Executive Summary
Backgrounder
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Code Blue: The Case for Serious State Medical Liability Reform

Randolph W. Pate, J.D., M.P.H., and Derek Hunter

In many states, a medical liability crisis is prompting physicians to scale back their practices or shut their doors entirely. As a result, patients are losing access to vital health services and must travel farther and wait longer to receive needed care. For the many doctors and millions of their patients who are concerned about access to quality medical care, serious relief will come only from smart and innovative state-based reforms.

The High Price of Inaction. The rising cost of liability insurance and the state laws that govern medical malpractice are jeopardizing patient access to care in many states, especially in rural areas. The high price of practicing medicine is forcing a growing number of physicians to limit their areas of practice, retire early, or move their practices to other states. It also encourages defensive medicine practices in which a doctor departs from doing what is best for the patient because of the fear of lawsuits.

What State Lawmakers Can Do. Each state should address the medical malpractice crisis in a way that reflects its particular circumstances. State legislators have a menu of reform options from which to select those that would work best in their respective states.

- **Early offer.** Early offer allows quick recovery of economic losses associated with an injury, including lawyers' fees. It is intended to provide a strong motivation to settle claims quickly without the typical years of delay in the courts. With the disposition of medical injury claims soon after they have been discovered, more doctors would feel free to share information about bad outcomes and openly discuss ways to avoid them in the future.
- **Patient indemnity insurance.** Patient indemnity insurance is a new category of insurance that could benefit both doctors and patients. It would allow patients to purchase coverage for adverse medical events, much as people can purchase insurance against unlikely events like airline disasters.
- **Special health courts.** Health court proposals have received bipartisan support as a possible improvement on the current tort system. In a health court system, judges would receive specialized training in medical topics in addition to their legal training. While lawyers would still represent the parties at trial, judges would rely more heavily on court-appointed expert witnesses to offer unbiased testimony on the range of possible treatment options as well as clinical guidelines on the standard of care.
- **Limited liability for Medicaid, charity, and emergency care.** States could provide an alter-

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native to standard tort liability for Medicaid patients as well as for patients receiving charity or emergency care. Doctors who treat the poor *pro bono*, particularly those who care for especially difficult-to-treat patients, should get relief. The same holds true for physicians working in emergency rooms, who invariably treat patients whom they have never seen before.

- **The MICRA model.** With three decades of proven results, California's largely successful Medical Injury Compensation Reform Act (MICRA) of 1975 is a model that other states can use to craft their own medical malpractice reforms. State lawmakers can incorporate MICRA components into their legislative remedies.
- **Learning from Oregon's bad example.** In 1987, Oregon enacted a cap on non-economic damages in response to a previous malpractice crisis. By 1990, the reforms had taken hold, alleviating the crisis and helping to reduce premiums by 50 percent. However, in 1999, the Oregon Supreme Court declared the cap unconstitutional. Over the next five years, premiums skyrocketed. The Oregon example shows that effective reforms must not only restore a measure of certainty to the insurance market, but also survive constitutional muster.
- **Real competition to reduce medical errors.** While the goal of zero medical errors is perhaps unattainable, reducing the number of errors would reduce the need for medical malpractice litigation. A better health system would allow providers to compete on the basis of the quality of care that they offer, creating better value for consumers. Empowered consumers make the best regulators. In time, consumers would begin to subsidize the providers that do the best job and cut off funding for providers who underperform. In the battle to offer the best value, providers will reduce their medical error rates and improve their services.

States can encourage real competition in health care by requiring providers to use transparent pricing, rolling back insurance coverage mandates, encouraging consumer-driven insurance options like health savings accounts (HSAs), and collecting and publishing better information on health care quality and outcomes.

While reforming the system to reduce frivolous suits and make the system fairer for everyone, state legislators must be careful to protect those who have a genuine claim of malpractice. Reimbursement for out-of-pocket expenses, lost wages, and compensation for pain and suffering should be readily available, but they should also be reasonable and reserved for real cases of negligent conduct, not for simply bad medical outcomes.

Conclusion. The medical malpractice crisis in the United States must be addressed. Access to affordable care is being compromised for millions of Americans. Far too many highly skilled and caring hands can no longer afford to practice medicine, while trial lawyers are reaping the benefits of an outdated, outmoded system. States need to stop the exodus of good physicians while protecting the right of patients to seek redress for medical injuries.

While reforming the medical malpractice system will not cure all of America's health care woes, the right kind of reform could virtually eliminate the long-drawn-out lawsuits in which the biggest winners are the trial lawyers, not the parties. It could free doctors from the crush of ever-increasing liability premiums and empower patients to choose their own destinies.

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In many states, a medical liability crisis is prompting physicians to scale back their practices or shut their doors entirely. As a result, patients are losing access to vital health services and must travel farther and wait longer to receive needed care. The problem is especially acute in rural areas, where attracting health care providers is already more difficult.

For the many doctors and millions of their patients who are concerned about access to quality medical care, serious relief will come only from smart and innovative state-based reforms. When doctors quit their medical practices or move to other states to practice medicine because they can no longer afford liability insurance, Americans should begin a very serious conversation with their governors and state legislators.

State Responsibility

In the debate over medical malpractice reform, one fundamental point should not be overlooked: The states, not the federal government, should be the primary engine for reforming the medical liability system. The U.S. Constitution grants authority to Congress to pass laws within certain enumerated areas, leaving all other issues for the states to decide.[1] Over the past decade, well-intentioned federal lawmakers have made several attempts to pass medical liability legislation, but the job rightfully belongs to the states.[2]

Not only has this been the position of a handful of conservatives in Congress who have opposed federal

Talking Points

- Across the country, a medical liability crisis is prompting physicians to scale back their practices or shut their doors entirely. As a result, patients are losing access to vital health services and must travel farther and wait longer to receive needed care.
- The rising cost of liability insurance and the state laws that govern medical malpractice are jeopardizing patient access to care in many states, especially in rural areas. The high price of practicing medicine is forcing a growing number of physicians to limit their areas of practice, retire early, or move their practices to other states.
- Each state must address the medical malpractice crisis in a way that reflects its particular circumstances. State legislators can choose from a menu of reform options, including early offer, patient indemnity insurance, and special health courts.
- The best medical malpractice solutions will enhance patients' rights while curbing the system's excesses.

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tort reforms, but it was also the conclusion of the Reagan Administration. During a similar malpractice crisis in the mid-1980s, the Department of Health and Human Services issued a series of policy recommendations that included state-based tort reforms; however, the report was careful to leave the issue ultimately to the states.[3] While the federal government can play an important leadership role in facilitating and modeling malpractice reforms, it should not dictate solutions.[4]

When state tort law seriously distorts or threatens to eliminate (through bankruptcy) the market for a particular product that moves in interstate commerce, such as a critical child vaccine or an important life-saving drug, Congress may choose to exercise its express authority to "regulate Commerce…among the several States."[5] Thus, Congress may preempt one state's product liability law with a federal regulatory scheme (which it has done in part with laws on the manufacture and sale of vaccines and pharmaceutical drugs) if individual state laws might effectively end the commercial market for that product in every other state.

Nevertheless, the national government has no general authority to overrule the state tort law that is designed to provide remedies for victims of physical assaults that occur within a particular state, especially between two of its residents. Even though the state law may be quite unfair in practice, medical malpractice law falls in this latter category. As the flow of doctors out of tort "hellholes"[6] proves, and as the difference in medical malpractice insurance premiums from state to state confirms, one state's bad medical malpractice law does not directly affect the provision of medical care in other states that have better civil justice systems. Beyond the constitutional limits regarding a national response, there are significant practical advantages to state-based reform efforts.

While the latest congressional attempt to impose nationwide medical malpractice reforms appears to have stalled yet again in the Senate, states are working within their traditional and constitutional roles to solve the malpractice crisis. In 2005, over 400 malpractice reform measures were introduced in 48 state legislatures, and 27 legislatures enacted some kind of malpractice reform.[7] Over the past few years, a number of states—including Texas, Mississippi, Missouri, and Georgia—have passed major tort reform overhauls. Every state has some kind of medical malpractice reform in place.

As states work to amend and improve their malpractice systems, a heavy-handed federal approach is both unwise and unnecessary. Simply put, the malpractice problem calls for using a scalpel, not a sledgehammer. Each state should address its most critical needs in a political climate that respects traditional federal and state authority.

