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KILLING THE GOLDEN GOOSE BY EVALUATING MEDICAL CARE THROUGH THE RETROSCOPE: TORT REFORM FROM THE DEFENSE PERSPECTIVE

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I. INTRODUCTION

Speaking to the recent rash of airline bankruptcies, a concerned friend asserted that when he flies, he wants the plane to be in the control of a happy, relaxed, focused pilot. Similarly, when he undergoes surgery, he wants the knife to be in the hands of a surgeon whose only concern is the

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procedure at hand. It is not too broad of a generalization to assert that even the most calloused of Plaintiffs' attorneys would prefer not to be operated on by a physician who has just completed a deposition. Rather, all Americans want our health care providers focused on what they do best—providing care to us so that we may live.

We represent health care professionals and institutions comprised of the same. Those professionals are typically medical physicians—men and women who spent their undergraduate years immersed in rigorous curricula watching from the library as their classmates *partied on*; spent months preparing for and anxiously sitting for the MCAT; devoted the years in their 20's to tackling the understanding of high-level science involving the complex mechanism known as the human body while foregoing sleep and a social life to attend to clinical rotations; followed by watching from the hospital as their friends embarked on the commencement of family life and careers while the doctors instead embarked on the endurance test known as residency. Through their sacrifice and dedication these men and women provide a service, which cannot be matched—they keep us healthy and they give us a gift more precious than any other possession—our very lives. These men and women who heal us when we are injured are truly our *golden geese*.

Yet, these men and women, receive as their *just due* the *thanks* of literally being called killers, injurers, deprivers of support, inflictors of cerebral palsy, disability, mental distress, loss of capacity to enjoy life, etc., etc., etc. . . . as Plaintiffs simply pay a court fee and, in most states, pretty much say whatever they want about the doctor with impunity. Without a thought of how such allegations might affect the psyche of another human being who has provided service to them, much less the physicians' families, who often sacrifice their own time and relationships with their loved ones so that the doctor can care for others, some Plaintiffs hurl accusations at physicians that are no different than someone accusing another of driving down the highway with the car stereo blaring, applying make-up, drinking a cup of coffee and cavalierly hitting a pedestrian with their automobile—i.e., injury and death by way of negligence. "Doctor, you killed my child . . . injured my father . . . made me a quadriplegic." And Plaintiffs' attorneys wonder why doctors cannot simply get *thick skinned* and considered lawsuits simply the *cost of doing business*?

Civil actions based on allegations of medical malpractice in the United States are currently treated as cases of simple negligence. That is, in theory, civil liability attaches when a health care provider and/or institution fails to conform behavior to a certain standard of conduct for which they have a legal duty, combined with a reasonably close causal connection

between such conduct and a resulting injury which consists of actual loss or damage resulting to the interests of another.[1] In practice, however, judging a doctor's actions under a negligence standard isn't always so neat and tidy, for triers of fact have one critical fact at their disposal that defendant health care providers significantly lack when making treatment decisions—*the outcome*. In fact, a significant predictor of success in the American tort system in medical malpractice cases is the degree of injury, *not* the existence of malpractice.[2]

In our combined experience, we have had the pleasure of both defending and befriending hundreds of physicians and other health care providers and administrators, all of whom, without exception, felt that a patient truly injured by a medical mistake should be compensated. Their frustration is not with compensation of the truly injured, it is rather dismay with a system that is outcome driven[3]—a system where a health care provider's work is judged under the retroscope with the benefit of knowing all of the facts which the health care provider did not have at their disposal at the time of care. While our clients are concerned and financially squeezed by increasing medical malpractice premiums, they are equally as concerned with questions of fundamental fairness.

Recently, a physician analogized medical diagnosis and treatment to traveling through fog where the entire picture is not clear, but guiding decisions must be made. When medical malpractice suits are filed, those medical decisions are then evaluated as if made in the full sunlight with the outcome as the backdrop for the standard of care. While at least one anti-tort reform group routinely refers to doctors as "cavalier,"[4] in our experience, we have not met one doctor who did not genuinely care about his patient nor have we met a doctor who wished a poor outcome on his patient.

This article examines the slow, painful demise of the health care provider *golden goose* by a patient compensation system which fails to meet its stated goal by instead decreasing access to medical care, driving up the costs of medical care and most importantly, damaging the enthusiasm, the drive and the dedication of the people upon whom we depend for our very lives. As defense attorneys, we support the public policy goals of

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[1] W.P. Keeton, *Prosser and Keeton On Torts* §30 (5th ed., 1984).
[2] David M. Studdert et al., *Medical Malpractice*, 350 New Eng. J. Med. 283, 286 (Jan. 15, 2004) (citing J.S. Kakalik & N.M. Pace, *Costs and Compensation Paid in Tort Litigation* (RAND 1986)).
[3] A significant predictive factor of success in a medical malpractice lawsuit is degree of injury—not incidence of malpractice. *Id.* (citing P.C. Weiler, et al., *A Measure of Malpractice: MedicalIinjury, Malpractice Litigation, and Patient Compensation* (Harv. U. Press 1993)).
[4] Public Citizen, *Medical Malpractice Briefing Book: Challenging the Misleading Claims of the Doctor's Lobby*, v (Aug. 2004) (available at http://www.citizen.org/documents/MedMalBriefingBook08-09-04.pdf (accessed Jan. 11, 2006)).

accessible, quality care and the provision of a fair and accurate system of patient compensation. To that end, the changes in the system put into place by means of current tort reform legislation, specifically the damages caps system, will be examined. Although other innovative systems for dealing with medical malpractice claims have been proposed,[5] and one has been introduced in Congress in 2005,[6] we will address and we support the cap system as being, at present, the most feasible means of the stabilization of medical malpractice premiums and the medical provision system as well as the deterrence of frivolous lawsuits. We will then examine proposed federal legislation as a means of providing a system that truly provides for fair and honest compensation of truly injured patients while fairly treating doctors to allow them to do what they do best—care for patients.

II. THE PROBLEM: THE PATIENT COMPENSATION SYSTEM IN AMERICA IS FLAWED

Both physicians and patients are victims of a seriously flawed malpractice system in the United States.[7] In particular, the process of airing and resolving claims through litigation is destructive for all concerned, while the "dynamics of malpractice insurance drive premiums into crisis cycles with pernicious consequences."[8] While both the Plaintiffs' and Defense bars agree that the goals of a compensation system are the same, an overview of the current tort system shows that while pursuing such claims under such a system might have an internal logic, in practice, the joint social goals of promoting safer medicine and compensating wrongfully-injured patients are not being achieved.[9] Instead, the system drives our nation's physicians out of private practice, increases the costs of health care, and encourages "the ordering of tests and procedures that are of marginal or no medical benefit, primarily for the purpose of reducing medicolegal risk."[10] As a former president of the American Medical Association succinctly capsulated the problem, "[a]n over-litigious system is anathema to building a strong and effective national patient safety program."[11]

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[5] Other proposed medical malpractice compensation schemes include the creation of health care courts, non-fault workers compensation-type systems, enterprise liability for hospitals and early-offer negotiation. *See* Studdert et al., *supra* n. 2, at 289.

[6] The Fair and Reliable Medical Justice Act, introduced in the United States Senate in June 2005, would create a pilot program in a limited number of selected states to establish special health care courts for medical malpractice claim determination. Sen. 1337, 109th Cong. (June 29, 2005). This proposed bipartisan legislation is sponsored by groups such as the American College of Obstetricians and Gynecologists and is currently in Committee.

