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Two Tiers of Plaintiffs: How North Carolina's Tort Reform Efforts Discriminate Against Low-Income Plaintiffs

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TWO TIERS OF PLAINTIFFS: HOW NORTH CAROLINA'S TORT REFORM EFFORTS DISCRIMINATE AGAINST LOW-INCOME PLAINTIFFS*

"We are saying to doctors and hospitals it's OK to kill somebody who comes from a poor family because ultimately they aren't going to have the same effect on our medical-malpractice insurance as somebody who comes from a rich family."[1]

1. Rachel Zimmerman & Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J. (Oct. 8, 2004), http://www.wsj.com/articles/SB109717758841639476 [https://perma.cc/UDB9-6YM6 (staff uploaded archive)].

INTRODUCTION

In its most general form, "[t]ort reform . . . refers to legislative proposals or enactments that modify the common law rules of torts."[2] However, in recent years, tort reform has taken on a more politically charged meaning, manifesting itself through "legislation to limit, or 'cap,' damages awarded to plaintiffs in malpractice cases."[3] Tort reform has been a controversial topic for decades, particularly within the context of medical malpractice litigation.[4] Proponents of tort reform point to an increase in frivolous lawsuits, runaway jury verdicts, malpractice insurance premiums, and healthcare costs.[5] Furthermore, proponents cite an uptick in the practice of defensive medicine, which occurs when doctors recommend unnecessary medical tests and procedures to minimize the risk of malpractice litigation.[6] Such proponents have described tort reform as "passing laws to deter outrageous jury verdicts and windfall recoveries to undeserving parties."[7] Conversely, critics argue that these concerns are not as drastic as proponents claim and instead focus on the impact that tort reform has on plaintiffs' abilities to bring legitimate lawsuits.[8] Regardless of which side is "right" about tort reform, the clear trend has been for states to pass laws making it more difficult for plaintiffs to obtain large jury awards in medical malpractice and

2. Julie Davies, *Reforming the Tort Reform Agenda*, 25 WASH. U. J.L. & POL'Y 119, 120 n.3 (2007).

3. Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515, 515 (2005); *see also* Roland Christensen, Comment*, Behind the Curtain of Tort Reform*, 2016 BYU L. Rev. 261, 264 (2016) (describing tort reform as a "political agenda developed in response to perceived problems with the current tort system").

4. *See* Burton Craige, *The Brave New World of Malpractice Litigation*, N.C. ST. B. J., Spring 2012, at 16, 16–17 (describing how the damages cap has generated "intense debate"); Theodore R. LeBlang, *The Medical Malpractice Crisis—Is There A Solution?*, 27 J. LEGAL MED. 1, 9 (2006) (noting "the controversy surrounding malpractice tort reform strategies and their effectiveness"); David Donovan, *Latest Data Show State's Tort Reform Act Delivered a Knock-Down Blow*, N.C. LAWS. WKLY. (July 24, 2015), http://nclawyersweekly.com/2015/07/24/latest-data-show-that-states-tort-reform-act-delivered-a-knock-down-blow/ [https://perma.cc/8FFJ-HF56] ("It's definitely not a level playing field. The truth is that they [doctors] have the advantage pretty much every step of the way. The crisis in medical malpractice litigation is that too many legitimate claims now go uncompensated.").

5. *See* Burton Craige, *The Medical Malpractice "Crisis": Myth and Reality*, N.C. ST. B. J., Summer 2004, at 8–9.

6. *See* M. Sonal Sekhar & N. Vyas, *Defensive Medicine: A Bane to Healthcare*, ANN. MED. HEALTH SCI. RES., Apr.–June 2013, at 295, 295–96, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3728884/ [https://perma.cc/RP3S-KPA8 (dark archive)].

7. Christensen, *supra* note 3, at 263–64.

8. *See* Craige, *supra* note 4, at 16–17.

personal injury cases.[9] This legislation has often taken the form of noneconomic damages caps, which statutorily limit the amount of money a jury may award a successful plaintiff for subjective damage calculations, such as pain and suffering.[10] In contrast, economic damages include compensation for objectively verifiable monetary losses, such as past and future medical expenses and wages.[11]

These reforms have resulted in the systematic devaluation of certain groups of plaintiffs—namely lower-income plaintiffs—as lawyers are forced to consider the likelihood of recovering significant economic damages as the barometer for a successful claim.[12] When noneconomic damages are capped, the chance of a plaintiff receiving a large jury verdict is increasingly dependent on the economic damages available. Therefore, if two plaintiffs—one a Silicon Valley executive and one a stay-at-home mother—present factually identical cases, an attorney has far more incentive to represent the executive who may be able to receive millions of dollars in lost wages and future earnings, as opposed to the unemployed individual who stands to win very little in the way of economic damages.[13] These facts presented themselves in a California medical malpractice claim, resulting in a $2 million settlement for the executive and a $300,000 settlement for the stay-at-home mother.[14]

North Carolina joined this national trend when the General Assembly passed a series of tort reform bills in June and July of 2011, drastically altering the landscape of medical malpractice law in the state.[15] These reforms collectively comprise a series of procedural,

9. As of 2016, thirty-three states adhere to some form of statutorily imposed damages cap when calculating the amount of damages a jury may award a successful plaintiff. *Medical Malpractice Damage Caps*, MED. MALPRACTICE CTR., http://www.malpracticecenter.com/legal/damage-caps [https://perma.cc/2A7P-KTJ5].

10. *See* N.C. GEN. STAT. § 90-21.19 (2015).

11. *Non-economic Damages*, BLACK'S LAW DICTIONARY (10th ed. 2015); *Ending the Confusion: Economic, Non-Economic, and Punitive Damages*, AM. COLL. OF SURGEONS, https://www.facs.org/advocacy/federal/liability/ending-the-confusion [https://perma.cc/4LTB-4B6D].

12. *See* Zimmerman & Hallinan, *supra* note 1 ("The American Medical Association, a supporter of tort reform, acknowledges that some plaintiffs with little in the way of economic damages have a hard time finding lawyers. 'If their claim is not of high monetary value, then it's hard for them to find an attorney,' says Dr. Donald J. Palmisano, immediate past president of the AMA.").

13. *Id*. (describing such a scenario).

14. *Id*.

15. Act of July 25, 2011, ch. 400, sec. 3, § 1A-1, 2011 N.C. Sess. Laws 1712, 1713–14 (codified at N.C. GEN. STAT. § 1A-1, Rule 9(j) (2015)); sec. 4, § 8C-702(h), 2011 N.C. Sess. Laws at 1714 (codified at N.C. GEN. STAT. § 8C-702(h) (2015)); secs. 5–7, §§ 90-21.11–12, 2011 N.C. Sess. Laws at 1714–16 (codified at N.C. GEN. STAT. §§ 90-21.11–12, 19 (2015)); Act of June 27, 2011, ch. 317, § 1A-1, 2011 N.C. Sess. Laws 1253, 1253–54 (codified at N.C.

evidentiary, and substantive changes to North Carolina's preexisting medical malpractice law, making it more difficult for plaintiffs to bring successful medical malpractice claims at nearly every phase of litigation.[16]

This Comment will first analyze the three major types of changes made by these reforms—procedural, evidentiary, and substantive—and the impact of these reforms on medical malpractice claims before, during, and after trial, and on the various plaintiff groups bringing such claims. This Comment will next look to the available North Carolina data to determine what effects these reforms have already had on plaintiffs' claims. Next, because personal data about plaintiffs in medical malpractice cases is not made publicly available in North Carolina, this Comment will rely on tort reform bills passed in other states where these data are publicly available to explore the possible discriminatory effects the reform legislation may have on various plaintiff groups in North Carolina. This Comment posits that the combination of these procedural, evidentiary, and substantive changes have not only led to a permanent decrease in the number of medical malpractice claims being filed, but have also created a discriminatory system that prevents certain groups of plaintiffs—namely the poor—from having their rightful day in court. This Comment will then consider the constitutionality of these reforms in an effort to predict their likely future effects. Finally, this Comment will suggest possible alternatives to the current medical malpractice system in North Carolina.

I. STATUTORY REFORMS

North Carolina's tort reforms made significant procedural, evidentiary, and substantive changes to the state's medical malpractice laws. These changes—particularly the noneconomic damages cap—have played a significant role in curtailing the ability of a plaintiff to recover damages and benefiting defendant-physicians at the expense of plaintiffs. The most controversial portion of these reforms has been the $500,000 liability limit for noneconomic

Gen. Stat. § 1A-1, Rule 7(b)(4) (2015)); An Act to Provide Tort Reform for North Carolina Citizens and Businesses, ch. 283, sec. 1.3, § 8C-702(a), 2011 N.C. Sess. Laws 1048, 1049 (codified at N.C. GEN. STAT. § 8C-702(a) (2015)); *see also* Katherine Flynn Henry & Phillip Jackson, *North Carolina's Tort Reform: An Overview*, N.C. ST. BUS. J., Spring 2012, at 12, 16 n.1 ("There are three session laws that comprise this tort reform legislation: (a) S.L. 2011-400 (S.B. 33), (b) S.L. 2011-283 (H.B. 542), and (c) S.L. 2011-317 (S.B. 586)."). While Senate Bill 33 has gained the most notoriety for its noneconomic damages cap, this Comment will refer to these collective changes as "the reforms" or "these reforms."

16. Henry & Jackson, *supra* note 15, at 12–14.

damages,[17] a change to the substantive law that drastically reduced the amount of damages that plaintiffs could be awarded.[18] While this damages cap is certainly one of the biggest changes to the preexisting law, it is just one of several significant statutory reforms that benefit defendant-physicians at the expense of plaintiffs. For example, these reforms set a higher procedural standard for the pre-filing expert witness review requirement, making it more difficult for plaintiffs to successfully file a medical malpractice claim and increasing litigation costs.[19] These reforms also raised the evidentiary standard for expert witnesses to provide causation opinions, adding a challenge for plaintiffs trying to find qualified experts to testify during trial.[20] Furthermore, these reforms raised the evidentiary standard for all emergency medical conditions, even if they occur outside of an emergency room setting, providing physicians with more protection from malpractice complaints than required under federal law.[21] This Comment will analyze the procedural, evidentiary, and substantive changes in this order and explain why each of these changes has decreased plaintiffs' abilities to bring successful malpractice claims.