Tort Law Crisis

While medical malpractice laws differ from state to state, they all fall into the category of tort law. A tort is "a *wrongful* act…that results in injury to another per-

1. The Tenth Amendment to the U.S. Constitution states: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."
2. The U.S. House of Representatives has passed 10 medical liability reform bills since the Republicans took control in 1995. Jan Austin, ed., *CQ Almanac Plus 2003*, 59th ed. (Washington, D.C.: Congressional Quarterly Books, 2004), pp. 13–15. The House passed the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005 (H.R. 5) on July 29, 2005. The legislation awaits Senate action.
3. U.S. Department of Health and Human Services, *Report of the Task Force on Medical Liability and Malpractice*, August 1987.
4. See, generally, Michael I. Krauss and Robert A. Levy, "Can Tort Reform and Federalism Coexist?" Cato Institute *Policy Analysis* No. 514, April 14, 2004.
5. U.S. Constitution, Article I, § 8, Clause 3.
6. See American Tort Reform Association, "Judicial Hellholes 2005," December 13, 2005, at *www.atra.org/reports/hellholes/report.pdf* (January 6, 2006).
7. National Conference of State Legislatures, "State Medical Malpractice Reform: 2005 Numbers at a Glance," updated June 24, 2005, at *www.ncsl.org/standcomm/sclaw/medmalataglance.htm* (December 2, 2005).

son, property, reputation, or the like, and for which the injured party is entitled to compensation."[8]

Over the centuries, courts have arrived at some tried and true concepts to govern tort cases, one of which is the idea of fault.[9] Under the fault principle, people assume their own risks unless their injury is the result of someone else's faulty (i.e., wrongful, culpable, or negligent) behavior.[10] It is important to remember that not every injured person is entitled to compensation under medical malpractice law. Only those plaintiffs who can show the defendant's negligence or wrongful act should recover damages.

It has been argued that the medical malpractice system exists to compensate injured patients and punish physicians for negligent conduct.[11] Yet these goals are met neither in theory nor in practice.

The theoretical problem is simple: The legal hurdles that plaintiffs must overcome to win malpractice cases mean that, even under the best circumstances, many injured patients go uncompensated and many negligent doctors are not detected. For example, a doctor's conduct during surgery may have caused severe injury to a patient, yet the doctor's conduct may still have conformed to the applicable standard of care. In such cases, the plaintiff is unable to prove the defendant's negligence and must bear the entire burden of the injury.

On the other hand, a doctor may have been negligent, but the wrongful conduct did not result in injury. This happens in "near miss" situations, in which an error occurs but injury is avoided. Despite the doctor's negligence, tort law has no application unless someone is actually injured. If no one is hurt, the negligent doctor is not liable.

Tort law's rigidity makes it an ineffective compensation system for injured parties or watchdog for the medical profession. Today, if anyone tried to devise a system to clamp down on negligent doctors and compensate injured patients, the tort system would not be it.

When one looks at how tort law is applied in the real world, matters appear even worse. Studies have found that only 2 percent of patients injured by a physician's negligence ever file a lawsuit. Conversely, only 17 percent of suits filed appear to involve real physician negligence.[12] One commentator likens the operation of the tort system to a traffic cop who gives out more tickets to drivers who run green lights than to drivers who run red lights.[13]

In light of these apparent failings, state lawmakers need to understand what tort law is not. Tort law is not an accurate, fair, or effective tool for policing medical errors, a backup insurance policy for injured patients, a means to redistribute wealth from doctors to patients, or an avenue to attain policy goals that could not be achieved at the ballot box. Abuse of the courts to achieve these broader goals, not abuse of the tort system itself, is at the heart of the current crisis.[14]

8. *Webster's Unabridged Dictionary*, 2nd ed., s.v. "Tort" (emphasis added).
9. The present-day medical malpractice system is based on the judge-made law handed down from the old English common law courts. One English jurist recently summarized common law as "the formal statement of the results and conclusions of the common sense of mankind." Phillip K. Howard, "When Judges Won't Judge," *The Wall Street Journal*, October 22, 2003.
10. One exception to the principle of fault in tort cases occurs in certain product liability cases in which a statutory "strict liability" standard applies. In those cases in which the legislature has altered standard tort liability rules, it is not necessary for the plaintiff to prove the defendant was at fault.
11. For example, see W. Page Keeton, Dan B. Dobbs, Robert E. Keeton, and David G. Owen, eds., *Prosser and Keeton on the Law of Torts*, 5th ed. (St. Paul, Minn.: West Publishing, 1984), and David M. Studdert *et al.*, "Medical Malpractice," *The New England Journal of Medicine*, Vol. 350, No. 3 (January 15, 2004), p. 283.
12. David M. Studdert, Michelle M. Mello, and Troyen A. Brennan, "Medical Malpractice," *The New England Journal of Medicine*, Vol. 350, No. 3 (January 15, 2004), p. 285.
13. Paul C. Weiler, Howard H. Hiatt, Joseph P. Newhouse, William G. Johnson, Troyen A. Brennan, and Lucian L. Leape, *A Measure of Malpractice: Medical Injury, Malpractice Litigation and Patient Compensation* (Cambridge, Mass.: Harvard University Press, 1993).

A return to the traditional understanding of the tort system is in order. Despite its shortcomings, the tort system may be the best mechanism available for resolving disputes that are not governed by contracts between the parties. In the past, the tort system performed the admirable function of protecting the right to redress while preserving individual property rights and liberties. Rather than tackling societal problems and dealing with people as groups—which is the province of legislatures—the tort system was intended to resolve disputes between individuals.

Historically, tort law has handled the intractable disputes that cannot be resolved in any other way and has drawn the bright lines needed to allocate risks in an entrepreneurial society.[15] To understand how far the American tort system has drifted from its moorings, state lawmakers should gain a solid appreciation of the system's traditional role as a dispute resolution tool.

A Variety of Remedies

Some states have already taken a broad range of steps to reform their malpractice laws. These steps have included granting legal immunity to medical professionals under certain circumstances, such as in the delivery of emergency or charity care; imposing a statute of limitations or repose in medical malpractice suits; instituting new rules governing the qualifications and uses of expert witnesses; providing for periodic payment of large damage awards over time rather than awarding lump sums; opening up new alternatives to courtroom litigation, such as arbitration; and limiting attorney fees and non-economic damages, including pain and suffering, loss of enjoyment of life, and other damages that are difficult to estimate in dollar terms.[16]

In addition to the successful reforms already enacted by California and other states, state lawmakers should consider innovative solutions that enhance consumers' rights while increasing access to quality and affordable medical care. State officials should also explore the creation and licensing of new forms of insurance, including patient indemnity insurance. This would apply in cases in which patients have been injured but physicians cannot be construed as being at fault.

How Patients Pay the High Price of Inaction

For those who are enrolled in private health insurance, America may have the best health care system in the world. However, the rising cost of liability insurance and the state laws that govern medical malpractice are jeopardizing patient access to care in many states, especially in rural areas. The high price of practicing medicine is forcing a growing number of physicians to limit their areas of practice, retire early, or move their practices to other states. These ominous developments are damaging the financing and delivery of health care.

Reduced Access to Care. An April 2002 study by Harris Interactive found that one-third of physicians shied away from particular specialties, including high-risk specialties like neurosurgery and emergency medicine, out of fear of greater liability exposure.[17] In Las Vegas, Nevada, the only level-one trauma center (which serves four states) was forced to close in early 2002 when all of its surgeons walked off the job because they could no longer afford the cost of malpractice insurance.[18] For some doctors, malpractice insurance premiums jumped fivefold from $40,000 to $200,000 in a single year.[19] The Las Vegas walkout lasted 10

14. See Stephen B. Presser, "How Did We Get Here? What Litigation Was, What It is Now, What It Might Be," Common Good, June 27, 2005, at *cgood.org/assets/attachments/142.pdf* (December 2, 2005).
15. *Ibid.*
16. For a summary of all 50 states' medical malpractice laws, see National Conference of State Legislatures, "State Medical Malpractice Tort Laws," updated January 13, 2005, at *www.ncsl.org/standcomm/sclaw/medmaltorttable205.htm* (December 2, 2005).
17. Harris Interactive, "Fear of Litigation Study: The Impact on Medicine," Study No. 15780, April 11, 2002, at *cgood.org/assets/attachments/57.pdf* (December 2, 2005).
18. William Booth, "Las Vegas Trauma Center Closes as Doctors Quit; Surgeons Cite Rising Costs of Malpractice Insurance, Lawsuits," *The Washington Post*, July 4, 2002, p. A2.

