\\_poll/index.asp?PID=300](http://www.harrisinteractive.com/harris_poll/index.asp?PID=300) (reporting that in a survey of physicians, 79% admitted to ordering unnecessary tests, 74% stated they made unnecessary referrals, and 51% said they suggested unnecessary biopsies). The AMA estimated that between \$70 and \$126 billion is spent annually on defensive medicine. AMA, *supra* note 33, at 8. By comparison, the National Practitioners Data Base estimates that medical malpractice litigation jury awards against *physicians* in 2003 were just \$172 million. See Schmitt, *supra* note 37, at 24.

41. See Am. Trial Laws. Ass'n, The Truth About Medical Malpractice in America, <http://www.atla.org/ActivistCenter/Tier3/TalkingPoints/MedMal.aspx> (last visited May 31, 2006) [hereinafter "ATLA"] (asserting that despite claims of defensive medicine, physicians are not reducing the frequency of medical errors).

42. See Am. Trial Laws. Ass'n, Confidentiality of Medical Mistakes Kills, <http://www.atla.org/pressroom/facts/mederrors/confidentialitykills.aspx> (last visited May 31, 2006) (discussing the atmosphere of confidentiality within the medical community when it comes to reporting medical errors).

43. INST. OF MED., TO ERR IS HUMAN 26 (Linda T. Kohn et. al. eds., 2000) [hereinafter "INST. OF MED."].

44. See Jackiw, *supra* note 17, at 510–11.

[M]edical error [is] on the list of the top ten causes of death in the United States for 1997, alongside well-known killers such as heart disease (726,974 deaths), cancer (539,577 deaths), cerebrovascular disease (159,791 deaths), chronic obstructive

medical errors result in death;<sup>45</sup> HealthGrades, a public corporation specializing in ratings, information, and advisory services within the healthcare fields, estimated there were an estimated 1.14 million incidents of medical error (both fatal and non-fatal) in the United States between 2000 and 2002.<sup>46</sup>

Increases in medical error not only result in increased litigation but also result in increased medical expenses (i.e. when a patient is injured but not killed by medical error, there is an increase in expenditures to care for that patient).<sup>47</sup> Though there is no clear indication of the annual cost of medical error, the Institute of Medicine estimated the cost of corrective treatment to be \$17 billion annually.<sup>48</sup>

The crux of the argument assigning blame for the increase in medical malpractice premiums to doctors is that the frequency of medical errors naturally leads to a higher rate of medical malpractice claims; these claims, regardless of the win rate for physicians, result in increased costs to insurers.<sup>49</sup> In order to recuperate from the escalating losses, insurers raise premiums.<sup>50</sup>

In response to the statistics and arguments blaming physicians for the medical malpractice insurance crisis, the AMA stated there is a miscalculation in the rate of medical error and reasserted its argument that the problem is in the tort litigation system.<sup>51</sup> In its compendium on medical malpractice insurance, under the heading of "Patient Safety Efforts," the AMA highlighted both its financial contributions to the National Patient Safety Foundation and its lobbying efforts during the term of the 108<sup>th</sup> Congress to pass legislation allowing for a voluntary, legally protected reporting

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pulmonary disease (109,029 deaths), diabetes (62,636 deaths), suicide (30,535 deaths), and nephritis (25,331 deaths).

*Id.* (citing SHEILA LEATHERMAN & DOUGLAS MCCARTHY, *QUALITY OF HEALTH CARE IN THE UNITED STATES: A CHARTBOOK 61* (2002) [hereinafter "LEATHERMAN"]).

45. Jackiw, *supra* note 17, at 511.

46. HEALTHGRADES, *HEALTHGRADES QUALITY STUDY: PATIENT SAFETY IN AMERICAN HOSPITALS 3* (2004), available at [http://www.healthgrades.com/media/english/pdf/HG\\_Patient\\_Safety\\_Study\\_Final.pdf](http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf) [hereinafter "HEALTHGRADES"].

47. See Jackiw, *supra* note 17, at 511 (noting medical errors not resulting in death require additional costs on behalf of the healthcare system to correct the error).

48. *Id.* (citing INST. OF MED., *supra* note 43, at 41).

49. See Jackiw, *supra* note 17, at 511–12 (stating the cost of medical error "is reflected in medical malpractice litigation, driving up the dollar amounts of claims and their payouts and consequently, causing malpractice insurance premiums to rise").

50. See *id.*

51. See AMA, *supra* note 33, at 57–58 (discussing the AMA's contribution of \$7.3 million to the National Patient Safety Foundation prior to the 2000 release of *To Err is Human*, which reported 44,000 to 98,000 medical error deaths occur each year, and the AMA's lobbying efforts to pass both a House and a Senate bill requiring additional reporting requirements).

system.<sup>52</sup> The main point of the AMA's response to medical errors was that while the AMA is a "[t]rue advocate[] of patient safety . . . trial lawyers stand in firm opposition to changing our broken liability system, because today's injured patients are tomorrow's multimillion dollar clients."<sup>53</sup> The AMA further stated that the current liability system does not encourage patient safety because it "[e]ncourages defensive medicine," "[c]reates a lottery mentality throughout the nation's court system," and "[e]nriches certain trial lawyers at the expense of patients and physicians."<sup>54</sup>

### 3. Blame the Insurance Companies

To comprehend the argument that insurers are to blame for the medical malpractice insurance crisis, one must begin with how insurance companies earn the majority of their profits—investments. Typically, insurance companies take the income from premiums and invest that money on the float—the amount of time the insurance company holds the premium before payout on a claim is necessary.<sup>55</sup>

Though insurers are regulated on a state-by-state basis, the typical state requires 80 percent of medical malpractice premiums collected from physicians within that state to be invested in high-grade, low-return bonds.<sup>56</sup> When the bond market is strong, premiums are low; when bonds dip, premiums are raised to offset the loss in the market.<sup>57</sup> There appears to be a direct correlation between the medical malpractice insurance crises of the 1970s, 1980s, and 2000s and the health of the economy.<sup>58</sup> While the insurance crises of the 1970s and 1980s produced a substantial amount of tort reform, it was not until the economy rebounded that medical malpractice premiums stabilized.<sup>59</sup> The most recent crisis fits soundly within this theory; throughout the economic boom of the 1990s, medical malpractice premiums were relatively stable and, for insurers,

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52. See *id.* at 58–59 (touting its efforts to pass H.R. 663, 108th Cong. (2003) and S. 720, 108th Cong. (2003)).

53. *Id.* at 58.

54. *Id.* at 57.

55. While the float for automobile insurance is as short as 15 months, the float on medical malpractice premiums is between 5 and 10 years. See AIR, *supra* note 39, at 4; see also NPDB, *supra* note 33, at 4 (identifying the time between incident and payment in medical malpractice as being 4.59 years).

56. Nathanson, *supra* note 11, at 1082; GAO, *supra* note 16, at 4.

57. See GAO, *supra* note 16, at 4 (stating insurers needed to subsidize the loss in investment income by raising premiums).

58. Nathanson, *supra* note 11, at 1082.

59. *Id.*

medical malpractice was one of the most profitable insurance lines.<sup>60</sup> However, after the economic bubble burst in late 1999/early 2000, medical malpractice policies were no longer profitable.<sup>61</sup> Between 1990 and 2000, insurance companies experienced a consistent decrease in net profits from 17.4% to -4.7% of the insurance companies' total net worth.<sup>62</sup>

Opponents of tort reform assert that insurers are solely to blame for medical malpractice insurance crises either because the economy alone is responsible for the increases in premiums or because previous "mismanagement" on the part of the insurers led to shortfalls in income causing the increases in premiums. Both of these explanations have significant weaknesses. First, not all lines of insurance are being raised as drastically as the premiums in medical malpractice.<sup>63</sup> Second, the requirement that 80% of premiums be placed in high-grade bonds is not unique to medical malpractice insurance.<sup>64</sup> Since almost all insurance policies are subject to similar regulations, one would expect a market dip to affect all insurance policy lines (or at least to affect all medical malpractice policies)<sup>65</sup> nationwide.<sup>66</sup> Instead, insurers are simply paying more on medical malpractice policies than they are on other insurance lines.<sup>67</sup>

Those who oppose tort reform and advocate for insurance reform claim that insurers are "mismanaging" premiums.<sup>68</sup> However, assuming that by "mismanagement" these critics of the insurance

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60. Jackiw, *supra* note 17, at 512 (asserting that after the increases in medical malpractice premiums during the 1970s and 1980s, premiums stabilized and profitability on medical malpractice lines were high).

61. *See id.* at 513 (stating that after the economy entered recession, which was later exacerbated by the attacks on September 11, 2001, investments on medical malpractice premiums suffered large losses forcing insurers to raise premiums, discontinue coverage, or go out of business).

62. GAO, *supra* note 16, at 29.

63. *See* Nathanson, *supra* note 11, at 1086 (stating that "only the medical malpractice and product liability lines have seen recurrent crises over the past thirty years, as dictated by the bond market. Therefore, there clearly is something different about these lines that makes them more market sensitive than others.").

64. GAO, *supra* note 16, at 4.

65. *See id.* at 9-14 (demonstrating graphically the variations in medical malpractice premiums increases among states and specialties).

66. *See* AMA, *supra* note 33, at 47 (noting that if economic cycles were entirely to blame for increases in medical malpractice premiums, one would expect malpractice rates to increase in all states and not just some states).

67. *See* HARTWIG, *supra* note 2, at 9 (estimating medical malpractice insurers in 2002 paid \$1.65 for every \$1.00 of income from premiums; for all insurance lines combined, insurers paid only \$1.08 for every \$1.00 of income from premiums).

68. *See* Nathanson, *supra* note 11, at 1084 (stating in response to the AIR study that "it is difficult to understand how the economic link between bond rates and premium rates is somehow the result of the insurance industry's mismanagement of investments").

industry mean that the insurers have invested premiums in an unwise or unprofitable manner, this categorization is erroneous. Medical malpractice insurers, like all insurers, are subject to significant governmental regulations.<sup>69</sup> If the source of the crisis is that insurers are abiding by the law and investing in the bond market, then the underlying law should be changed; to blame the insurance companies for following the law is illogical.<sup>70</sup>

While “mismanagement” may not be the problem, per se, insurers are not completely faultless. When insurers are able to realize a higher return on investments during periods of strong interest rates, insurers tend to reduce and/or stabilize the rates on medical malpractice premiums.<sup>71</sup> Insurers lower rates in order to expand geographically or to strengthen market share by undercutting other insurers’ rates.<sup>72</sup> Prior to the current medical malpractice insurance crisis, insurers were charging less than necessary to make a profit solely on the premiums.<sup>73</sup> When interest rates could no longer subsidize the loss from the medical malpractice insurance lines, insurers not only needed to raise premiums by the rate of the increased loss, but also by the amount the insurers previously were able to offset with the investment income. By engaging in this shortsighted cyclical business model insurers amplified the medical malpractice insurance crises.<sup>74</sup>

No one, not the AMA, the American Trial Lawyers Association, the Insurance Information Institute, or the Governmental Accounting Office, has precisely determined what causes medical malpractice insurance crises.<sup>75</sup> While several factors are clearly present during a

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69. See GAO, *supra* note 16, at 8 (noting that medical malpractice insurers are regulated by state insurance commissioners and subject to the laws of the states in which they operate).

