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INDIVIDUAL RESPONSIBILITY AND ACCOUNTABILITY: AMERICAN WATCHWORDS FOR EXCELLENCE IN HEALTH CARE

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The 1994 Republican landslide was evidence of the American people's insistence on individual responsibility and accountability. These values apply to the provision of quality health care as well as government. Simply stated, there can be no quality health care without accountability.

Much has been made of the Republican Party's Contract With America.¹ Tort reform, listed in the Republican Contract, would eliminate individual responsibility and accountability by immunizing physicians and hospitals from sanctions resulting from their negligence.² This immunity from responsibility is something the medical profession has been trying to achieve for 150 years.³

Part One of this article will discuss the myths surrounding medical malpractice in America. Part Two will discuss how malpractice litigation, or the threat of it, actually helps to prevent malpractice and increases the quality of health care in the United

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¹ See 1994 Republican Contract with America. The Republican Party's Contract with America expresses in writing the goals of the Republican controlled Congress. The Republican party labelled it their "Contract with America."

² See PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE 144 (1993). "[T]he bedrock principle must be that if [the system of] malpractice is to be retained [in light of the proposed tort reforms] as a device for both compensating and preventing medical malpractice injuries, then any reforms must not hinder access of patients to this system of redress nor weaken the incentives offered to providers for careful, high quality treatment." *Id.*

³ See KENNETH A. DEVILLE, MEDICAL MALPRACTICE IN NINETEENTH CENTURY AMERICA 25 (1990). The "great deluge" of malpractice suits commencing in the mid-1800s were the "first symptoms of a professional disease that would plague the medical community for the next 150 years." *Id.* The explosion of malpractice suits in the 1980s was demonstrative of the dramatic shift in attitudes towards the medical profession. *Id.* at 26.

States and will suggest solutions to the real malpractice crisis facing this country—bad medicine.

I. MYTHS ABOUT MALPRACTICE

The following are a few statements made by physicians concerning medical malpractice in America:

1. Lawsuits “occur so often that even a respectable surgeon may well fear the results of his surgical practice.”⁴

2. “Mischievous” lawyers have forced some doctors to allow the “patients to go unassisted in their afflictions.”⁵

3. “Suits for malpractice were so very frequent” that many physicians have “abandoned the practice.”⁶

4. Physicians are “constantly liable to vexatious suits, instituted by ignorant, unprincipled persons, sometimes urged on, it is presumed, by those who have a private grudge.”⁷

Does this sound familiar? All of these statements were reported in prominent medical journals in the mid-1800s.⁸

President George Bush’s 1992 crusade against lawyers in “tas-seled loafers” made lawyer-bashing a key component of his health care reform plan. Politicians of both parties, the American Medical Association (“AMA”), the insurance industry, and other tort reform advocates joined George Bush in espousing this line that the medical establishment has been pursuing for more than a century.⁹

This misinformation campaign has succeeded in persuading many policy-makers that the malpractice crisis in America is nothing more than an invention by greedy lawyers on behalf of

⁴ *Id.* at 25 (quoting Alden March, prominent New York physician).

⁵ *Id.* (quoting writer for *MEDICAL EXAMINER* in 1851).

⁶ *Id.* (quoting Frank Hamilton, New York physician).

⁷ *Id.*

⁸ DEVILLE, *supra* note 3, at 25-26. The virtual non-existence of medical malpractice suits from 1790-1835 led to a feeling of “relative judicial safety” for practicing physicians. *Id.* at 2. However, almost immediately thereafter patients began suing their physicians at an unprecedented rate. *Id.* at 25. As a result, statements such as those enumerated in the text became quite familiar.

⁹ WELER ET AL., *supra* note 2, at 135 (asserting that “popular and political interest was sparked when President Bush unveiled his ideas for a ‘kinder, gentler’ model of malpractice litigation . . . which rested on anecdotal evidence selected to suit the self-interests and ideological commitments of the protagonists”).

clients who have no legitimate grievance.¹⁰ The facts show differently.

Approximately 100,000 Americans die each year, and 500,000 more are injured, as a result of negligence in hospitals.¹¹ These numbers do not even account for the thousands of additional deaths that occur because of negligence in doctors' offices and free-standing clinics.¹²

Despite the AMA's paranoia about lawsuits, fewer than ten percent of the incidents of negligence result in lawsuits.¹³ According to a study published in the *Annals of Internal Medicine*, the overwhelming percentage of judgments and settlements in malpractice cases are justified and are commensurate with the nature of the patient's injury.¹⁴ There is no evidence that doctors are being sued in large numbers without good cause. Studies like the one mentioned offer much evidence to the contrary.

Part of the problem is that many physicians, like the general public, do not understand the true nature of medical malpractice.¹⁵ Doctors are not being routinely sued merely because an unhappy patient does not like an unavoidable result. A physician cannot be sued because he or she was not as skillful as another physician might have been.¹⁶ Nor can he or she be sued because of a mistake made in good faith after careful examination and

¹⁰ See generally HARVEY F. WACHSMAN, *LETHAL MEDICINE: THE EPIDEMIC OF MEDICAL MALPRACTICE IN AMERICA* 54 (1993) (challenging theory of President Bush and many of his supporters that medical malpractice "crisis" is because of greedy lawyers).

¹¹ *Id.* at 11-13 (discussing surveys by Harvard University team in 1990 and California Medical Association in 1977).

¹² See generally Daniel Kramer, *The Harvard Study, An Analysis*, N.Y. L.J., Mar. 9, 1990, at 1 (explaining that study concentrated on medical malpractice in hospital setting only and had it considered malpractice that occurs in doctors' offices number would be larger).

¹³ See Leo Uzych, *Malpractice Reform on Lawmakers' Minds: Despite Inflamed Emotion, Litigation Not Out of Control*, THE LEGAL INTELLIGENCER, Feb. 14, 1995, at 8 (describing number of lawsuits arising from medical negligence as minute). The Uzych article focused on a study of 280 patients who suffered from medical negligence of which only eight filed suit. *Id.*

¹⁴ See Mark I. Taragin et al., Response, *The Medical Malpractice System*, 118 ANNALS OF INTERNAL MED. 909, 909 (1993) (establishing that, based on countless hours of research, "exorbitant awards are rare . . . [and] jury decisions are typically not arbitrary"); see also FRANK M. MCCLELLAN, *MEDICAL MALPRACTICE: LAW TACTICS AND ETHICS* 78 (1993) (discussing recent study which concluded that "[t]he defensibility of [a] case . . . predominantly influences whether any payment is made" and suggested that "unjustified payments are probably uncommon").

¹⁵ WACHSMAN, *supra* note 10, at 53.