[7] Medical News Today, *Effect of Damage Caps in Medical Malpractice Suits, Health Affairs, JAMA Studies Examine*, http://www.medicalnewstoday.com/medicalnews.php?newsid=25517 (June 2, 2005).

[8] *Id*.

[9] Studdert et al., *supra* n. 2, at 283-284.

[10] *Id*. at 286.

[11] Donald J. Palmisano, *Statement of the AMA to the Committee on Energy and Commerce, Subcommittee on Health Re: Assessing the Need to Enact Medical Liability Reform*,

A. *The Current Malpractice System Does Not Do Its Job*

The overriding goal of all negligence law applies to medical malpractice law as well: to provide incentives for physicians to take appropriate precautions against medical injury and to adequately compensate those patients injured by medical care.[12] However, studies reveal that the malpractice system is a profoundly inaccurate mechanism for distributing compensation to patients.[13] Many refer to the current medical malpractice system as "the 'lawsuit lottery,' which provides windfalls for some patients, but no compensation for the vast majority of patients injured by medical care."[14] Further, evidence supporting the notion that the system in any way deters medical negligence is very limited.[15]

A review of statistics from around the country reveal a flawed and inefficient system for compensating injured patients. Of all malpractice cases filed against health care providers, nearly seventy-five percent are closed without any payment to the patient.[16] Furthermore, less than thirty percent of all money that doctors pay in liability insurance fees actually goes to patients.[17] Rather than compensating patients, attorneys' fees account for forty percent or more of multi-million dollar payouts, according to the *National Center for Policy Analysis*.[18] Viewed from another angle, approximately sixty cents of every dollar expended on the medical malpractice system goes to pay overhead, i.e., administrative costs comprised predominantly of legal fees.[19] This figure is fully twice the overhead rate for an average workers' compensation scheme.[20]

Moreover, a Harvard research team concluded that, in New York, the alarming incompetence of the liability system is "a searing indictment of

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http://www.ama-assn.org/ama/pub/category/print/12992.html (Feb. 27, 2003) [hereinafter Energy & Commerce Statement].

[12] *See* Daniel P. Kessler & Mark B. McClellan, *How liability law affects medical productivity*, 21 J. Health Econ. 931 (2002).

[13] Studdert et al., *supra* n. 2, at 285.

[14] *Id*. at 283.

[15] *See id*. at 286 (citing Mello & Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reforms*, 80 Tex. L. Rev. 1595 (2002)).

[16] Am. Med. Assn., *Medical Liability Reform—NOW!, A compendium of facts supporting medical liability reform and debunking arguments against reform.*, http://www.ama-assn.org/ama1/pub/upload/mm/378/mlrnowoct192005.pdf (updated Oct. 19, 2005) (accessed Jan. 11, 2006) [hereinafter *The Facts*].

[17] *Id*.; *see also* Am. Med. Assn., *America's Medical Liability Crisis: We All Pay for the Broken System* (Feb. 2005) available at http://www.ama-assn.org/ama1/pub/upload/mm/399/mlr_fastfacts.pdf (accessed Dec. 23, 2005) (citing Tillinghast-Towers Perrin, U.S. Tort Costs: 2003 Update) [hereinafter *America's Liability Crisis*].

[18] Natl. Ctr. for Policy Analysis, *Lawsuits Hike Healthcare Costs*, http://www.ncpa.org/iss/leg/2002/pd073102f.html (July 31, 2002).

[19] Studdert et al., *supra* n. 2, at 286 (citing J.S. Kakalik & N.M. Pace, *Costs and Compensation Paid in Tort Litigation*, (RAND 1986)).

[20] *Id.*

the performance of the malpractice system."[21] Their study revealed that, in the state of New York, only seventeen percent, or approximately *one out of six*, of medical malpractice civil actions actually filed, appeared to actually involve a negligent injury.[22] Thus, despite Plaintiffs' attorneys contention that frivolous lawsuits are rare, incredibly, five out of six claimants in the Harvard study sought compensation for injuries that were *not* the result of medical negligence.[23] Speaking to this disparity, one group of medical authors suggested "the analogy of a traffic cop who regularly gives out more tickets to drivers who go through green lights than to those who run red lights."[24]

The Harvard conclusions were virtually identical to a study conducted in Utah and Colorado in the late 1990's, leading to the conclusion that the inconsistency observed between injury and litigation were neither regionally nor temporally isolated.[25] Then, a ten-year follow-up survey of the Harvard data from New York showed that the key predictor of payment was the plaintiff's degree of disability, not the presence of negligence.[26] Put another way, "the primary determinant of whether an injury will receive compensation is the *extent of the injury, not the extent of fault*."[27] Who would choose to be part of a profession that is the target of such a system?

In addition to failing to provide redress for negligently injured patients, the malpractice liability system fails to provide incentives for optimal medical care or to deter substandard care. While trial attorneys passionately, but incorrectly, assert that the threat of litigation assures that doctors will practice more safely, in reality "the punitive, individualistic, adversarial approach of tort law is antithetical to the nonpunitive, systems-oriented, cooperative strategies promoted by the leaders of the patient-safety movement."[28] A few studies have attempted to model the relationships between malpractice claims experience and subsequent rates of adverse events, negligence rates, or quality-of-care indicators.[29] When the data is considered as a whole, the evidence that the system deters medical negligence can be characterized as limited at best.[30] In fact, rather than providing incentives or deterring negligent behavior, threats of malpractice liability have instead caused more stress, pressure, and anxiety, all the while

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[21] *Id.* at 285 (citing the Harv. Med. Prac. Study, analyzing 30,000 hospital discharges and 3,500 malpractice claims in the mid-1980s).
[22] *Id.*
[23] *Id.*
[24] *Id*. (citing P.C. Weiler et al., *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (Harv. U. Press, 1993)).
[25] *Id*.
[26] *Id*.
[27] Kessler & McClellan, *supra* n. 12, at 931 (emphasis added).
[28] Studdert et al., *supra* n. 2, at 287.
[29] *Id*. at 286.
[30] *Id*.

distracting clinical decision making.[31]

B. *The Current System Encourages the Expensive and Deleterious Practice of Defensive Medicine*

If physicians perceive that medical malpractice system assessments are not consistent with the standard of care and with their own individual medical practices, they may try to satisfy all possible standards by practicing defensive medicine, whether consciously or unconsciously.[32] Defensive medicine most often occurs when physicians order tests or procedures not based on their clinical judgment but rather to protect or cover themselves from potential litigation.[33] Physicians may also refer patients to emergency departments, safety net hospitals, and academic health centers to avoid lawsuits.[34] A nationwide survey by the American Medical Association, revealed that fully seventy-nine percent of physicians reported that the "fear of being sued" caused them to order more tests because of concerns of potential medical liability lawsuits.[35]

But the practice of defensive medicine does not simply include the ordering of more tests or taking additional precautions in order to avoid liability. Defensive medicine also involves declining to supply care that has expected medical benefit in order to avoid malpractice, thereby reducing access to care (i.e. negative defensive medicine).[36] More specifically, some physicians respond to the threat of malpractice litigation by declining to take calls in the emergency room and by declining elective referrals from emergency departments and safety net clinics.[37] Fully forty-two percent of the physicians surveyed by the Harvard School of Public Health said that liability concerns have forced them to restrict some practices since 2000, including eliminating procedures and avoiding patients with complex medical problems or those who appeared litigious.[38]