70. See Nathanson, *supra* note 11, at 1084 (stating that if the crisis is the result of a mismanaged scheme promulgated by the state governments, then the blame rests properly with those governments, not the insurers).

71. See *id.* at 1085 (asserting rather than “mismanagement” on the part of insurers, economic strength affects insurance premiums because insurers’ shortsightedness during times of economic boom lead some to slash premiums).

72. *Id.* at 1085; see also GAO, *supra* note 16, at 4 (“[D]uring the 1990’s insurers competed vigorously for medical malpractice business, and several factors . . . permitted them to offer prices that in hindsight, for some insurers, did not completely cover their ultimate losses on that business.”).

73. See GAO, *supra* note 57 and accompanying text.

74. See Nathanson, *supra* note 11, at 1085 (asserting that the practice of maintaining a combined ratio of greater than one hundred in an effort to undercut competitors’ prices “certainly adds to the severity of the crises”).

75. See GAO, *supra* note 16, at 43 (stating that “[m]ultiple factors have combined to increase medical malpractice premium rates . . . , but losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term . . . . However, the

crisis—increased jury awards, decreasing medical malpractice insurance providers, medical error, economic decline—it is unclear to what extent each of these factors plays in the development of such crises.<sup>76</sup> However, one thing is certain—if trends continue, in the near future, physicians in certain states and physicians in particular specialties may be edged out of the market, placing the future of medical care in the United States in jeopardy. Therefore, in the wake of the most recent crisis, the focus should be how to avoid future crises. Before enacting drastic changes to medical malpractice litigation, it is important to identify the goal of the reform, to determine how that goal can be achieved pragmatically, and to understand the restrictions placed on such reforms by the twin objectives of tort law.

#### *D. Achieving Medical Malpractice Reform Within the Objectives of Tort Law*

In determining what constitutes the “optimal” medical malpractice tort reform, one must align the goal of medical malpractice tort reform with the objectives of tort law. The ultimate goal of medical malpractice tort reform must be to stabilize medical malpractice insurance premiums.<sup>77</sup> The objectives of medical malpractice tort law are to increase the quality of healthcare<sup>78</sup> through deterrence of future incidences of malpractice<sup>79</sup> and to provide sufficient redress for injuries resulting from actual negligence.<sup>80</sup> Reconciling the twin objectives of tort law with the goal of tort reform creates a quandary: what type of reform stabilizes medical malpractice premiums while at the same time deters future incidents of malpractice and allows legitimately injured plaintiffs to recover fully for their injuries?

As Professor Nathanson explained, the only way to achieve the goal of stabilizing medical malpractice premiums is to level out the

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year-to-year increase in premium rates can vary substantially because of perceived future losses and a variety of other factors, including investment returns . . .”).

76. See *id.* at 43–44.

77. See Nathanson, *supra* note 11, at 1089–90 (arguing the goal of tort reform should be to reduce the combined ratio to one hundred).

78. See Jackiw, *supra* note 17, at 519 (mentioning reform is needed to promote patient safety).

79. See Jeffrey O’Connell & Andrew S. Boutros, *Treating Medical Malpractice Claims Under a Variant of the Business Judgment Rule*, 77 NOTRE DAME L. REV. 373, 375–76 (stating the dual goal of medical malpractice tort law is deterrence and compensation).

80. *Id.*

combined ratio,<sup>81</sup> a measure by which insurance companies assess the profitability of insurance policies. The combined ratio represents the insurers' profitability without regard to investment income or investment loss.<sup>82</sup> The combined ratio is essentially two ratios—the loss ratio and the expense ratio.<sup>83</sup> The loss ratio is the relationship between losses and premiums; the expense ratio is the relationship between underwriting costs and premiums.<sup>84</sup> The goal is for the combined ratio to be no greater than 100; at 100 the insurers are spending and receiving the same amount of money—it is the break-even point.<sup>85</sup> When the combined ratio is greater than 100, the insurer is spending more in claims, defense costs, and administrative costs than it actually receives from premiums.

While the combined ratio determines whether there is profitability based *solely* on the income/expense calculations, insurers, as seen above, invest the premiums as well. When the economy is strong, insurers yield a higher rate of return on their investments; therefore, insurers can be over 100 for the combined ratio and still make a profit during periods of economic strength.<sup>86</sup> Between 1991 and 2000, the combined ratio for medical malpractice insurance rose from 103.7 to 133.5.<sup>87</sup> In 2001, insurers witnessed a further increase in the combined ratio to 140;<sup>88</sup> essentially, for every \$1.00 in income from medical malpractice premiums, insurers paid \$1.40 in claims, settlements, defense costs, and administrative expenses.<sup>89</sup>

The combined ratio increased during the period between 1991 and 2000 for two reasons: increased payouts/settlements and

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81. Nathanson, *supra* note 11, at 1088–90 (arguing that once it is understood that insurers measure profitability through the combined ratio, the only way to ensure a stabilized medical malpractice insurance market is to ensure a stable combined ratio).

82. *Id.* at 1088.

83. *Id.* at 1087–88.

84. *Id.*

85. *See id.* at 1088 (stating “a combined ratio of 100 is considered the ‘break even’ point, with combined ratios under 100 indicating a net profit (absent investment income), and combined ratios over 100 indicating a net loss (again, absent investment income)”).

86. *See id.* at 1088 (stating that insurers can tolerate the difference between the income and expense ratios during a strong market).

87. *Id.* at 1088–89.

88. *Id.* at 1089; *see also* AMA, *supra* note 33, at 54 (asserting the combined ratio in 2003 for medical malpractice insurance was 136.9 and that the combined ratio of all property casualty insurance for the same year was 100.1) (citing AM BEST, BEST'S AGGREGATES & AVERAGES - PROPERTY/CASUALTY, UNITED STATES AND CANADA: 2004, at 346, 352 (2004)); HARTWIG, *supra* note 2, at 9 (indicating the combined ratio in 2003 for medical malpractice insurance was 165 while the combined ratio for all insurance lines combined was 107.2).

89. *See* Nathanson, *supra* note 11, at 1089.

increased defense costs.<sup>90</sup> While payouts and settlements are easy targets to blame for the elevated combined ratio, defense costs make up a significant portion of the expense ratio. The Insurance Information Institute estimated that 40 percent of all medical malpractice insurance expenses are spent on defense costs;<sup>91</sup> most insurance lines spend only approximately 13 percent of total expenses on defense costs.<sup>92</sup>

However, from a business perspective, large defense costs are money well spent for the insurers. Physician Insurers Association of America estimated that of all medical malpractice claims filed in the United States, only 0.9 percent end in a jury verdict for the plaintiff.<sup>93</sup> While 27.4 percent of the cases filed will end in settlement, 67.7 percent are dropped or dismissed without payment to the plaintiff.<sup>94</sup> Therefore, medical malpractice claims have only a 5 percent chance of making it to trial; once at trial, those cases have only a 20 percent chance of a verdict for the plaintiff.

So, while some critics, especially the American Trial Lawyers Association (“ATLA”), would like to blame the medical malpractice insurance crisis solely on insurers (or jointly on insurers and physicians),<sup>95</sup> insurers are paying more per premium dollar in verdicts, settlements, and defense costs than ever before. As noted above, medical malpractice premiums are growing faster than other

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90. See *id.* at 1090 (stating the combined ratio can be reduced either by lowering payouts or by lowering defense costs and noting that most tort reform currently focuses on lowering *payouts* only and not defense costs).

91. *Id.* at 1091 (citing INS. INFO. INST., THE INSURANCE INFORMATION INSTITUTE FACT BOOK 118 (2002) [hereinafter “FACT BOOK”]).

92. See Natbanson, *supra* note 11, at 1091 (citing FACT BOOK, *supra* note 91, at 118). The United States Department of Health and Human Services estimated that the average medical malpractice case costs \$24,669 to defend. HHS, *supra* note 19, at 8. One reason the average defense cost is estimated at this surprisingly low number is because it includes the average of *all* defense costs, including those suits that are dismissed or dropped without payment.

93. Schmitt, *supra* note 37, at 24–27.

94. *Id.* The remaining four percent of cases resulted in a jury verdict for the defense. *Id.* Therefore, essentially, of the cases that go to trial, plaintiffs have only a twenty percent chance of victory.

95. See ATLA, *supra* note 41 (stating “[t]he best solution to this insurance premium crisis is a cap on the outrageous amount of money HMOs and insurance companies can charge doctors for medical malpractice insurance” and “[d]espite claims about ‘defensive medicine,’ Americans are [not] getting the care they need”).

insurance lines because of the high losses in the combined ratio,<sup>96</sup> a measurement for which the strength of the economy is irrelevant.<sup>97</sup>

Thus, for medical malpractice reform to achieve its goal—stabilizing and/or reducing medical malpractice insurance premiums—the return must stabilize or reduce the combined ratio. Specifically, the optimal medical malpractice reform must reduce and stabilize the expense ratio. There are only three ways to stabilize the expense ratio: reduce payouts to plaintiffs, reduce defense costs, or reduce administrative costs. In determining the means to achieve the goal of reducing the combined ratio, the twin objectives of tort law should restrict the available alternatives of reform. Because medical malpractice reform should not come at the expense of insufficient redress for legitimately injured plaintiffs or ineffective deterrence of future negligence, reform must only affect the truly frivolous suits. If the reform casts a broader net than seeking to eliminate the class of unmeritorious suits, then the reform would essentially sanction negligence on the part of physicians.

### III. THE SHORTFALLS OF THE CURRENT SOLUTIONS

Before an effective solution to avoid future medical malpractice insurance crises can be developed, it is important to understand the benefits and weaknesses of previous tactics. While each of the following approaches is designed to curb medical malpractice insurance crises, they have achieved only varying degrees of success. Additionally, each of these tactics has had differing impacts on the goal of medical malpractice reform and the objectives of tort law.

#### A. *Caps on Non-Economic Damages*

Probably the most popular version of medical malpractice reform since the medical malpractice insurance crisis of the 1970s has been caps on jury awards. Currently, nineteen states limit the amount of recovery juries are able to award in medical malpractice cases.<sup>98</sup> While some states have overall caps on damages—both

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96. See AMA, *supra* note 33, at 54 (estimating a 36.8 point difference between the medical malpractice combined ratio and the combined ratio of all property casualty insurance in 2003); HARTWIG, *supra* note 2, at 9 (indicating a 57.8 point difference between the medical malpractice combined ratio and the combined ratio for all insurance lines combined in 2002).