A. Procedural Changes

These reforms included several procedural changes to North Carolina's preexisting law that have made it more difficult for plaintiffs to reach the trial stage when filing medical malpractice claims. Most notably, these reforms included amending North Carolina Rule of Civil Procedure 9(j) to make the plaintiffs' pre-filing expert witness review requirement more stringent.[22] "The legislature specifically drafted Rule 9(j) to govern the initiation of medical malpractice actions"[23] in North Carolina in order to "prevent frivolous malpractice claims by requiring expert review *before* filing

17. *See id.* at 14, 16 (supporting the passage of such reforms). *But see* Craige, *supra* note 4, at 16 (questioning the true rationale behind these reforms).

18. *See* Act of July 25, 2011, ch. 400, sec. 7, § 90-21.19, 2011 N.C. Sess. Laws at 1715–16.

19. *See* N.C. GEN. STAT. § 1A-9(j) (2015); Henry & Jackson, *supra* note 15, at 12; *infra* text accompanying notes 43–45 (discussing expert witness costs).

20. *See* § 8C-702(h); Henry & Jackson, *supra* note 15, at 13.

21. *See* § 90-21.12(b) (requring proof by clear and convincing evidence); Henry & Jackson, *supra* note 15, at 14; *see also* 42 U.S.C. § 1395dd(e)(1)(B) (2012); Elizabeth Hill, Recent Development, *Senate Bill 33 Grants Protection to Emergency Room Providers . . . and Just about Everyone Else, Too*, 91 N.C. L. REV. 720, 720–21 (2013).

22. *See* Act of July 25, 2011, ch. 400, sec. 3, § 1A-9(j), N.C. Sess. Laws at 1713–14 (codified at N.C. GEN. STAT. § 1A-9(j)); Henry & Jackson, *supra* note 15, at 12.

23. Thigpen v. Ngo, 355 N.C. 198, 203, 558 S.E.2d 162, 166 (2002).

of the action."[24] Given the high cost of medical malpractice litigation, such a requirement should serve to limit the amount of leverage a plaintiff has when attempting to settle a frivolous claim.[25] "It is well established that if a complaint is filed without a Rule 9(j) certification, Rule 9(j) mandates that the trial court grant a defendant's motion to dismiss."[26] Formerly, Rule 9(j) stated that

> [a]ny complaint alleging medical malpractice by a health care provider . . . shall be dismissed unless: (1) The pleading specifically asserts that the medical care has been reviewed by a person who is reasonably expected to qualify as an expert witness under Rule 702 of the Rules of Evidence and who is willing to testify that the medical care did not comply with the applicable standard of care.[27]

Under this former version of the rule, only a cursory review of medical records was required for a complaint alleging medical malpractice to be deemed in compliance with Rule 9(j).[28] For example, in *Hylton v. Koontz*,[29] a medical malpractice claim was brought on behalf of the decedent after a gallbladder removal procedure resulted in his death.[30] In this case, the plaintiff's counsel provided a summary of the plaintiff's medical care on the telephone to an expert witness.[31] The North Carolina Court of Appeals held that although an expert witness did not review the plaintiff's *actual* medical records prior to the filing of the complaint, "[a] review of a summary of the treatment provided to a patient [was] sufficient compliance with Rule 9(j)," reasoning that "[t]here is no requirement the expert review the actual medical records prior to expressing his opinion with regard to the medical care provided."[32] Based on this

24. Moore v. Proper, 366 N.C. 25, 31, 726 S.E.2d 812, 817 (2012) (affirming language used in *Thigpen*, 355 N.C. at 203, 558 S.E.2d at 166 following the passage of the 2011 reforms).

25. *See infra* notes 110–15 and accompanying text (discussing expert witness costs).

26. Ford v. McCain, 192 N.C. App. 667, 671, 666 S.E.2d 153, 156 (2008) (demonstrating the importance of Rule 9(j) filings even before the requirements were tightened by the 2011 tort reform statutes).

27. N.C. GEN. STAT. § 1A-9(j) (2009) *amended by* Act of July 25, 2011, ch. 400, sec. 3, § 1A-9(j), 2011 N.C. Sess. Laws 1712, 1713–14 (2011) (codified at N.C. GEN. STAT. § 1A-9(j) (2015)).

28. *See* Henry & Jackson, *supra* note 15, at 12.

29. 138 N.C. App. 511, 530 S.E.2d 108 (2000).

30. *Id.* at 512, 530 S.E.2d at 109.

31. *Id.* at 513, 530 S.E.2d at 109.

32. *Id.* at 515–16, 530 S.E.2d at 111.

information, the plaintiff's expert witness argued that the defendant-physician breached the applicable standard of care.[33]

Plaintiffs now face a higher procedural standard under Rule 9(j), which was amended to require the dismissal of a medical malpractice claim unless:

> The pleading specifically asserts that the medical care *and all medical records pertaining to the alleged negligence that are available to the plaintiff after reasonable inquiry have* been reviewed by a person who is reasonably expected to qualify as an expert witness under Rule 702 of the Rules of Evidence and who is willing to testify that the medical care did not comply with the applicable standard of care.[34]

Hylton thus serves as a prime example of a case that would likely be dismissed under today's statute.[35] In *Hylton,* the plaintiff's expert witness relied upon a summary of the medical care provided via a phone conversation.[36] Under the amended Rule 9(j), this would be unlikely to qualify as a review of "all medical records pertaining to the alleged negligence that are available to the plaintiff after reasonable inquiry."[37] Not only does this change to Rule 9(j) create a higher procedural standard, but it also places a more onerous burden on plaintiffs to file a claim within the three-year statute of limitations, as requests for medical records can take some time to process.[38]

Furthermore, it is likely that this stricter procedural standard will increase the costs of pre-trial preparation, as attorneys must spend more hours accumulating and reviewing all reasonably available medical records relevant to the case at hand. While medical malpractice plaintiffs are able to retain counsel on a contingency basis,[39] they are explicitly precluded by state law from hiring expert

33. *Id*. at 516, 530 S.E.2d at 111.

34. Act of July 25, 2011, ch. 400, sec. 3, § 1A-9(j), 2011 N.C. Sess. Laws 1712, 1713–14 (codified at N.C. GEN STAT § 1A-9(j) (2015)) (emphasis added).

35. Although no North Carolina case has explicitly overruled *Hylton*, the amended statute seems to directly oppose *Hylton*'s holding.

36. *Hylton*, 138 N.C. App. at 513, 530 S.E.2d at 109.

37. N.C. GEN. STAT. § 1A-9(j) (2015); *see also* Henry & Jackson, *supra* note 15, at 12 ("The revised Rule 9(j) makes clear that such a cursory review is no longer sufficient. Rule 9(j) now requires that the material reviewed must include 'all medical records pertaining to the alleged negligence that are available to the plaintiff after reasonable inquiry.'").

38. § 1-15(c); Donovan, *supra* note 4 (providing the opinions of a North Carolina plaintiff's attorney, stating that "[j]ust because you send a request for medical records doesn't mean that you receive those records in a timely fashion").

39. *See Contingency Fee,* BLACK'S LAW DICTIONARY (8th ed. 2004) ("A fee charged for a lawyer's services only if the lawsuit is successful or is favorably settled out of court. Contingent fees are usu[ally] calculated as a percentage of the client's net recovery . . . .").

witnesses to testify on such a basis.[40] Therefore, the plaintiff or plaintiff's attorney must bear these costs.[41]

While the costs of expert witnesses vary dramatically, medical experts tend to cost more than other expert witnesses.[42] According to one study, while the national average hourly fee for file review and preparation for non-medical experts was $245, the same hourly fee for medical experts was $350.[43] Furthermore, while the average hourly fee for trial testimony by non-medical experts was $275, the same hourly fee for medical experts was $500.[44]

By increasing the costs of litigation, low-income plaintiffs are placed in a disadvantageous position because they may not be able to afford these increased fees. Moreover, even if plaintiffs' attorneys are willing to front these costs, this may come at the expense of a greater contingency fee, limiting the amount of money a successful plaintiff may ultimately receive.[45] Given the necessity of expert witnesses in medical malpractice cases,[46] the inability of plainitffs to pay—or the unwillingness of plaintiffs' attorneys to front—expert witness costs may severely hinder a plaintiff's chances of succeeding on a meritorious claim.

40. § 8C-702(f) ("In an action alleging medical malpractice, an expert witness shall not testify on a contingency fee basis.").

41. *Paying Experts*, AM. B. ASS'N (Winter 1997), https://www.americanbar.org/content/newsletter/publications/solo_newsletter_home/payexprt.html [https://perma.cc/H5HP-GUDA] ("While many law firms are willing to cover the costs of expert witnesses and hope for reimbursement out of the winnings, it is not uncommon for lawyers to ask clients to help pay the costs up front.").

42. *See Expert Witness Fee Calculator,* THE EXPERT INST., https://www.theexpertinstitute.com/expert-witness-fees/ [https://perma.cc/294L-79SL] (comparing the costs of medical and non-medical experts); *Expert Witness Fees: How Much Does An Expert Witness Cost?*, SEAK, INC., http://blog.seakexperts.com/expert-witness-fees-how-much-does-an-expert-witness-cost/ [https://perma.cc/GA97-VSR6] (providing the results of a study done by SEAK, Inc., an expert witness directory).

43. *Expert Witness Fees: How Much Does An Expert Witness Cost?*, *supra* note 42.

44. *Id.*

45. *See Paying Experts*, *supra* note 41 (describing a situation in which an attorney was willing to reduce her contingency fee if clients would bear these up front costs).

46. *See* B. Sonny Bal, *The Expert Witness in Medical Malpractice Litigation*, 467 CLINICAL ORTHOPEDICS AND RELATED RES. 383, 383 (Feb. 2009), https://link.springer.com/content/pdf/10.1007%2Fs11999-008-0634-4.pdf [https://perma.cc/73XJ-PVXM] ("A member of the profession is needed to tell the judge and jury what the defending physician should have done or not done under the particular circumstances, and whether such conduct constituted negligence by violating the standards of care of the profession. Therefore, in medical malpractice litigation, expert witness testimony is nearly always necessary.").