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[31] *Infra*. § II(D)(1).
[32] Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 Am. J.L. & Med. 501, 530 (2004).
[33] Joseph L. Murphy, *A Physicians' Perspective on the Medical Malpractice Crisis*, 13 Ann. Health L. 623, 626 (2004).
[34] Donald J. Palmisano, *Heath Care in Crisis: The Need for Medical Liability Reform*, 5 Yale J. Health Policy L. & Ethics 371, 375 (Winter 2005).
[35] *The Facts*, *supra* n. 16 (citing *Fear of Litigation Study; The Impact on Medicine*, Common Good, (Apr. 11, 2002)).
[36] Daniel P. Kessler, William M. Sage, & David J. Becker, *The Impact of Malpractice Reforms on the Supply of Physician Services*, J. Am. Med. Assn. vol. 293, no. 21 at 2618 (2005).
[37] Palmisano, *supra* n. 34, at 375; s*ee also* BNA, *Maintaining Adequate On-Call Coverage Increasingly Challenging Task for Hospitals*, Health L. Rptr., Vol. 14, No. 37 at 1231 (Sept. 22, 2005), available at http://pubs.bna.com/ip/BNA/hlr.nsf/is/a0b1k0d0t9, (accessed Sept. 22, 2005) (BNA password required) (citing malpractice liability and increases in malpractice premiums as some of several reasons for the problem).
[38] Murphy, *supra* n. 33, at 626.

In a survey of Pennsylvania physicians in "high-risk" specialties such as Emergency Medicine, General Surgery, Orthopedic Surgery, Neurosurgery, Obstetrics/Gynecology and Radiology, researchers from the Harvard School of Public Health found a staggering ninety-three percent reported that they deviate from "sound medical practice" to lower the risk of lawsuits.[39]

Unfortunately for doctors, it is ironic that defensive medicine may in fact be counterproductive and actually might increase malpractice risk.[40] Physicians who order tests or perform diagnostic procedures with low predictive values or provide aggressive treatment for low-risk conditions increase the likelihood that such practices will become the legal standard of care.[41] Furthermore, physicians who provide unnecessary invasive procedures and surgery may, in fact, violate the standard of care, actually causing more malpractice, which could be the basis for litigation.[42] Doctors find themselves in the position of being *damned if you do, damned if you don't*.

However, in the current litigious environment, where doctors in some areas are literally targets for Plaintiffs' attorneys whose incomes are based primarily on medical malpractice lawsuits, some physicians appear to practice defensive medicine as a reflex response, even though there is no evidence that they serve their own purposes but where there is substantial possibility that they are increasing their malpractice liability.[43] The threat of being personally attacked by such a lawsuit as well as the perceived burden of crushing malpractice premiums may overwhelm even objective evidence of potential effects of defensive actions on malpractice exposure for such physicians.[44]

Not only does defensive medicine waste physicians' time and efforts, as well as possibly expose both patients to risk of harm and physicians to greater risk of liability, the practice of defensive medicine is incredibly costly. The precise costs of practicing defensive medicine are difficult to quantify, but the United States Department of Health and Human Services estimates that defensive medicine practices cost anywhere from

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[39] David M. Studdert, et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, J. Am. Med. Assn., Vol. 293, No. 21 at 2617 (2005) (One caveat of the authors is that these physicians have a strong vested interest and they suggest that "self-reports of defensive medicine may be biased toward giving a socially desirable response or achieving political goals.") [hereinafter *Defensive Medicine*].

[40] Peter P. Budetti, *Tort Reform and the Patient Safety Movement: Seeking Common Ground*, J. Am. Med. Assn., Vol. 293, No. 21 at 2660 (2005).

[41] *See Defensive Medicine*, *supra* n. 39, at 2616 (describing various medical practices now characterized as *defensive*).

[42] Budetti, *supra* n. 40, at 2660-2661.

[43] *Id.* at 2661.

[44] *Id.*; *see also* Studdert et al., *supra* n. 2, at 287.

$70 billion to $126 billion per year.[45] Another study conducted by economic researchers at Stanford estimated that $84 billion to $151 billion could be saved on defensive medicine each year.[46] It is axiomatic that when health care costs are driven up, health insurance becomes more expensive and harder to obtain. It is no wonder that there are so many uninsured Americans.

C. *The Current System Drives Up the Costs of Health Care*

The U.S. tort liability system is the most expensive in the world, with annual direct costs alone totaling nearly $180 billion dollars, or $650 for every man, woman and child who is a citizen of the United States.[47] Of those costs, only twenty percent of the dollars spent actually go to claimants for economic damages.[48]

Thus it comes as no surprise that, in reporting the results of a recent study, the U.S. Department of Health and Human Service concluded that medical malpractice lawsuits are driving up the cost of health care in America.[49] Overall litigation costs, which include the effects of defensive medicine, liability premiums, risk management, outsized awards, and legal costs,[50] add $50 billion to $110 billion to the costs of private health care each year and another $30 billion to $60 billion to federal government payments for Medicare, Medicaid and other programs.[51]

Furthermore, medical malpractice payouts to Plaintiffs comprise a significant portion of those medical malpractice litigation costs. For example, approximately $1 billion in medical malpractice compensation was paid out in the two states of New York and Pennsylvania alone in 2000.[52] The total costs of medical malpractice litigation, excluding defensive medicine estimates and insurance premiums, now exceeds $26 billion annually and continues to grow.[53]

In looking for the source of such astronomical costs, one need not

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[45] *The Facts*, *supra* n. 16, at 6 (citing U.S. Dept. Health & Human Servs., *Addressing the New Health Care Crisis*,, (March 2003)).
[46] *America's Liability Crisis*, *supra* n. 17, at 1 ("[c]alculation[s] based on Kessler & McClellan, *Quarterly Journal of Economics* 1996; 2003 CMS data on national health expenditures").
[47] White H. Council Econ. Advisors, *Who Pays for Tort Liability Claims?* (Apr., 2002) (available at http://www.policyalmanac.org/economic/archive/torts.shtml (accessed Jan. 4, 2006)).
[48] *Id.*
[49] Natl. Ctr. for Policy Analysis, *supra* n. 18.
[50] *The Facts*, *supra* n. 16, at 8 (citing *Price Waterhouse Cooper's* study, Apr. 2002).
[51] Natl. Ctr. for Policy Analysis, *supra* n. 18.
[52] Richard E. Anderson, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 Yale J. Health Policy, L. & Ethics 341, 347 (2005); *see also* Natl. Underwriter, *Study: Tort Costs Still Edging Up, Albeit More Slowly*
http://www.nationalunderwriter.com/pandc/hotnews/viewPC.asp?article=1_17_05_15_15901.xml&src=5 (accessed Dec. 28, 2005) [hereinafter *National Underwriter Study*].
[53] *National Underwriter Study*, *supra* n. 52.

look farther than the trend of damage awards in this country. Nearly eight percent of all individual paid claims now exceed $1 million, which is double of that figure just five years ago.[54] In just a one-year period (between 1999 and 2000) the median jury award increased forty-three percent.[55] Further, median jury awards for medical liability claims grew at seven times the rate of inflation, while settlement payouts grew at nearly three times the rate of inflation.[56] Even more telling however, is that the proportion of jury awards topping $1 million increased from thirty-four percent in 1996 to fifty-two percent in 2000.[57] By 2003, the average jury award had increased to about $3.5 million.[58]