days, until negotiators struck a deal allowing some physicians to become county employees, bringing them under the hospital's $50,000 liability cap.[20] Similar walkouts have occurred in New Jersey, West Virginia, and Florida.[21]

In 2004, the Maryland State Medical Society announced that 28.4 percent of Maryland doctors were thinking of closing their doors, selling, or retiring, and another 9.8 percent said that they might leave the state because of medical malpractice insurance premiums.[22] "The state's largest malpractice insurer had raised premiums 33 percent for [2004] and 28 percent the year before, prompting doctors to warn that it would force many of them to leave practice or leave the state."[23]

According to Michael Preston, executive director of the Maryland State Medical Society, "Even if only a fraction of these doctors chooses to leave in the coming months, you are looking at the prospect of patients having difficulty finding a doctor when and where they need, especially in emergency rooms." Doctors at Prince George's Hospital Center outside Washington, D.C., also announced that in November 2004, because of rising premiums, they would stop performing all non-emergency surgeries.[24]

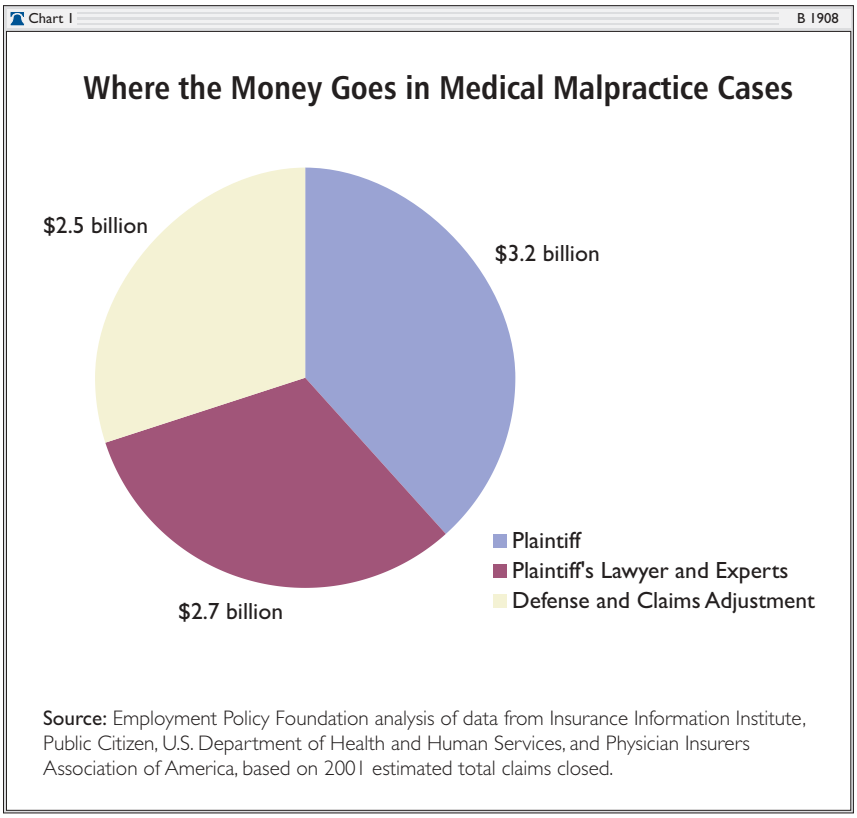
In 2005, over Republican Governor Robert L. Ehrlich's veto, the Maryland state legislature enacted legislation to impose a tax increase on health maintenance organizations (HMOs) to fund a stop-loss subsidy for doctors to help them pay for liability insurance premiums. The subsidy is an attempt to keep doctors' premiums at 2004 levels by requiring taxpayers to pay the difference for the next few years, after which the subsidy will disappear and the doctors will again pay for all premiums. Meanwhile, the American College of Emergency Physicians' *2006 National Report Card on the State of Emergency Medicine* gave Maryland's medical liability environment a grade of "F" for failing to address important malpractice concerns affecting emergency physicians.[25]

While it is difficult to pinpoint the effect of the malpractice crisis on an individual physician's decision to move or close shop, the available evidence should give patients and legislators in many states cause for alarm. For example, an August 2003 General Accounting Office report concluded, "Actions taken by health care providers in response to malpractice pressures have contributed to localized health care access problems" in a number of states, including Florida and Pennsylvania. The GAO further found that access problems tended to occur more often in rural areas, which commonly have difficulty attracting health care providers.[26] A recent study in Florida concluded that over half of the state's physicians had reduced or eliminated services, and these changes appeared to be related to increased liability premiums.[27] On the other hand, states with lower malpractice premiums tend to have more doctors per capita, including surgeons and specialists.[28]

19. "Nation in Brief," *The Washington Post*, July 14, 2002, p. A8.
20. *Ibid.*
21. William E. Encinosa and Fred J. Hellinger, "Have State Caps on Malpractice Awards Increased the Supply of Physicians?" *Health Affairs*, May 31, 2005.
22. Robert Redding Jr. and Jim McElhatton, "Maryland Faces 40 Percent Loss of Physicians," *The Washington Times*, October 6, 2004, at *washtimes.com/metro/20041006-011905-2332r.htm* (December 5, 2005).
23. M. William Salganik, "CareFirst to Pass Along HMO Tax It Pays Now," *The Baltimore Sun*, December 3, 2005, at *www.baltimoresun.com/business/bal-bz.carefirst03dec03,1,1365107,print.story* (January 9, 2006).
24. Redding and McElhatton, "Maryland Faces 40 Percent Loss of Physicians."
25. American College of Emergency Physicians, *The National Report Card on the State of Emergency Medicine: Evaluating the Environment of Emergency Care Systems State by State*, January 2006, p. 59, at *http://my.acep.org/site/DocServer/2006-NationalReportCard.pdf?docID=221* (January 10, 2006).
26. U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO–03–836, August 2003, at *www.gao.gov/new.items/d03836.pdf* (December 13, 2005). The General Accounting Office was renamed the Government Accountability Office on July 7, 2004.

State lawmakers should remember that the medical malpractice climate is an important factor in a doctor's decision on where to practice. To a large degree, it does not matter whether the lawsuits have no merit. The cost of fighting them and the high risk of an undeserved damage award at some point cause insurance premiums to skyrocket, making it nearly impossible for doctors to obtain malpractice insurance.

Furthermore, potential economic risks are only part of the climate. Repetitive litigation exacts an emotional toll from the doctor being sued and can damage the doctor's professional reputation with an undeserved damage award.



Soaring Costs. Although there is no lack of multimillion-dollar jury awards, plaintiffs who win malpractice cases see only a fraction of the amount recovered. According to the President's Council of Economic Advisers, "58 percent of tort costs go to pay for administration, claimants' attorneys' fees, and defense costs."[29] (See Chart 1.)

Injured plaintiffs receive only 28 cents on the dollar of all the money flowing into the malpractice system, including insurance premiums. The rest goes to pay overhead.[30] While trial lawyers help themselves to the lion's share of malpractice awards, the current medical malpractice system shortchanges injured plaintiffs.

Demoralized Doctors. In January 2003, physicians in West Virginia walked off the job, fearing that medical liability was limiting their ability to provide patients with high-quality care. In Pennsylvania, doctors faced premium increases of 40 percent in 2003, while specialists in Arkansas and Florida faced increases of 112 percent and 75 percent, respectively.[31]

Moreover, in addition to feeling the sting of escalating insurance premiums, doctors are increasingly harassed by the legal system itself. There is no

27. Robert G. Brooks, Nir Menachemi, Art Clawson, and Les Beitsch, "Availability of Physician Services in Florida, Revisited," *Archives of Internal Medicine*, Vol. 165, No. 18 (October 10, 2005), pp. 2136–2141.
28. Daniel P. Kessler, William M. Sage, and David J. Becker, "Impact of Malpractice Reforms on the Supply of Physician Services," *Journal of the American Medical Association*, Vol. 293, No. 21 (June 1, 2005), pp. 2618–2625.
29. Council of Economic Advisers, "Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System," April 2002, at *www.whitehouse.gov/cea/tortliabilitysystem_apr02.pdf* (December 5, 2005).
30. Employment Policy Foundation, "Medical Malpractice Litigation Raises Health Care Cost, Reduces Access and Lowers Quality of Care," *Issue Backgrounder*, June 19, 2003, at *www.epf.org/pubs/newsletters/2003/ib20030619.pdf* (December 5, 2005).
31. Press release, "President Calls for Medical Liability Reform," White House, January 16, 2003, p. 2, at *www.whitehouse.gov/news/releases/2003/01/20030116.html* (December 5, 2005).

evidence that doctors are more negligent than other people, yet they are repeatedly called into court to defend their actions and their reputations. For example, 70 percent of Maryland obstetrician-gynecologists have been sued at least once, and the average settlement is over $1 million.[32] Half of all neurosurgeons and one-sixth of all physicians are sued every year; and even though the vast majority of claims against doctors (at least 70 percent) end in no payment to the plaintiff, defending a claim, whether or not the claim has merit, costs doctors and insurers an average of nearly $23,000.[33] As a result, many doctors decide to stop performing lawsuit-prone procedures (e.g., delivering babies) or limit their practices to seeing low-risk patients. Charity care necessarily suffers because it involves a high relative risk of a lawsuit.