97. Arguably, in a stronger economy, insurers can withstand a higher combined ratio without increasing rates or, at least, without escalating rates as drastically.

98. See WEISS, *supra* note 19, at 16 (listing nineteen states in 2003 with caps on damages; those states are: Alaska, California, Colorado, Hawaii, Idaho, Indiana, Kansas, Louisiana,

economic and non-economic<sup>99</sup>—most states with caps limit only non-economic damages, including pain and suffering, loss of consortium, and hedonic damages.<sup>100</sup> Most states use what is referred to as a “hard cap,” which is a cap limiting recovery at a specific dollar amount.<sup>101</sup>

The 109<sup>th</sup> Congress is currently considering a federal medical malpractice reform statute that conforms to the prototypical state non-economic damage cap.<sup>102</sup> The federal statute calls for a hard cap on non-economic damages at \$250,000.<sup>103</sup> In addition, the federal statute aims to limit punitive damages to \$250,000 or twice the compensatory damages in that particular case—whichever is greater.<sup>104</sup> Though this statute, “House Bill 5”, passed the House of Representatives in 2005,<sup>105</sup> it is currently stalled in the Senate.<sup>106</sup>

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Maryland, Massachusetts, Michigan, Missouri, Montana, New Mexico, North Dakota, Utah, Virginia, West Virginia, and Wisconsin).

99. See N.M. STAT. ANN. § 41-5-6 (Michie 2006) (stating that “[e]xcept for punitive damages and medical care and related benefits, the aggregate dollar amount recoverable by all persons for or arising from any injury or death to a patient as a result of malpractice shall not exceed six hundred thousand dollars (\$600,000) per occurrence”).

100. See, e.g., CAL. CIV. CODE § 3333.2 (West 2006) (stating noneconomic damages compensating for “pain, suffering, inconvenience, physical impairment, disfigurement and other non[-]pecuniary damage” cannot exceed \$250,000).

101. See, e.g., *id.* Other states allow for a shifting or sliding cap that allows noneconomic damages to be awarded in proportion to compensatory damages. See, e.g., OHIO REV. CODE ANN. § 2323.43 (West 2006):

[T]he amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a civil action under this section to recover damages for injury, death, or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of three hundred fifty thousand dollars for each plaintiff or a maximum of five hundred thousand dollars for each occurrence.

102. See H.R. 5, 109th Cong. (2005). In addition to capping punitive damages and non-economic damages, the House bill limits the percentage of recovery that can be used for attorneys' fees, *see id.* § 5, limits the statute of limitations for filing, *see id.* § 3, exempts producers of medicine and medical devices from punitive damages if the producers complied with FDA standards, *see id.* § 7(c), allows for evidence of collateral sources of benefit to be entered at trial, *see id.* § 6, and permits periodic payments of future economic damages as opposed to requiring a lump sum payment, *see id.* § 8.

103. See *id.* § 4(b) (stating all non-economic damage cannot exceed \$250,000, “regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury”). Noneconomic damages are defined as “damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.” *Id.* § 9(15).

104. See *id.* § 7(b)(2) (stating “[t]he amount of punitive damages, if awarded, in a health care lawsuit may be as much as \$250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation”).

105. It passed by a vote of 230-194. H.R. 5, 109th Cong. (2005).

The goal of non-economic damage caps is clear—lower the total amount of money that a jury can award to a single plaintiff so as to reduce the expense ratio and thus decrease the premiums charged to physicians.<sup>107</sup> The theory is that caps will achieve the goal of lowering medical malpractice premiums in three ways: (1) caps will directly lower jury awards; (2) caps will have a trickle-down effect, lowering settlement amounts; and (3) caps will discourage frivolous litigation thus decreasing defense costs.<sup>108</sup>

While the tactic of lowering jury awards has been realized in states with caps, the ultimate goal of caps—the reduction or stabilization of premiums—has not been achieved. According to Weiss Ratings, in states that imposed caps on medical malpractice claims, payouts increased by 83.3 percent between 1991 and 2002; in states without caps, payouts increased by 127.9 percent during these same years.<sup>109</sup> Despite the capped states' lower increase in payouts, insurance premiums in those states actually increased at a rate faster than premiums in states without caps.<sup>110</sup> One reason for the disparity may be that in states with caps the frequency of litigation increased at a rate faster than in the non-capped states. The states with caps experienced a median increase in premiums of 48.2 percent; states without caps experienced a median increase of only 35.9 percent.<sup>111</sup> Similarly, only 10.5 percent of the states with caps experienced declining or stabilizing medical malpractice premiums, but 18.7 percent of the states without medical malpractice damage caps experienced declining or stabilizing rates.<sup>112</sup>

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106. S. 354, a bill with identical language to H.R. 5, was introduced in the Senate and referred to committee on February 2, 2005. There has been no action subsequent to the committee referral.

107. H.R. 5 § 2(b)(3) (stating one of the purposes of the bill is to ensure recovery of “reasonable noneconomic damages”; “reasonable,” in light of the purpose of the statute, inferentially means decreased). It should be noted that an additional purpose of the caps on noneconomic damages is to deter the total number of medical malpractice suits filed. *See id.* (stating that the act is designed to “ensure that persons with *meritorious* health care injury claims receive fair and adequate compensation”) (emphasis added).

108. *See* Nathanson, *supra* note 11, at 1102 (summarizing the argument for damage caps and stating that proponents of caps theorize that increases in jury awards created increases in settlements as well).

109. *See* WEISS, *supra* note 19, at 3 (noting from 1991 to 2002, in states without caps, the median payout was \$116,297; in states with caps, the payout was 15.7% lower (\$98,079)).

110. *See id.* at 7–8 (noting from 1991 to 2002, in states with caps, the median annual medical malpractice insurance premium rose by \$9,832, while in states without caps, the median annual medical malpractice insurance premium increased by only \$7,938).

111. *Id.* at 3.

112. *Id.* at 8. Admittedly, this statistic may be misleading in that arguably the states that passed legislation creating caps did so in response to a more robust medical malpractice litigation environment.

Though the statistics from Weiss Ratings cast serious doubt on the effectiveness of caps on jury awards, both the AMA and the Insurance Information Institute continue to advocate for caps on non-economic damages.<sup>113</sup> Generally, both organizations point to California's caps on medical malpractice damages as an example of the benefits of "hard" caps. In 1975, California passed the Medical Insurance Consumer Reform Act ("MICRA"), placing a hard cap on non-economic damages at \$250,000.<sup>114</sup> However, from passage of the cap until 1988, California experienced a continued increase in medical malpractice premiums.<sup>115</sup> It was not until the economic recovery of the 1980s and the passage of Proposition 103,<sup>116</sup> a proposition requiring a reduction in current insurance rates and limiting the ability of insurers to increase rates in the future, that medical malpractice premiums began to decline.<sup>117</sup> Additionally, the National Practitioners Data Base notes that due to uncertainty in legislation, California's settlement awards may be artificially depressed.<sup>118</sup>

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113. See Am. Med. Ass'n, AMA's 2004 Health Care Advocacy Agenda, <http://www.ama-assn.org/ama/pub/category/7861.html> (last visited May 31, 2006) (stating the AMA's agenda for medical malpractice reform is to "[s]ecure enough votes in U.S. Senate to pass federal MICRA style reforms"); INS. INFO. INST., MEDICAL MALPRACTICE INSURANCE 7-9 (2003), available at [http://server.iii.org/yy\\_obj\\_data/binary/729103\\_1\\_0/Medmal.pdf](http://server.iii.org/yy_obj_data/binary/729103_1_0/Medmal.pdf) (discussing the benefits of California's medical malpractice noneconomic damages cap).

114. See CAL. CIV. CODE § 3333.2 (West 2006) (limiting recovery for all "non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage" to \$250,000).

115. See Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417, 459 (2004) (stating in 1988, medical malpractice premiums reached an all time high for the state of California—450% greater than the premiums in 1975—prior to the cap and passage of MICRA).

116. See CAL. INS. CODE § 1861.01 (West 2006) (commonly referred to as Proposition 103, this statute required every insurer—medical malpractice, automobile, or otherwise—to reduce premiums by 20% from the rate charged in 1987; additionally, insurers thereafter were required to seek permission from the state insurance commissioner before additional increases could be made). The AMA vehemently denies the effectiveness of Proposition 103. See AMA, *supra* note 33, at 47-49 (asserting that Proposition 103 covers only increases greater than 15% in a single year and that the proposition does not cover all insurers in the state). However, while the AMA points out the differences between California's current medical malpractice insurance market and the rest of the nation, it fails to analyze California's market trends as distinct time periods—pre-Proposition 103 and post-Proposition 103; the AMA only looks at the overall trend from the passage of MICRA in 1975 through 2002. Therefore, though the AMA conclusively stated "Proposition 103 is not responsible for keeping California's medical liability premiums down," it has not exhibited any evidence supporting that assertion. See AMA, *supra* note 33, at 47-49.

117. See Glassman, *supra* note 115, at 459 (attributing the reduction in medical malpractice premiums in California to the direct regulation on insurance premiums and not the cap on non-economic damages).

118. In California, settlements for \$30,000 or less do not need to be reported to the state medical board. NPDB, *supra* note 33, at 23 n.16; see CAL. BUS. & PROF. CODE § 801 (West 2006) (stating that "[e]very insurer providing professional liability insurance to a physician and surgeon . . . shall send a complete report to the Medical Board of California . . . as to any

One reason that medical malpractice caps alone will not reduce medical malpractice insurance premiums, or costs to the insurers, is the infrequency with which medical malpractice claims are actually tried. Recall that only 5 percent of all medical malpractice claims actually go to trial.<sup>119</sup> Over the same period of time, of all medical malpractice claims filed, only 0.9 percent of those claims resulted in a jury verdict in favor of the plaintiff.<sup>120</sup> The only cases directly affected by damage caps will be those few cases actually tried and resulting in a verdict for the plaintiff. The impact of non-economic damage caps will therefore be indirect, at best, on the remaining 99 percent of cases.<sup>121</sup>

Caps are similarly ineffective at reducing medical malpractice insurance premiums because only around half of the small number of cases resulting in jury verdicts for the plaintiff are large enough to be affected by the caps.<sup>122</sup> In 2002, according to the AMA, the median medical malpractice jury verdict was \$300,000;<sup>123</sup> statistically, therefore, the proposed federal cap of \$250,000 *might*<sup>124</sup> affect just over half of the total cases resulting in a verdict for the plaintiff.<sup>125</sup> Therefore, the total number of cases directly affected by caps is even smaller than estimated above. Because only 0.9 percent of all medical malpractice cases result in a jury verdict for the plaintiff and because the median award is only \$50,000 more than the currently proposed federal cap, less than 0.9 percent of all medical malpractice cases will actually be directly affected by the cap.