In addition, medical malpractice cases are extremely costly to defend, averaging nearly $23,000 per claim.[59] In cases going all the way through a jury trial before a defense verdict, the average expenses still exceed $85,000.[60]

As a result,[61] hospitals have increased their budgeted amounts for medical liability coverage by thirty-four percent for 2005.[62] The median increase was twenty percent (roughly $665,000) with several hospitals having to nearly double the amount they budgeted.[63] While the vast majority of hospitals (seventy-seven percent) reported either no increase or a minimal increase in the number of medical liability claims made and/or lawsuits filed, fifty-nine percent reported that the average amount paid out

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[54] Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, Health Affairs (Jan. 21, 2004) (available at http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1 (accessed Dec. 28, 2005)).
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] Am. Med. Assn., *AMA Statement to the Senate HELP Committee and the Senate Judiciary Committee, Re: Patient Access Crisis: The Role of Medical Litigation*, http://www.ama-assn.org/ama/pub/category/12990.html (last updated Sept. 15, 2004) [hereinafter Senate HELP Committee Statement].
[59] Anderson, *supra* n. 52, at 345.
[60] *Id.* at 346.
[61] Critics of tort reform say that malpractice costs make up just a fraction of the cause of the dramatic increases in malpractice insurance premiums. *See* Symposium, *The Current Medical Liability Insurance Crisis: An Overview of the Problem, Its Catalysts and Solutions*, 13 Ann. Health L. 505 (2004). However, according to Larry Smarr, President of the Physician Insurers Association of America ("PIAA"), investment losses accounted for, at most, sixteen percent of premium increases in recent years ("We don't deny that there are multiple reasons why [malpractice premium] rates are going up, [b]ut it's 'mainly due to the increase in the value of claims.'"). Lisa Girion, *Malpractice Payouts Have Not Soared, Reports Say; The two studies suggest awards have little to do with skyrocketing liability insurance rates*, L.A. Times C1 (June 1, 2005). Further, according to Brown Brothers Harriman, approximately eighty-five percent of the assets of medical liability insurers are invested in bonds including virtually risk-free treasuries, not stocks. Michael J. Kelly, *The True Cause of Escalating Liability Premiums*, Pierce County Med. Bull. (Oct. 2004) (available at http://www.pcmswa.org/pp_oct1.htm (accessed Dec. 28, 2005)).
[62] Maryland Hosp. Assn., *2004 MHA Medical Liability Insurance Survey Results*, 1 (2004) [hereinafter *MHA Report*].
[63] *Id.*

over the last five year period has increased significantly.[64] It appears that the main source of the problem is an increase in the amount paid per claim, rather than an increase in the number of claims.[65]

D. *Patients, Physicians and Safety Become Victims*

The two most controversial issues at the forefront of the tort reform controversy are patient safety and medical malpractice insurance premiums. The Plaintiffs' bar continues to characterize its efforts to preserve its thirty-forty percent contingent income as self-proclaimed guardians of *patient safety*. As defense attorneys, we can say without hesitation that every physician, health care provider and hospital administrator whom we have ever represented held patient safety out as their over-riding goal. As has been discussed, the tort system can actually decrease, rather than increase, patient safety efforts.

Patient safety requires an adequate physician supply. Yet, skyrocketing medical liability premiums force physicians in states without reforms to limit services, retire early, or move to states with reforms.[66] These costs of the medical liability crisis have as dramatic consequences, not only the significant direct effects on physicians, but also the indirect deleterious effects on patients and the health care system as a whole.[67]

However, there is a natural deep-seated tension between the malpractice system and the goals and initiatives of the so-called "patient-safety movement," i.e., the Plaintiffs' bar.[68] But contrary to the assertions of the Plaintiffs' bar that the tort system works to compensate injured patients and deter medical error, in reality medical liability claims undermine health care quality by taking a toll on physicians, discouraging the reporting of medical errors, and limiting medical practice and driving doctors out of regions.[69]

1. Personal Toll on Physicians

As would be experienced by any but the most calloused of persons,

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[64] *Id.* at 2; *see also* Greater N.Y. Hosp. Assn., *Medical Malpractice Insurance Costs and Coverage*, 2, (Jan. 2005) ("According to the [National Association of Insurance Commissioners], based on 2002 data, New York's insurers have the fourth worst loss experience of any state in the country, paying out an average of $1.44 in claims and expenses for every $1 collected in premiums. . . . If carriers increased their premiums to achieve better financial performance, however, it would only worsen the malpractice crisis by making coverage more unaffordable.").
[65] *MHA Report*, *supra* n. 62, at 2.
[66] Palmisano, *supra* n. 34, at 373.
[67] *Id.*
[68] Studdert, et al., *supra* n. 2, at 290.
[69] *See* Donald J. Palmisano, *AMA Testimony re: Reducing the Excessive Burden the Liability System Places on the Healthcare Delivery System*, http://www.ama-assn.org/ama/pub/category/12991.html (last updated Sept. 15, 2004) [hereinafter Palmisano Judiciary Committee Testimony]; *see also* Studdert, et al., *supra* n. 2, at 287.

a physician, who by very definition has dedicated his/her life to the healing arts, suffers emotionally when served with a summons accusing him/her of causing injury or death to another person. Physicians who have been sued report consistent occurrences of severely depressed moods, inner tension, anger, and frustration.[70] Furthermore, the availability of health care is diminished because "dissatisfied physicians are also more likely to leave clinical practice or relocate, disrupting continuity of care and jeopardizing access to services in under served regions."[71]

Beyond the purely personal effects of such a reaction, such responses in the form of physicians' perceptions matter to the rest of us for two reasons: 1) "perceptions influence behavior with respect to practice environment and clinical decision making[;]" and 2) "perceptions influence the physician-patient relationship and the interpersonal quality of care."[72] In fact, patients of physicians with higher levels of job satisfaction are benefited, in that studies have shown that patients of such doctors exhibit superior adherence to medical treatment.[73]

A survey of medical specialists in Pennsylvania, found that ninety-one percent of such physicians reported that the malpractice system and its effects limit doctors' ability to provide the highest quality medical care.[74] Fully three-quarters of the specialists surveyed agreed with the statement, "[b]ecause of concerns about malpractice liability, I view every patient as a potential malpractice lawsuit."[75] One surveyed physician stated, "[w]hen you are constantly looking over your shoulder and thinking that any less-than-perfect outcome is going to result in a lawsuit, it's not exactly the best psychological environment to try to concentrate on what you are doing with the patient."[76] Likewise, an obstetrician-gynecologist in Garden City, New York said, "[e]very time I walk into an operating room, I put my family's life savings on the line."[77] Similarly, after twenty-five years of practice, obstetrician Dr. Michael Horn, stopped delivering babies in 2002: "It's just the potential, the not knowing if someone will seek an outlandish reward. I

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[70] Sara C. Charles, M.D. et al., *Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation*, 142 Am. J. Psych. 437 (Apr. 1985) (355 physicians surveyed from the Chicago Medical Society).

[71] Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, Health Affairs 43 (July 2004-Aug. 2004).

[72] *Id.* at 42.

[73] *Id.* at 43.

[74] *Id.* at 49.

[75] *Id.* at 48-49.