¹⁶ See W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 32, at 188 (5th ed. 1984) (noting that negligence is never presumed and that it must be supported and proven by expert testimony); see also *Pike v. Honsinger*, 155 N.Y. 201, 209, 49 N.E. 760, 762 (1898) (establishing that even in 19th Century doctors were held liable in malpractice

thoughtful diagnosis.¹⁷ The law, as interpreted in *Pike v. Honsinger*,¹⁸ makes it clear that a physician must meet certain standards. In *Pike*, the court stated that:

[A physician has the] duty to use reasonable care and diligence in the exercise of his skill. . . . The law holds him liable for an injury to his patient resulting from want of requisite skill or knowledge or the omission to exercise reasonable care or failure to use his best judgment. . . . The rule of reasonable care and diligence does not require the use of the highest possible degree of care. . . . It is not enough that there has been a less degree of care than some other medical man might have shown or less than even he himself might have bestowed, but there must be a want of ordinary and reasonable care, leading to a bad result.¹⁹

This is the standard against which medical malpractice suits are measured.²⁰

Clearly, the medical malpractice crisis lies not in the number of lawsuits filed, but in the amount of malpractice committed.²¹ This crisis is of epidemic proportions. Malpractice litigation, rather than being an anathema, could prove to be an aid to the medical profession by exposing substandard practices and practitioners, and, as a result, help the profession to maintain the highest possible standards.

Lawsuits expose negligent doctors and point out areas in which obvious errors are repeatedly made. Litigation can act as a valuable tool, not only to enforce medical standards, but also in order to prevent the practice of bad medicine. Unfortunately, the response of the medical profession and insurance establishments has been to attack the messenger by blaming the injured patients, their

only when they did not possess requisite skill and learning or did not use appropriate standard of care).

¹⁷ See *Pike*, 155 N.Y. at 209. The rule requiring physicians to use their best judgment does not hold them liable for mere error in judgment so long as they do what they think is best based on a careful examination. *Id.* at 210.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ See, e.g., Kramer, *supra* note 12, at 1. In fact, the standard enumerated in *Pike* is the same standard that the team for Harvard used in their study which concluded that 100,000 deaths each year are caused by medical malpractice. *Id.*

²¹ WACHSMAN, *supra* note 10, at 55. "The facts show that not only *isn't* the legal system being overwhelmed with unwarranted lawsuits, but only a small portion of the malpractice being committed . . . is going to court." *Id.*

lawyers, and the legal system rather than the real problem—the practice of bad medicine.

A. *Myth One: Shortage of Obstetricians Due to Threat of Lawsuits*

In 1850, the argument was posited that there would be no surgeons left as a result of medical malpractice lawsuits.²² Similarly, politicians and the AMA argue today that lawsuits are driving obstetricians out of business.²³ It is argued that many obstetricians are sick of worrying about the threat of unjustified lawsuits,²⁴ and that they are tired of paying ever-increasing malpractice insurance premiums.²⁵ As a result, the argument concludes, these obstetricians stop delivering babies.²⁶

Many communities, particularly rural ones, are desperately underserved.²⁷ The truth is, however, that if obstetricians abandon their practices and some communities are underserved, it has nothing to do with lawsuits. Doctors go where wealthier patients are found.²⁸ Further, they tend to specialize and work in geographic regions that are the most rewarding.²⁹

AMA reports support this conclusion. An AMA study has noted that physicians in rural areas earn on average about one-fifth as

²² WASCHMAN, *supra* note 10, at 162.

²³ See, e.g., Donald H. Taylor, Jr. et al., *One State's Response to the Malpractice Insurance Crisis: North Carolina's Rural Obstetrical Care Incentive Program*, 107 PUB. HEALTH REP. 523, 523-29 (1992) (arguing that high insurance costs and years of lawsuits have forced some physicians to either stop practicing obstetrics or reduce number of high risk patients treated).

²⁴ See John H. Niles, M.D., *John H. Niles Doctor Columbia Hospital for Women Senate Judiciary/Courts and Administrative Practice Medical Malpractice*, May 24, 1994, available in LEXIS, Legis. Library, Cngtst. file (stating that "physicians' chance of being sued for medical liability bears little relation to whether [physicians] have been negligent").

²⁵ *Id.* (explaining that insurance premiums for obstetricians have gone up approximately 550% in last 15 years).

²⁶ See Joanne Silberner, *When to Sue Your Doctor; Minimizing the Headaches of Malpractice Medicine*, U.S. NEWS & WORLD REP., Dec. 14, 1987, at 66, 68 (reporting on decrease in obstetricians delivering babies due to malpractice insurance).

²⁷ See generally Dianne Schleuning et al., *Addressing Barriers to Prenatal Care: A Case Study of the Access to Maternity Care Committee in Washington State*, 106 PUB. HEALTH REP. 30, 47-52 (1991). "The loss of obstetrical providers was most apparent in rural communities." *Id.* at 47.

²⁸ See Sara Collins, *Desperate for Doctors*, U.S. NEWS & WORLD REP., Sept. 20, 1993, at 30, 32. "[D]octors in cities tend to cluster in wealthier areas—where residents are more likely to have private insurance—and avoid neighborhoods with large numbers of low income people". *Id.* at 30.

²⁹ *Id.*

much as physicians in metropolitan areas.³⁰ It is not surprising that fewer young obstetricians wish to practice in a rural community when the same practice in an urban area or suburb would generate five times the income.

Nassau County is an affluent suburb of New York City where obstetricians pay among the highest malpractice insurance rates in the nation. Yet there are more obstetricians per capita in Nassau than almost anywhere else in the country.³¹ There is no shortage of obstetricians, despite the high cost of malpractice insurance.³² This seems to prove that while there appears to be a paucity of obstetricians in some rural areas, it is less the result of lawsuits and more a reflection of a natural tendency on the part of physicians, as with anyone else, to locate in the regions with the best quality of life and the most affluent patients.³³

As far as the cost of insurance goes, even after the cost of malpractice insurance and other business expenses like office rent and staff salaries, the average obstetrician and gynecologist in America earns \$207,000.³⁴ That compares quite favorably with the average pre-tax net for all physicians, which, after expenses, is \$164,000. Obviously, insurance premiums are not having an undo effect on the ability of obstetricians to make a living.

The truth is that some doctors move away from obstetrics because it is a difficult specialty to practice well. Many doctors get tired of being called to the hospital at all hours of the night. Therefore, as they get older, they stop delivering babies. Likewise, some young medical students are choosing not to specialize in obstetrics for the same reasons.

When young doctors begin their obstetrics and gynecologist practices, most of their patients are young women, many of whom are pregnant. Therefore, a large portion of the practice is delivering babies. These patients age with the doctor, changing the nature of the practice. As the patients become middle-aged, the doc-

³⁰ *Id.* A recruiter for an East Harlem health center in New York has been unable to recruit obstetricians because salaries are too low. *Id.*

³¹ WACHSMAN, *supra* note 10, at 162.