Similarly, the theoretical indirect effect of compensatory damage caps on settlements is even less. The AMA estimated that the

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settlement over thirty thousand dollars ..."). As a result, a disproportionate number of settlements are settled at or just below \$30,000. NPDB, *supra* note 33, at 23 n.16. In 2003 for example, nearly ten percent of all medical malpractice settlements in California were for an amount just under the reporting limit, and another five percent of settlements were for exactly \$30,000. *Id.*

119. See Schmitt, *supra* note 37, at 27.

120. *Id.*

121. There have been no statistical breakdowns to show the indirect effect of compensatory damage caps on settlement amounts. Therefore, the argument that there is any effect on settlements is theoretical. And, as seen below, even if this indirect effect exists, it only has the potential to work in less than half of all medical malpractice cases. See *infra* notes 122–126 and accompanying text.

122. See Nathanson, *supra* note 11, at 1108.

123. AMA, *supra* note 33, at 3.

124. To be sure, the median award cited includes noneconomic, economic, and punitive damages. Thus, a cap on only noneconomic damages will directly affect even fewer cases than those at the \$250,000 mark.

125. See Gunnar, *supra* note 37, at 476 (performing a similar analysis with the 2000 average jury award which was estimated to be only \$126,270); see also Nathanson, *supra* note 11, at 1107 (estimating the total percentage of medical cases resulting in a verdict for the plaintiff at 1.3%).

median medical malpractice settlement is only \$200,000.<sup>126</sup> Therefore, compensatory damage caps will have absolutely no indirect effect on more than half of all medical malpractice settlements.

Additionally, caps on damages do nothing to reduce defense costs for insurers. Insurers spend 40% of all expenses in medical malpractice policies on defense costs.<sup>127</sup> Again, caps can only affect defense costs indirectly. The argument behind this indirect effect is that if recovery were lower, plaintiffs' attorneys would be less willing to handle frivolous medical malpractice claims.<sup>128</sup> However, this argument ignores both the nature of the contingency fee system and the crux of the argument for medical malpractice litigation reform—that abuses by trial lawyers are unjustly inflating the cost of medical malpractice insurance.

The pragmatic goal of caps ignores the reality that many plaintiffs' attorneys operate on a contingency fee basis and must, therefore, file more cases than are expected to result in a payout.<sup>129</sup> A contingency fee necessarily means that in the event of a loss, the attorney recovers nothing for her time and expenses. If 67.7% of the medical malpractice cases are dropped or dismissed,<sup>130</sup> then the plaintiffs' bar must rely on those cases resulting in settlements or jury verdicts to make up for their lost expenses. Therefore, if the plaintiffs' bar cannot recover those lost expenses in a single large verdict for non-economic damages, the only alternative is to file a greater number of smaller verdict cases in order to make up for the lost income. Logically, therefore, caps may actually increase the total number of claims filed and, therefore, the defense costs as well. Proponents of reform want legislators to adopt a dual view of the plaintiffs' bar. Proponents argue that reform is needed because medical malpractice insurance crises are the result of "greedy" trial lawyers; these proponents, however, inherently assume that after reform the greed will somehow be curbed.<sup>131</sup>

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126. AMA, *supra* note 33, at 3.

127. See Nathanson, *supra* note 11, at 1091 (citing FACT BOOK, *supra* note 91, at 118).

128. See Daniel J. Capra, "An Accident and a Dream:" *Problems with the Latest Attack on the Civil Justice System*, 20 PACE L. REV. 339, 390–91 (2000) (refuting the Public Policy Institute's argument that contingency fees lead to overpayment of plaintiffs' lawyers and result in frivolous lawsuits).

129. See Lester Brickman, *Effective Hourly Rates of Contingency-Fee Lawyers: Competing Data and Non-Competitive Fees*, 81 WASH. U. L.Q. 653, 655–56 (2003) (stating "[c]ontingency fees are designed to—and do—yield higher effective hourly rates than do hourly rate fees to reflect the risks that lawyers bear").

130. Schmitt, *supra* note 37, at 27.

131. See AMA, *supra* note 33, at 58 (arguing that "trial lawyers stand in firm opposition to changing our broken liability system, because today's injured patients are tomorrow's

Though there is no empirical, concrete evidence to support the following assertion, logically, this natural desire to maintain the *status quo* (or more realistically to maximize income) may be the reason that while payouts in states with caps have increased at a rate slower than in states without caps, premiums are still increasing at a rate faster than states without caps.<sup>132</sup> It is possible that rather than losing money in a single claim, insurers are actually losing more money due to an increase in the frequency of claims within those particular states.<sup>133</sup>

Assuming, *arguendo*, that caps do indeed reduce insurance premiums, the decrease in payouts does not necessarily comport with the redressability objective of tort law—allowing people with legitimate claims to recover for their injuries. The recent trend is to classify non-economic damages—like loss of consortium, pain and suffering, and hedonic damages—as modern lawyerly inventions.<sup>134</sup> However, these grounds for recovery are well founded in traditional tort law.<sup>135</sup> Logically, the cases that are going to bear the brunt of the caps will be those cases that are legitimate and call for sizable recoveries.<sup>136</sup> The unmeritorious claims will still be viable under the cap system; both parties will be encouraged to settle quickly and cheaply at or below defense costs.<sup>137</sup>

Critics of caps argue that the plaintiffs most affected by caps on non-economic damages are children, the elderly, and stay-at-home parents because *economic* damages for these classes of plaintiffs are

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multimillion dollar clients”); HARTWIG, *supra* note 2, at 9 (asserting “trial lawyers have destroyed commercial viability of [medical malpractice insurance]”).

132. See *supra* notes 109–112 and accompanying text.

133. Further research is required in order to determine whether frequency of suits is increasing in any particular state. While it was previously noted that medical malpractice suits have been stable over recent years, see *supra* note 38 and accompanying text, despite best efforts, this author has been unable to discover state-by-state breakdowns of filings and has only unearthed national statistics or statistical samples.

134. See HHS, *supra* note 19, at 8:

[A]warded on top of compensation for the injured patient’s actual economic loss, non-economic damages are said to be compensation for intangible losses, such as pain and suffering, loss of consortium, hedonic (loss of the enjoyment of life) damages, and various other theories that are imaginatively created by lawyers to increase the amount awarded.

135. See *Cross v. Guthery*, 2 Root 90 (Conn. Cir. Ct. 1794) (allowing for recovery of loss of consortium); *City of Columbus v. Strassner*, 25 N.E. 65, 67 (Ind. 1890) (discussing the possibility of recovery for loss of personal enjoyment); JEFFREY O’CONNELL & RITA S. SIMON, *PAYMENT FOR PAIN AND SUFFERING* 3 (1972) (tracing American awards for pain and suffering to the late 18th century).

136. Nathanson, *supra* note 11, at 1109.

137. *Id.* at 1109.

already low since they have no lost income.<sup>138</sup> Theoretically, if economic damages are low and non-economic damages are capped, any indirect attempt to limit the number of medical malpractice claims will be realized at a disproportionate rate by this group of plaintiffs. The value of these cases, therefore, may be insufficient to compel plaintiffs' lawyers to take on the risk of a losing verdict. Thus, these plaintiffs may receive no compensation whatsoever for their injuries.<sup>139</sup>

As for the second objective of medical malpractice tort law—improving the quality of healthcare through deterrence—caps are similarly ineffective. Caps will protect only “bad medicine” while, in effect, punishing “good medicine.”<sup>140</sup> Presumptively, those patients injured by severe acts of negligence will incur the largest non-economic damages; physicians committing such acts will be protected in part for the liability they would traditionally incur. However, doctors who are victims of frivolous lawsuits will not be protected from the suit, only from non-economic damages exceeding \$250,000.

The proposed goal of tort reform and the objectives of tort law are threefold: (1) stabilize medical malpractice insurance premiums, which is achieved by decreasing the combined ratio; (2) promote better medicine through deterrence; and (3) allow for legitimate claims to receive full redress. As seen above, the combined ratio likely will be unaffected by non-economic damage caps because so few cases will be directly affected by the cap, defense costs will experience almost no impact, and caps may actually encourage litigation. Second, under the caps, claims that otherwise would be legitimately entitled to full non-economic damages will be unable to win such awards. And finally, the cap on damages does not have any effect on the quality of medicine and health care; if anything, caps protect doctors who are performing “bad medicine.”

### *B. Caps on Punitive Damages*

Punitive damages caps are another popular medical malpractice reform. They are often found in conjunction with caps on non-economic damages. While in some states punitive damages are

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138. Symposium, *Justice and Democracy Forum: The Law and Politics of Tort Reform*, 4 NEV. L. J. 377, 397 (2003) [hereinafter “Conference”] (noting that “senior citizens, parents who do not work outside the home, and children” only have “noneconomic loss, or what we call ‘physical and mental pain, suffering, disability and anguish’”).

139. More than 70% of medical malpractice cases result in no recovery for the plaintiff and thus no attorneys' fees. Schmitt, *supra* note 37, at 27 (noting that only 28.3% of medical malpractice cases result in settlement or trial verdict for the plaintiff).

140. Nathanson, *supra* note 11, at 1110.

capped in a manner similar to non-economic damage caps,<sup>141</sup> other states propose to limit punitive awards through adjustments in the applicable burden of proof.<sup>142</sup> Several states have adjusted the burden of proof for punitive damages from the preponderance of the evidence standard to the clear and convincing evidence standard,<sup>143</sup> and, in the rare case, to the beyond a reasonable doubt standard.<sup>144</sup>

Caps on punitive damages and caps on non-economic damages share identical goals<sup>145</sup> and nearly identical weaknesses.<sup>146</sup> The major difference between limiting punitive damages in medical malpractice claims and limiting non-economic compensatory damages is that punitive damages do not affect the plaintiff's ability to recover fully for his injuries, because no one party is entitled to receive punitives.<sup>147</sup>

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141. See MO. ANN. STAT. § 538.210 (West 2006) (placing a \$350,000 cap on punitives).

142. See H.R. 5, 108th Cong. (2003) (proposing the national standard for punitive damages in medical malpractice cases should be the "clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer").

143. See, e.g., FLA. STAT. ANN. § 768.72 (West 2006) ("A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence."); see also Nathanson, *supra* note 11, at 1104 (noting thirty-three states require a showing of clear and convincing evidence before awarding punitive damages).

144. See COLO. REV. STAT. § 13-25-127(2) (2006) (stating "[e]xemplary damages against the party against whom the claim is asserted shall only be awarded in a civil action when the party asserting the claim proves beyond a reasonable doubt the commission of a wrong").