[76] *Id.* at 49.

[77] Donald J. Palmisano, *Statement of the AMA to the Committee on Small Businesses: U.S. House of Representatives re: Medical Liability Reform: Stopping the Skyrocketing Price of Healthcare*, 8 (Feb. 17, 2005) (available at http://www.ama-assn.org/ama1/pub/upload/mm/399/mlr_testimony_021505.pdf (accessed Jan. 11, 2006)) (quoting Dr. John Cafaro—some doctors are paying $130,000 for only $1 Million worth of protection, "[b]ut we are getting sued for $85 and $90 million at a time," he said, "You do the math.") [hereinafter Palmisano Small Business Testimony].

don't want to expose myself or my family."[78]

The threat of liability exposure affects not only the current status of medicine but impacts the future of American health care. Eighty-five percent of specialists practicing in Pennsylvania reported that they were not very likely or not at all likely to recommend someone graduating from medical school to practice in Pennsylvania.[79] In fact, almost half of America's medical students indicate that the liability crisis was a factor in their choice of specialty.[80] Dr. William Herd, chairman of Obstetrics and Gynecology at Wright State University School of Medicine, claims that the liability crisis already is driving young doctors out of the Dayton area: "In the last two years, not a single one of our [OB-GYN] residents has set up a practice in Dayton, or even Ohio."[81]

2. Deterrence of Reporting Medical Errors

Public policy as well as good medical practice has always required that health professionals and organizations should be encouraged to report and evaluate health care errors and to share their experiences with others in order to prevent similar occurrences.[82] Nevertheless, a 2002 Harris Interactive Study (*The Fear of Litigation Study—The Impact on Medicine*)[83] concluded that a majority of physicians believe that the fear of liability discourages open discussion and the creation of systems to reduce health care errors.[84] Rather, anxiety about exposure to malpractice litigation overshadows interest in patient safety activities, both in underreporting to adverse-event reporting systems and lack of communication with patients about errors.[85] The failure to take corrective action and failure to discuss openly the consequences of medical errors distort public policy, delay change, and lead to thousands of patient injuries and deaths.[86] "Thus, in spite of the mission of malpractice law to improve the quality of care through deterrence . . . the fear of litigation obstructs progress in ensuring patient safety."[87]

3. Limitation of Access to Medical Practices

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[78] Senate HELP Committee Statement, *supra* n. 58 (citing Burlington County Times, Oct. 2, 2002).
[79] Mello et al., *supra* n. 71, at 46.
[80] *America's Liability Crisis*, *supra* n. 17 (citing AMA Division of Market Research and Analysis, Nov. 2003).
[81] Palmisano Small Business Testimony, *supra* n. 77, at 9 (citing Dayton Daily News, August 28, 2002).
[82] Liang & Ren, *supra* n. 32, at 515-516; Palmisano, *supra* n. 34. at 375.
[83] Harris Interactive, Inc., *Common Good: The Fear of Litigation Study - The Impact on Medicine* (available at http://cgood.org/assets/attachments/68.pdf (accessed Feb. 2, 2006)).
[84] Palmisano Judiciary Committee Testimony, *supra* n. 69, at 2.
[85] Studdert et al., *supra* n. 2, at 287.
[86] Michael L. Millenson, *The Silence; Medicine's continued quiet refusal to take quality improvement actions has undermined the moral foundations of medical professionalism*, Health Affairs (Mar.–Apr. 2003).
[87] Studdert, et al., *supra* n. 2, at 287.

Perhaps the most dangerous consequence of the malpractice liability crisis is the effect on physician supply. Twenty states are in a "medical liability crisis," characterized by a loss of access to health care due to the pressures of medical malpractice because, in these states, lawsuit costs as well as settlement and jury awards have caused physician's insurance premiums to skyrocket.[88] "As a result, patients lose access to care when physicians are forced to restrict their practice, such as [declining to] deliver[] babies or perform high-risk surgeries."[89]

The American Medical Association estimates that approximately three-quarters of practice-based physicians work in the small practice setting which includes thirty-three percent in solo practice and twenty-six percent in practices with between two and four physicians.[90] As with any small business, such physician practices do not have the economic resources necessary to absorb or shift the costs of rapidly astronomically increasing insurance premiums.[91] Rather, when overhead expenses increase, physicians must either increase fees (which is increasingly difficult because of Medicare, Medicaid, or managed health care plans) or cut other expenses just to sustain their practices.[92] When physicians are forced to trim expenses, their limited options force difficult choices, such as cutting staff, limiting staff benefits, or foregoing the purchase of advanced medical equipment.[93] In some cases, in order to find or even obtain medical liability insurance, physicians must limit certain aspects of their practice.[94]

The concept of the doctor as the "lawsuit target" is confirmed by the staggering fact that there are currently more than 125,000 lawsuits against physicians actively on file (more than twice the number of medical students currently enrolled in American medical schools), while fifty percent of neurosurgeons [and almost twenty-five percent of the nation's ER physicians] are sued every year.[95] The high-risk physicians in states lacking legal reforms pay "annual malpractice insurance premiums in excess of $100,000 and in some cases in excess of $200,000 per year, per doctor."[96] One can only imagine the dollars needed to be generated to pay such staggering premiums.

Yet, as stated above, the most dramatic consequences are felt by the very patients the malpractice system was purportedly designed to protect. For example, almost half of American hospitals report that the medical

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[88] *America's Liability Crisis*, *supra* n. 17.
[89] *Id*.
[90] Palmisano Small Business Testimony, *supra* n. 77, at 8.
[91] *Id*. at 2.
[92] *Id*.
[93] *Id.*
[94] *Id*.
[95] *America's Liability Crisis*, *supra* n. 17 (citing *Archives of Internal Medicine*, June 14, 2004).
[96] Anderson, *supra* n. 52, at 345.

liability crisis has resulted in the loss of physicians and/or reduced coverage in emergency departments.[97] The dramatic increase in medical malpractice costs is shown by the fact that Ty Cobb Health System CEO, Chuck Adams, earmarked enough money for a 100 percent increase in the annual medical malpractice premium, only to receive the bill increasing his deductible tenfold, and booming the premium from $552,000 to $3.15 million, a 469 percent increase.[98] Such a change, and the expense it incurred, prevented improvements such as a renovation of an emergency room in this health care system.[99]

As a result of increased medical malpractice costs, curtailment of medical care is widespread. A Maryland Hospital Association survey reported that "[i]f hospitals did not have the expense of additional medical liability coverage, 9 out of 10 hospitals report that they would have spent that money to upgrade technology, buy new equipment, and modernize their patient care facilities."[100] In addition, "[o]ver 8 out of 10 hospitals surveyed would have spent the money they diverted to medical liability coverage for improving patient safety and addressing workforce issues."[101]

Some trauma centers have even had to downgrade the care they provide or even close their facility.[102] For example when two Joliet, Illinois neurosurgeons stopped practicing brain surgery in February, 2003, the city's only two hospitals were left without full time coverage for head trauma cases.[103] The two hospitals report that because they are now unable to handle all emergency head trauma cases, they have to stabilize and transport serious cases forty-five minutes to the nearest trauma center.[104] Similar recent data from the Boston area show that only twenty-three neurosurgeons based outside of metro Boston serve thirty-nine hospitals and that the time frame necessary to recruit a neurosurgeon increased from twenty-three months in 2002 to thirty months in 2004.[105]