³² *Id.*

³³ See generally STEVEN E. PEGALIS & HARVEY F. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE § 8:3 (2d ed. 1992) (discussing obstetrical risk). "The argument that high malpractice insurance rates have cut into the availability of appropriate obstetrical services has been one of those anecdotal myths never borne out by facts or common sense." *Id.*

³⁴ See Spencer Rich, *Doctors' Average Income \$164,300*, WASH. POST, May 21, 1992, at A10.

tor is required to perform hysterectomies and other types of surgery, and thus, that becomes a major part of the practice. The physician can at this point maintain a successful practice without the sacrifices that necessarily accompany treating pregnant women.

Often, an older doctor will associate with a younger doctor. The older doctor then refers any young pregnant patients to his new associate. The older doctor tells his or her insurance company that he or she no longer practices obstetrics, and the doctor becomes another statistic.

Unfortunately, the myth of the vanishing obstetrician is accepted as fact, even at the highest levels of government. Such high powered lobbying groups as the AMA and the American Tort Reform Association have succeeded, through spending millions of dollars annually, in misleading the American public and the media in the belief that obstetrics is a dying specialty.

B. Myth Two: The High Cost of Defensive Medicine

Another myth regarding medical malpractice in the United States is about so-called "defensive medicine." According to the AMA, doctors practice "defensive medicine" by conducting costly and unnecessary tests on patients to protect themselves against malpractice claims. The AMA asserts that this practice drives up the overall cost of health care,³⁵ amounting to \$25 billion of defensive medicine practiced each year.³⁶ President Bush, in a 1991 speech at Johns Hopkins University, went so far as to claim that the cost of defensive medicine totalled as much as \$75 billion per year.³⁷

Defensive medicine, as the AMA describes it, does not exist.³⁸ It is a contradiction in terms. If tests are being performed to assist a doctor's diagnosis or treatment, then they are not unnecessary.³⁹

³⁵ See *Wilkinson v. Vesey*, 295 A.2d 676, 683 (R.I. 1972) (discussing defensive medicine as practice of ordering tests just to be availed of any lawsuit).

³⁶ See *AMA Applauds House of Representatives for Passing Health Care Liability Reform*, U.S. Newswire, Mar. 10, 1995, available in LEXIS, Nexis Library, Wires file. Robert E. McAfee, M.D., AMA president, stated that "[t]he health care liability system costs this country nearly \$50 billion a year, \$25 billion of which is spent on defensive medicine." *Id.*

³⁷ President George Bush, Speech at Johns Hopkins University (1991).

³⁸ See, e.g., Walter Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)*, 73 CORNELL L. REV. 170, 178 n.26 (1988) (stating that there is no such thing as defensive medicine but only careful medicine).

³⁹ See generally *Reforms Unlikely to Affect Defensive Medicine, OTA says: AMA Criticizes Report*, HEALTH LAW REP., July 28, 1994, at 1048. "Defensive medicine is not always con-

These tests are part of a thorough and comprehensive medical examination which benefits the patient. They have nothing to do with protection against lawsuits.

If doctors perform unnecessary tests, they are more likely to perform them for the money.⁴⁰ Cases abound of physicians ordering patients to undergo tests and procedures that they do not need, then billing the patient or the insurance company for the additional cost. This practice is nothing new.⁴¹

If defensive medicine, as defined by the AMA, does exist, it is not only bad medicine, but a crime. The taking of another person's money for one's own purposes—whether it is used to purchase unnecessary tests or to buy a yacht—constitutes embezzlement and fraud.⁴² Any doctor charging a fee for a test with no value to the patient would be taking money for his or her own benefit rather than for the service that is supposed to be provided to the patient. That is a crime and offenders should be prosecuted.

Ironically, unnecessary tests or other "defensive medicine" could not help in the defense against a malpractice claim. If a test is unnecessary or irrelevant to a patient's treatment, how could it possibly assist in the defense of a malpractice lawsuit? A malpractice lawsuit seeks to show that substandard care led to the injury of a patient.⁴³ A physician producing irrelevant test results could not prove through them that his or her care was therefore standard. The AMA could perform a valuable service by producing the names of doctors who they claim are practicing defensive medicine.

Taking exception to the AMA's view of this situation, there are those who argue that what has been defined as "defensive

scious behavior, or bad for patients. . . . [Many] medical procedures are ordered to minimize the risk of being wrong when the medical consequences of being wrong are severe." *Id.*

⁴⁰ See generally *Rockefeller, Danforth Urge Reform of Nation's Medical Malpractice System*, MED. REP., Aug. 7, 1992 (stating that "physicians are ordering more tests in large part to increase their incomes, not necessarily to stave off malpractice suits").

⁴¹ *Id.*

⁴² See RESTATEMENT (SECOND) OF TORTS § 871 cmt. e (1939). "The actor's conduct is fraudulent if he intentionally causes another to act or refrain from acting by means of intentionally false or misleading conduct or by his intentional concealment of facts or by his intentional failure to disclose a fact that he has a duty to reveal to the other." See also *State v. Griffin*, 79 S.E.2d 230, 233 (N.C. 1953). "The embezzlement statute makes criminal the fraudulent conversion of personal property by one occupying some position of trust or some fiduciary relationship. . . ." *Id.*

⁴³ See, e.g., *Byrd v. State*, 637 So. 2d 114, 122 (La. 1994). "To recover for medical malpractice, a plaintiff must prove not only that the applicable standard of care was breached, but also that the doctor's substandard conduct caused an injury." *Id.*

medicine" is actually good medicine.⁴⁴ A report in the *Journal of the American Medical Association* indicates that, at least in terms of dollars, thirty percent of defensive medicine reflects extra time spent by doctors with their patients; forty-one percent involves additional follow-up visits after a procedure is performed or a course of treatment is begun; and another twenty percent is spent on additional record keeping.⁴⁵

In reference to the principal causes of medical malpractice—failing to be present when needed, failing to take a complete medical history, and failing to perform a thorough physical examination—it could be that the threat of malpractice lawsuits are actually forcing doctors to provide better care.⁴⁶ Although they may not like spending more time with their patients or keeping more accurate records, that's what good medicine is all about.

As Dr. Paul Weiler, an author of *The Harvard Study*, said: "If we were to find that the tort system was producing more defensive driving, and we asked the public if they supported such an incentive, my guess is that the vast majority, including most doctors, would say it was a good thing."⁴⁷ In other words, if defensive medicine means practicing in a way that reduces unnecessary injury to patients, it is beneficial and should be applauded by the medical profession.