B. Evidentiary Changes

In addition to these procedural changes, several evidentiary reforms were passed, increasing plaintiffs' burdens during trial. These reforms amended North Carolina Rule of Evidence 702(a) regarding the sufficiency of expert witness testimony[47] and increased the evidentiary standard for claims filed under the Emergency Medical Treatment and Active Labor Act ("EMTALA")[48] from a "preponderance of the evidence" standard to a "clear and convincing evidence" standard.[49]

1. Amendment to North Carolina Rule of Evidence 702(a)

As previously written, the rule stated that "[i]f scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion."[50] These reforms, however, amended North Carolina Rule of Evidence 702(a)[51] to better align with Federal Rule of Evidence 702[52]—titled "Testimony by Expert Witnesses"—based on the standard the Supreme Court set forth in *Daubert v. Merrell Dow Pharmaceuticals, Inc*.[53] The revised rule keeps the entirety of the former's language but

47. An Act to Provide Tort Reform for North Carolina Citizens and Businesses, ch. 283, sec. 1.3, § 8C-702(a), 2011 N.C. Sess. Laws 1048, 1049 (2011) (codified at N.C. GEN. STAT. § 8C-702(a) (2015)); *see also* Robert C. Ervin, Applying North Carolina Rule of Evidence 702(a), at 1 (Oct. 2015) (unpublished manuscript), https://www.sog.unc.edu/sites/www.sog.unc.edu/files/course_materials/R15%20Daubert%20Presentation%202015.pdf [http://perma.cc/ZJ3S-MCFU] (explaining the various implications of this amended rule).

48. *See* 42 U.S.C. § 1395dd (2012).

49. Act of July 25, 2011, ch. 400, § 6, 2011 N.C. Sess. Laws 1712, 1715 (codified at N.C. GEN. STAT. § 90-21.12(b) (2015)).

50. N.C. GEN. STAT. § 8C-702(a) (2009).

51. An Act to Provide Tort Reform for North Carolina Citizens and Businesses, Ch. 283, sec. 1.3, § 8C-702(a), 2011 N.C. Sess. Laws 1048, 1049 (codified at N.C. GEN. STAT. § 8C-702(a) (2015)).

52. FED. R. EVID. 702.

53. 509 U.S. 579 (1993). In *Daubert*, the United States Supreme Court struck down the "general acceptance" standard established in *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923) in regards to the admissibility of scientific evidence. *Id*. at 597.

> In an attempt to give guidance to the lower courts in making a determination of scientific reliability, the Court suggested a *nonexclusive* list of factors to be considered. Specifically mentioned were (1) whether the technique or theory can be or has been tested; (2) whether the theory or technique has been subject to peer review and publication; (3) the known or potential rate of error; (4) the existence and maintenance of standards and controls; and (5) the degree to which the theory or technique has been generally accepted in the scientific community.

adds that a witness may only testify as a qualified expert "if all of the following apply: (1) [t]he testimony is based upon sufficient facts or data[;] (2) [t]he testimony is the product of reliable principles and methods[; and] (3) [t]he witness has applied the principles and methods reliably to the facts of the case."[54]

North Carolina courts have recognized the difference between the former North Carolina standard and the federal standard. Prior to the passing of this amendment to the North Carolina rule, the Supreme Court of North Carolina observed that the "application of the North Carolina approach is decidedly less mechanistic and rigorous than the 'exacting standards of reliability' demanded by the federal approach."[55] Under the former standard, once a trial court made a preliminary determination about the reliability of any expert's proffered testimony, "any lingering questions or controversy concerning the quality of the expert's conclusions [went] to the weight of the testimony rather than its admissibility."[56] Therefore, the previous approach "significantly curtailed the ability of the trial court to serve as a gatekeeper related to expert testimony."[57] Five years after these reforms were passed, the Supreme Court of North Carolina finally held that "the General Assembly has made it clear that North Carolina is now a *Daubert* state."[58]

Under the standard set forth in *Daubert* and its progeny,[59] which is now implemented in North Carolina, the quality and reliability of

Kenneth S. Broun, *Scientific Evidence in North Carolina After Howerton—A Presumption of Admissibility?*, 10 N.C. ST. BUS. J. 8, 9 (2005) (citing *Daubert*, 509 U.S. at 593–94). For an extensive analysis on the effects of *Daubert* on medical testimony in other states, see Gerald J. Todaro, *The Admissibility of Medical Testimony in Ohio: Daubert, Joiner, and Ohio's Relevance-Reliability Standard*, 46 CLEV. ST. L. REV. 319 (1998).

54. N.C. GEN. STAT. § 8C-702(a) (2015).

55. Howerton v. Arai Helmet, Ltd., 358 N.C. 440, 464, 597 S.E.2d 674, 690 (2004) (quoting Weisgram v. Marley Co., 528 U.S. 440, 445 (2000)), *superseded by statute*, An Act to Provide Tort Reform for North Carolina Citizens and Businesses, Ch. 283, sec. 1.3, § 8C-702(a), 2011 N.C. Sess. Laws at 1049, *as recognized in* State v. McGrady, 368 N.C. 880, 787 S.E.2d (2016).

56. *Id*. at 461, 597 S.E.2d at 688.

57. Henry & Jackson, *supra* note 15, at 13.

58. State v. McGrady, 368 N.C. 880, 886–88, 787 S.E.2d 1, 7–8 (2016) (overturning *Howerton*). In *Howerton,* the Supreme Court of North Carolina stated that "North Carolina is not, nor has it ever been, a *Daubert* jurisdiction." 358 N.C. at 469, 597 S.E.2d at 693.

59. The "Daubert trilogy" refers to three cases—*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, *General Electric Co. v. Joiner*, and *Kumho Tire Co. v. Carmichael*—providing guidance on the admission of of scientific evidence according to Federal Rule 702. *See* Megan Dillhoff, *Science, Law, and Truth: Defining the Scope of the Daubert Trilogy*, 86 NOTRE DAME L. REV. 1289, 1290 (2011). These cases each deal with a different aspect of this standard. *See* Kumho Tire Co. v Carmichael, 526 U.S. 137, 147

expert testimony is considered *before* such evidence may be ruled admissible.[60] There is no doubt that this new standard provides judges with a greater gatekeeper role in determining the admissibility of expert testimony, rather than assigning the jury with this task.[61] Theoretically, this more exacting evidentiary standard should make it more difficult for plaintiffs to introduce expert testimony at trial, since *Daubert* requires that each of the three factors be met in order for an expert witness to provide an opinion.[62] Indeed, "[c]ritics of medical malpractice litigation expressed optimism that *Daubert* would eliminate unreliable expert testimony in these cases."[63] However, the impact that this change has had on medical malpractice cases is unclear.[64] While cases exist in *Daubert* states where a trial judge excluded expert witness testimony under this heightened standard,[65] it is difficult to say whether such testimony would have been excluded under the previous standard as well.[66] Thus, the impact of *Daubert* on

(1999) (holding that *Daubert* applies not only to scientific testimony, but to all expert testimony); Gen. Elec. Co. v. Joiner, 522 U.S. 136, 143, 154 (1997) (holding that a court's focus must be on the methodology and techniques used by expert witnesses, rather than their conclusions, while also stressing the importance of deference to trial courts); Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 593–94 (1993) (providing a list of several nonexclusive factors for courts to consider).

60. *See McGrady*, 368 N.C. at 892–93, 787 S.E.2d at 10–11 ("The trial court . . . concludes, based on these findings, whether the proffered expert testimony meets Rule 702(a)'s requirements of qualification, relevance, and reliability.").

61. *See* Dillhoff, *supra* note 59, at 1290 ("Importantly, [*Daubert*, *Joiner*, and *Kumho Tire*] assign the role of gatekeeper primarily to judges rather than juries when it comes to scientific evidence and testimony."); Henry & Jackson, *supra* note 15, at 13 (describing the "robust gatekeeper role" of the trial court in regards to expert testimony under this new standard).

62. *See Daubert*, 509 U.S. at 593–94; *see also* An Act to Provide Tort Reform for North Carolina Citizens and Businesses, Ch. 283, *sec.* 1.3, § 8C-702(a), 2011 N.C. Sess. Laws 1048, 1049 (codified at N.C. GEN. STAT. § 8C-702(a) (2015)).

63. *Expertise in Law, Medicine, and Health Care*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Apr. 2011), https://archive.ahrq.gov/research/findings/evidence-based-reports/jhppl/shuman2.html [https://perma.cc/34PS-Q8XC].

64. *Id*. ("From the few reported cases addressing *Daubert*'s application to standard-of-care issues in medical malpractice cases, no clear pattern of more rigorous scrutiny emerges.").

65. *See* Williams v. Hedican, 561 N.W.2d 817, 830, 832 (Iowa 1997) (holding that the trial court abused its discretion under *Daubert* in medical malpractice case by excluding expert's testimony, stating that "[w]e do not accept the proposition that statistical proof has to be presented before a medical expert can testify on causation"); Bunting v. Jamieson, 984 P.2d 467, 474 (Wyo. 1999) (holding that the trial court abused its discretion under *Daubert* by excluding expert testimony of physician on causation issue in medical malpractice case based upon judgment of failure to satisfy the *Daubert* "peer review" factor).

66. Since general acceptance is still a factor considered under *Daubert*, it is plausible that expert witness testimony that is not generally accepted would fail both the general acceptance test established in *Frye* as well as the stricter standard set forth in *Daubert*. *See*

the difficulty for plaintiffs of introducing expert testimony in medical malpractice cases has been described as "modest."[67]

2. Change in Evidentiary Standard for EMTALA Claims

Under the preexisting law, medical malpractice cases based on claims that defendants provided improper emergency medical care required a "greater weight of the evidence" standard as the burden of proof.[68] Moreover, the statute as previously written made no distinction between ordinary and emergency medical conditions.[69] These reforms, however, amended the statute to increase the burden of proof for emergency medical conditions, raising it from a "greater weight of the evidence"[70] to a "clear and convincing" evidentiary standard.[71] The amended statute reads:

> In any medical malpractice action arising out of the furnishing or the failure to furnish professional services in the treatment of an emergency medical condition, as the term "emergency medical condition" is defined in 42 U.S.C. § 1395dd(e)(1), the claimant must prove a violation of the standards of practice set forth in subsection (a) of this section *by clear and convincing evidence*.[72]

The "clear and convincing" standard "means that the party must present evidence that leaves the [factfinder] with a firm belief or conviction that it is highly probable that the factual contentions of the claim or defense are true."[73] While this standard "does not require proof beyond a reasonable doubt," it "is a higher standard of proof

Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 594 (1993) ("Finally, 'general acceptance' can yet have a bearing on the inquiry."). Courts undertaking a *Daubert* analysis, however, do not indicate whether such testimony would meet this previous standard. *See id.*

67. *Expertise in Law, Medicine, and Health Care*, *supra* note 63.

68. *See* N.C. GEN. STAT. § 90-21.12 (2009) ("[T]he defendant health care provider shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice . . . .").