Fully eighty-two percent of Americans believe that doctors are being forced to leave their practices because excessive litigation puts the

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[97] Am. Med. Assn., *Medical Liability Reform—NOW!*, 3 (Jun. 14, 2004) (citing *American Hospital Association* 2003 survey) (available at http://www.ama-assn.org/ama1/pub/upload/mm/450/mlrnowjune112004.pdf (accessed Jan. 11, 2006)).
[98] Senate HELP Committee Statement, *supra* n. 58, at 5 (citing Atlanta Journal Constitution, Aug. 11, 2002).
[99] *Id.*
[100] MHA Report, *supra* n. 62, at 3.
[101] *Id.*
[102] *America's Liability Crisis*, *supra* n. 17 (citing *Archives of Internal Medicine*, June 14, 2004, *American College of Emergency Physicians*, February 2005); s*ee also* BNA, *supra* n. 37 (citing malpractice liability and increases in malpractice premiums as some of several reasons for the problem).
[103] Senate HELP Committee Statement, *supra* n. 58, at 5 (citing Chicago Tribune, Feb. 16, 2003).
[104] *Id.*
[105] Palmisano Small Business Testimony, *supra* n.77, at 2.

costs of liability insurance out of reach.[106] One such physician, Dr. Rebecca Glaser, a popular breast cancer specialist, retired from surgery on April 1, 2004 because of high liability premiums.[107] "'I think it's horrifying when we lose a physician who has literally a one-of-a-kind practice,' said Donna Buchheit, one of Glaser's breast cancer patients. . . . 'It is literally a life and death issue. The legislature needs to understand that. It is not melodramatic to say that there will be women who die this year because of this. I certainly hope I won't become one of them.'"[108]

III. A SOLUTION: FEDERAL TORT REFORM IS ESSENTIAL FOR ADEQUATE PATIENT SAFETY

A. *The History of the American Medical Malpractice Tort Reform Movement*

Medical liability tort reform did not come to the American legal forefront until the 1970s. Before that time, medical malpractice claims were not a significant part of the tort litigation system.[109] During the 1970s and 1980s, the United States experienced separate medical malpractice insurance crises that resulted in sharply increased premiums and even non-availability of malpractice insurance, due in part to the withdrawal of insurance companies from the business of medical malpractice coverage.[110] While Plaintiffs' attorneys blamed insurance financial mismanagement as the sole cause of these crises, the Government Accounting Office ("GAO") concluded that losses on medical malpractice claims were, and continue to be, the primary driver of medical malpractice premium rate increases.[111] In response, state legislatures enacted tort reform laws to address fears that the number of medical malpractice claims would leave patients without necessary medical services.[112] Physicians also attempted to stem the tide of the crisis by creating "physician-sponsored malpractice insurers."[113]

In 1975, a mountain of malpractice litigation in California sent insurance premiums to record levels, causing most insurers in the state to determine that medicine was not an insurable risk and to refuse coverage to

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[106] *America's Medical Liability Crisis*, *supra* n. 17 (citing Wirthlin World Wide, 2004).
[107] Palmisano Small Business Testimony, *supra* n 77, at 11 (citing Dayton Daily News, Feb. 28, 2004).
[108] *Id.* at 9.
[109] Melissa Patterson, *The Medical Malpractice Crisis: The Product of Insurance Companies and a Threat to Women's Health*, 8 Quinnipiac Health L.J. 109, 112 (2004).
[110] *Id.* at 113.
[111] U.S. Gen. Acctg. Off., *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premiuim Rates*, GOA Highlights, www.gao.gov/cgi-bin/getrpt?GAO-03-702 (accessed Jan. 11, 2006)
[112] *Id.*; *See also* Christopher Stidvent, *Tort Reform in Alaska: Much Ado About Nothing?*, 16 Alaska L. Rev. 61, 67 (1999) ("In the 1970s, legislatures identified public worries that increasing medical malpractice claims were raising physician insurance costs to the point that such costs would lead to a decrease in the availability of essential medical services.").
[113] Patterson, *supra* n. 109, at 113.

health care providers.[114] California doctors went on strike and took their case to Sacramento.[115] The state legislature responded with the Medical Injury Compensation Reform Act ("MICRA") and never looked back.[116] Between 1976 and 2002, malpractice premiums in California rose 235 percent, while premiums in the rest of the country rose more than 750 percent.[117] Before the MICRA was adopted, California's percentage of loss payments was significantly higher than its proportion of physicians as compared to the rest of the country.[118] Since then, medical malpractice costs have fallen substantially as a percentage of the U.S. total, while physician residency in the state has held steady at approximately fifteen percent of the U.S. total.[119]

Under California's MICRA law, noneconomic damages are capped at $250,000 (while actual damages remain unchecked), defendants can introduce evidence of collateral sources of compensation for injury, the statute of limitations period to bring a claim is shortened, and damage payments may be periodic, allowing awards to be paid over the time frame they are intended to cover.[120] Additionally, MICRA contains attorney's contingency fees with a sliding scale. For example, a California patient-plaintiff keeps $778,333 of a $1 million jury award under MICRA; but, in states without contingency fee reforms, that same patient's portion of the same $1 million judgment amount would only be $600,000 because the personal injury lawyer typically takes a forty percent contingent fee.[121] Thus, not only does MICRA's contingency fee provision directly benefit the injured patient, it also makes it more difficult for attorneys to finance large numbers of non-meritorious cases with the few that they win.[122]

MICRA's features not only aim to control malpractice litigation, but they also limit jury awards and keep insurance rates in check. According to the Insurance Information Institute, awards greater than $1 million are three times more frequent in New York than in California[123]—a state almost twice as large as New York.[124] Additionally, despite Los Angeles' high cost of living, its malpractice insurance premiums are less than half of the rates in

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[114] Anderson, *supra* n. 52, at 350.
[115] *Id.*
[116] *Id*.; *see also* Cal. Med. Assn., *MICRA's Basic Provisions*, http://www.calphys.org/html/bb112.asp (accessed Oct. 14, 2005).
[117] Palmisano, *supra* n. 34, at 379.
[118] American Academy of Actuaries, *Issue Brief: Medical Malpractice Tort Reform: Lessons From The States*, 3-4, http://www.actuary.org/pdf/health/medmalp.pdf (accessed Nov. 29, 2005).
[119] *Id*.
[120] Anderson, *supra* n. 52, at 350; Liang & Ren, *supra* n. 32, at 505.
[121] *America's Liability Crisis*, *supra* n. 17 (citing Physician Insurers Association of American, 2004).
[122] Anderson, *supra* n. 52, at 350-351.
[123] Palmisano Small Business Testimony, *supra* n. 77, at 8 (citing *Poughkeepsie Journal*, Apr. 1, 2003).
[124] U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/06000.html, and http://quickfacts.census.gov/qfd/states/36000.html (Oct. 17, 2005).