Widespread Defensive Medicine. The Congressional Budget Office estimates that malpractice costs account for less than 2 percent of total health care spending in the United States.[34] However, that estimate does not include the cost of "defensive medicine" resulting from the fear of litigation.

Simply stated, defensive medicine occurs when, because of the fear of lawsuits, a doctor departs from doing what is best for the patient. There are two types of defensive medicine: positive and negative. Positive defensive medicine means ordering more tests or providing more treatment than necessary. Negative defensive medicine means providing less care than needed, refusing to treat high-risk cases, or passing them off to other providers because of liability fears.

Both types of defensive medicine harm patients because the fear of being sued, not the best interests of the patient, is the main motivator. Defensive medicine is especially harmful when doctors perform unnecessary tests that are painful or risky (e.g., unneeded breast biopsies) or when they turn away a patient with a complex medical condition to avoid possible liability for a bad outcome.

Defensive medicine is a pervasive problem in today's litigious climate. A recent study of over 800 Pennsylvania physicians in high-risk specialties found that 93 percent admitted to practicing some sort of defensive medicine.[35] A nationwide survey of 300 physicians reported that 79 percent had personally ordered more tests than necessary, while 91 percent reported seeing other physicians order such tests. Fear of litigation also causes physicians to refer patients to specialists (74 percent), prescribe medications such as antibiotics (41 percent), and suggest biopsies or other invasive procedures (51 percent) more frequently than their professional judgment would otherwise have suggested if they were not in fear of litigation.[36] The same survey found that 94 percent of physicians, 79 percent of nurses, and 88 percent of hospital administrators thought that defensive medicine contributed "in a significant way to health care costs."

While defensive medicine and its human and financial costs are very real, it is difficult to place a price tag on the phenomenon. Studies have found ample evidence of its existence, but very little literature addresses its true costs.[37] A recent exception is the work of Professor Christopher Conover of

32. Robert Redding Jr., "Most OB-GYNs Sued at Least Once; Settlements Costly," *The Washington Times*, December 12, 2004, p. A9, at *www.washingtontimes.com/metro/20041211-114116-5399r.htm* (December 5, 2005).
33. Richard E. Anderson, M.D., "Defending the Practice of Medicine," *Archives of Internal Medicine*, Vol. 164, No. 11 (June 14, 2004), p. 1174.
34. Congressional Budget Office, "Limiting Tort Liability for Medical Malpractice," *Economic and Budget Issue Brief*, January 8, 2004, at *www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf* (December 5, 2005).
35. David M. Studdert, Michelle M. Mello, William M. Sage, Catherine M. DesRoches, Jordon Peugh, Kinga Zapert, and Troyen A. Brennan, "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment," *Journal of the American Medical Association*, Vol. 293, No. 21 (June 1, 2005), pp. 2609–2617.
36. Harris Interactive, "Fear of Litigation Study."
37. For a discussion of defensive medicine and its potential costs to the health care system, see Joint Economic Committee, U.S. Congress, *Liability for Medical Malpractice: Issues and Evidence*, May 2003, at *www.house.gov/jec/tort/05-06-03.pdf* (December 5, 2005).

Duke University. In his cost-benefit study of regulation in the health care sector, Professor Conover estimated that "the medical tort system imposes costs of $113.7 billion (of which roughly $70 billion represents defensive medicine) but provides benefits amounting to $33 billion," reflecting a net loss to society of $80.7 billion a year.[38]

How State Medical Liability Solutions Differ

Not all states face a medical malpractice crisis.[39] Several states have addressed the runaway cost of malpractice insurance by reforming their tort laws. By limiting the size of jury awards to reasonable amounts, they have discouraged frivolous lawsuits and kept the cost of malpractice insurance at manageable levels. In fact, states that have damage award caps boast malpractice premiums that are 17.1 percent lower than states without caps.[40]

Effective damage award caps encourage physicians to keep their doors open and attract new physicians to locate in the state.[41] In rural counties, which often have more difficulty attracting qualified health care providers, effective caps help to entice more obstetrician-gynecologists and surgical specialists.[42]

Damage Caps. In 2004, Mississippi reformed its tort laws. While the reforms have not been in place long enough for their effectiveness to be measured, the situation in Mississippi leading up to the reforms was dire. Since 1995, Mississippi juries had awarded $1.8 billion to plaintiffs.[43] As a result, the majority of cities in Mississippi with populations under 20,000 no longer had doctors to deliver babies.[44] The new reforms cap non-economic damages, such as damages for physical and psychological pain, at $500,000.

The new law also includes "venue reforms" that require civil cases to be filed in counties where the defendant resides or where the injury occurred.[45] This will eliminate "venue shopping," the practice of seeking favorable jurisdictions or judges. A recent study illustrated just how crucial getting a case before the right judge can be: "Doctors and other health care professionals are far more likely to lose before a trial judge appointed by a Democratic President"—50 percent more likely, in fact.[46]

Like Mississippi, Texas saw an exodus of doctors due to skyrocketing liability insurance premiums and the threat of unfair charges and baseless litigation. In September 2003, the Texas legislature passed comprehensive tort reform, bolstered by an amendment to the state constitution approved by referendum. The reforms included a $250,000 cap on non-economic damages in medical malpractice cases. Early results show that the cap has been effective in lowering malpractice

38. Christopher J. Conover, "Health Care Regulation: A $169 Billion Hidden Tax," Cato Institute *Policy Analysis* No. 527, October 4, 2004, at *www.cato.org/pubs/pas/pa527.pdf* (December 5, 2005).
39. As of May 2005, the American Medical Association listed 20 "States in crisis," 23 "States showing problem signs," six "States currently okay," and one state (Texas) under the category "Effective reforms halting crisis." American Medical Association "Medical Liability Crisis Map," May 2005, at *www.ama-assn.org/ama/noindex/category/11871.html* (December 5, 2005).
40. Ken Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Affairs*, January 21, 2004, at *content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1* (December 5, 2005).
41. Daniel P. Kessler, William M. Sage, and David J. Becker, "Impact of Malpractice Reforms on the Supply of Physician Services," *Journal of the American Medical Association*, Vol. 293, No. 21 (June 1, 2005), pp. 2618–2625.
42. William E. Encinosa and Fred J. Hellinger, "Have State Caps on Malpractice Awards Increased the Supply of Physicians?" *Health Affairs*, May 31, 2005, at *content.healthaffairs.org/cgi/reprint/hlthaff.w5.250v1* (December 5, 2005).
43. George F. Will, "Tort Reform Now," *The Washington Post*, September 29, 2002, p. B7.
44. Wendy McElroy, "Lawsuits Fueling Health Care Crisis," Fox News, May 14, 2002.
45. American Tort Reform Association, "Mississippi Reforms," at *www.atra.org/states/MS* (December 5, 2005).
46. PR Newswire, "In Medical Malpractice Cases, It Really Matters If the Federal Trial Judge Was Appointed by Democrat or Republican President," September 15, 2004.

insurance rates, increasing the number of physicians, and attracting new insurers to compete in the malpractice market.[47] Consequently, Texas is the only state in the country that the American Medical Association has removed from its medical liability crisis map.[48]

Nationally, the Employment Policy Foundation estimates that damage award caps could save from $54.8 billion to $97.5 billion per year in hospital and physician services. The same source also reports that the soaring cost of medical malpractice increases the cost of employer-based health insurance by 12.7 percent and decreases the number of individuals and families with employer-based coverage by 2.7 million people nationwide.[49]

Caps on Lawyers' Fees. Seventeen states currently impose legal limits on the fees that lawyers can collect in medical malpractice cases: California, Connecticut, Delaware, Florida, Illinois, Indiana, Maine, Massachusetts, Michigan, Nevada, New Jersey, New York, Oklahoma, Tennessee, Utah, Wisconsin, and Wyoming.[50] Most of these states have established a sliding scale of contingency fees based on the size of the award, with the percentage of the award collected by the attorneys shrinking as the award gets bigger.