145. Reducing the expense ratio by decreasing payouts.

146. The first weakness is that the majority of awards are too low to implicate the cap, making the effect on the expense ratio indirect at best. Returning to the statistic that the median jury award is \$300,000, AMA, *supra* note 33, at 3, under *State Farm Mut. Auto. Ins. Co. v. Campbell* a single digit ratio should exist between compensatory and punitive damages. 538 U.S. 408, 425 (2003) ("We decline again to impose a bright-line ratio which a punitive damages award cannot exceed. Our jurisprudence and the principles it has now established demonstrate, however, that, in practice, few awards exceeding a single-digit ratio between punitive and compensatory damages, to a significant degree, will satisfy due process."). Under that theory, the theoretical maximum ratio (1:9) would require \$30,000 in compensatory damages which would mean that the punitive damages (if awarded) in the median medical malpractice case would be only \$270,000—just \$20,000 over the proposed federal cap on punitives. Therefore, in at least half of all medical malpractice cases, caps on punitive damages would result in a gain for the insurers of \$20,000 or less.

The second weakness is that punitive caps protect "bad medicine" without reducing the truly frivolous suits. Nathanson, *supra* note 11, at 1110 (discussing the arguments regarding the protection of "bad medicine" through caps on noneconomic damages). Like caps on noneconomic damages, caps on punitive damages will protect those doctors who are actually liable for committing acts of gross negligence since arguably those are the awards that will exceed the cap. However, caps on punitives will not protect doctors who have not committed acts of gross negligence because rarely will punitives be levied against such physicians and even more rarely will those punitive damages exceed the cap.

147. *Smitb v. Wade*, 461 U.S. 30, 59 (1983).

Punitive damages are generally seen as a windfall to plaintiffs, who are entitled to receive full compensation for their injuries—but no more. Even assuming that a

Punitive damages are not designed to compensate for economic or non-economic injuries; punitive damages are only intended to create a deterrence effect.<sup>148</sup> However, it is arguable that limiting punitive damages will preclude some plaintiffs from achieving any redress for their injuries.<sup>149</sup> While limitations on punitives do not affect an individual plaintiff's ability to recover fully from the injury, these limits may discourage attorneys from representing legitimately injured plaintiffs where low economic damages are expected.<sup>150</sup>

### C. Arbitration/Screening Panels

Another popular method of tort reform in medical malpractice cases has been the use of state-sponsored arbitration or screening panels.<sup>151</sup> Most statutorily required arbitration panels are non-binding—either party can choose to take the case to trial if that party disagrees with the outcome of the arbitration proceeding.<sup>152</sup> In some states, even the invocation of the arbitration/screening panel is

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punitive 'fine' should be imposed after a civil trial, the penalty should go to the state, not to the plaintiff—who by hypothesis is fully compensated.

*Id.*; see also Elizabeth J. Cabraser, *Unfinished Business: Reaching the Due Process Limits of Punitive Damages in Tobacco Litigation Through Unitary Classwide Adjudication*, 36 WAKE FOREST L. REV. 979, 981 (2001) ("Punitive damages are not an entitlement of the victims, but of society: a punitive damages award is a civil punishment visited upon defendants to vindicate the public interest in deterrence, and to penalize conduct that violates the social contract and injures society."); Leo M. Stepanian II, *The Feasibility of Full State Extraction of Punitive Damage Awards*, 32 DUQ. L. REV. 301, 308 (1994) (noting awards of compensatory damages in tort law are designed to fully compensate the plaintiff for her injuries and that punitives are therefore seen as a windfall for the plaintiff).

148. See Cabraser, *supra* note 147, at 980–81 (asserting punitive damages are designed as a civil penalty for violations of the social compact and serve only deterrent and exemplary functions).

149. Troy L. Cady, Note, *Disadvantaging the Disadvantaged: The Discriminatory Effects of Punitive Damage Caps*, 25 HOFSTRA L. REV. 1005, 1005–07 (1997) (arguing the plaintiffs' bar may be less willing to handle cases on a contingency fee basis if the possibility of recouping expenses through punitive damages is unavailable).

150. The difference is theoretical at best. While it is true that punitives are not entitlements in personal injury cases, punitives may be the proverbial carrot needed to encourage litigation, especially in cases where economic recovery is limited. So while caps on punitive damages do not necessarily limit the medical malpractice plaintiff from being compensated fully by the jury, caps on punitive damages may make a legitimate case so financially unattractive that a jury will never hear it.

151. See Nathanson, *supra* note 11, at 1093 (estimating screening panels exist in approximately twenty-five states); see also Albert Yoon, *Mandatory Arbitration and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the West*, 6 AM. L. & ECON. REV. 95, 96 (2004) (stating that in nineteen states, there are statutorily required arbitration panels for medical malpractice).

152. See Yoon, *supra* note 151, at 96 (asserting no state currently makes the decisions of an arbitration/screening panel for medical malpractice binding).

optional.<sup>153</sup> The make-up of the arbitration panels varies by state, but the panels generally are composed of three to seven members; some panels require a certain number of the members to be physicians and attorneys.<sup>154</sup> In theory, the goal of lowering medical malpractice insurance premiums is accomplished by weeding out unjustified or frivolous claims, encouraging settlement, and reducing the number of cases that go to trial.<sup>155</sup>

Unfortunately, the goal of arbitration panels has failed to be realized by the various states that have implemented this procedure.<sup>156</sup> The most notable failure of arbitration panels is their inability to reduce the combined ratio.<sup>157</sup> In actuality, the use of arbitration panels actually increases the combined ratio.<sup>158</sup> The escalation is a result of two factors: arbitration panels increase the chances of victory for plaintiffs while decreasing the costs for plaintiffs' attorneys.<sup>159</sup> In states with arbitration panels, defendants won 62 percent of the time in front of these panels; however, in those same states, prior to the arbitration panels, defendants were victorious in 70 percent of the medical malpractice cases.<sup>160</sup> Additionally, the cost of bringing a medical malpractice suit was significantly reduced when tried before an arbitration panel rather than a jury.<sup>161</sup> The reality experienced by the states with arbitration panels was that a decrease in the cost of litigation coupled with an increased chance for a plaintiff victory actually fostered more

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153. See CONN. GEN. STAT. ANN. § 38a-33 (West 2006) (stating “[w]henver all parties to a claim for malpractice agree, they may request the Insurance Commissioner . . . to select a panel . . . from the Malpractice Screening Panel”) (emphasis added).

154. See Yoon, *supra* note 151, at 100 (discussing the pool from which Nevada draws its arbitration panel members).

155. See Harold A. Sakayan, *Arbitration and Screening Panels: Recent Experience and Trends*, 17 FORUM 682, 682 (1982):

[U]tilizing arbitration and screening panels for resolving medical malpractice disputes, state legislatures expected to: 1. increase delivery of health services; 2. decrease cost of medical care; 3. reduce the volume of nonmeritorious litigation; 4. reduce the backlog of malpractice cases which ordinarily proceed to trial; 5. encourage prompt and early dispositions of meritorious claims at the pre-litigation stage; and 6. reduce the [spiraling] costs of medical care.

156. See Nathanson, *supra* note 11, at 1099 (asserting that “[b]ecause these panels not only fail to reduce the combined ratio but, in some instances, actually serve to raise it, they are worthless at best and exacerbate the medical malpractice insurance problem at worst”).

157. *Id.*

158. *Id.*

159. *Id.* at 1101.

160. *Id.* at 1100.

161. *Id.* at 1101 (arguing that litigation costs are lowered in part due to the increase in the probability of recovery).

litigation.<sup>162</sup> The decline in payouts was unable to compensate for the increase in frequency of payouts and for the increase in defense costs required to handle the additional suits.<sup>163</sup> Though defendants suffered a greater number of defeats in the arbitration panels, the awards granted to plaintiffs were reduced.<sup>164</sup>

As for the twin objectives of tort law, arbitration panels, at best, make limited headway in increasing patient safety and allowing for additional legitimate redress.<sup>165</sup> In terms of improving patient safety, arbitration/screening panels do little to directly affect the quality of healthcare. However, the fact that medical professionals serve on many of these panels may create a greater degree of legitimacy in the minds of the physician-defendants.<sup>166</sup> The credibility accompanying awards handed down by those trained in the medical profession may lead to greater acceptance by physicians of their own errors and, thus, indirectly encourage professional self-improvement. With regards to allowing legitimate plaintiffs to recover fully, though amounts awarded by panels were lower than those amounts previously awarded by juries, there is no indication that the panels' awards were insufficient. Thus, assuming the panel awards to be sufficient compensation, the use of panels may foster the tort objective of redressability. However, from a reform perspective aimed at reducing the expense ratio, the screening panels failed.

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162. *Id.* (asserting that under the arbitration/screening panel procedures, because of the increased chance of recovery, claims that would not otherwise have been filed are brought forward).

163. *Id.* (“[A]lthough arbitration/screening panels may very well lessen the likelihood of a substantial plaintiff’s verdict, they nonetheless ultimately prove irrelevant at best to the combined ratio because, as a tradeoff, they tend to find for plaintiffs substantially more frequently than do juries.”).

164. *Id.* (stating arbitration panel awards averaged \$289,000, while jury awards averaged \$412,000).

165. However, arbitration panels also allow for additional illegitimate claims to be filed.

166. See *Medical Liability Issues: Hearing on H.R. 5 Before the H. Comm. on Energy and Commerce*, 108th Cong. (2003) (statement of Donald J. Palmisano, President, American Medical Association) (stating “reports mak[e] clear that the medical liability litigation system in the United States has evolved into a ‘lawsuit lottery’”); S. Y. Tan, *The Medical Malpractice Crisis: Will No-Fault Cure the Disease?*, 9 U. HAW. L. REV. 241, 256–57 (1987):

Because it may be impossible to evaluate and assess fault in certain instances, the physician commonly perceives herself as a victim of hindsight, unjustifiably exposed to adverse publicity. Initial depression gives way to anger and disappointment over what she perceives as patient ingratitude and greed. A doctor’s attitude towards and rapport with subsequent patients may suffer from such an unhappy encounter. This erosion of the doctor-patient trust relationship extends to those physicians not directly involved in litigation. Doctors, in general, are increasingly adopting a defensive posture towards their patients out of misplaced or exaggerated fear. Irrespective of whether such behavior is justified, the fact remains that the present fault-based tort system threatens destruction of the traditional doctor-patient relationship.

### D. Specialized Courts

A recently emerging reform idea has been to create specialized courts within each state that will hear all medical malpractice cases. The theory behind specialized medical malpractice courts mirrors the logic of other specialized courts, such as tax courts, business litigation courts, or patent courts.<sup>167</sup> The basic notion is that specialists better handle some matters.<sup>168</sup> Having a judge who specializes in medical malpractice would streamline the litigation process, making it both more efficient and less expensive.<sup>169</sup> Additionally, specialized courts would help create a uniform body of law for a particular jurisdiction, thus fostering predictability in the law; the hope is that the predictability of the court would lead to predictability within the insurance field and thus appropriate premium amounts.<sup>170</sup> During the 2004 legislative sessions, at least three states proposed legislation to move the specialized medical malpractice courts from the theoretical to the practical.<sup>171</sup> The 108<sup>th</sup> Congress also proposed legislation

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167. Lang, *supra* note 13, at 307–09 (discussing the reasoning for the formation of previous specialized courts).