Cleveland, Ohio and as low as one-sixth of the rates in Miami, Florida.[125] The California experience indicates that properly implemented medical malpractice tort reform can reduce the cost of medical malpractice insurance.[126]

While medical malpractice insurance was more readily available in the 1980s, the cost of premiums for physicians became an epic and widespread problem.[127] In 1986, state legislatures, following California's lead, began enacting legislation that capped the noneconomic and punitive damages a jury could award tort victims in medical liability cases.[128] Caps varied in range, from $250,000 to $875,000.[129] By 2004, medical malpractice premiums were 17.1 percent lower in those states that capped court awards.[130]

Proponents of tort reform often asserted that damages were "out of control," pointing to large jury verdicts in support of their position.[131] Opponents of tort reform, on the other hand, persistently attacked the constitutionality of the measures.[132] Opponents argued, in some cases successfully, that caps represented "a violation of a [plaintiff's] equal protection guarantees, in that they discriminated against tort victims whose damages exceeded the amount they could recover."[133] In the following years, some state courts struck down these caps as unconstitutional, marking a defeat for tort reform advocates.[134] Nonetheless, proponents of reform were able to introduce medical liability reform ideology into the mainstream, thus paving the way for modern tort reform legislation.[135]

B. *The Ohio Medical Malpractice Reform Experience*

Ohio is an example of the roller-coaster ride experienced by citizens, through their legislators, attempting to bring some sanity to the medical malpractice arena. Specifically, the current landscape of tort reform legislation in Ohio has been shaped by the legislature's attempts to establish noneconomic damages caps over the last 30 years. In 1975, the Ohio legislature enacted a $200,000 limit on noneconomic damages except for

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[125] Palmisano, *supra* n. 34, at 378 (citing the *Medical Liability Monitor*, an independent Chicago-based publication which provides comprehensive rate reports for all 50 states).
[126] American Academy of Actuaries, *supra* n. 118, at 4.
[127] Patterson, *supra* n. 109, at 113.
[128] Stidvent, *supra* n. 112, at 70.
[129] *Id* "New Hampshire set the highest cap, at $875,000, while Colorado established the lowest at $250,000 'unless clear and convincing evidence indicates greater damages warranted.'" *Id.* at 70 n. 38.
[130] *Medical Malpractice: Analysis Shows Premiums Lower in States with Caps on Damage Awards.*, Hosp. L. Wkly. (Feb. 12, 2005).
[131] *Id.*
[132] Stidvent, *supra* n. 112, at 70. Note that these jury verdicts often included large punitive damages.
[133] *Id.*
[134] *Id.*
[135] *Id.*

wrongful death.[136] Sixteen years after the law's enactment in 1991, the Ohio Supreme Court determined that such a cap violated due process and found the law unconstitutional.[137] The Ohio legislature attempted to reinstate the cap in 1997,[138] but that law was short-lived as the Ohio Supreme Court struck it down again only two years later.[139]

The recent revival of a noneconomic damages cap occurred after the passage of Ohio's comprehensive medical liability reform bill, Senate Bill 281, which took effect on April 11, 2003.[140] The law limits the compensatory damages for noneconomic loss that may be awarded in medical, dental, optometric, and chiropractic claims.[141] Generally, an aggrieved plaintiff may be awarded "the greater of [$250,000] or an amount equal to three times the plaintiff's economic loss . . . to a maximum of [$350,000] for each plaintiff or a maximum of [$500,000] for each occurrence."[142] If the noneconomic losses are for permanent and substantial physical deformity etc., then $500,000 may be awarded for each plaintiff or $1 million for each occurrence.[143] In addition to providing a ceiling on noneconomic damages in medical liability claims, the reform law also

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[136] 1975 Ohio Laws 2809, 2813 (codified at Ohio Rev. Code Ann. § 2307.43 (Act effective July 1, 1976, repealed 1997, 2001)).

[137] *Morris v. Savoy*, 576 N.E.2d 765, 770-71 (Ohio 1991) (holding that $200,000 cap violated due process clause of Ohio Constitution).

[138] 1995-96 Ohio Laws 3867, 3978-80 (codified at Ohio Rev. Code Ann. § 2323.54 (Act effective Jan. 27, 1997, repealed 2001)).

[139] *State ex rel. Ohio Acad. of Trial Lawyers v. Sheward*, 715 N.E.2d 1062, 1095 (Ohio 1999).

[140] Catherine M. Sharkey, *Article: Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. Rev. 391, 499 (2005). Note that Senate Bill 281 has been codified into multiple laws. *See* Ohio Rev. Code Ann. § 2323.41-43, 55 (West 2004) (collateral benefits, good faith motions, limits on noneconomic damages, and future damages and period payments); Ohio Rev. Code Ann. § 2305.113 (West 2004 & Supp. 2005) (statute or limitations and repose); Ohio Rev. Code Ann. § 2711.23 (West 2004) (arbitration agreements); Ohio Rev. Code Ann. § 2743.43 (West 2004) (expert testimony).

[141] Final Bill Analysis "Act Summary" quoting Act of Dec. 10, 2002, No. S-281, 2003 Ohio Legis. Serv. L-3250, L-3265-67 (Banks-Baldwin) (codified at Ohio Rev. Code Ann. § 2323.43 (West 2004)).

[142] Ohio Rev. Code Ann. § 2323.43(A).

> In a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property, all of the following apply: (1) There shall not be any limitation on compensatory damages that represent the economic loss of the person who is awarded the damages in the civil action; (2) Except as otherwise provided in division (A)(3) of this section, the amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a civil action under this section to recover damages for injury, death, or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of three hundred fifty thousand dollars for each plaintiff or a maximum of five hundred thousand dollars for each occurrence. *Id.*

[143] *Id*. at § 2323.43(A)(3).

> The amount recoverable for noneconomic loss in a civil action under this section may exceed the amount described in division (A)(2) of this section but shall not exceed five hundred thousand dollars for each plaintiff or one million dollars for each occurrence if the noneconomic losses of the plaintiff are for either of the following: (a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system; (b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life sustaining activities. *Id.*

protects against frivolous lawsuits through attorney sanction[144] and permits physician defendants to introduce evidence of the plaintiff's receipt of collateral benefits, with some exceptions.[145]

Ohio's comprehensive medical liability reform bill maintained the applicable statute of limitations for medical liability claims at one year.[146] Additionally, the legislation includes a statute of repose providing that an action may not be brought more than four years after the occurrence of the act or omission constituting the alleged basis of the claim with certain exceptions.[147] The new law expands the definition of a medical claim to

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[144] *Id.* at § 2323.42(C).

> If the court determines that there was no reasonable good faith basis upon which the plaintiff asserted the claim in question against the moving defendant or that, at some point during the litigation, the plaintiff lacked a good faith basis for continuing to assert that claim, the court shall award all of the following in favor of the moving defendant: (1) All court costs incurred by the moving defendant; (2) Reasonable attorneys' fees incurred by the moving defendant in defense of the claim after the time that the court determines that no reasonable good faith basis existed upon which to assert or continue to assert the claim; (3) Reasonable attorneys' fees incurred in support of the good faith motion. *Id*.

[145] *Id.* at § 2323.41(A).

> In any civil action upon a medical, dental, optometric, or chiropractic claim, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim, except if the source of collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation. *Id.*

[146] *Id.* at § 2305.113(A).

> Except as otherwise provided in this section, an action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued. *Id*.
>
> (1) If prior to the expiration of the one-year period specified in division (A) of this section, a claimant who allegedly possesses a medical, dental, optometric, or chiropractic claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within one hundred eighty days after the notice is so given. *Id.* at § 2305.113(B).

[147] *Id.* at § 2305.113(C).