69. *See* Act of May 12, 1976, ch. 977, sec. 4, § 8-93, 1975 N.C. Sess. Laws 3, 4 (codified as amended at N.C. Gen. Stat. § 90-21.12 (2015)); *see also* N.C. GEN. STAT. § 90-21.12 (2009); *infra* notes 77–88 and accompanying text (defining an emergency medical condition).

70. N.C. GEN. STAT. § 90-21.12 (2009).

71. N.C. GEN. STAT. § 90-21.12(b) (2015).

72. *Id*. (emphasis added).

73. NINTH CIRCUIT JURY INSTRUCTIONS COMMITTEE, MANUAL OF MODEL CIVIL JURY INSTRUCTIONS FOR THE DIST. COURTS OF THE NINTH CIRCUIT § 1.7 (2017), www3.ce9.uscourts.gov/jury-instructions/sites/default/files/WPD/Civil_Instructions_2017_9.pdf [https://perma.cc/5DEW-S5AB].

than proof by a preponderance of the evidence."[74] The rationale behind raising the burden of proof for emergency room physicians is understandable, as these physicians would otherwise be at extreme risk of malpractice allegations due to the high-risk nature of their work.[75] However, this reform protects all physicians—not just emergency room physicians—with this increased standard, provided that the claim arose from an emergency medical condition.[76] This is due to the interplay between North Carolina's standard of care statute and the chosen definition of an emergency medical condition.

The North Carolina statute uses the same definition of emergency medical condition as EMTALA, which defines the term as:

> [A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . . .[77]

The definition of emergency medical condition also encompasses situations in which there is inadequate time to safely transfer a pregnant woman before delivery or when such a transfer would pose

74. *Id.*

75. Aaron E. Carroll & Jennifer L. Buddenbaum, *High and Low-Risk Specialties Experience with the U.S. Medical Malpractice System*, BIOMED CENT. HEALTH SERVS. RES. (Nov. 6, 2013), http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-465 [http://perma.cc/9CJM-9VKW] (defining "emergency medicine, general surgery, obstetrics and gynecologic surgery, and radiology as . . . 'high-liability risk' specialties"). Because these physicians work in an "information-poor, high-risk . . . environment," the common fear is that these physicians are most at risk of practicing defensive medicine, thus increasing overall healthcare spending. *See* Steve Cohen, *On Tort Reform, It's Time to Declare Victory and Withdraw*, FORBES (Mar. 2, 2015, 9:59 AM), http://www.forbes.com/sites/stevecohen/2015/03/02/on-tort-reform-its-time-to-declare-victory-and-withdraw/2/#70f9fda43388 [http://perma.cc/T8QP-AD9M].

76. Henry & Jackson, *supra* note 15, at 14 (noting that the North Carolina reform legislation should cover situations involving emergency medical treatment "no matter the specialty of the health care provided involved").

77. § 1395dd(e)(1)(A). The Supreme Court of North Carolina has found federal jurisprudence persuasive when defining such conditions, agreeing that "emergency medical conditions are sudden, severe and short-lived physical injuries or illnesses that require immediate treatment to prevent further harm." Diaz v. Div. of Soc. Servs., 360 N.C. 384, 387–88, 628 S.E.2d 1, 4 (2006) (quoting Greenery Rehab. Grp., Inc. v. Hammon, 150 F.3d 226, 232 (2d Cir. 1998)); *see* Craige, *supra* note 4, at 17 ("Following *Diaz*, our courts must confine the heightened burden of proof to those rare emergency situations in which 'instant' actions was required to prevent serious harm.").

a threat to the woman or her unborn child.[78] It is important to note, however, that the EMTALA definition of an emergency medical condition does not specify that such a condition must arise only in an emergency room setting.[79] Within the context of the rest of the EMTALA statute, federal EMTALA claims brought alleging an improper medical screening always arise from an allegedly improper screening or failure to screen that took place in a hospital's emergency department.[80] Thus, it would have been redundant for Congress to specify that the statute only applies to emergency medical conditions arising in a hospital's emergency department.

In contrast to the federal law, the amended North Carolina law extends to a much broader range of medical settings than just emergency departments. By utilizing the EMTALA definition of an emergency medical condition, without the context of the entire EMTALA statute requiring that the condition arise in an emergency department,[81] the North Carolina General Assembly allowed for the clear and convincing evidentiary standard to apply "well beyond those situations where the health care provider is an emergency room physician."[82] For example, since EMTALA's emergency medical condition definition includes cases in which a pregnant woman is in active labor and about to deliver,[83] many malpractice allegations stemming from childbirth must now pass the "clear and convincing" evidence standard, rather than the lower "preponderance of the evidence" standard.[84] As a result, many obstetricians are provided extra protection from medical malpractice complaints, even in cases of ordinary childbirth.[85]

The expansive application of this broad definition has even led some to raise the question of legislative intent, arguing that the

78. § 1395dd(e)(1)(B).

79. *See* § 1395dd(e).

80. § 1395dd(a) ("In the case of a hospital that has a hospital emergency department, if any individual . . . *comes to the emergency department* and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists." (emphasis added)).

81. N.C. GEN. STAT. § 90-21.12(d) (2015).

82. Henry & Jackson, *supra* note 15, at 14.

83. 42 U.S.C. § 1395dd(e)(1)(B).

84. *See* Hill, *supra* note 21, at 721 (exploring the possibly unintended effects of the protections offered by this reform).

85. *Id.* (explaining how the amended statute changed malpractice claims in the field of obstetrics).

General Assembly may not have intended to use such a broad definition.[86] In fact, each of the five earlier edited versions and the original filed version of this bill explicitly limited its protection to emergency medical conditions in a hospital's emergency department.[87] Furthermore, "other legislative history—including committee hearing minutes and committee bill summaries—suggests that the General Assembly intended for the protection to apply solely to hospital emergency providers."[88] Given the legislature's apparent focus on the emergency room setting, it is surprising that the General Assembly ultimately passed such a broad provision.

Regardless of the General Assembly's precise intent, it is clear that the law as it currently stands provides another example of how these reforms have made it more difficult for plaintiffs to prevail at trial by providing extra protection to a wide range of physicians, rather than only to emergency room physicians. Whether this amendment was intended to apply so broadly or not, applying this increased evidentiary burden to a wide array of medical situations provides yet another example of how the legislature has protected defendant-physicians to the detriment of plaintiffs.

86. *Id*. at 720 (arguing that by failing to limit this definition to emergency room health care providers, "the General Assembly inadvertently or unwisely extended the heightened protection intended solely for emergency room health care providers to providers in a myriad of other contexts").

87. *Id.* at 722–24 (citing S.B. 33, 2011 Gen. Assemb., Reg. Sess., Draft (N.C. Apr. 20, 2011) ("In any medical malpractice action arising out of the furnishing or the failure to furnish professional services in a hospital emergency room, the claimant must prove a violation of the standard of health care set forth in subsection (a) of this section by clear and convincing evidence"); S.B. 33, 2011 Gen. Assemb., Reg. Sess., Draft (N.C. Apr. 19, 2011) ("In any medical malpractice action arising out of . . . professional services in a hospital emergency room . . . ."); S.B. 33, 2011 Gen. Assemb., Reg. Sess., Draft (Mar. 2, 2011) ("In any medical malpractice action arising out of the furnishing or the failure to furnish services imposed by [EMTALA] for an emergency medical condition. . . ."); S.B. 33, 2011 Gen. Assemb., Reg. Sess., Draft (Mar. 1, 2011) ("In any medical malpractice action arising out of the furnishing or the failure to furnish services pursuant to obligations imposed by [EMTALA] . . . ."); S.B. 33, 2011 Gen. Assemb., Reg. Sess., Draft (N.C. Feb. 3, 2011) ("In any medical malpractice action arising out of . . . services pursuant to obligations imposed by [EMTALA] for an emergency medical condition . . . ."); S.B. 33, 2011 Gen. Assemb., Reg. Sess., Draft (N.C. Feb. 2, 2011) ("In any medical malpractice action arising out of the provision of emergency services as defined in G.S. 58-3-190(g)(2) [including the screening and treatment of emergency conditions in emergency departments].")).

88. *Id*. at 724. For example, Senator Nesbitt stated that "the ER is a very special institution" and that "those guys deserve some special protections." *Id*. (citing *Senate Judiciary I Committee Feb. 24, 2011 Minutes,* 2011 Gen. Assemb., Reg. Sess. (N.C. 2011)).

C. Substantive Changes

While these increased procedural, evidentiary, and substantive burdens have significantly affected many aspects of medical malpractice law by making it more difficult for plaintiffs to bring successful malpractice claims, the most controversial change to the preexisting law has been the $500,000[89] liability limit for noneconomic damages.[90] This cap serves to limit the amount of noneconomic damages a successful plaintiff may receive. Thus, if a jury awards a plaintiff $1 million in noneconomic damages for pain and suffering, this amount will be reduced to the statutory limit of $500,000.[91] Noneconomic damages are defined as "[d]amages to compensate for pain, suffering, emotional distress, loss of consortium, inconvenience, and any other nonpecuniary compensatory damage."[92] Punitive damages are not considered noneconomic damages under this definition.[93] In contrast, economic damages include "compensation for objectively verifiable monetary losses such as past and future medical expenses, [and the] loss of past and future earnings."[94]

Before the passage of these reforms, no such damages cap existed in North Carolina.[95] By its very nature, the damages cap portion of the statute was added in order to limit jury awards in medical malpractice cases. The jury is not informed of the existence of this cap,[96] and any jury awards including more than $500,000 in noneconomic damages will be modified by the judge to conform to the damages cap.[97]

There is an exception to this rule, however, if the trier of fact finds both that "[t]he plaintiff suffered disfigurement, loss of use of part of the body, permanent injury or death" and "[t]he defendant's acts or failures, which are the proximate cause of the plaintiff's injuries, were committed *in reckless disregard of the rights of others,*

89. Every three years, the $500,000 limit is subject to adjustments to account for inflation based on the Consumer Price Index. N.C. GEN. STAT. § 90-21.19(a) (2015). For convenience sake, this Comment will refer to the cap limit as $500,000 although it is slightly higher today.

90. *See supra* notes 17–18 and accompanying text (describing this controversy).

91. *See* § 90-21.19(a) ("Judgment shall not be entered against any defendant for noneconomic damages in excess of five hundred thousand dollars . . . .").

92. § 90-21.19(c)(2).