"Defensive medicine" as defined by the AMA, however, is a difficult concept to accept. In an industry known for producing scientific data, no one has ever produced a study to support the claim that defensive medicine exists, let alone that it costs the taxpayers many billions of dollars a year. Further, no one has produced the name of a single doctor who has engaged in "defensive medicine" or a single patient upon whom it has been practiced. In fact, the only scientific study performed on this was conducted by the Federal Office of Technology Assessment. This study concluded that the cost of defensive medicine, to the extent that it does exist, is

⁴⁴ See Gellhorn, *supra* note 38, at 178.

⁴⁵ JAMA (May 22/29, 1989).

⁴⁶ See, e.g., Robin E. Margolis, *Healthtrends*, HEALTHSPAN, Sept. 29, 1994. "[D]efensive medicine motivated by fear of malpractice litigation is not useless, but actually encourages physicians to be careful"

⁴⁷ Brian McCormick, *Most Doctors Say They Practice Defensive Medicine*, *American Medical Association Survey*, AM. MED. NEWS, May 25, 1992; see also J.L. Montgomery, *Say No to Inadequate Tort Reform*, 95 POSTGRADUATE MEDICINE 37 (supporting Dr. Weiler's statement).

negligible and has virtually no impact on the cost of health care in America.⁴⁸

C. *Myth Three: Malpractice Premiums Increase the Cost of Medical Treatment*

Rather than be hindered by a lack of evidence, propagators of the "defensive medicine" myth rail against its cost and argue that malpractice lawsuits add to the country's overall health-care bill because the threat of lawsuits cause doctors' insurance premiums to rise.⁴⁹ Just as this myth is debunked as it relates specifically to obstetricians, it is equally indefensible as it pertains to the medical profession as a whole.

Of the \$840 billion per year spent in this country on health care, only \$5.6 billion is spent by doctors and hospitals on malpractice insurance.⁵⁰ That's less than one percent. Even at this level, insurance companies are reaping huge profits on the fees they collect.⁵¹

The total amount of all malpractice awards in America is less than the interest insurance companies earn on invested premiums.⁵² Not surprisingly, the fact that billions paid by doctors in insurance premiums over the years are still in insurance company coffers became the subject of a study by the United States General Accounting Office in 1987.⁵³ Based on the study, it was reported

⁴⁸ See Margolis, *supra* note 46, at 29 (suggesting defensive medicine behaviors are not financial drain on health care system).

⁴⁹ See, e.g., Robert G. Miceli, *Deprivation of Due Process For Physicians; The "Failure to Diagnose" Cause of Action*, 33 Sr. LOUIS U. L.J. 859, 940 (1989) (arguing that baseless lawsuits cause defensive medicine resulting in higher doctor's insurance premiums); see also Larry S. Stewart, *Damage Caps Add to Pain And Suffering*, WASH. TIMES, Nov. 7, 1994, at 18 (asserting that defensive medicine drives up health care costs).

⁵⁰ See Fran Kritz, *Malpractice May Ride the New Reform Wave: With Help From AMA and Congress, Exorbitantly High Premiums—and Settlements—Could Come Down*, MED. WORLD NEWS, Apr. 1993, at 70 (noting that doctors pay five to six billion dollars in premiums each year while health care costs overall reached 840 billion in 1992).

⁵¹ See Stewart, *supra* note 49, at 18. "[M]edical malpractice as a line of insurance had the highest profit as a percentage of premiums in 1991. Losses paid by insurers in 1991 for medical negligence amounted to only .31% (or 31 cents out of every dollar) of national health care costs." *Id.*; see also *The Real Malpractice Crisis—It's Not Over Yet*, PEOPLE'S MED. SOC'Y NEWSL., Aug. 1989, at 6 (reporting that Minnesota's medical malpractice insurers were charging doctors up to three times normal malpractice premiums, even though malpractice crisis was non-existent).

⁵² See Mary Rowland, *The Liability Crisis Hits Home*, WORKING WOMAN, June 1986, at 106 (showing how insurance companies earn so much money on invested premiums that it exceeds amount actually paid out in malpractice awards).

⁵³ Study, (U.S. GENERAL ACCOUNTING OFFICE) (1987).

that liability insurance companies had realized profits in excess of \$110 billion during the decade.⁵⁴

One New York company, Medical Liability Mutual, started with no assets in 1975 and accumulated over \$3 billion in assets by the end of 1991.⁵⁵ This is a prime example of profits far exceeding any liabilities which one company might incur.

Practically speaking, the annual cost of insurance overall—\$5.6 billion—is not substantial enough to have much impact on America's spiraling health-care costs. Nevertheless, if this is an area that policy-makers continue to focus on, they should also examine the profits made by the insurance companies.

According to a 1991 study performed by the Coalition for Consumer Rights ("Coalition"), a Chicago based consumer advocacy group, all of the costs associated with medical malpractice account for only one percent of total health-care expenditures in America.⁵⁶

The Coalition stated that medical malpractice costs are negligible in light of such factors as inflation, demographics, and the advent of newer, more costly treatments in conjunction with limited competition, fraud, and waste among the medical profession.⁵⁷ In the 1991 report, the Coalition also stated: "To the extent that tort law forces doctors to exercise a reasonable standard of care, costly injuries and adverse events are actually limited. . . . Reducing the actual amount of doctor negligence should be the cost-containment strategy for policy-makers concerned about medical malpractice."⁵⁸ In other words, if the medical profession is truly interested in reducing the cost of health care in America, it should try to reduce the amount of malpractice that is committed by its members.

⁵⁴ *Id.*

⁵⁵ WACHSMAN, *supra* note 10, at 168.

⁵⁶ Report on Medical Malpractice Costs, Coalition for Consumer Rights (Chicago) 1991.

⁵⁷ *Id.*

⁵⁸ *Id.*

D. *Myth Four: Lawyers Encourage Unfounded Malpractice Claims*

Another pernicious myth is that since most malpractice lawyers have a contingency fee arrangement with their clients,⁵⁹ in which the lawyer's fee is based on a percentage of the award granted in the lawsuit, clients have nothing to lose by suing a doctor. The system, the argument states, has become a lottery, with unhappy patients encouraged by greedy lawyers to take a chance that they will be able to win a large award.

Though there may be some unscrupulous attorneys, realistically, it does not make sense for a lawyer to encourage a client to sue unless he or she truly believes the case to be valid. A malpractice lawsuit takes years of work, including legal research, investigation of medical information, and depositions of witnesses. Apart from the moral and ethical reasons for not bringing a frivolous lawsuit, a lawyer being paid on a contingency basis, no matter how much time and energy he or she devotes to a case, will not get paid if the judge throws it out of court. Therefore, ethics, logic, and even economics argue against lawyers bringing unwarranted and frivolous lawsuits.