The purpose of limiting lawyers' fees is not to keep lawyers from getting paid, but to allow injured plaintiffs to keep more of their awards and to prevent lawyers from reaping unethically huge rewards for representing injured clients. For example, Massachusetts limits attorneys' contingency fees to 20 percent if imposing a higher fee would prevent an injured plaintiff from paying past and future medical bills.[51]

State limits on lawyers' fees illustrate the ethical shortcomings plaguing today's legal environment. Ethics laws governing the legal profession declare that fees must be "reasonable." The reasonableness of a fee differs from case to case based on the lawyer's time, effort, skill, and reputation and the risk of success or failure.[52]

For the most part, however, plaintiffs' attorneys charge a standard contingency fee (often 50 percent or more of the award) to all clients regardless of the specific details of a case. This common practice raises ethical concerns about overcharging plaintiffs who have relatively straightforward cases or a high chance of winning.[53] While the American Bar Association opposes attorneys' fee caps, it has acknowledged the ethical problems associated with charging standard contingency fees and has recommended that states take "protective measures."[54]

What State Lawmakers Can Do to Solve the Problem

Each state must address the medical malpractice crisis in a way that reflects its particular circumstances. In addressing the medical malpractice issue and working to correct the failures of the cur-

47. Eleanor Barrett, "Report: Gains Realized with Texas Med-Mal Reforms," *BestWire*, August 3, 2005.

48. American Medical Association, "Medical Liability Crisis Map."

49. Employment Policy Foundation, "Medical Malpractice Litigation Raises Health Care Cost."

50. National Conference of State Legislatures, "State Medical Malpractice Tort Laws."

51. Mass. Ann. Laws, Ch. 231, § 60I.

52. American Bar Association, *Model Rules of Professional Conduct*, 2004 ed., Rule 1.5, at *www.abanet.org/cpr/mrpc/rule_1_5.html* (December 6, 2005).

53. See Jefferey O'Connell, Carlos M. Brown, and Michael D. Smith, "Yellow Page Ads as Evidence of Widespread Overcharging by the Plaintiffs' Personal Injury Bar—And a Proposed Solution," *Connecticut Insurance Law Journal*, Vol. 6, No. 2 (1999–2000), p. 423. The practice has earned the American Trial Lawyers Association (ATLA) the pejorative nickname "At-Least-a-Third Lawyers Association."

54. American Bar Association, Tort Trial & Insurance Practice Section, Task Force on Contingent Fees, *Report on Contingent Fees in Medical Malpractice Litigation*, September 20, 2004, at *www.abanet.org/tips/contingent/MedMalReport092004DCW2.pdf* (December 8, 2005).

rent system, state officials should keep in mind four primary objectives:

1. Promoting patient safety,
2. Maintaining or improving access to quality medical care,
3. Protecting injured patients, and
4. Reducing health care costs.

This will require fostering a legal and professional environment in which doctors, nurses, and medical specialists are free to report and discuss their mistakes openly while working together to reduce errors. State reformers must also keep in mind both the rights of those who have been wronged to seek redress through civil litigation and, most important, the best interests of society.

While reforming the system to reduce frivolous suits and make the system fairer for everyone, state legislators must be careful to protect those who have genuine malpractice claims. Reimbursement for out-of-pocket expenses, lost wages, and compensation for pain and suffering should be readily available, but they should also be reasonable and reserved for real cases of negligent conduct, not for simply bad medical outcomes. State legislators have a menu of reform options from which to select those that would work best in their respective states.

Option #1: Implement the Early Offer Rule

The best medical malpractice solutions will enhance patients' rights while curbing the system's excesses. While rationalizing the malpractice system, state legislators can help patients to recover economic losses more expeditiously and give more injured victims access to the system. That is the motivation behind the "early offer" rule (also called "rapid recovery" or "make a first best offer"). U.S. Representative Richard Gephardt (D–MO) sponsored early offer legislation in the 98th Congress, explaining the rule as follows:

> A patient with a problem can file a complaint to recover his economic losses…includ[ing] the additional medical care that was required, his loss of income and his lawyer's fees. It would not include pain and suffering. The provider involved—physician, hospital, or both—would then have 6 months to settle the claim for economic loss. If such settlement were offered, the patient would lose the option of going to court and seeking compensation for pain and suffering. Thus the provider is generally protected against the threat of a surprisingly large, or even punitive settlement. And, the patient is paid during the period when he really needs the money…. [I]f the patient feels that truly malicious negligence is involved, he retains the option of suing for intentional injury [under a beyond a reasonable doubt proof standard]…. In the event the provider fails to offer a settlement within this 6-month period, the patient retains the right to use the court system and go for a bigger settlement.[55]

The consumer advantage of the early offer rule is that, while it limits the ability of claimants to recover large non-economic damage awards in court, it allows quick recovery of economic losses associated with an injury, including lawyers' fees. Further stipulations of the rule might provide that the patient's claim is to be reduced by the amount of payment already received from other, collateral sources (such as health insurance) and allow for periodic payment of awards. If the defendant refuses to make an early offer in the time allotted, the plaintiff can proceed in court under the standard rules.[56]

Early offer is intended to provide a strong motivation to settle claims quickly, without the typical years of delay in the courts. Jeffrey O'Connell, University of Virginia law professor and leading advo-

55. Representative Richard Gephardt (D–MO), comments on the Alternative Medical Liability Act (H.R. 5400) before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, June 28, 1984.

56. Jeffrey O'Connell and Patrick B. Bryan, "More Hippocrates, Less Hypocrisy: 'Early Offers' as a Means of Implementing the Institute of Medicine's Recommendations on Malpractice Law," *Journal of Law and Health*, Vol. 15, No. 1 (2000).

cate of early offer, describes a defendant's calculation under the rule:

> Given the huge costs of defending court cases and the gamble of having to pay large sums already paid by collateral sources, and for intangible [non-economic] losses, many defendants would be prompted to pay for net economic losses not just in cases they are sure to lose but even in many cases in which the issue is legitimately in doubt. One leading defense lawyer has hypothesized that of the 250 medical malpractice cases his large office was then defending, all in various stages of litigation, he would advise making an early offer in 200 (or eighty percent) of those cases if such a law were in effect.[57]

During the 104th Congress, Senators Mitch McConnell (R–KY) and Robert Dole (R–KS) introduced two important changes in their own early offer proposal.[58] First, they lowered the standard necessary for a claimant to prove intentional or wanton negligence to a clear and convincing standard, which is much less stringent than the reasonable doubt standard advocated by Representative Gephardt. Next, they allowed for the establishment of minimum dollar payments in cases of serious injury in which economic damages are low. This change was intended to prevent defendants from taking advantage of cases in which the plaintiff may have suffered a serious injury but with minimal economic losses, such as injuries to the elderly, the unemployed, or young children.

There are many advantages to a well-designed early offer system. Settling medical injury claims soon after they have been discovered would encourage more doctors to share information about mistakes and bad outcomes and to discuss openly ways to avoid them in the future. Injured plaintiffs would be compensated for their injuries quickly, when they need the money most, without having to wait years for the court system to operate. Overhead costs, including legal fees, would be greatly reduced, and the full protection of the tort system would be available for plaintiffs who feel that malicious or wanton conduct of the physician was involved in causing their injuries.

Option #2: Explore Patient Indemnity Insurance

States could also create and license patient indemnity insurance (PII), a new category of insurance that would benefit both doctors and patients.[59] Consumers already insure themselves against many types of hazards, from plane crashes to losing packages in the mail to missing work due to illness. PII would allow patients to purchase coverage for adverse medical events, much as people can purchase insurance against unlikely events like airline disasters.