168. “[I]n technologically complex areas specialized adjudicators would produce better results: that a chemist’s insight into inventiveness should be employed in deciding whether a pharmaceutical patent was infringed; that a physician’s expertise should be used to resolve conflicts among medically trained witnesses in a malpractice suit.” Rochelle Cooper Dreyfuss, *The Federal Circuit: A Case Study in Specialized Courts*, 64 N.Y.U. L. REV. 1, 2 (1989) (discussing Judge Learned Hand’s dicta in *Parke-Davis & Co. v. H.K. Mulford Co.*, 189 F. 95, 115 (S.D.N.Y. 1911)).

In Germany, where the national spirit eagerly seeks for all the assistance it can get from the whole range of human knowledge, they do quite differently. The court summons technical judges to whom technical questions are submitted and who can intelligently pass upon the issues without blindly groping among testimony upon matters wholly out of their ken. How long we shall continue to blunder along without the aid of unpartisan and authoritative scientific assistance in the administration of justice, no one knows; but all fair persons not conventionalized by provincial legal habits of mind ought, I should think, unite to effect some such advance.

*Parke-Davis & Co.*, 189 F. at 115.

169. Lang, *supra* note 13, at 310 (stating “specialization allows for reliance on judicial expertise, which can expedite the decisionmaking process and thereby increase efficiency”).

170. *See id.* (arguing predictability in the law will help foster a stronger doctor-patient relationship, lower the frequency of defensive medicine, and eventually reduce the cost of healthcare).

171. In New Jersey, the proposed legislation suggested the creation of a court to handle:

a. any action for injury against a health care provider based on professional negligence . . . b. any action concerning disputes surrounding medical malpractice liability insurance . . . c. medical malpractice disputes where the parties have agreed in writing that the Special Medical Malpractice Part shall have jurisdiction; and . . . any other matters as may be provided by statute.

Assemb. B. 1972, 211th Leg., Reg. Sess. (N.J. 2004); *see* H.R. 1199, 187th Gen. Assem., Reg. Sess. (Pa. 2003) (proposing the creation of a medical claims court along with other limitations on

designed to foster such specialized courts.<sup>172</sup> The intent of the bill was to award grants to states that considered alternative forms of tort reform, including specialized courts.<sup>173</sup> However, neither the state proposals, nor the federal incentives passed their respective legislative bodies during the 2004 sessions.

The theory behind specialized courts has little direct impact on the goal of medical malpractice reform and the twin objectives of tort law. As for stabilizing the combined ratio, recall that the defense costs associated with each medical malpractice suit are estimated to be 40 percent of the total medical malpractice policy expenses.<sup>174</sup> While specialized courts theoretically should lower defense costs as a result of efficient and expeditious proceedings, these courts do not limit the total number of illegitimate suits filed—specialized courts have no mechanism to weed out the 67.7 percent of suits that are dismissed or dropped without payout. To lower the combined ratio, any tort reform must limit the total number of suits, and by implication of tort law's redressability objective, the reform must limit only the frivolous suits. Specialized courts, like arbitration panels, do nothing to limit the filing of unmeritorious suits. Even a specialized judge will be constrained by the rules of civil procedure and will only be able to dismiss those cases that meet the standards for dismissal and summary judgment. At best, like arbitration panels, specialized courts may affect deterrence by increasing the legitimacy of the tort system in the eyes of physicians so as to create a stronger cause and effect relationship between negligent acts and payouts.

### *E. Certificates of Merit*

Professor Nathanson identified certificates of merit as the current tort reform tactic with the most direct impact on the combined ratio because of their ability to reduce the number of unmeritorious cases filed in state courts.<sup>175</sup> A certificate of merit verifies that a plaintiff has a genuine cause of action. Plaintiffs who have already

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recovery for medical malpractice injuries); S.B. 3040, 93d Gen. Assem., Reg. Sess. (III. 2004) (suggesting the creation of appellate level courts to handle all medical malpractice appeals).

172. See S. 1518, 108th Cong. (2003) (stating the intended purpose of the bill was "to restore reliability to the medical justice system by fostering alternatives to current medical tort litigation").

173. See *id.* (dictating that grant money will be available to states that attempt to implement one of three proposed alternatives, including the creation of a "special health care court").

174. Nathanson, *supra* note 11, at 1091.

175. *Id.* at 1119 (asserting that certificates of merit reduce the number of unmeritorious claims filed and that "the most effective mode of reform will necessarily be the one that effectively reduces the percentage of meritless claims filed").

filed or, in some states, who are about to file a medical malpractice claim, must present the court with such a certificate, or an affidavit from a medical expert, stating that the plaintiff has a legitimate claim.<sup>176</sup> Failure to file a certificate requires dismissal.<sup>177</sup>

The notable gap in this procedure is the reality of the professional witness—a medically trained expert who no longer practices medicine and only testifies as an expert in exchange for a fee.<sup>178</sup> Illinois, however, solved this inherent problem by increasing the requirements to serve as a medical expert for the purpose of filing the certificate.<sup>179</sup> The Illinois statute requires the court to “consider” both the amount of time the expert witness spends annually practicing or teaching medicine and how closely related the expert’s area of medical practice is to the defendant’s practice.<sup>180</sup> Maryland takes an alternate approach, requiring that any medical expert testifying in a medical malpractice suit not have spent more than 20 percent of her time each year giving personal injury litigation testimony.<sup>181</sup>

Provided that the gap identified above regarding who can serve as the affiant-expert is filled with other legislative devices, certificates of merit should reduce the combined ratio. By requiring a medical expert to certify the reasonableness of a claim before or shortly after filing, insurers arguably should be able to reduce the combined ratio through a decrease in the frequency of claims maintained against physicians. Following the imposition of the state’s certificate of merit requirement, Maryland experienced a 36 percent decrease in medical malpractice claims.<sup>182</sup> While the statistical decrease does not indicate whether the claims that were not filed in the years subsequent to the

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176. See, e.g., DEL. CODE ANN. tit. 18, § 6853 (2006):

No healthcare negligence lawsuit shall be filed in this State unless the complaint is accompanied by: (1) An affidavit of merit as to each defendant signed by an expert witness . . . stating that there are reasonable grounds to believe that there has been healthcare medical negligence committed by each defendant.

177. *Id.* (requiring the clerk to refuse acceptance of a medical malpractice complaint if unaccompanied by a certificate of merit).

178. See Ira H. Leesfield, *Picking and Picking Apart Experts and Perfecting Discovery*, 2004 ATLA-CLE 27 (discussing tactics for discrediting an expert by portraying him as a “professional expert”). See generally *In re Silica Prods. Liab. Litig.*, 398 F.Supp.2d 563 (S.D. Tex. 2005) (outlining within the contexts of silica litigation the conflicts that arise even among physicians when serving as hired expert witnesses).

179. See 735 ILL. COMP. STAT. ANN. 5/8-2501 (2006) (requiring the court to look at several factors prior to accepting a witness as a medical expert).

180. *Id.*

181. See MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-04(b)(4) (2006) (stating “the attesting expert may not devote annually more than 20 percent of the expert’s professional activities to activities that directly involve testimony in personal injury claims”).

182. Terry L. Trimble, *Recent Developments in the Maryland General Assembly*, 55 MD. L. REV. 847, 907 (1996).

certification requirement were meritorious, arguably, the 36 percent decrease may be reflection of the 67.7 percent of medical malpractice cases that are dropped or dismissed annually without payment. To the insurer, it should not matter how the combined ratio is reduced—whether through a reduction in payouts or a reduction in defense costs. Additionally, from a business perspective there are undoubtedly unmeritorious cases that are settled at the level of anticipated defense costs just for the sake of certainty. Certification requirements should reduce this form of payout as well.

With regards to increases in patient safety, certificates of merit should create an additional amount of deterrence similar to arbitration/screening panels or specialized courts. That is, while there is no additional independent component of certificates of merit deterring physician error, the knowledge that a case cannot be maintained without a colleague certifying the reasonable probability of negligence should add credibility to the medical malpractice tort system. And finally, patients with legitimate injuries will be able to recover fully, through both economic and non-economic damages.

#### IV. A PROPOSAL TO AVOID MEDICAL MALPRACTICE INSURANCE CRISES

Two changes to the current state of the law will help achieve the goal of medical malpractice reform without offending the twin objectives of tort law.<sup>183</sup> First, implementing a certificate of merit requirement coupled with strict restrictions on who can serve as the certifying expert will eliminate truly frivolous claims. Second, by redefining how the “standard of care” is proven at trial, juries will confront a less complicated task when rendering a verdict, which should result in increased accuracy and predictability in verdicts.

##### *A. Certificates of Merit*

As examined above, certificates of merit actually limit the number of frivolous medical malpractice suits filed and, arguably,

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183. As mentioned previously, the subject matter to be discussed in this Note is designed to focus on solutions to medical malpractice insurance crises that fall within the realm of the legal profession. The proposals below are confined to that arena. However, it should be noted that in the alternative, medical malpractice premiums could be partially stabilized through further regulations of the insurance industry, specifically through measures designed to keep the combined ratio at or near 100 even in times of economic prosperity. Similarly, as was demonstrated above, medical malpractice insurance crises are affected by the presence of a large amount of medical error. Thus, an additional mechanism through which to stabilize medical malpractice premiums would be to reduce the rate of medical error. While the remainder of the Note will focus on reforming the legal relationship between doctors and patients, future reforms should take into account the roles of these two major players—the insurers and the physicians.

exclude *only* the frivolous suits.<sup>184</sup> The two concerns with certificates of merits can be addressed independently. First, it has been argued that certificates of merit restrict plaintiffs' access to the courts. Second, some claim that a certificate of merit requirement alone can be easily manipulated through the use of professional expert witnesses.

Critics have argued that certificates of merit restrict access to the courts through filing deadlines and costs of the certifying expert. The filing deadline concern is easily resolved by providing a sufficient amount of time to allow for the certificates to be issued. In all tort litigation, plaintiffs often find themselves rushing to file suit prior to the expiration of the statute of limitations. To allow plaintiffs an adequate opportunity to sue, a reasonable window of time must be granted between the filing of the suit and the requirement for the certificate of merit. Of the states that currently require certificates of merit, the window between filing the claim and filing the certificate varies widely. Some states, like Delaware, require the certificate to be filed at the same time as the complaint.<sup>185</sup> New Jersey, on the other hand, requires the certificate of merit to be filed within sixty days of the defendant's answer to the complaint.<sup>186</sup> While some states have implemented rather complex certification processes, an uncomplicated certification window between the filing of the suit and the filing of the certificate is more appropriate.