E. *Myth Five: Jury Awards are too High*

The AMA and others miss the point when they argue that the current system of malpractice litigation does not work, that awards have grown too high, and that the awards do not bear any relation to the costs associated with the injuries received. The AMA paints a picture of juries that are misled by sharp lawyers into granting big judgments to undeserving plaintiffs. Juries are smarter than that.

For example, juries are outraged when a baby is born brain-damaged due to a doctor's failure to show up in the labor room and notice that a fetus was in distress, or when a doctor ignores a woman's breast cancer until it is too late, or when a physician's blatant neglect or incompetence causes the needless death of a patient.⁶⁰ Juries want to make sure that the plaintiff is properly

⁵⁹ See Kenneth S. Abraham, *Medical Liability Reform; A Conceptual Framework*, JAMA, July 1, 1988, at 70. "The typical medical malpractice plaintiff pays his or her attorney a percentage of any amount recovered." *Id.*

⁶⁰ See, e.g., *Robinson v. Charleston Area Med. Ctr.*, 414 S.E.2d 877, 889 (W.Va. 1991) (jury awarded \$3.5 million to parents of brain damaged child regardless of state's \$1 mil-

compensated for his or her injury. As a result, awards are granted by juries with the hope that it will provide proper compensation as well as send a message to doctors that such behavior will not be tolerated.⁶¹ This is not the act of a duped jury, the jury has a definite purpose in mind.

Some observers feel juries should not be allowed to consider a plaintiff's pain and suffering when contemplating the amount to award the plaintiff.⁶² Others vehemently disagree and think that any injury which affects a plaintiff's lifestyle, if caused by negligence, should command a greater compensation.⁶³

II. MALPRACTICE CRISIS IS A RESULT OF POOR PRACTICE, NOT LAWSUITS

Virtually every objective investigation of the medical malpractice crisis in America has shown conclusively that the cause of the crisis is not lawsuits, but malpractice. A United States Senate Subcommittee concluded over twenty years ago that "most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority have proved justifiable."⁶⁴ Furthermore, a 1992 study reported in the *Annals of Internal Medicine* confirms that this is still the case.⁶⁵

lion cap); see also *Monias v. Endal*, 623 A.2d 656, 658 (Md. 1993) (affirming jury award of about \$950,000 in damages for doctor's failure to diagnose breast cancer in early stages).

⁶¹ See William J. Curran, *Law-Medicine Notes: The Malpractice Commission Report*, *NEW ENG. J. MED.*, June 7, 1993, at 1222-23. According to a study conducted for the Rand Corporation and reported in the *New England Journal of Medicine*:

Damages awarded in a malpractice suit must be viewed not only as compensating the victim but also as deterring health-care providers from negligent behavior. The negligence system makes a great deal more sense if it is understood primarily as a means to deter careless behavior rather than to compensate its victims. By finding fault and assessing damages against the negligent provider, the system sends all providers a signal that discourages future carelessness and reduces future damages.

Id.

⁶² *Id.*

⁶³ *Id.*

But someone whose injury affects his life-style—say the ability to participate in recreation or the ability to have children—is paying a price that is properly included in a damages award. . . . The effect on life-style is enormous and a jury properly assesses the loss as a real injury that can only be compensated monetarily. In these terms, even the largest awards do not seem excessive.

Id.

⁶⁴ STAFF OF SENATE COMM. ON EXECUTIVE REORGANIZATION, *MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN* (Comm. Print 1969).

⁶⁵ See also Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 *ANNALS OF INTERNAL MEDICINE* 780, 780-81 (1992) (noting that 62% of malpractice claims are justifiable and that doctors' conduct did not conform to standard of care).

Unfortunately, as a result of the medical and insurance lobbyists' efforts, rather than cracking down on incompetent doctors, there are moves afoot to place the public at an even greater risk and deny victims the opportunity to seek justice. Rather than take steps to protect patients and encourage the practice of higher quality medicine, these groups seek to limit lawsuits against negligent doctors by enacting various types of tort reform legislation.⁶⁶

The proposed tort reform legislation would, in essence, lock the public out of the courtroom and limit the recourse available to injured people.⁶⁷ Tort reform plans come with different names, including caps on awards, no-fault, and arbitration.⁶⁸ Proponents claim that these plans would benefit the public and provide compensation to a greater number of injured people.⁶⁹ Such proponents suggest that cap awards would prevent an overly emotional jury from imposing an unfairly high judgment, which, as a result, drives up insurance premiums.⁷⁰

It is also argued that arbitration would make it easier for patients to seek compensation because they would no longer need to hire a lawyer and go through the courts.⁷¹ Furthermore, a no-fault system would presumably ensure that those who suffer injuries would be compensated.⁷² Since individual doctors would no longer be sued, and a doctor's liability would no longer be an issue, there would be no cover-ups of negligence and, while no one would be

⁶⁶ See *Alliance Urges Gingrich to Add Malpractice to Tort Reform Bill*, PENSIONS & BENEFITS DAILY (BNA) Jan. 23, 1995, at d12. The Health Care Liability Alliance is comprised of roughly two dozen health care provider trade associations and malpractice insurers. *Id.*

⁶⁷ See Robert L. Lowes, *Can Malpractice Really Be Kept Out of Court?*, 71 MEDICAL ECONOMICS 106, 120-21 (1994) (noting plaintiffs' attorneys' view that patient's waiver of rights is unfair because plaintiff does not understand nature of what he's giving up until after he's injured).

⁶⁸ *Id.* at 121 (espousing no-fault in some situations); see also *Health System Reform: Issues Related to Health Care Liability: Hearings Before the Subcommittee on Courts and Admin. Practice of the Senate Comm. on the Judiciary*, 103d Cong., 2d Sess. (1994) [hereinafter *1994 Hearings*] (statement of John B. Niles, M.D., on behalf of the Health Care Liability Alliance) (noting approval of caps on awards for non-economic damages and arbitration).

⁶⁹ *1994 Hearings*, *supra* note 68 (noting that discussed model ensures full and fair compensation).

⁷⁰ *Id.* (discussing effect judgments have on insurance premiums).

⁷¹ See Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 783 (1994) (noting potential benefits of alternative dispute resolution to aggrieved patients).