Patients could purchase as little or as much coverage as they choose for a relatively low price. Premiums would depend on the level of coverage desired, the patient's risk factors, and the medical treatment involved. Patients already, before entering many medical treatments, routinely sign consent forms in which they acknowledge the potential risk of injury or bad outcomes. In some cases, physicians might even choose to cover the cost of PII themselves if the patient's circumstances warrant it.

Since adverse events resulting from a medical error are relatively rare, PII could be a viable business for insurance companies and could lower premiums for doctors.[60] The insurance companies or the states could clearly spell out the criteria under which payments would be made, avoiding litigation.

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57. *Ibid.*

58. See S. 1861, 104th Cong., 2nd Sess.

59. The PII concept was also put forth during the Reagan Administration in the aforementioned 1987 *Report of the Task Force on Medical Liability and Malpractice*.

60. A study of medical errors in an intensive care unit showed that health care providers were functioning at a 99 percent rate of proficiency. Of the errors that occurred in 1 percent of cases in intensive care units, 29 percent potentially could have led to serious injury or death. Lucian L. Leape, M.D., "Error in Medicine," *Journal of the American Medical Association*, Vol. 272, No. 23 (December 21, 1994), p. 1851.

State officials might also consider a variation of PII by setting a lower cap for non-economic damages and allowing patients to purchase PII for damages above that amount. Thus, regardless of whether or not such damages are awarded at trial, the patient would still be able to receive compensation.

Even under this variation, PII would not replace malpractice liability insurance. Doctors would still be required to carry liability insurance to cover the cost of real economic damages incurred by patients due to doctors' negligence, but removing the uncertainty associated with the possibility of an astronomical non-economic damage award from the insurance equation would cause liability insurance premiums to fall.

In conjunction with PII, states should set up a public reporting system that would report all cases of real malpractice by physicians after a determination has been made. These cases would involve recklessness or gross negligence, performance of medical procedures by doctors who are unqualified to perform them, and other practices that unnecessarily put patients at risk. Public reporting systems would serve to inform the public, including health plans and employers, about the relatively small number of "bad docs" who should be avoided. Reporting systems would also allow state medical licensing boards to take action against problem doctors, including revoking their licenses.

An effective PII system would reduce the role of expensive, time-consuming litigation in compensating injured patients. Lessening the ambiguity involved in reaching settlements and increasing personal responsibility for managing one's own risks would reduce the need for lawyers' involvement. While little market research has been conducted to test its effectiveness, state lawmakers could incorporate PII demonstration projects into their broader malpractice reform proposals.

Option #3: Establish Special Health Courts

In medical malpractice cases, judges and juries are often presented with difficult issues of physician liability that turn on complex scientific and statistical questions. Both sides in malpractice cases hire their own medical experts to testify at trial, and these witnesses are paid to present their clients' side of the story in the most favorable light possible. Faced with conflicting stories by two apparently credible scientists, confused juries must then decide which expert was the more convincing. Judges, who are often no more educated in medical and scientific matters than juries are, can offer juries little help in navigating these difficult questions.

Unable to decide between conflicting experts in a complex malpractice case, juries often turn to inappropriate considerations that are irrelevant to the legal questions of causation and the standard of care. For example, research has found that jury verdicts correlate more with the severity of the plaintiff's injury than with actual physician negligence.[61] This means that, whether or not the doctor's actions were negligent, the worse the injuries involved, the more likely the jury was to decide in the plaintiff's favor.

In a recent Vioxx case, Texas jurors were faced with determining whether the drug caused the plaintiff's husband to die of a heart attack. Finding for the plaintiff in this case meant that the jury decided, by a preponderance of the evidence, that "a blood clot you didn't find caused a heart attack that left no evidence of heart muscle damage"—a conclusion that one medical expert called "absolutely speculative."[62] For jurors, the scientific evidence about the existence of the blood clot, the heart attack, and even the conclusions written on the death certificate mattered little. "Whenever [the defendant Merck & Co.] was up there, it was like wah, wah, wah," said one juror. "We didn't know what the heck they were talking about." In fact, some jurors seemed more interested in the possibility of "sending a message" and appearing on television than in weighing the scientific evidence. "They only get on Oprah if they vote for the plaintiff," said one jury consultant during the trial.[63]

61. Troyen A. Brennan, Colin M. Sox, and Helen R. Burstin, "Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation," *The New England Journal of Medicine*, Vol. 335, No. 26 (December 26, 1996), pp. 1963–1967.

62. Betsy McCaughey, "Medical Courts," *The Wall Street Journal*, August 25, 2005.

With decisions like the one in the Vioxx case, in which the jury awarded $253 million to the plaintiff, it is no wonder that doctors complain of receiving mixed messages from courts and juries on the standard of care. Armed with the benefit of 20/20 hindsight, the juries' expectations of doctors are often raised to unrealistic levels.[64] With no clear message on a realistic standard of care, doctors perceive jury decisions to be random and are left to practice defensive medicine in an atmosphere of uncertainty.

Health courts have received bipartisan support as a possible improvement on the current tort system.[65] Under a health court system, judges would receive specialized training in medical topics in addition to their knowledge of the law. While lawyers would still represent the parties at trial, judges would rely more heavily on court-appointed expert witnesses to offer unbiased testimony on the range of possible treatment options as well as clinical guidelines that make up the standard of care.

The Seventh Amendment right to have a jury decide initial factual questions in most medical malpractice cases might prevent these special health courts from forcing parties to forgo a jury determination. However, health court legislation can include incentives to encourage both parties to waive a jury determination voluntarily and have their cases decided by the specialized trial judges. First, the courts could be structured and staffed in a way that makes juryless trials (or "bench trials") more attractive in terms of speed and expense. Second, a state might encourage medical professionals and patients to discuss this option when care is initiated and sign a contract to the effect that any dispute would be resolved in a bench trial. It is unlikely that every pre-injury waiver of jury trials would be upheld as knowing and effective, but the vast majority probably would be upheld. Medical professionals could charge higher rates for those patients who create more uncertainty by refusing to agree to the waiver.

In the event that the judge decides the liability and damages issues, he or she issues a written determination of the standard of care and whether or not the provider's actions conformed to the standard. The written determination then becomes part of a consistently applied body of law to which physicians can look with more certainty.[66]

Medically trained judges will be better able to wade through difficult evidence to get to the real facts. That is exactly what happened when federal Judge Janis Graham Jack, who was formerly a nurse, discovered the scam behind scientific evidence presented by plaintiffs' lawyers in silicosis litigation. After conducting her own probe of the plaintiffs' evidence, Judge Jack wrote, "These diagnoses were about litigation rather than health care," finding that the claims had been "manufactured for money." A federal grand jury is now investigating the perpetrators of the scam.[67]

Leading health court proposals also combine aspects of the workman's compensation, Social Security, and Medicare administrative law systems. These functions are aimed at accelerating the handling of claims, lowering administrative costs, and expanding the number of claimants who can receive compensation for their injuries. For example, health courts could identify clear

63. Heather Won Tesoriero, Ilan Brat, Gary McWilliams, and Barbara Martinez, "Merck Loss Jolts Drug Giant, Industry," *The Wall Street Journal*, August 22, 2005.

64. Jeffrey O'Connell and Christopher Pohl, "Book Review: How Reliable Is Medical Malpractice Law?" *Journal of Law and Health*, Vol. 12, No. 2 (1998), pp. 367–368, a review of Neil Vidmar, *Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards* (Ann Arbor, Mich.: University of Michigan Press, 1995).

65. See Common Good, "An Urgent Call for Special Health Courts: America Needs a Reliable System of Medical Justice," at *cgood.org/brochure-hcare.html* (December 8, 2005).

66. Nancy Udell and David B. Kendall, "Health Courts: Fair and Reliable Justice for Injured Patients," Progressive Policy Institute *Policy Report*, February 2005, at *www.ppionline.org/documents/healthcourts_0217.pdf* (December 8, 2005).

67. Editorial, "The Silicosis Sheriff," *The Wall Street Journal*, July 14, 2005, p. A10.

cases of medical errors that automatically qualify for compensation, called accelerated compensation events (or ACEs). According to most schemes, health courts would apply a lowered standard of avoidability rather than focusing on issues of individual negligence.[68]

Finally, judges would award damages, including non-economic damages, based on pre-established schedules.[69] This would guarantee that similarly situated claimants receive similar awards. Quicker and more consistent disposition of malpractice claims would eliminate much of the hassle and frustration associated with the inefficiency of the current tort system.