93. *Id.*

94. AM. COLL. OF SURGEONS, *supra* note 11.

95. N.C. GEN STAT § 90-21.19 (2009) (amended by Act of July 25, ch. 400, § 7, 2011 N.C. Sess. Laws 1712, 1715–16 (2011) (codified at N.C. Gen. Stat. § 90-21.19 (2015)) (stating North Carolina's medical malpractice policy before the damages cap was enacted).

96. N.C. GEN. STAT. § 90-21.19(d) (2015).

97. § 90-21.19(a).

grossly negligent, fraudulent, intentional or with malice."[98] In other words, plaintiffs who suffer catastrophic injury must prove that the defendant acted with either gross negligence or reckless disregard of the patient's rights in order to circumvent the damages cap.[99] Therefore, the exception primarily accounts for the extreme cases where a physician's conduct is so egregious that his mental state can be implicitly proven by his actions. In those extreme and unusual situations where a physician unnecessarily places a patient at risk of serious harm, such as where a negligent doctor was incapacitated by drugs or alcohol, the exception may apply and the cap will not limit the awarded noneconomic damages.[100]

II. CONSEQUENCES OF TORT REFORM IN NORTH CAROLINA ON MEDICAL MALPRACTICE CASE FILINGS

As previously discussed, each facet of these reforms serves to increase the burden on plaintiffs in medical malpractice cases. The restructured procedural and evidentiary requirements make reaching the trial stage increasingly difficult and expensive for plaintiffs, and plaintiffs who are able to prevail at trial face a limit on the amount of money they are able to recover. Therefore, these reforms have led to a seemingly permanent decrease in the number of medical malpractice claims filed, as the likelihood of attorneys taking on malpractice cases is similarly diminishing.[101]

Although these reforms went into effect in 2011, data on the number of medical malpractice suits filed before and after the reforms only recently indicate that the reforms have led to a more permanent decrease in filings of these cases. Between 1998 and 2003, an annual average of 617 medical malpractice suits were filed in North Carolina, approximately 51.4 suits each month.[102] Between

98. § 90-21.19(b).

99. *See* Craige, *supra* note 4, at 17. The Supreme Court of North Carolina has interpreted gross negligence to be an act "done purposely and with knowledge that such act is a breach of duty to others, i.e., a *conscious* disregard of the safety of others." Yancey v. Lea, 354 N.C. 48, 53, 550 S.E.2d 155, 158 (2001).

100. Craige, *supra* note 4, at 17 (stating that although this exception exists, few cases will actually fall within this egregious standard).

101. *See* Donovan, *supra* note 4 ("[S]ome cases that previously might have brought in big verdicts are now difficult for lawyers to justify taking on given the high cost of litigating medical malpractice claims and the uncertainty of prevailing on them."); Zimmerman & Hallinan, *supra* note 1 (arguing that damages caps are forcing attorneys to turn away medical malpractice claims from plaintiffs with legitimate claims who don't represent big economic losses); s*ee also infra* Part III (discussing plaintiffs' attorneys' increased reliance on economic damages).

102. Craige, *supra* note 5, at 9.

2000 and 2003, the number of malpractice suits filed remained relatively stable, rising only one percent in the three-year period, below the rate of population growth over the same time period.[103] In the 26 months prior to September 2011, the average number of medical malpractice cases filed in state courts dropped to 40.1 suits each month.[104] Once it became clear, however, that the damages cap was going into effect, plaintiffs rushed to file their claims in court before the damages cap would take effect, and in September 2011, the number of cases increased more than eightfold to 322 cases in a single month.[105] Between 2013 and 2015, an average of 25.5 medical malpractice cases have been filed in state courts each month, a 36.4% reduction in cases from the 26-month period before 2011.[106]

This increase in cases, and the subsequent decline, was reasonably expected. Because the statute of limitations for medical malpractice cases is three years,[107] it is possible that many people who filed their claims in September 2011 otherwise may have waited to bring these claims sometime between 2011 and 2014. Thus, in the three years following this change, an even greater lag in case filings could be expected than would be seen over the long term, since many of these cases were filed in 2011, rather than being evenly dispersed between 2011 and 2014. Furthermore, it is difficult to determine how long it will take for the average number of cases to stabilize, although now that more than three years have passed since the law took effect, it is becoming increasingly practical to analyze the impact of these reforms.[108] It appears as if the number of medical malpractice case filings will remain below what was seen before these reforms were enacted.

III. INCREASED RELIANCE BY PLAINTIFFS' ATTORNEYS ON ECONOMIC DAMAGES

While these statistics indicate that fewer medical malpractice claims are being filed since the passage of these reforms, statistics alone do not answer the question of why these claims are dropping. The increased procedural and evidentiary burdens certainly account for some of this decrease. The more plausible explanation for the

103. *Id*. at 8.

104. Donovan, *supra* note 4 (relying on data from the Administrative Office of the Courts).

105. *Id*.

106. *Id*.

107. N.C. GEN. STAT. § 1-15(c) (2015).

108. Donovan, *supra* note 4.

extent of the decrease in case filings, however, is the consequence of the noneconomic damages cap, because attorneys are placing more emphasis on recovering economic damages,[109] disproportionately harming low-income plaintiffs.

Medical malpractice cases are costly for plaintiffs and potentially risky for their attorneys, who are typically paid on a contingency basis.[110] In 2004, routine malpractice cases cost North Carolina plaintiffs over $50,000 in litigation expenses, while the cost to litigate more complex cases exceeded $100,000.[111] Similar costs have been reported in other states, as one Texas attorney estimated that a typical case "involves hiring a half dozen expert witnesses and costs about $100,000."[112] Plaintiffs' attorneys often accept these cases on a contingency basis,[113] meaning these attorneys only get paid if they settle or win at trial.[114] Therefore, attorneys already have an incentive to accept cases that they realistically think they can win.[115]

In the wake of tort reform, attorneys now have even more of an incentive to only accept cases from the *types* of plaintiffs who can be expected to receive large payouts. This does not just mean plaintiffs with factually strong cases, but also plaintiffs who possess the qualities of a strong candidate for a large jury award based on economic damages.[116] Because the damages cap only limits noneconomic damages, plaintiffs who can be expected to receive a large amount of economic damages are now much more valuable to attorneys paid on a contingency basis. Economic damages "can be estimated . . . and monetarily compensated."[117] These damages may include

109. *See id.* (expressing attorneys' preferences for plaintiffs with high earning capacity).

110. Richie Kemp, *When Attorneys Come Back for Seconds: Increased Attorney Fees for Extraordinary Work in Medical Malpractice Cases*, 25 J. LEGAL MED. 79, 89 (2004) ("A typical medical malpractice case is undertaken by a plaintiff's attorney under a contingent fee agreement.").

111. Craige, *supra* note 5, at 9.

112. Zimmerman & Hallinan, *supra* note 1; *see also* Kemp, *supra* note 110, at 89 ("[Attorneys] ordinarily risk between $50,000 and $100,000 preparing and litigating the average medical malpractice action. They must take depositions, obtain expert testimony, and file numerous documents with the court, all of which costs money.").

113. Kemp, *supra* note 110, at 89.

114. A contingent fee contract for legal services is a contract under which the amount or the payment of the attorney's fee is dependent upon the outcome of the litigation or matter. Romulado P. Eclavea, Annotation, *Validity, Construction, and Effect of Contract Providing for Contingent Fee to Defendant's Attorney,* 9 A.L.R. 4th 191, 193 n.1 (1981).

115. Craige, *supra* note 5, at 9 ("If the patient loses, neither the patient nor the lawyer is paid anything. Recognizing these obstacles, attorneys know they risk financial ruin unless they file well-founded malpractice claims.")

116. *See* Donavan, *supra* note 4 (expressing attorneys' preferences for plaintiffs with high earning capacity).

117. *Pecuniary Damages*, BLACK'S LAW DICTIONARY (10th ed. 2014).

compensation for objectively verifiable monetary losses, such as past and future medical expenses and the loss of past or future earnings.[118]

In contrast, juries must make more fluid value determinations for noneconomic damages, as it is difficult to place an exact value on pain and suffering. While the value of medical expenses depends on the individual facts of each case, juries determine the value of past and future earnings based on the economic status of the plaintiff by analyzing the amount of past wages lost by the plaintiff due to the injury in addition to the prospective loss of future wages.[119] If two plaintiffs present cases with equal injuries and medical expenses, the more valuable plaintiff will be the one with more lost wages. According to one North Carolina plaintiff's attorney, young, working individuals possess far more value to juries in the context of lost wages, and therefore these reforms have caused juries to systematically devalue children, unemployed individuals, and retired individuals.[120]

This phenomenon has proven true in other states with damages caps as well. For example, California's Medical Injury Compensation Reform Act ("MICRA"), passed in 1975, limits all noneconomic damages awards in medical malpractice cases to $250,000.[121] One California attorney recounted his experience handling virtually identical breast cancer patients.[122] Both plaintiffs were mothers in their late forties, had two children, and ultimately died from the disease.[123] "One plaintiff was a housewife and her case was settled for $300,000. The other was a Silicon Valley executive whose family won a $2 million settlement."[124] Other attorneys have cited similar stories. For example, one attorney handled two similar malpractice cases, each involving the death of a young mother.[125] In each case, the jury awarded noneconomic damages of $3 million.[126] Due to California's cap on noneconomic damages, however, these awards were reduced to $250,000 as required under MICRA.[127] One plaintiff who held a

118. AM. COLL. OF SURGEONS, *supra* note 11.

119. JACOB A. STEIN ON PERSONAL INJURY DAMAGES § 9:5, at 9-14 (3d ed. 1997) (noting that economic damages are determined by "calculat[ing] the lost wages of the claimant by simply determining what wages were being earned at the time of the injury and using the appropriate multiplier to arrive at the [future] lost wages figure").

120. *See* Donovan, *supra* note 4.

121. CAL. CIV. CODE § 3333.2 (West 2017).

122. *See* Zimmerman & Hallinan, *supra* note 1.

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *See* CAL. CIV. CODE § 3333.2 (West 2017); Zimmerman & Hallinan, *supra* note 1.

master's degree and worked as a school administrator was awarded $1.6 million in economic damages, while the other plaintiff, an unmarried woman on welfare, received just $200,000 in economic damages.[128]

These anecdotes provide poignant examples of situations where plaintiffs with factually similar cases received significantly different damages awards due to their relative economic status. This pattern is troubling because when noneconomic damages are capped, plaintiffs' attorneys are forced to consider the likely economic damages in a case, thus making wealthy plaintiffs far more valuable to attorneys than low-income plaintiffs who are not expected to receive much in the form of economic damages. Given the high cost of medical malpractice cases, attorneys must make responsible fiscal judgments when taking on new cases, irrespective of the factual strength of such cases. Therefore, such caps serve to systematically devalue low-income plaintiffs—even those with meritorious claims—who may not be able to command enough money in damages to justify attorneys taking on their cases. As a result, fewer cases are being filed.