⁷² See Dennis J. Rasor, Note, *Mandatory Medical Screening Panels: A Need to Re-Evaluate*, 9 OHIO ST. J. ON DISP. RESOL. 115, 134 (1993) (noting purposes of no-fault system).

able to get the large awards presently available, everyone would receive some level of compensation.⁷³

The fact is, however, that these tort reform measures have four things in common: insurance companies save money; incompetent doctors avoid blame and any meaningful form of discipline; patients and their families, who have been destroyed in the process, are prevented from obtaining financial compensation, the only kind of justice available to them, and the general public is left unprotected from doctors who may maim and kill their patients.⁷⁴

Various tort reform measures have made their way through the legislatures of a number of states. For instance, California has put limits on the amount of money plaintiffs can receive for non-economic damages, i.e. pain and suffering.⁷⁵ Similarly, New York breaks from custom and allows awards of more than \$250,000 to be paid out to the plaintiff over a number of years, rather than the usual one lump-sum.⁷⁶

Perhaps the most damaging tort reform assault has come from Washington D.C., where Congress is considering legislation that would ultimately force states to institute major changes in the way medical malpractice cases are resolved.⁷⁷ Several proposals have been advanced, including: placing caps on non-economic damages;⁷⁸ limiting joint and several liability;⁷⁹ and allowing the payment of large awards in installments.⁸⁰

⁷³ *Id.* (noting benefit to physician-patient relationship); see also Julie Cohen, *Tort Reform Unlikely in Health Bill*, THE RECORDER (Amer. Lawyer Media L.P.), Aug. 25, 1994, at 6 (noting reform opponent's argument that medical malpractice crisis is caused by number of injured patients, not number of suits).

⁷⁴ It is unfortunate that tort reform advocates make the argument that lawsuits have caused a malpractice crisis when that in fact is simply untrue. See Cohen, *supra* note 73.

⁷⁵ See CAL. CIV. CODE § 3333.2 (West Supp. 1994) (limiting recovery against health care provider to \$250,000 for non-economic loss).

⁷⁶ See N.Y. CIV. PRAC. L. & R. 5031(e) (McKinney Supp. 1994) (noting future payments of damages shall be paid in periodic installments).

⁷⁷ See, e.g., H.R. REP. NO. 352, 104th Cong., 1st Sess. (1995) (discussing uniform national standards for resolution of medical malpractice claims); H.R. REP. NO. 229, 104th Cong., 1st Sess. (1995) (citing imposition of certain requirements on medical malpractice liability); S. REP. NO. 11, 104th Cong., 1st Sess. (1995) (providing grants to states that promote development of alternative dispute resolution).

⁷⁸ See H.R. REP. NO. 352, 104th Cong., 1st Sess. § 104(a) (noting cap of \$250,000 on non-economic damages); H.R. REP. NO. 229, 104th Cong., 1st Sess. § 7(a) (noting \$250,000 cap for non-economic medical malpractice losses); S. REP. NO. 11, 104th Cong., 1st Sess. § 202(b) (noting cap applies regardless of number of defendants).

⁷⁹ See H.R. REP. NO. 352, 104th Cong., 1st Sess. § 104(c) (noting that liability shall be several only, not joint); S. REP. NO. 11, 104th Cong., 1st Sess. § 203 (stating all losses shall be allocated proportionate to fault).

⁸⁰ See H.R. REP. NO. 352, 104th Cong., 1st Sess. § 105(a) (permitting payments for future losses to be paid periodically); H.R. REP. NO. 229, 104th Cong., 1st Sess. § 7(b) (noting

Such proposals may spur the development of alternative dispute resolution ("ADR"), arbitration, no-fault and other methods of resolving claims out of court.⁸¹ As the foregoing will illustrate, each of these proposals is flawed.

As a means of resolving disputes, ADR often means a no-fault system similar to workers' compensation. Under such a system, everyone who is injured by a doctor would receive compensation without going to court.⁸² Yet, there would be no findings of liability or guilt against doctors.⁸³ Perhaps most unfortunate is that even though long and costly court proceedings would be eliminated, injured patients generally would receive fairly small awards.⁸⁴

The Commonwealth of Virginia, for example, instituted a no-fault system in 1988 to deal solely with cases of brain damaged children.⁸⁵ Not surprisingly, during the first five years of this program, from January 1, 1988 to January 1, 1993, not one single award was made to a brain damaged child or to the parents.⁸⁶ Then, in early 1993, the Virginia Attorney General's office reported that they had made three awards, for a paltry total of \$65,000, less than \$22,000 for each brain damaged child.⁸⁷ It appears that this no-fault system has saved the insurance companies and doctors an unbelievable amount of money while severely and negatively impacting powerless victims.

The benefits of a relatively effective no-fault system are solely theoretical. Since there would be no finding of fault, doctors would have to be sufficiently insured for injuries that are not necessarily the result of negligence as well as those that are. Thus, a far greater number of claims would have to be paid, which would surely be reflected in insurance premiums. No-fault would also

liability for payments to be made periodically if award exceeds \$50,000); S. REP. NO. 11, 104th Cong., 1st Sess. § 202(a) (noting any person required to pay more than \$100,000 does not have to pay in lump sum payment).

⁸¹ See H.R. REP. NO. 352, 104th Cong., 1st Sess. § 201-03 (outlining plans for alternative dispute resolution); S. REP. 11, 104th Cong., 1st Sess. § 102 (outlining standards for alternative dispute resolution grant).

⁸² See *Razor*, *supra* note 72, at 134 (discussing how there would be no need to go to court).

⁸³ *Id.* (noting that quality control network would likely suffer).

⁸⁴ *Id.* (stating that plaintiffs in medical malpractice claims sacrifice their ability to receive full compensation).

⁸⁵ See VA. CODE ANN. § 38.2-5002-B (Michie 1994) (establishing statutory relief exclusive of all other rights).

⁸⁶ Information obtained by author directly from Virginia Attorney General's Office.

⁸⁷ *Id.*

fail to serve the intended purpose of entirely eliminating lawsuits. There will always be disputes, just as there are under workers' compensation and under the no-fault systems of automobile insurance.⁸⁸ In fact, the combined cost of litigation and of payments to patients who were injured, but not as a result of negligence, could conceivably more than offset the overall savings that a no-fault system might otherwise achieve.⁸⁹

In addition, by eliminating the standard of fault, any deterrent effect that malpractice lawsuits now have on incompetent doctors also would be eliminated.⁹⁰ "Replacing the present tort system with a no-fault insurance scheme would not necessarily be cheaper, [and] might well abolish the deterrent signal of distorted clinical decision making."⁹¹

Other ADR mechanisms frequently discussed involve either substituting or supplementing juries with panels of "experts," who presumably are better able to understand the complicated facts of a malpractice case than lay people.⁹² Such panels might be part of the arbitration process and take the place of a trial by jury.⁹³

Alternatively, they may be screening panels that rule on the merits of cases before trial.⁹⁴ The theory behind such panels is that juries lack the ability to form intelligent opinions on such complicated matters, and thus make emotional decisions resulting in unreasonably high awards to plaintiffs. Proponents of tort reform claim that juries, which are perfectly capable of ruling on whether to send a murderer to the electric chair, are not competent to rule fairly and impartially when a physician is accused of malpractice. Moreover, eliminating trials by jury singles out the medical profession for protection against lawsuits, a protection that is not afforded to any other profession in this country.