Option #4: Limit Liability for Physicians in Medicaid

Medicaid, funded jointly by the federal government and the states, is the huge health care program for the poor. As this vast entitlement program has nearly doubled in size over the past 10 years, state governments have reduced Medicaid reimbursements to physicians to keep the beleaguered program solvent.[70]

Low reimbursements coupled with bureaucratic hassle and red tape have caused doctors to cut back on the number of Medicaid patients that they treat. Nationally, one out of five physicians is refusing to see new Medicaid patients.[71] In many states, reimbursements have failed to keep up with the cost of providing care, and physicians routinely incur a financial loss when treating Medicaid patients.

One way states can encourage physicians to participate in Medicaid is to offer liability protection for doctors treating Medicaid patients. States could provide an alternative to standard tort liability for Medicaid patients, such as early offer arrangements. The federal government could do the same thing within the Medicare program. Although the national government may not have the authority to preempt all state malpractice laws that govern private parties, it is not powerless to modify its own spending programs by making them conditional on state reforms that promote the effectiveness and fiscal integrity of those very programs.

The benefits of such a system are clear: It would encourage doctors to see more Medicare and Medicaid patients, and an alternative system of resolving malpractice claims could provide quicker compensation to injured claimants, who often cannot wait years for the tort system to compensate them for their out-of-pocket expenses.

Option #5: Limit Liability for Charity or Emergency Care

A related issue is the provision of charity or emergency care. Doctors who treat the poor *pro bono*, particularly those who care for patients who are especially difficult to treat, deserve relief. The same holds true for physicians working in emergency rooms, who invariably treat patients whom they have never seen before. As Jane Orient, M.D., executive director of the Association of American Physicians, has noted, "Emergencies are always high risk situations. Doctors are fatigued, pressured, and working with incomplete information."[72] Physicians in such circumstances are especially in need of tort liability relief.

In an effort to encourage charity and emergency care, states can take a variety of approaches. Currently, states most commonly limit liability for

68. Udell and Kendall, "Health Courts."

69. Even in jury trials, determination of damages could probably be left to judges without violating the Seventh Amendment.

70. Michael O. Leavitt, "Medicaid: A Time to Act," speech to the World Health Congress, Washington, D.C., February 1, 2005, at *www.hhs.gov/news/speech/2005/050201.html* (December 8, 2005).

71. Julie A. Schoenman, Ph.D., and Jacob J. Feldman, Ph.D., "2002 Survey of Physicians About the Medicare Program," Medicare Payment Advisory Commission, December 2002, p. 2, at *www.medpac.gov/publications/contractor_reports/Mar03_02PhysSurvRpt2.pdf* (December 8, 2005). See also Nina Owcharenko, "The Top Ten Reasons for Medicaid Reform," Heritage Foundation *WebMemo* No. 718, April 12, 2005, at *www.heritage.org/Research/HealthCare/wm718.cfm*.

72. Jane Orient, M.D., executive director, Association of American Physicians and Surgeons, personal communication, January 4, 2005.

charity care by raising the liability standard from negligence to gross negligence and by indemnifying physicians as if they were state employees. For example, Florida's successful Volunteer Health Care Provider Program extends the state's sovereign immunity protection to physicians treating uninsured patients.[73] Texas's 2003 tort reforms included a lower cap on non-economic damages for hospitals that provide significant amounts of charity care.[74]

States may also consider extending these protections to emergency care practitioners. For example, Georgia recently enacted legislation that raises the burden of proof to clear and convincing evidence of gross negligence for malpractice claims against emergency room physicians.[75]

Option #6: Follow the MICRA Model

With three decades of proven results, California's largely successful Medical Injury Compensation Reform Act (MICRA) of 1975 is a model that states can use to craft their own medical malpractice reforms. Due to the impact of MICRA, California liability insurance costs one-third the price of insurance in liability crisis states. Surprisingly, while California remains one of the most litigious states in the Union, its physicians pay 30 percent less in constant dollars for liability insurance than they paid in 1976.[76]

Specifically, reforms based on the MICRA model would:

- **Secure the ability of injured patients to receive quick, unlimited compensation for their economic losses.** Economic losses are broadly defined to include lost wages, hospital bills, and even unpaid services like care for children or parents.
- **Ensure that recoveries for non-economic damages do not exceed a reasonable amount** (e.g., $250,000).
- **Reserve punitive damages for cases in which they are truly justified** and limit punitive damages to a reasonable amount.
- **Provide for periodic payment of judgments over time** rather than in single lump sums, ensuring that appropriate payments are available when patients need them. Periodic payments also make it more likely that physician-defendants will be able to survive large damage awards.
- **Ensure that old cases cannot be brought years after an event occurs** (through statutes of limitations or repose).
- **Reduce the amount that doctors must pay if a plaintiff has received other payments** from an insurer to compensate for their losses (collateral source rules).
- **Provide that defendants must pay judgments only in proportion to their degree of fault** (joint and several liability reform). For instance, this reform prevents defendants who are only 1 percent liable from paying 100 percent of the judgment.[77]

State lawmakers can incorporate these proposals or variants of these proposals as part of their state legislative remedies. It is important to remember that any solution must help to restore a level of certainty to the liability insurance market in order to have the desired effect of reducing premiums and improving access to care.

Option #7: Learn from Oregon's Bad Example

Oregon provides an example of what not to do. In 1987, Oregon enacted a cap on non-economic dam-

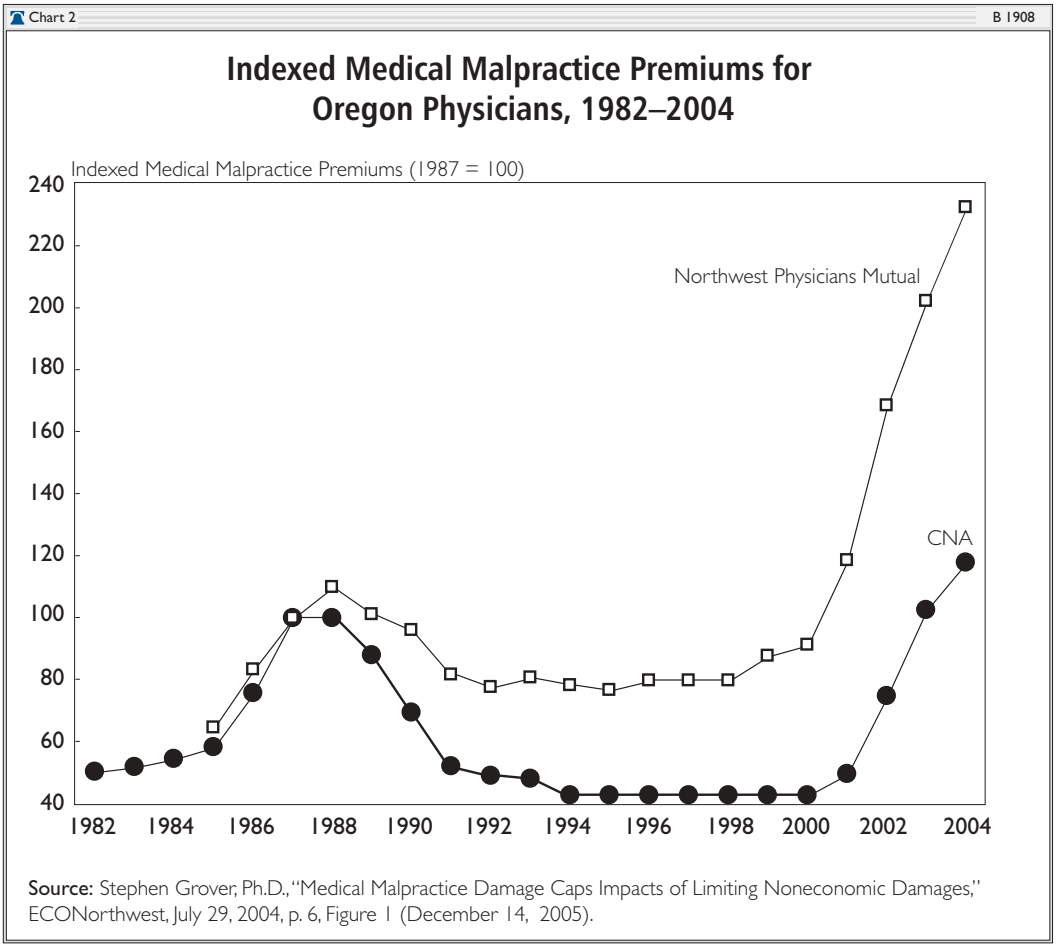
73. Howard B. Shapiro, "Providing Charity Care: A Primer on Liability Risk," *Family Practice Management*, Vol. 10 No. 1 (January 2003), pp. 29–38, at *www.aafp.org/fpm/20030100/52prov.html* (December 8, 2005).