IV. ESTIMATING THE IMPACT OF NORTH CAROLINA'S TORT REFORM ON VARIOUS PLAINTIFF GROUPS VIA COMPARISONS TO STATES THAT PREVIOUSLY ENACTED SIMILAR REFORMS

A. Comparing North Carolina to Texas

In North Carolina, it is difficult to precisely assess to what extent different plaintiff groups have been affected by these reforms, since data about individual plaintiffs are not made publicly available. Unlike in North Carolina, data on individual medical malpractice plaintiffs are publicly available in Texas, a state that passed similar tort reform laws in 2003.[129] These data can be used to predict what effects these laws may have on different plaintiff groups.[130] However, there is one major caveat when making these comparisons: Texas

128. *See* Zimmerman & Hallinan, *supra* note 1.

129. *See* Act of June 10, 2003, ch. 204(G), § 74.301(a) (codified at TEX. CIV. PRAC. & REM. CODE ANN. § 74.301 (West, Westlaw through 2017 Reg. & First Called Sess.)) (implementing a $250,000 limit on noneconomic damages in medical malpractice claims as of Sept. 1, 2003).

130. *See* David A. Hyman et. al., *Estimating the Effect of Damages Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. OF LEGAL ANALYSIS 335, 356–57 (2009) (using claims data from 1988 through 2004 to predict what effect Texas's noneconomic damages cap had on various groups of plaintiffs).

capped its noneconomic damages at $250,000,[131] half the amount set in North Carolina.[132] Therefore, since lower noneconomic damages can be awarded in Texas than in North Carolina, it should come as no surprise that the effects of the Texas damages cap would be greater than what has been seen thus far in North Carolina.[133] For example, while the number of medical malpractice claims in North Carolina have dropped by 36.4% from their pre-2011 levels,[134] Texas has seen a roughly 70% decrease in the number of such claims between 2003 and 2012.[135]

While sources have extrapolated these statistics to estimate the effects of a $500,000 cap,[136] there are certain variables that may not be accounted for, and therefore these numbers are best viewed as informed estimates, not ironclad predictions. For example, such retroactive simulation data cannot account for cases that were not accepted by attorneys due to the existence of a damages cap or plaintiffs that may have been deterred from ever filing a complaint in the first place, as these numbers only account for filed cases.[137]

Despite these limitations, this information is still extremely valuable for several reasons. First, Texas passed its reforms in 2003, and therefore more scholarly research has been undertaken in Texas than in North Carolina, which passed its reform in 2011.[138] Second, Texas makes the record of such cases publicly available; the Texas Closed Claims Database ("TCCD") is a publicly accessible database that contains individual reports of closed professional liability

131. TEX. CIV. PRAC. & REM. CODE ANN. § 74.301(a) (West, Westlaw through 2017 Reg. & First Called Sess.); *see also* Charles Silver, David A. Hyman, & Bernard S. Black, *The Impact of the 2003 Texas Medical Malpractice Damages Cap on Physician Supply and Insurer Payouts: Separating Facts from Rhetoric*, ADVOCATE, Fall 2008, at 25 (analyzing the effects of Texas's $250,000 liability limit on noneconomic damages).

132. N.C. GEN. STAT. § 90-21.19(a) (2015).

133. *See* Hyman et al., *supra* note 130, at 389 (comparing the estimated effects of a $250,000 and $500,000 noneconomic damages cap on allowed verdicts and payouts).

134. Donovan, *supra* note 4.

135. Steve Jacob, *Studies: Texas Tort Reform Has Had No Effect on Physician Supply, Lowering Costs*, D CEO HEALTHCARE (Aug. 28, 2012), http://healthcare.dmagazine.com /2012/08/28/studies-texas-tort-reform-had-no-effect-on-physician-supply-lowering-costs/ [https://perma.cc/R4FM-ZVXN] (describing studies that found the decrease in claims has not led to an increase in the supply of physicians or a decrese in healthcare costs) .

136. *See* Hyman et al., *supra* note 130, at 389.

137. *See id.* at 358.

138. *See, e.g.*, *id.* at 355; Silver et al., *supra* note 131 at 25; Ronald M. Stewart et al., *Malpractice Risk and Cost Are Significantly Reduced after Tort Reform*, 212 J. OF THE AM. COLL. OF SURGEONS 463, 463 (2011).

insurance payouts by all defendants for claims exceeding $10,000.[139] North Carolina does not have such a publicly accessible database.

A study by Hyman et al. applied the damages cap to pre-2003 data to project the effects that Texas's reforms had on medical malpractice plaintiffs, illustrating how such a cap has affected various groups of plaintiffs.[140] The information from this study therefore serves as an estimate of the disparity between damages awarded prior to the reforms and those awarded after 2003. This study estimated that for tried cases, the Texas cap "would have eliminated approximately $119 million in non-economic damages, or 73 percent of allowed non-economic damages after other caps."[141] More specifically, this amounts to what would have been a 38% reduction in allowed verdicts, the amount of money a jury may award a plaintiff after the damages cap has been applied.[142] While 47% of the studied cases were affected by Texas's cap, it is estimated that a $500,000 cap would affect only 32% of verdicts.[143] It is also estimated that North Carolina's $500,000 cap would lead to a 29% reduction in the mean allowed verdict, compared to Texas's 43% reduction.[144]

B. Breakdown of Texas Data by Employment Status

Further breakdown of the data into discrete plaintiff groups illustrates that plaintiffs who were employed experienced a much lower reduction in the aggregate allowed verdict than their unemployed counterparts. For example, the data were separated based on plaintiffs' employment status to determine what effect the noneconomic damages cap would have on employed and unemployed plaintiffs.[145] A study of 141 unemployed plaintiffs resulted in a 47% reduction in the aggregate allowed verdict.[146] A study of 158

139. Hyman et al., *supra* note 130, at 362–63.

140. *Id.* at 382.

141. *Id.* at 378.

142. *Id*. at 405. A 38% reduction in allowed verdicts equates to a 27% reduction in actual payouts—the amount of money the plaintiff actually received from the defendant. This discrepancy arises becauase in many cases where plaintiffs prevail at trial, but do not end up receiving the entire jury award because insurance companies will pay only up to a certain amount. This is largely because physicians often purchase insurance policies with relatively low payout maximums. For example, in Texas, many physicians have policy limits between $100,000 and $200,000. Therefore—even without a damages cap—in many instances, much of a given jury verdict never actually gets paid to the plaintiff. *Id.* at 400.

143. *Id.* at 384.

144. *Id.* at 389.

145. *Id*. at 382.

146. Equivalent to a 37% reduction in actual payout. *Id*. at 382.

employed plaintiffs, however, resulted in only a 32% reduction in the aggregate allowed verdict.[147]

Why is it that employed plaintiffs saw less of a reduction than their unemployed counterparts? Since economic damages include lost wages and unemployed plaintiffs are unable to recover lost wages, employed plaintiffs are far more valuable in states with limits on noneconomic damages. For example, someone who makes $1 million per year and misses a year of work due to medical malpractice would be entitled to these lost wages. In contrast, an unemployed plaintiff similarly injured did not lose any wages during that same span. This reality has created incentives for lawyers to accept high-earning plaintiffs as clients, rather than unemployed plaintiffs, due to the potential to obtain higher damages based on lost wages.[148] "Critics [of the noneconomic damages cap] say it is increasingly preventing victims and their families from getting their day in court, especially low-income workers, children and the elderly."[149]

C. Breakdown of Texas Data by Age

Employment status is not the only factor that may be affecting plaintiff selection, as significant differences also existed in the aggregate reduction of allowed verdicts in Texas between the elderly, non-elderly adults, and children. The elderly plaintiff class (ages 65+) experienced an aggregate reduction of 51% for allowed verdicts.[150] Adult non-elderly plaintiffs (ages 19–64) experienced a 37% decrease for allowed verdicts, while children (ages 2 months–18 years) experienced a 43% decrease.[151] This discrepancy should come as no surprise after seeing the disparities between plaintiffs based on employment status. Adult non-elderly plaintiffs experienced the smallest decrease because these plaintiffs are the most likely to receive large awards for economic damages based on lost wages, considering they make up the majority of the workforce. The amount

147. Equivalent to a 17% reduction in actual payout. *Id*.

148. *See* Zimmerman & Hallinan, *supra* note 1 (arguing that "lawyers are turning away cases involving victims that don't represent big economic losses—most notably retired people, children and housewives").

149. Daniel Costello, *Malpractice Law May Deny Justice*, L.A. TIMES (Dec. 29, 2007), http://articles.latimes.com/2007/dec/29/business/fi-malpractice29 [https://perma.cc/284G-QQEG]. *See supra* text accompanying notes 121–28 (describing plaintiffs in California who received different payouts depending on their economic status).

150. Equivalent to a 38% reduction in actual payout. Hyman et al., *supra* note 130, at 382.

151. Equivalent to a 22% reduction in actual payout for adult non-elderly plaintiffs and a 37% reduction for children. *Id*.

of economic damages is not only limited to past lost wages but may also include a future lost earning potential. These numbers are easily quantifiable for plaintiffs who have salaries. The elderly, however, often are no longer working and do not plan on working in the future. Therefore, they cannot be awarded damages for any past or future lost wages.[152]

Damages for children present a slightly different calculation problem than for the elderly. They are not currently working and therefore cannot receive damages for lost wages, so they may be less attractive clients for plaintiffs' attorneys paid on a contingency basis. However, children may be able to receive economic damages for lost earning capacity, the amount of money the child would have been able to earn in the future but for the injury. While children may be able to obtain such an award, there are often issues in determining whether a jury award for lost earning capacity is too speculative when dealing with children. In *Fox-Kirk v. Hannon*,[153] for example, a personal injury claim was brought on behalf of a two-year-old child.[154] The North Carolina Court of Appeals upheld a jury award of $1,675,000 to the child, holding that the plaintiff had presented sufficient evidence pertaining to the child's mental and physical condition prior to her injury "to provide the jury with a reasonable basis upon which to estimate damages of [the child's] lost earnings."[155] The court reasoned that "[i]t is . . . recognized that some speculation is inherent in the projection of future earning capacity of a child or an adult."[156]

There are limitations in place, however, that may hinder a child's ability to recover economic damages for lost earning capacity. In *DiDonato v. Wortman*,[157] the Supreme Court of North Carolina found that a stillborn child was unable to recover any damages for economic harm, reasoning that "[w]hen a child is stillborn we can know nothing about its intelligence, abilities, interests and other factors relevant to the monetary contribution it might or might not—someday have

152. *See* Michael L. Rustad, *Neglecting the Neglected: The Imact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits,* 14 ELDER L.J. 331, 335 (2007) ("Capping noneconomic damages is in effect a death penalty for many elder abuse and mistreatment claims because the victims are unable to find attorneys to represent them when noneconomic damages are downsized.").