A variation of the panel system is one in which, even if the panel decides against the plaintiff, he or she may still proceed with the

⁸⁸ See WACHSMAN, *supra* note 10, at 76-77.

⁸⁹ See Gellhorn, *supra* note 38, at 193-94 n.26 (stating that costs of comprehensive no-fault system would be staggering).

⁹⁰ See WACHSMAN, *supra* note 10, at 177.

⁹¹ William B. Schwartz & Neil K. Komesar, *Doctors, Damages and Deterrence—An Economic View of Medical Malpractice*, NEW ENG. J. MED., June 8, 1978, at 1282.

⁹² See Razor, *supra* note 72, at 139 (illustrating features of state screening panels in Appendix chart A).

⁹³ *Id.* at 136-37.

⁹⁴ *Id.* at 116. "Some screening panels are similar to arbitration because they result in formal decisions by a third party as to the legal rights and responsibilities of the parties." *Id.*

lawsuit.⁹⁵ The rationale behind this system is that, under these circumstances, the panel does not deny victims their right to a trial by jury. Rather, it simply deters plaintiffs from pursuing frivolous lawsuits.⁹⁶ In effect, however, this stage adds to the cost and time of the process, and thus deters meritorious lawsuits as well as frivolous ones.⁹⁷

Some panel proposals suggest that if the panel rules against the plaintiff and he or she proceeds to trial anyway, the plaintiff would have to pay the doctor's legal bills if the lawsuit fails.⁹⁸ Such a system adds insult to injury. Since a losing action would result in double legal fees, many plaintiffs without substantial financial resources would be deterred from even initiating the action. There are never any guarantees of victory in court. As a result, many people, particularly the poor, who are already injured and in debt as a result of their medical bills, would be deterred from pursuing legal action for fear of losing, and possibly being held liable for their adversary's attorneys' fees.

Another tort reform proposal would place limits on the amount of money a patient could receive for non-economic damages such as pain and suffering, emotional distress, disfigurement, and loss of companionship.⁹⁹ Proponents of these types of caps argue that when someone has been injured or killed as a result of such medical incompetence, the compensation that the individual or family receives should reflect only the economic loss that has been suf-

⁹⁵ See Lowes, *supra* note 67, at 106 (discussing problems with non-binding alternative dispute resolution).

⁹⁶ See Raser, *supra* note 72, at 124-26 (discussing constitutional issues arising from requirements screening panel requirements).

⁹⁷ *Id.* at 127-30 (discussing additional burdens screening panels put upon plaintiffs).

⁹⁸ See, e.g., H.R. REP. NO. 352, 104th Cong., 1st Sess. § 106(a) (1995); see also Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181, 194 (1990) (noting several states' statutes requiring sanctions for plaintiffs who ignored unfavorable panel decisions and were unsuccessful at trial). Several of these statutes do not look kindly upon plaintiffs who proceed after an unfavorable panel decision. *Id.*; MASS. GEN. L. ch. 231, § 60B, para. 6 (Supp. 1989) (requiring plaintiff to post \$6,000 bond before proceeding to trial after unfavorable panel decision); MICH. COMP. LAWS ANN § 600.4915(2) (West Supp. 1988) (requiring \$5,000 bond to proceed to trial if panel finds claim to be frivolous); NEV. REV. STAT. § 41A.056(2) (Supp. 1989) (imposing sanctions against plaintiffs who proceed to trial after unfavorable panel decisions and lose).

⁹⁹ See, e.g., Kevin S. Mahoney, Note, *Alaska's Cap on Non-economic Damages: Unfair, Unwise and Unconstitutional*, 11 ALASKA L. REV. 67, 86-87 (1994) (discussing Alaska statute [§ 9.17.010] which places \$500,000 cap on any act of negligence including medical malpractice). *Contra* Carson v. Maurer, 424 A.2d 825, 836 (N.H. 1980) (striking down statute limiting medical malpractice non-economic damages to \$250,000).

For a list of all states addressing caps on medical malpractice recoveries, see FRANK M. MCCLELLAN, *MEDICAL MALPRACTICE* 85-86 (1994).

ferred.¹⁰⁰ They believe that the injured party should be compensated for such things as medical bills and lost wages, but should not become eligible for a windfall at the expense of the doctor and the insurance company.¹⁰¹

Indiana laws include both caps on awards and panels to screen cases before they go to trial.¹⁰² Physicians' groups said that Indiana law was a model for national reform when it was passed in 1975.¹⁰³ But, according to the *Indianapolis Star*, "the act has turned out to benefit the two groups who lobbied hardest for its passage—doctors and their insurance companies—far more than it benefits malpractice victims and their families."¹⁰⁴

Indiana caps awards of any kind at \$750,000,¹⁰⁵ an amount that does not begin to compensate victims for the costs that can be incurred as a result of medical malpractice. A young child, for example, severely injured or brain damaged at birth, may incur millions of dollars of expenses during his or her life. Verdicts that may seem large by today's standard may turn out to be inadequate decades into the future, especially because inflation consistently reduces the value of the dollar, while at the same time, medical costs continue to increase. To illustrate, fifty years ago a \$50,000 award for a brain-damaged child might have seemed like a lot of money, but it would hardly be sufficient today to meet the needs of that same victim.

Who really ends up paying when awards are capped? Few medical malpractice victims can afford to pay medical expenses on their own. If the legal system has not provided adequate means, or if caps on awards prevent injured plaintiffs from receiving what they deserve, it is the government that ends up paying the difference, usually in the form of programs like Medicaid, Medicare and

¹⁰⁰ See, e.g., JEFFREY O'CONNELL, ENDING INSULT TO INJURY: NO FAULT INSURANCE FOR PRODUCTS AND SERVICES 112-15 (1975) (advocating no-fault liability for solely economic damages).

¹⁰¹ *Id.*

¹⁰² IND. CODE ANN. § 27-12-14-3 (Burns 1993) (capping awards); IND. CODE ANN. § 27-12-10-1 (Burns 1993) (screening panels).

¹⁰³ See generally Frank Cornelius, *Crushed by My Own Reform*, N.Y. TIMES, Oct. 7, 1994, at A3 (urging repeal of Indiana's Medical Malpractice Act). The author, who lobbied the Indiana Legislature in favor of the Act, noted that, at the time, the Act "was acclaimed as a pioneering reform of the medical malpractice laws . . ." *Id.* The author later became a victim of the stringent cap of \$500,000 imposed by the Act. *Id.*

¹⁰⁴ See Joseph T. Halliman & Susan M. Headden, *Malpractice Laws Stacked Against Victims: Doctors, Insurance Companies Reap Biggest Benefits*, INDIANAPOLIS STAR, June 26, 1990, at 1.