In order to most effectively reduce the combined ratio, it is important that the certification process not require action on the part of the defendant. Specifically, certification is designed to reduce the combined ratio by decreasing defense costs, a result which follows from identifying frivolous litigation at an early stage. If the defendant is required to make a filing prior to certification, then some amount of defense cost will be incurred. Instead, the defendant should be free from legal obligation until after the certification of the suit. Therefore, the proposed legal reform should (1) require filing of the suit within the current statute of limitations; (2) provide a sufficient window between filing suit and certifying the case as meritorious; and (3) not

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184. See Nathanson, *supra* note 11, at 1111 (emphasizing the thirty-six percent decrease in medical malpractice suits in Maryland following the passage of its certificate of merit requirement). Again, it should be noted that there is no indication in the available research as to whether or not the suits being deterred are considered to be "frivolous" or "meritorious." Arguably, a sufficient system with checks will ensure that meritorious suits are not eliminated through this process.

185. DEL. CODE ANN. tit. 18, § 6853 (2006). However, an exception can be made which will grant up to a sixty day extension. *Id.*

186. N.J. STAT. ANN. § 2A:53A-27 (West 2006).

require the defendant to take any action—including filing an answer—until a reasonable time after the certification.

As for the latter concern regarding the cost of the certifying expert, when compared to the current requirements for proving a medical malpractice claim, a certificate of merit places no additional burden on the plaintiff. Currently, plaintiffs must prove the standard of care through the use of expert testimony.<sup>187</sup> To require the plaintiff to obtain that expert at an early stage in the pretrial proceedings shifts only the time frame of this expense; it neither alters the need to undergo this burden, nor creates an additional expense.<sup>188</sup> Additionally, the second part of this proposal—using court appointed experts to define the standard of care—will further reduce the plaintiffs' expenses for expert witnesses.

Certificates of merit alone are insufficient unless coupled with strict requirements dictating who can serve as a certifying expert. As discussed above, Illinois and Maryland have developed processes to regulate who may certify cases.<sup>189</sup> While Maryland places a hard requirement on the expert, insisting that he spend no more than 20 percent of his professional time testifying,<sup>190</sup> Illinois arguably has a looser standard requiring the court only to consider four factors when making its determination.<sup>191</sup> If the goal is indeed to eliminate

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187. 61 Am. Jur. 2d *Physicians, Surgeons, and Other Healers* § 307:

[A] plaintiff claiming medical malpractice has not only the burden of proving that the treatment complained of was negligent and that such negligence was the proximate cause of the injury, but also the burden of establishing by expert medical testimony that the act or omission of the accused physician fell below the community standard of care.

188. See Nathanson, *supra* note 11, at 1116 (discussing court decisions affirming the use of certificates of merit as constitutional in several states, e.g., *DeLuna v. St. Elizabeth's Hosp.*, 588 N.E.2d 1139, 1145 (Ill. 1992); *Lindberg v. Hosp. Corp. of Am.*, 545 So. 2d 1384 (Fla. Dist. Ct. App. 1989); and *Pearlstein v. Malunney*, 500 So. 2d 585 (Fla. Dist. Ct. App. 1986)). Arguably, expert testimony is not needed in cases that only settle. Therefore, considering the high volume of settlements in medical malpractice cases, the retaining of an expert at an early stage in the litigation may be an additional expense in some cases. However, since there is no constitutional guarantee to settlement, only a guarantee of access to the courts, there is little merit in the argument that an alteration of the time period within which to retain an expert offends the Constitution.

189. 735 ILL. COMP. STAT. ANN. 5/8-2501 (2006) (limiting expert testimony based on several factors including time spent annually practicing medicine); MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-04(b)(4) (2006) (limiting expert testimony based on total amount of time proposed expert annually spent testifying in personal injury trials).

190. MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-04(b)(4) (2006).

191. In Illinois, the court is required to consider:

(a) Whether the witness is board certified or board eligible, or has completed a residency, in the same or substantially similar medical specialties as the defendant and is otherwise qualified by significant experience with the standard of care, methods, procedures, and treatments relevant to the allegations against the defendant; (b) Whether the witness has devoted a majority of his or her work time to

frivolous suits, a strict standard similar to Maryland's should be applied; flexibility creates the opportunity for abuse. However, a strict requirement does not necessarily mean that the standard must be tied to the amount of time spent testifying. Arguably, the more important factors when evaluating an expert are (1) the amount of time spent annually practicing or teaching medicine and (2) the correlation between the specialty or field of the defendant and the specialty or field of the expert.<sup>192</sup> An ideal statute would incorporate both the Illinois statute's requirements for the certifying expert and the Maryland statute's strict requirement that those elements be present.

Applying the certificate of merit requirement will achieve the goal of tort reform without offending the twin objectives of tort law. Certificates of merit will reduce the combined ratio—not through a decrease in payouts but through a decrease in defense costs. By reducing the combined ratio through decreases in defense costs, certificates of merit have an inherent advantage over caps on damages—legitimately injured plaintiffs can recover fully from their injuries, both economic and non-economic. The only plaintiffs affected by the certificate of merit will be those with illegitimate claims. The sole difference felt by the legitimate medical malpractice plaintiff would be a shift in the time period when the medical expert is retained.

While certificates of merit will do nothing directly to increase the quality of health care through greater deterrence of physician error, indirectly, the quality of health care should improve. If physicians are aware that in order to file a malpractice suit, a plaintiff must obtain certification by a member of the medical community who practices in the physician's specialty and who is not a professional expert, physicians will be able to practice less defensive medicine and will have an additional incentive to ensure that patient care is within the acceptable standard of care. Currently, physicians perceive the process of medical malpractice litigation as a wheel of fortune—regardless of the level of care given, any physician can be held liable

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the practice of medicine, teaching or University based research in relation to the medical care and type of treatment at issue which gave rise to the medical problem of which the plaintiff complains; (c) Whether the witness is licensed in the same profession with the same class of license as the defendant if the defendant is an individual; and (d) Whether, in the case against a nonspecialist, the witness can demonstrate a sufficient familiarity with the standard of care practiced in this State.

735 ILL. COMP. STAT. ANN. 5/8-2501 (2006).

192. To define what a "sufficiently close" field may be, legislators may want to look to the sub-classing of specialties currently used within the medical community.

for an adverse event.<sup>193</sup> By legitimizing the tort system in the minds of the physicians, medical malpractice can achieve a greater level of deterrence.

### *B. Court Appointed Experts to Define the Standard of Care*

The modern malpractice suit requires expert testimony to prove the standard of care and allows plaintiffs to recover only by proving that the defendant deviated from that standard.<sup>194</sup> Because the standard of care is defined by medical experts, the duty owed to patients is repeatedly defined by the medical community itself.<sup>195</sup> Previously, the standard of care was defined using the locality rule—the appropriate standard of care was determined by the standard of care within the defendant's community.<sup>196</sup> However, as technology increased, geographical considerations were eliminated; starting with *Hall v. Hilburn*<sup>197</sup> there has been a move towards a national standard of care.<sup>198</sup> While it would be nearly impossible for a medical association or a state to put together a checklist or a series of guidelines for what constitutes the national standard of care for every complication that arises, the current use of the dueling experts is not the best manner by which to prove the standard of care.

Currently, courts may be asking too much of the medical malpractice jury. The jury must consider competing medical expert testimony regarding the standard of care; it must understand the complex nature of medicine and the human body; it must determine which of the experts is the most credible; and it must compare the actions of the defendant to one of the two, or, more realistically, several, expert opinions. Arguably, this task is too complicated for the average juror.<sup>199</sup>

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193. See Tan, *supra* note 166, at 256–57 (discussing the extent to which doctors are adopting a “defensive posture towards their patients”).

194. See 61 Am. Jur. 2d *Physicians, Surgeons, and Other Healers* § 287 (stating that proving the “standard of medical care” through expert testimony is an essential element of a medical malpractice claim).

195. See Amy Jurevic Sokol & Christopher J. Molzen, *The Changing Standard of Care in Medicine*, 23 J. Legal Med. 449, 472 (2002) (asserting that tort law has always deferred to the medical community to define its own degree of duty).

196. *Id.* at 474.

197. 466 So. 2d 856 (Miss. 1985).

198. See Sokol, *supra* note 195, at 474 (asserting that the *Hall* court replaced the locality rule in favor of a national standard because it “recognized that technology had altered forever medical knowledge and training”).

199. The average juror has only a high school education. See Alan Feigenbaum, Note, *Special Juries: Detering Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV.

While the standard of care is supposed to be an objective standard against which the jurors are to measure the defendant's actions,<sup>200</sup> in reality, it is anything but objective. The method of dueling experts itself runs counter to the theory that there is an objective standard of care. If the standard of care were truly "objective," both the plaintiff and defense experts would identify an identical standard of care.

The Federal Rules of Evidence, along with most states' rules of evidence, allow courts to impanel their own experts.<sup>201</sup> In relation to ordinary negligence cases, the standard of care in medical malpractice cases functions as the duty element—an element traditionally determined by the court, not the jury.<sup>202</sup> From a pretrial standpoint, the use of court-appointed experts would allow the court to determine the standard of care and, when the conduct of the defendant-physician is not in dispute, the court would have the opportunity to grant motions of summary judgment. Rather than allow for a duel between experts in the presence of the jury, courts should employ a single medical expert, appointed by the court, for the purpose of conveying the standard of care. Though the duty owed may still be an arguable point, it should be handled like a pretrial argument, or more realistically like jury instructions. Just as the court informs the jury of the applicable standard of law to apply to a case, so too should the court, via the court appointed medical expert, inform the jury of the applicable standard of care to be applied.

The primary critique of this proposal is the feasibility of its application. As discussed above, medical malpractice has a long history in the United States, and the process of proving medical malpractice has been well established. In some states, the process of the dueling experts has been codified by state statute. In the states where proving medical malpractice is based in common law doctrine alone, the switch to a single court-appointed expert can be found wholly in the discretion of the court. Additionally, it is arguable that

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1361, 1392 (2003) (citing Dan Drazan, *The Case for Special Juries in Toxic Tort Litigation*, 72 JUDICATURE 292, 295 (1989)).

200. See O'Connell, *supra* note 79, at 381 (noting that physicians are not held strictly liable for negative outcomes; instead, their actions are compared to an "objective" standard of care).

201. See FED. R. EVID. 706 (2006) (stating "[t]he court may on its own motion . . . enter an order to show cause why expert witnesses should not be appointed" and the court "may appoint expert witnesses of its own selection"); see, e.g., CAL. EVID. CODE § 460 (West 2006) (iterating "[w]here the advice of persons learned in the subject matter is required in order to enable the court to take judicial notice of a matter, the court on its own motion or on motion of any party may appoint one or more such persons to provide such advice").