74. Mary Chris Jaklevic, "Charity Has Its Benefits," *Modern Healthcare*, Vol. 34, Issue 23 (June 7, 2004), p. 14.

75. Georgia General Assembly, Senate Bill 3, 2005–2006 Legislative Session, enacted February 13, 2005, at *www.legis.state.ga.us/legis/2005_06/pdf/sb3.pdf* (December 8, 2005).

76. Richard E. Anderson, M.D., "Further Examine the Malpractice Plague," *Physician's Money Digest*, OB/GYN ed., November/December 2002, p. 18.

77. Press release, "President Calls for Medical Liability Reform."



ages in response to a previous malpractice crisis. By 1990, the reforms had taken hold, alleviating the crisis and helping to reduce premiums by 50 percent.[78]

That changed in 1999, when the Oregon Supreme Court declared the cap unconstitutional.[79] Over the next five years, premiums increased by over 100 percent, and by 332 percent for some specialists. Two leading Oregon malpractice insurers hiked premiums for all doctors by 80 percent in one year—the fourth highest increase in the country—while other insurers left the state.[80] (See Chart 2.) Insurers were forced to increase rates in response to a shocking statistic: In the two years following the Oregon Supreme Court's decision, paid claims increased by 400 percent.[81]

For state lawmakers, the Oregon example shows that ineffective malpractice reform may be worse than no reform at all. To be effective, reforms must not only restore a measure of certainty to the insurance market, but also survive constitutional muster. Thus, depending on the solution and the judicial makeup of the state, reformers should consider proposing constitutional amendments alongside malpractice reform legislation.

78. Stephen Grover, Ph.D., "Medical Malpractice Damage Caps: Impacts of Limiting Noneconomic Damages," ECONorthwest, July 29, 2004, at *www.theoma.org/Files/ECON_NW_MEDMAL_REPORT.pdf* (December 8, 2005).

79. See *Lakin v. Senco Products, Inc.*, 329 Or. 62, 987 P.2d 463 (1999).

80. Grover, "Medical Malpractice Damage Caps."

81. Anderson, "Further Examine the Malpractice Plague," p. 18.

Option #8: Promote Real Competition to Reduce Medical Errors

While the goal of zero medical errors is perhaps unattainable, the most effective way to attack the root of the medical malpractice problem is to reduce the number of people injured.[82] According to the Institute of Medicine, preventable medical errors kill somewhere between 44,000 and 98,000 Americans each year, making medical error more deadly than breast cancer, car crashes, or AIDS.[83]

Regardless of who is at fault or whether there is legal negligence involved, this alarming number needs to be reduced as much as possible and as quickly as possible. One way to do this is to unleash the power of consumers to take control of their own destinies in the health care system.

Health care is not a commodity in which all doctors, nurses, and hospitals are the same. Yet according to a recent article by Michael E. Porter, a Harvard professor and business strategist, and Elizabeth Olmsted Teisberg, a business professor at the University of Virginia, this attitude hampers today's health care system. Porter and Teisberg found that providers in the health care market compete for access to insurers' patient pools on the basis of price alone (as in the commodities market) rather than competing based on the value of the services they provide (as in other markets). Health care consumers today are generally prevented from shopping for the best provider to treat their particular condition. Instead, people are penalized for seeking care outside the pre-approved doctors in their insurance company's network. Providers belonging to the network are virtually guaranteed the business, dampening the incentive to push for better value.[84]

The lesson is both simple and easily grasped: When purchasers like employers and insurance companies view health care as a commodity, too much attention is paid to cutting costs and not enough attention is paid to improving the safety and effectiveness of the health care delivered.

In an industry in which choice is restricted and competition for value is rare, consumers turn to the legal system to compensate them when they receive poor value (or believe that they have received poor value). Some disgruntled consumers have found a sympathetic ear in the courts, where judges and juries see tort cases as a means to lash out at the maladies of the health care system.[85]

However, tort law is ineffective at ensuring quality health care. As noted, it is very difficult for an injured patient to sue and win in court. Furthermore, most medical errors go unrecognized and uncompensated. Finally, the fear of lawsuits will not ensure good quality on its own. Without real incentives to improve care, legal fears will only reinforce a minimal standard of care (i.e., doctors will behave only well enough to avoid being sued).[86]

Authors like Porter and Teisberg have envisioned a better health care system that would allow providers to compete on the basis of individual health conditions, creating better value for consumers. Rather than being forced to accept health care services essentially "as is" and then sue later on if something goes wrong, consumers would be presented with new and better options. Competition based on quality would allow consumers to vote with their feet about which providers and services they prefer. Instead of relying on the fear of lawsuits to enforce a minimal standard of care, providers would need to innovate and improve constantly to remain competitive.

82. However, it should be noted that even error-free medicine does not guarantee a favorable outcome, especially for high-risk patients.

83. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academies Press, 2000), p. 1.

84. See Michael E. Porter and Elizabeth Olmsted Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*, June 2004, pp. 64–76.

85. Michael I. Krauss, "Tort Law and Private Ordering," *Saint Louis University Law Journal*, Vol. 35 (Spring 1991), pp. 649–650.

86. See James Reason, "Human Error: Models and Management," *British Medical Journal*, Vol. 320, Issue 7237 (March 18, 2000), pp. 768–770.

Empowered consumers make the best regulators. Over time, consumers would begin to subsidize the providers that do the best job and cut off funding for providers who underperform, forcing them either to make improvements or to find another job. In the battle to offer the best value, providers will reduce medical error rates and improve services.

While the federal government plays a central role in this area, states can take several steps to encourage real competition and consumer choice in health care. Requiring providers to use transparent pricing will reduce the confusion surrounding the question of how much health care services really cost. Rolling back coverage mandates for insurance plans will allow people to purchase plans that better suit their needs. Encouraging consumer-driven options like health savings accounts (HSAs) will increase consumers' ability to demand better quality from and communication with their doctors.[87] By collecting and publishing better information on health care quality and outcomes, states can help to inform the public about quality and drive the demand for better health care.[88]

Conclusion

The medical malpractice crisis in the United States must be addressed. Access to affordable care is being compromised for millions of Americans. The doctors' ability simply to afford to practice medicine is slipping through the fingers of far too many highly skilled and caring hands while trial lawyers reap the benefits of an outdated, outmoded system. States need to stop the exodus of good physicians while protecting the right of patients to seek redress for real medical injuries.

Options for states include rationalizing and refocusing malpractice awards to compensate quickly for economic losses like lost pay and medical bills, reserving punitive damages for the small number of warranted malpractice cases, and limiting attorneys' fees to guarantee that patients get the highest possible proportions of awards in medical malpractice cases. For example, the Fair and Reliable Medical Justice Act (S. 1337), federal legislation introduced by Senators Mike Enzi (R–WY) and Max Baucus (D–MT), would grant states money to create innovative solutions to the malpractice crisis, such as specialized health courts. States may also wish to consider creating patient indemnity insurance, a new breed of insurance that would compensate for injuries at a level chosen by the patient. States should mix and match the solutions presented in this paper, tailoring reforms to meet specific challenges.

While reforming the medical malpractice system will not cure all of America's health care woes, the right kind of reform could virtually eliminate the long-drawn-out lawsuits in which the biggest winners are the trial lawyers, not the parties. It could free doctors from the crush of ever-increasing liability premiums and empower patients to choose their own destinies.

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87. See Nina Owcharenko, "Bringing True Competitiveness to Health Care," Heritage Foundation *WebMemo* No. 502, May 12, 2004, at *www.heritage.org/Research/HealthCare/wm502.cfm*.

88. For an example of state efforts to give consumers better information about health care quality, see Florida Department of Health, Agency for Health Care Administration, Florida Compare Care, at *www.floridacomparecare.com* (January 9, 2006). This Web-based database offers Florida consumers information about the performance of selected health care providers, including measures of hospital infection rates and mortality rates.