¹⁰⁵ IND. CODE ANN. § 27-12-14-3 (Burns 1993).

the various services for the disabled.¹⁰⁶ This system is unfair because the taxpayers ultimately pay the bill while the guilty physician and his or her insurance company get off-the-hook by paying only a fraction of the true cost of negligence.

The panel system has not proven to be a great success in Indiana either. The panels, which render non-binding opinions on cases before they go to trial, were supposed to speed up the process. However, with a backlog of 1,200 cases, it takes almost three years to get a panel decision. Injured plaintiffs must wait three years before the trial process even begins.¹⁰⁷

Critics of the Indiana law also point out that, while the legislative objectives were to attract more doctors to the state and to reduce the cost of health care, neither has been accomplished. Indiana still has the tenth-lowest number of doctors per capita of any state in the country,¹⁰⁸ and the cost of a hospital stay is still higher than many other states that have not enacted this type of tort reform.¹⁰⁹

Another proposal that has been bandied about aims to either limit or eliminate joint and several liability.¹¹⁰ For example, consider the case of an obstetrician who fails to arrive to examine his or her patient when the patient goes into labor. If and when fetal distress occurs, the child will suffer brain-damage. In such a case, several parties might share liability: the obstetrician, for not showing up; the hospital, for failing to act in the doctor's absence when fetal distress occurred; and probably other physicians as well, such as the hospital resident and the anesthesiologist, who were all present and did not provide the care necessary to save the baby from injury.

¹⁰⁶ See generally McCLELLAN, *supra* note 99, at 65-66 (discussing and describing nature of Medicare and Medicaid programs).

¹⁰⁷ See, e.g., Anita J. Slonski, *How Long Can Indiana Remain a Malpractice Paradise?*, MED. ECON., Feb. 4, 1991, at 122. "The only thing the panels do is slow the whole process down." *Id.*

¹⁰⁸ See BUREAU OF THE CENSUS, U.S. DEP'T OF COM., STATISTICAL ABSTRACT OF THE UNITED STATES 1994 122 (1993). The rate of physicians per 100,000 residents in Indiana is 165, while the national average is 224. *Id.*

¹⁰⁹ *Id.* at 111. The cost of hospital care in Indiana, as of 1991, was approximately \$6 billion. *Id.*

¹¹⁰ See, e.g., S. REP. NO. 1579, 103d Cong., 1st Sess. § 5104 (1993); H.R. REP. NO. 3222, 103d Cong., 1st Sess. § 5104 (1993) [hereinafter Managed Competition Act of 1993]. In addition to abolishing joint and several liability, the Bills, sponsored by Sen. John Breaux (D. La.) and Rep. Jim Cooper (D. Tenn.), would also require alternative dispute resolution prior to trial, a cap of \$250,000 on non-economic damages, and periodic payments of future damages, among other provisions. *Id.* at §§ 5102, 5201, 5104-05.

Moreover, if it turns out that the obstetrician has no malpractice insurance, or, in the alternative, only a small policy that would be insufficient to compensate the victim, under joint and several liability, the other doctors and the hospital would each be held individually liable for paying to the victim whatever amount the jury awarded. That is the best method for ensuring that injured plaintiffs receive the awards that they are entitled to. After all, if an obstetrician's negligence includes the failure to maintain an adequate insurance policy, the victim should not be forced to suffer twice, once because of malpractice and again from failure to collect the judgment.

Tort reformers say that defendants in medical malpractice lawsuits should be responsible for paying damages only in direct proportion to the degree of their culpability.¹¹¹ Thus, if the jury finds the obstetrician sixty percent at fault, the hospital thirty percent at fault, and the resident and anesthesiologist each five percent at fault, tort reformers believe that each should be responsible for paying only their respective proportionate percentage of the total award. However, under this callous approach, if the obstetrician has no insurance, the plaintiff loses sixty percent of the award, while the insurance companies remain protected. Even more unfortunate is the fact that the child's family is left to figure out how best to pay for a lifetime of medical bills.

Another popular tort reform proposal would allow the doctors who have been found guilty of negligence and their insurance companies to pay out large awards over a period of time.¹¹² The logic of this proposal is that a large part of the award in a medical malpractice case is to cover the cost of future expenses.¹¹³ Since these expenses occur over time, tort reformers argue against requiring payment in one lump sum immediately after the judgment is rendered.

The reasons for payment in one lump sum are several fold. First, is the issue of fairness. A victim of medical malpractice

¹¹¹ See John W. Wade, *Should Joint and Several Liability of Multiple Tortfeasors be Abolished?*, 10 AM. J. TRIAL ADVOC. 193, 197 (1986) (criticizing advocates for abolition of joint and several liability).

¹¹² See, e.g., Managed Competition Act of 1993, *supra* note 110, at § 5105; see also McCLELLAN, *supra* note 99, at 86.

¹¹³ See, e.g., *American Bank Trust v. Community Hospital of Los Gatos-Saratoga*, 683 P.2d 670, 676 (Ca. 1984) (noting legislature's rational basis for determining that future damages should be paid periodically).

should have control over the full amount of the award, to spend as he or she deems fit. For example, a disabled person may want to spend a large amount of money immediately to purchase a specially designed home to accommodate their handicap; the family of an injured child might want to travel to another city to consult with other physicians; and another family might want to invest the money and use it later for the child's education. After going through the trauma of medical negligence and years of litigation, the plaintiff should be entitled to that freedom. Moreover, he or she should not have to go back each time there is an unusual expenditure to ask permission from the doctor or the insurance company to obtain additional funds.

In addition, if the defendant can hold on to that money and pay it out in installments, then the defendant will be able to invest it and keep the earnings on the money that rightly belongs to the plaintiff. If payment is made in a lump sum, the malpractice victim can invest the money and, as a result, increase the value of the award. As we have seen, insurance companies are already making tremendous profits because of the installment payment policy.¹¹⁴ They simply should not be allowed profit at the expense of people who are adjudicated as victims of medical malpractice.

It seems clear, not only from logical assumptions based on our own experience, but on information taken from states where tort reform legislation has been enacted, that these "reforms" do nothing to benefit the American public. Despite such evidence, however, the campaign for tort reform continues.

III. CONCLUSION

An honest analysis of all of the evidence clearly indicates that the American people need reforms that protect the public, not reforms that blame the injured, the disabled, and the victims of medical ineptitude and neglect. The reforms advanced by tort reform proponents, purportedly in the public interest, are actually in the interests of the thousands of physicians who will be allowed to practice bad medicine, undetected, undeterred, and untroubled by their conscience or the courts.

¹¹⁴ See *supra* notes 38-41 and accompanying text.