202. See John C.P. Goldberg & Benjamin C. Zipursky, *The Moral of MacPherson*, 146 U. PA. L. REV. 1733, 1745 (1998) (suggesting a relational conception of duty that will "more adequately explain the courts' institutional role in deciding duty questions").

after *Daubert v. Merrell-Dow Pharmaceuticals, Inc.*,<sup>203</sup> courts, or at least federal courts, implicitly already have the power to appoint court appointed medical malpractice experts through their “gatekeeping” function. *Daubert* altered the landscape regarding expert testimony and effectively transformed judges’ roles from passive referees to active players in the admission of expert testimony.<sup>204</sup> Judges are now required to screen expert testimony before it is delivered to the jury.<sup>205</sup>

In a post-*Daubert* world, judges, upon a motion for summary judgment, effectively have the ability to impanel a court appointed expert and to consider that expert’s opinion conclusive regarding the admissibility of the parties’ expert witnesses. For example, in a medical malpractice case, after the plaintiff files her complaint, the defense can move for summary judgment, arguing that the plaintiff will be unable to prove that the defendant breached the standard of care. It is likely that the defense will also submit an affidavit from its expert witness(es) identifying the defense’s version of the standard of care.<sup>206</sup> The plaintiff, in response, will introduce evidence showing that the physician did, in fact, deviate from the standard of care; because the plaintiff will likely disagree with the defense’s version of the applicable standard of care, the plaintiff will introduce expert testimony of her own.<sup>207</sup> Under *Daubert*, the court then has the duty to determine whether either of the expert testimonies will be admissible in court.<sup>208</sup> If the court finds that the plaintiff’s expert testimony is inadmissible and if there is no question of fact regarding the actions of the defendant, then the court should grant the motion for summary judgment.

The court appointed expert proposal, from a pretrial standpoint, takes an efficiency-based approach to cut through the probable, if not inevitable, battle between the parties. Rather than requiring both parties to retain their own experts and share the additional expense of a court-appointed expert, this proposal allows the court to employ the court appointed expert from the start.

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203. 509 U.S. 579 (1993).

204. See *id.* at 589 (“[T]he trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable.”); see also *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 147–48 (1999) (stating that the *Daubert* gatekeeping requirement applies to all expert testimony).

205. *Daubert*, 509 U.S. at 589

206. See *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986) (stating that the moving party needs to present additional evidence supporting the motion for summary judgment).

207. See *id.* at 324 (requiring the non-moving party to present evidence beyond the pleadings to defeat the motion for summary judgment).

208. See *id.* at 324 (stating that the evidence produced by the non-moving party need not necessarily be evidence admissible at trial).

Admittedly, this proposal would only allow for the court to dismiss truly frivolous claims. That is, on summary judgment, the complaint and supporting materials would be read in the light most favorable to the non-moving party, here the plaintiff.<sup>209</sup> If the court-appointed expert returns with an opinion that is not definitive in favor of the defense, then the case would have to go forward. Returning to the ultimate goal, this proposal is designed to reduce the combined ratio by eliminating only the frivolous claims, not the meritorious ones. The use of court appointed experts would achieve this ultimate goal by reducing the actual number of cases, while at the same time preserving all colorable claims for the possibility of full adjudication.

Similarly, from a jury trial perspective, *Daubert* has already empowered the court to use court-appointed experts in such a manner. Critics of the breadth of *Daubert* have argued that by cloaking an expert with the title of “court-appointed expert,” the jury will overvalue his testimony.<sup>210</sup> Assuming this critique to be correct, when a court employs a court-appointed expert to testify at trial, the court essentially dictates the standard of care to the jury, removing the subjective argument between the parties’ expert witnesses. The strength of the proposal thus is efficiency-based. If the court-appointed expert’s testimony will be treated by the jury as conclusive on the issue of the standard of care, why go through the additional time and expense of allowing the dueling experts to testify?

With this proposal, there may end up being variations between courts as to the standard of care. However, those variations can be limited in the same manner as the proposed certificate of merit requirements. Just as plaintiffs will be limited as to who can serve as the expert for the purposes of certifying the suits, so too should the courts be limited in the experts who will dictate the standard of care.<sup>211</sup>

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209. *United States v. Diebold*, 369 U.S. 654, 655 (1962) (defining the standard for summary judgment: “[o]n summary judgment the inferences to be drawn from the underlying facts contained in such materials must be viewed in the light most favorable to the party opposing the motion”).

210. Ellen Relkin, *Some Implications of Daubert and Its Potential for Misuse: Misapplication to Environmental Tort Cases and Abuse of Rule 706(a) Court-Appointed Experts*, 15 CARDOZO L. REV. 2255, 2256–57 (1994) (stating “the mere selection of a court-appointed expert will, in most cases, become outcome determinative”).

211. The main concern here is that many state trial judges are elected; inherent in elections is a need to fundraise. The standard of care should be something consistent for all parties regardless of political contribution. Though an elected judiciary is a larger issue to be set aside for another day, an immediate fix to the problem is to restrict the courts’ freedom in selection of experts. See James A. Gardner, *A Post Veith Strategy for Litigating Partisan Gerrymandering Claims*, 3 ELECTION L. J. 643, 651–52 (2004) (discussing the limitations on elected judges as a result of political affiliation and other reasons that restrain independence).

The use of court-appointed experts to determine the standard of care should decrease the combined ratio. Suits that are properly certified only show that there is a *reasonable belief* that medical malpractice caused the alleged injury. The court appointed expert at the pretrial phase will act as a second filter, removing any frivolous suits that make it through the certification stage by articulating a standard of care for the court. If there is no question of fact regarding the defendant's actions and if the court has a single standard of care against which to compare those actions, then motions for summary judgment will further reduce the number of unmeritorious suits. Additionally, the court-appointed experts would set out a single standard of care thus preventing any unqualified decisions regarding such standards on the part of the jury. Finally, and most importantly, the combined ratio will be reduced by freeing the defense from the financial burden of providing an expert witness for trial.<sup>212</sup> Also, a greater level of consistency in the determination of the standard of care should lead to a greater amount of predictability<sup>213</sup> and thus more informed decisions as to whether to settle or proceed to trial.

Again, as with the certificates of merit, physicians' awareness that non-biased members of their own profession will define the standard of care may legitimize the medical malpractice litigation system in the eyes of the physicians. Physicians would no longer be able to claim that the plaintiffs' bar will "spin" the issues to serve its own purposes; instead, physicians will answer almost exclusively to qualified peers.

Finally, patients with legitimate claims will not suffer as a result of the change in the manner through which the standard of care is defined. If anything, the plaintiffs' bar will save money if it does not have to incur the cost of the medical experts necessary to prove the standard of care. Removing the system of the dueling expert only affects unmeritorious suits; plaintiffs will still have the opportunity to prove breach. The only substantive change regards how the duty is defined.

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212. However, the state may need to pass on some of the cost associated with employing the medical expert to the parties involved in the suit. See FED. R. EVID. 706(b) (2006) (noting that "[i]n other civil actions and proceedings the compensation shall be paid by the parties in such proportion and at such time as the court directs").

213. See Tom Baker, Alon Harel & Tamar Kugler, *The Virtues of Uncertainty in Law: An Experimental Approach*, 89 IOWA L. REV. 443, 487 (2004) ("Varying the certainty of the size of the sanction or of the probability that it will be imposed also affects the deterrence value of the sanctioning system.").

## V. CONCLUSION

Though the most recent medical malpractice insurance crisis is coming to a close, the importance of resolving this crisis and deterring future crises persists. The time is now to craft workable solutions to these cyclical medical malpractice insurance crises. However, before rushing into politically popular reforms which may not achieve the goals of the reform and which may undercut the reasons for imposing liability in the first place, it is essential that those effecting change understand the factors that lead to such crises and realize that the possible solutions are not constrained by the precedent.

The cyclical crises that have swept the medical community are medical malpractice *insurance* crises, not necessarily medical malpractice *litigation* crises. Regardless of one's individual political beliefs, the burden being placed on physicians in this country must be appreciated; double and triple digit spikes in premiums are unacceptable in a profession upon which everyone so heavily relies.

Of the three parties involved in the current medical malpractice debate—the doctors, the plaintiffs' lawyers, and the insurance companies—each is both partially right and partially wrong. While each of these parties is doing something wrong—harboring apathy for medical errors, filing unmeritorious suits, lowering premiums during times of prosperity to encourage growth—each of these professions is correct in their arguments: doctors should not be forced out of the profession or feel obligated to practice defensive medicine due to increased payouts and the frequency of medical malpractice claims; the plaintiffs' bar should be allowed to recover the total amount of damages owed to plaintiffs in the wake of an injury caused by professional negligence; and insurers should be able to turn a profit on their insurance lines. If all parties maintain the position that their point of view is "correct" and that other parties must succumb to their position, all three professions will be subjected to future crises.

Non-economic damage caps are not the solution to medical malpractice insurance crises. Statistics show that caps on non-economic damages alone do not reduce medical malpractice insurance premiums. The fact of the matter is that non-economic damages awards in excess of the proposed federal cap are awarded so very infrequently that the proposed goal of caps—reducing premiums—will never be realized. Rather than apply this one-size-fits-all solution to a problem the source of which has not yet been identified completely, legislators should look for alternative solutions that will reduce premiums, while not disadvantaging negligently injured plaintiffs.

While the proposed remedies may be criticized from all sides, these proposals present important alternatives that logically impact the combined ratio, increase deterrence of medical error, and maintain the ability of negligently injured plaintiffs to recover fully. Whether legislative decisionmaking gravitates towards the proposed reforms herein or any other tactic for reform, it is essential that legislators focus on these three criteria: how the reform will affect the combined ratio, whether the reform will increase the quality of healthcare through deterrence of medical error, and whether the reform affects the ability of potential plaintiffs to recover fully for their injuries.

Finally, the proposed solutions—certificates of merit and court appointed experts to define the standard of care—are less drastic reforms than non-economic damage caps and may actually achieve the goal of medical malpractice reform, and not undermine the twin objectives of tort law. The use of certificates of merit and court appointed experts will reduce defense costs by decreasing the expenses associated with expert testimony and by providing additional opportunities for the court to filter out frivolous claims. At the same time, the proposed solutions may increase deterrence of medical error by legitimizing the medical malpractice system in the minds of physicians. Most importantly though, plaintiffs who are injured by breaches of the standard of care will be able to recover for all of their injuries.

*Kyle Miller\**

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\* I would like to thank Professor John C.P. Goldberg for his assistance while I was formulating the topic of this Note. Additionally, I would like to thank the members of the Vanderbilt Law Review, and specifically, I want to thank Christopher Champion, Allison Gruenwald, and Elise O'Connell for their diligent editing and thoughtful comments.

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