153. 142 N.C. App. 267, 542 S.E. 2d 346 (2001).

154. *Id.* at 267, 542 S.E.2d at 346.

155. *Id.* at 271, 542 S.E.2d at 350–51.

156. *Id.* at 272, 542 S.E.2d at 351.

157. 320 N.C. 423, 358 S.E.2d 489 (1987).

made to the beneficiaries in a wrongful death action."[158] The court explained that "[a] jury attempting to calculate an award for such damages would be reduced to 'sheer speculation.'"[159] Although it is possible in cases for some minors to receive economic damages in the form of lost earning capacity, the risk that such a calculation will be viewed by a court as "sheer speculation" serves as yet another disincentive for attorneys to take on such cases.

Such speculation has led some to argue that children in malpractice cases are objectively worth far more alive than dead.[160] "For plaintiffs' attorneys, the primary question in cases involving babies and others without income is whether medical needs are continuing."[161] An infant who sustains injuries in a negligent procedure may be able to receive economic damages for the cost of future, continuing medical care, including hospital expenses and any sort of therapy or care that may be needed.[162] However, while a malpractice claim for an infant who dies may be able to receive damages for past medical expenses, such a plaintiff is unable to receive damages for any future medical expenses. "It has the effect of making an infant who is severely injured more valuable than those who don't make it since families of children who die are limited to the cap."[163]

Such a situation can change the incentives of plaintiffs' attorneys, leading to unfortunate results in states with damages caps for medical malpractice cases. For example, Virginia has a cap on all damages in

158. *Id.* at 431–32, 358 S.E.2d at 494.

159. *Id*. at 432, 358 S.E.2d at 494 (quoting Gay v. Thompson, 266 N.C. 394, 402, 146 S.E.2d 425, 429 (1966)). While these cases reference personal injury and wrongful death claims, as opposed to medical malpractice claims, such an analysis is still applicable, as each of these statutes places no limitation on the accrual of economic damages available to a plaintiff. *See* N.C. GEN. STAT. § 28A-18-2(b) (2015) (describing the damages available to a plaintiff in a wrongful death suit, with no limitations on economic damages); King v. Britt, 267 N.C. 594, 597–98, 148 S.E.2d 594, 597–98 (1966) ("The law is well settled in this jurisdiction that in cases of personal injuries resulting from defendant's negligence, the plaintiff is entitled to recover the present worth of all damages naturally and proximately resulting from defendant's tort. The plaintiff . . . is to have a reasonable satisfaction for actual suffering, physical and mental, which are the immediate and necessary consequences of the injury. The award is to be made on the basis of a cash settlement of the plaintiff's injuries, past, present, and prospective. In assessing prospective damages, only the present cash value or present worth of such damages is to be awarded as the plaintiff is to be paid in advance for future losses.").

160. *See* Costello, *supra* note 149; Zimmerman & Hallinan, *supra* note 1.

161. Zimmerman & Hallinan, *supra* note 1.

162. *See id.*

163. Costello, *supra* note 149 (providing several examples of plaintiffs who have struggled to find attorneys willing to take the case of a someone who did not have a high income).

such cases.[164] One Virginia mother explained that after her daughter sustained severe brain injuries when a C-section was not performed during childbirth, she decided to sue the physician through a Maryland law firm specializing in medical malpractice.[165] One month later, however, the child died and the law firm dropped the case.[166] While the firm would not comment on its reason behind dropping the case, it is undisputable that the firm lost a major incentive to litigate this case after the death of the child, since economic damages in the form of future medical care could no longer be sought. While Virginia has a cap on total damages, not just noneconomic damages, North Carolina attorneys must still consider factors such as a plaintiff's employment status and age in order to determine the total amount recoverable when deciding whether or not to accept such cases.[167]

D. Summary of Statistical Comparison

The negative impact of the damages cap in Texas allows for an estimate of the harm that could be done in North Carolina through the implementation of a damages cap. Although Texas has set its damages cap at half that of North Carolina's cap—meaning that North Carolina's cap may have less of an impact on allowed verdicts and payouts—the North Carolina cap will still limit the ability of plaintiffs to succeed in medical malpractice claims. The addition of a damages cap in North Carolina sets multiple hurdles in the path of plaintiffs. Since this cap effectively values certain groups of plaintiffs over others, it is now even harder for unemployed plaintiffs to find an attorney willing to take their case. Furthermore, even if these

164. VA. CODE ANN. § 8.01-581.15 (2017) ("In any verdict returned against a health care provider in an action for malpractice . . . tried by a jury or . . . without a jury, the total amount recoverable for any injury to, or death of, a patient shall not exceed . . . $1.50 million."). Like the North Carolina cap, Virginia's cap rises each year, and currently sits at $2.30 million. *Id.*

165. Zimmerman & Hallinan, *supra* note 1.

166. *Id.*

167. While the available data do not separate cases based on gender, some have argued that damages caps make men more valuable plaintiffs than women. Men are paid more than women on average, so women's lost wages would likely be lower than men's lost wages on average. *See* Jeanne Sahadi, *6 Things to Know About the Gender Pay Gap*, CNN MONEY (Apr. 12, 2016), http://money.cnn.com/2016/04/12/pf/gender-pay-gap-equal-pay-day/ [https://perma.cc/7VMW-AQH3] (illustrating that women generally earn 79 cents for every dollar men earn). "When you put a cap on noneconomic damages . . . quite literally [women's] lives are valued lower." Zimmerman & Hallinan, *supra* note 1. For women who choose to stay at home rather than work, lawyers and economists have attempted to quantify "mommying activities" such as chauffeuring and cooking. These activities, however, have proven difficult to quantify and often do not amount to significant awards. *Id.*

plaintiffs do find an attorney willing to represent them, this cap may significantly reduce the amount plaintiffs can win even when their claims are successful.

V. CONSTITUTIONALITY OF NONECONOMIC DAMAGES CAPS

The discriminatory effects of noneconomic damages caps have led some to argue that these caps violate the Equal Protection Clause of the U.S. Constitution."[168] While North Carolina courts have not yet ruled on the constitutionality of the noneconomic damages cap, such caps have been attacked under equal protection challenges in many other states.[169] As of 2017, noneconomic damages caps have been challenged on equal protection grounds in sixteen states and survived in all but three.[170] While state courts are not bound by the federal three-level system of equal protection review,[171] state courts have most often rejected these challenges via rational basis review.[172] For example,

> [i]n a decision that blended the federal and state claims together, the California Supreme Court held that the MICRA caps did not violate the plaintiff's equal protection rights. The court concluded that there was no fundamental property right to collect an unlimited amount of tort damages, so rational-basis review was the correct standard to apply. The Court held that the MICRA caps met this standard, noting that the legislature was responding to a medical malpractice insurance crisis and that it was "obvious" that a $250,000 noneconomic

168. *See* Kelly & Mello, *supra* note 3, at 522 (exploring how different states' courts have dealt with constitutional challenges caps to medical malpractice damages); Zimmerman & Hallinan, *supra* note 1; *see also* U.S. CONST. amend. XIV, § 1.

169. *See Constitutional Challenges to State Caps on Non-economic Damages*, AM. MED. ASS'N, https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/arc-constitutional-challenges_1.pdf [https://perma.cc/EQZ2-UBFU] (listing states that have addressed the constitutionality of noneconomic damages caps and providing the rationale for these decisions).

170. *Id.*; *see also* Kelly & Mello, *supra* note 3, at 522. In 2017, Florida joined Alabama and New Hampshire as the only states to strike down noneconomic damages caps as unconstitutional for violating the equal protection clause. *See* Moore v. Mobile Infirmary Ass'n, 592 So.2d 156, 170 (Ala. 1991); North Broward Hosp. Dist. v. Kalitan, 219 So.3d 49, 50 (Fla. 2017); Brannigan v. Usitalo, 587 A.2d 1232, 1233 (N.H. 1991).

171. *See, e.g.,* Sibley v. Bd. of Supervisors of La. State Univ. 477 So. 2d 1094, 1107 (La. 1985) ("The federal three-level system [rational basis, intermediate scrutiny, and strict scrutiny] is in disarray and has failed to provide a theoretically sound framework for constitutional adjudication.").

172. Kelly & Mello, *supra* note 3, at 522 ("Under rationality review, a state law will be upheld as long as the classification has a rational relationship to a legitimate government objective.").

> damages cap was rationally related to the legitimate state interest of reducing the malpractice costs of providers and their insurers.[173]

While other states generally have rejected equal protection challenges to noneconomic damages cap, whether North Carolina chooses to follow suit likely will depend on what level of scrutiny courts choose to apply to such a constitutional challenge in the future.[174] Caps on noneconomic damages have also often been challenged on various other grounds, including separation of powers, access to courts, right to a jury trial, and due process violations.[175] These challenges on other grounds, however, have generally been rejected as well.[176] Given the continued existence of these caps in the majority of states, it seems unlikely—though not impossible—that North Carolina courts will overturn these reforms any time soon.

VI. POSSIBLE ALTERNATIVES

Although North Carolina is unlikely to overturn these reforms in the near future, possible alternatives are available. The harm to vulnerable plaintiffs from the damages cap is very real. Simply increasing the North Carolina damages cap, however, is not a clear-cut solution because setting a new damages cap would have two potentially conflicting goals: minimizing hardship both to physicians and patients. It is particularly difficult to determine at what amount a cap on noneconomic damages should be set to best meet these two potentially conflicting goals because doing so requires a normative rather than an empirical determination. Those who believe that defendant-physicians are still exposed to too much liability in North

173. *Id.* (quoting Fein v. Permanente Med. Grp., 695 P.2d 665, 680 (Cal. 1985)).

174. Some prominent members of the North Carolina legal community have voiced opinions that these damages caps are unconstitutional as a violation of the right to trial by jury, guaranteed by Article I of the North Carolina Constitution. For example, former Chief Justice Lake released a letter expressing the view that "North Carolina citizens have a 'sacred and inviolable' right to have a jury determine the amount of compensatory damages, including noneconomic damages, under our Constitution." Letter from former Chief Justice I. Beverly Lake Jr., Supreme Court of North Carolina, to the Members of the North Carolina Senate (Feb. 8, 2011) (on file with the North Carolina Law Review). Former Justice Brady also released a letter sharing Justice Lake's opinion: "[i]t has always been the case in a civilization which is based upon ordered liberty that a person wronged by the actions of another would be able to recover damages so as to make that person whole." Letter from former Justice Edward Thomas Brady, Supreme Court of North Carolina, to the members of the North Carolina Senate (Feb. 17, 2011) (on file with the North Carolina Law Review).

175. Kelly & Mello, *supra* note 3, at 519.

176. *Id.*

Carolina may prefer a lower damages cap, such as those in place in Texas or California. Those who believe that such caps prevent plaintiffs from being made whole would argue that—if a cap had to exist at all—it should be much higher than the current North Carolina cap.

Due to these challenges, North Carolina could look to alternatives other than capping damages awards. Florida and Virginia have, for example, enacted no-fault compensation schemes for birth-related neurological injuries.[177] While the topic of no-fault compensation schemes could be the subject of its own Comment, such schemes are briefly discussed as plausible alternatives both to North Carolina's current damages cap and to a simple increase to the state's current damages cap.

As its name suggests, a no-fault compensation scheme differs from traditional tort law in that compensation is not dependent on whether the physician is legally at fault—i.e. acted negligently—but instead whether the physician caused the injury.[178] Thus, no-fault schemes eliminate the requirement of proving negligence.[179] Rather than only awarding compensation if a plaintiff can show that a physician acted negligently, these systems look to the other three prongs of a negligence actions—whether a duty existed between the parties, whether an injury occurred, and whether the injury was caused by the physician's actions—and then look to whether the injury sustained fits within the statutory definition for compensable injuries.[180]

There are certainly strong arguments in favor of such a system. Regardless of whether a physician is at fault for a patient's injuries, the fact remains that the patient is injured. An approach that only provides compensation to patients who can prove negligence systematically overlooks patients who—despite their injuries—cannot prove negligence and thus receive nothing under a traditional tort system.

177. *See* FLA. STAT. ANN. § 766.303 (West, 2017) (establishing the Florida Birth-Related Neurological Injury Compensation Plan); VA. CODE ANN. § 38.2-5002 (2017) (establishing the Virginia Birth-Related Neurological Injury Compensation Program).

178. David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect of Error Prevention*, 286 J. OF THE AM. MED. ASS'N 217, 219 (2001).

179. *Id.*

180. *See* Jill Horwitz & Trovon A. Brennan, *No-Fault Compensation for Medical Injury: a Case Study*, 14 HEALTH AFF. 164, 166 (1995).

For example, Florida enacted the Birth-Related Neurological Injury Compensation Act in 1988.[181] This program was specifically created to address the rising costs and shrinking availability of malpractice insurers in these states.[182] Given the potential high cost of cases involving infants with birth-related neurological injuries, these programs were statutorily created to remove some of the most expensive cases from the state tort system and move them to an administrative no-fault system.[183] Rather than submitting these claims in court, they are instead filed in a separate administrative proceeding with Florida's Division of Administrative Hearings.[184]

It should be noted that Florida's no-fault compensation scheme does not solve the issues stemming from the existence of damages caps. In fact, Florida's system caps pain and suffering awards at $100,000.[185] However, "[m]ost parents of surviving, compensated infants receive the maximum amount, which may attract claimants [to pursue this remedy]."[186] This system is in stark contrast to an ordinary medical malpractice claim system—the context in which damages caps operate—under which plaintiffs often receive nothing.[187] Thus, systems such as Florida's alter the risk/reward incentives present in ordinary malpractice claims. While plaintiffs would receive less money in a successful administrative proceeding in a no-fault compensation system, as compared to a successful trial verdict,[188] plaintiffs have a far greater chance of being awarded something.[189] Given that most parties who bring this claim receive the maximum $100,000 for pain and suffering, they are able to hedge their bets by increasing their chances of receiving at least something for their injuries.[190] Furthermore, a claim petition under Florida's no-fault

181. Act Relating to Medical Incidents, Ch. 88-1, 1988 Fla. Laws 119; *see also* Horwitz & Brennan, *supra* note 180 at 166.

182. Horwitz & Brennan, *supra* note 180, at 166; *see also* FLA. STAT. ANN. § 766.301(1) (West 2017).

183. Horwitz & Brennan, *supra* note 180, at 167–68 ("Estimates suggest that up to 60 percent of all obstetricians' malpractice premiums were absorbed by litigation costs . . . for alleged birth-related cerebral palsy.").

184. *See* § 766.304.

185. *See* § 766.31(1)(b).

186. Horwitz & Brennan, *supra* note 180, at 169.

187. *See* Craige, *supra* note 4, at 17 ("In the 12 years from 1999 through 2010, plaintiffs won only 57 malpractice trials in North Carolina, with a median jury award of only $302,600.").

188. Puteri Nemie Kassim, *No-Fault Compensation for Medical Injuries: Trends and Challenges*, 33 MED. & LAW 21, 27 (2014).

189. *See* Horwitz & Brennan, *supra* note 180, at 170.

190. *See id.* at 169.

scheme costs just $15,[191] while an ordinary medical malpractice claim may cost somewhere between $50,000 and $100,000.[192] Thus, systems such as Florida's may be attractive for prospective plaintiffs who suffered injuries yet may not be able to prevail at trial.

The absence of a negligent party to pay a successful plaintiff begs the question of how such a scheme could be funded. Florida's no-fault system is funded largely by obstetricians, who pay a $5,000 premium per year to partake in this system.[193] Additionally, all other Florida physicians pay $250 per year, while nonpublic hospitals are typically required to pay $50 per live birth.[194] Lastly, the state of Florida provided this program with a one-time grant of $40 million to fund the program.[195]

No-fault compensation schemes have been established much more broadly in other countries. New Zealand, for example, abandoned its tort system in favor of a no-fault compensation system, "essentially barr[ing] medical malpractice litigation."[196] The New Zealand system is designed so that "claimants with similar disabilities receive similar compensation," with entitlement awards falling into four categories: "treatment and rehabilitation," "compensation for lost earnings," "lump-sum compensation," and "support for dependents."[197] While New Zealand's no-fault system offers "more-timely compensation to a greater number of injured patients,"[198] it is certainly not a perfect system. Most notably, many view New Zealand's no-fault system as providing inadequate recovery as compared to tort jurisdictions.[199] Thus, this system seems to value providing recovery to as many parties as possible,[200] while the American tort system seems to value maximizing recovery for plaintiffs who are able to bring successful claims.[201]

191. *Id.* at 168; *see also* FLA. STAT. ANN. § 766.305(2) (West 2017).

192. *See supra* notes 111–14 and accompanying text.

193. Horwitz & Brennan, *supra* note 180, at 169.

194. *Id.*

195. *Id.*

196. J. Marie Bismark & Ron Paterson, *No-Fault Compensation In New Zealand: Harmonizing Injury Compensation, Provider Accountability, And Patient Safety,* 25 HEALTH AFF. 278, 278 (2006).

197. *Id.* at 280–81.

198. *Id.* at 278.

199. *Id.* at 282.

200. *See id.* at 281 ("No-fault systems have the potential to compensate many more patients than malpractice litigation can . . . .)".

201. *See generally*, Alan. G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice "Crisis,"* 23 STAN. L. & POL'Y REV. 477, 479 (2012) (noting that opponents of medical malpractice damages caps view the America tort system as designed to offer plaintiffs unrestricted "redress.").

This Section is not to trying to suggest that no-fault compensation schemes are a perfect solution to the tort reform debate nationally or specifically in North Carolina. No-fault schemes have many inherent problems, particularly in regards to funding.[202] While the expansion of no-fault schemes in America may provide some low-income plaintiffs—who cannot find attorneys willing to take their cases—with opportunities to receive at least some form of monetary compensation, these awards may be negligible without proper funding. Thus, while the expansion of no-fault schemes may solve some issues in America's current tort system, many new problems may also be generated.

Both damages cap and no-fault compensation systems have advantages and disadvantages. Whether one prefers one or the other will likely depend on how one weighs the competing interests of defendant-physicians and plaintiff-patients. Because this answer depends on normative preferences about how to best compensate medical injuries, it is difficult to say if either system is "better" at handling such claims. However, it can be said that the popularity of New Zealand's system, as well as the existence of narrow no-fault schemes in Florida and Virginia, indicate that North Carolina should at least consider no-fault compensation as a possible alteration to the current tort system.

CONCLUSION

North Carolina's tort reform efforts are likely to have significant effects on plaintiffs at all stages of litigation. The strengthening of the pre-filing expert witness review requirement, by amending North Carolina Rule of Civil Procedure 9(j), makes it more expensive and time consuming for plaintiffs to find experts able to testify in their cases. The strengthening of qualification requirements for expert witnesses makes it more difficult for plaintiffs to find witnesses who can be qualified as experts under the new *Daubert* standard. The increased burden of proof for emergency medical conditions means that plaintiffs will have to meet this higher burden of proof even for emergency medical conditions that occur outside of a hospital emergency room. Finally, when combined with the $500,000 liability

202. *See, e.g.*, Sandy Martin, *NICA—Florida Birth-Related Neurological Injury Compensation Act: Four Reasons Why This Malpractice Reform Must Be Eliminated*, 26 NOVA L. REV. 609, 624–30 (2002) (detailing the issues with funding Florida's no-fault compensation scheme).

limit for noneconomic damages, plaintiffs who prevail at trial may see their jury awards greatly reduced.

These changes have had the cumulative effect of decreasing the amount of medical malpractice cases filed for two main reasons. First, these increased procedural and evidentiary burdens may bar some claims that would have been viable under the preexisting law. Second, and perhaps most importantly, this damages cap has had the effect of preventing low-income plaintiffs with legitimate cases from ever getting their day in court, as attorneys must now assess the economic feasibility of cases based on the likelihood of receiving economic damages. While it is arguable that North Carolina's $500,000 liability limit provides a better alternative than the $250,000 limit seen in other states, the truth of the matter is that any cap on noneconomic damages will have detrimental effects on low-income plaintiffs who cannot obtain as great an award as an equally injured plaintiff with more money.

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