> Except as to persons within the age of minority or of unsound mind as provided by section 2305.16 of the Revised Code, and except as provided in division (D) of this section, both of the following apply: (1) No action upon a medical, dental, optometric, or chiropractic claim shall be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim; (2) If an action upon a medical, dental, optometric, or chiropractic claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim, then, any action upon that claim is barred. *Id*.
>
> (1) If a person making a medical claim, dental claim, optometric claim, or chiropractic claim, in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four-year period specified in division (C)(1) of this section, the person may commence an action upon the claim not later than one year after the person discovers the injury resulting from that act or omission. (2) If the alleged basis of a medical claim, dental claim, optometric claim, or chiropractic claim is the occurrence of an act or omission that involves a foreign object that is left in the body of the person making the claim, the person may commence an action upon the claim not later than one year after the person discovered the foreign object or not later than one year after the person, with reasonable care and diligence, should have discovered the foreign object. (3) A person who commences an action upon a medical claim, dental claim,

include claims against advanced practice nurses and emergency medical technicians—basic, intermediate, and paramedic, and home or residential facilities.[148] Further, the new law contains provisions on future damages and period payment provisions,[149] arbitration agreements,[150] expert testimony,[151] annual reports,[152] the creation of the Ohio Medical Malpractice Commission,[153] and a study of the feasibility of the Patient Compensation Fund.[154]

Ohio's comprehensive medical liability reform bill has brought stability in the liability insurance market.[155] Prior to passage, premiums had been increasing at a rate in the thirty percent range. In 2005, they are increasing between ten to twenty percent.[156] Further, premiums increased at a lower rate in 2004 than they did in the two years prior.[157] This prompted some insurance companies to even lower rates for general practice physicians in certain regions of the state.[158] The CEO's of the five insurance companies writing seventy percent of Ohio's medical malpractice insurance

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optometric claim, or chiropractic claim under the circumstances described in division (D)(1) or (2) of this section has the affirmative burden of proving, by clear and convincing evidence, that the person, with reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within the three-year period described in division (D)(1) of this section or within the one-year period described in division (D)(2) of this section, whichever is applicable. *Id.* at § 2305.113(D).

[148] *Id.* at § 2305.113(E)(3).

"Medical claim" means any claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes the following: (a) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person; (b) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies: (i) The claim results from acts or omissions in providing medical care. (ii) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment. (c) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under section 3721.17 of the Revised Code. *Id*.

[149] *Id.* at § 2323.55.

[150] *Id.* at § 2711.23.

[151] *Id.* at § 2743.43.

[152] *Id.* at § 2303.23.

[153] 2003 S.B. 86, § 3 (Oh. 7/12/2004) (Uncodified Law) (A nine-member Medical Malpractice Commission is created to study the effects of the bill and to investigate medical malpractice problems generally.).

[154] 2002 S.B. 281, § 5 (Oh. 4/11/2003) (Uncodified Law) (The Fund would compensate plaintiffs for their noneconomic loss.).

[155] Michael Norbut, *Three Crisis States Show Improvement Since Tort Reform*, Am. Med. News (March 28, 2005) (available at http://www.amaassn.org/amednews/2005/03/28/prl10328.htm (accessed October 12, 2005)).

[156] *Id.* (quoting Tim Maglione, senior director of government relations for the Ohio State Medical Association).

[157] *Id.* (quoting Ann Womer Benjamin, Ohio Department of Insurance Director).

[158] *Id.*

told the Ohio Medical Malpractice Commission that insurers are now less wary of insuring physicians in the state since pain and suffering limitations have been put into effect.[159] Ohio insurers remain cautious about the Ohio market, however, until constitutional challenges to the reform legislation are fully and finally litigated.[160]

The momentum generated by the reform law as well as the provisions in the Act itself have also allowed the Ohio Medical Association to build its case against frivolous lawsuits by seeking sanctions against attorneys who purposefully clog the state's justice system.[161] "'Frivolous conduct' is defined as conduct of a party to a civil action that '. . . serves merely to harass or maliciously injure another party to the civil action . . .' or conduct '. . . not warranted under existing law and cannot be supported by a good faith argument for an extension, modification, or reversal of existing law.'"[162] Citing to this statutory authority, Ohio courts are now sanctioning plaintiffs and attorneys for filing frivolous lawsuits against local physicians.

In 2005, a judge ruled in favor of a physician who was the target of a frivolous lawsuit and ordered the plaintiff's attorney to pay defense costs.[163] In that case, the trial court conducted a hearing on the motion for sanctions on January 18, 2005.[164] The appellee, Dr. Zev Maycon, a Canton-area physician, asserted damages of $6,000, representing the amount of time he spent preparing for and attending the deposition and his preparation for trial.[165] In a judgment entry dated January 24, 2005, the trial court granted the motion for sanctions and ordered the plaintiff's attorney to pay $6,000.[166] The sanctions against the plaintiff's attorney were upheld by the Court of Appeals of Ohio in an unpublished opinion decided September 26, 2005.[167]

C. *Will The Ohio Medical Tort Legislation Stand? Federal Legislation Is Required*

Although current reforms provided by recent Ohio legislation have benefited Ohio citizens by providing stability in the medical sphere, constitutional attacks by Plaintiffs' attorneys are squarely underway and

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[159] *Insurers: Ohio market Stabilizing But More Work Needed*, Health & Med. Week 627 (May 10, 2004).
[160] *Id.*
[161] Norbut, *supra* n. 155 (quoting Ann Womer Benjamin, Ohio Department of Insurance Director).
[162] *Barbato v. Mercy Med. Ctr.*, 2005 Ohio App. LEXIS 4725, at * 12 (Ohio App. 5th Dist. Sept. 26, 2005) (citing R.C. 2323.51(A)(2)(a)(i) and (ii)).
[163] *Id.*
[164] *Id.*
[165] *Id.*
[166] *Id.* "'Catherine Cicchini Little, counsel for the Plaintiffs, Benjamin and Kelly Barbato, committed frivolous conduct under R.C. § 2323.51(A)(2)(a)(ii), in that her conduct, i.e. her continuing assertion of a claim of malpractice against Defendant Maycon was not warranted under existing law and could not be supported by a good faith argument for an extension, modification, or reversal of existing law;' Judgment Entry, Jan. 24, 2005, at 1-2." *Id.* at *11.
[167] *Id.* at *20.

have been successful in the past. An additional problem among the several states is that some states have been unable to enact tort reform in any form. The following tables demonstrate the lack of uniformity and, in many cases, unavailability of tort reform medical malpractice measures.

Medical Malpractice Damages Caps, Fifty-State Survey[168]

STATE	EFFECTIVE DATE	NONECONOMIC CAP	GENERAL CIVIL CAP
AK	1986		400K
CA	1975	250K	
CO	1988	300K / 1M total	
FL	2003	500K	
GA	2005	350K	
HI	1986		375K
ID	1987		250K
IN	1975	1.25M total	
KS	1987		250K
LA	1975	500K total	
ME	1999	400K	
MD	1986		500K
MA	1986	500K	
MI	1986	280K	
MS	2002	500K	
MO	1986	350K	
MT	1995	250K	
NE	1976	1.75M total	

[168] Catherine M. Sharkey, 80 N.Y.U. L. Rev. 391, Appendix I (2005).

NV	2002	350K	
NM	1992	600K total	
ND	1995		500K
OH	2003	250K or 3x economic loss up to 350K / 500K per occurrence	
OK	2003	300K	
SD	1985	500K	
TX	2003	750K	
UT	1986	400K	
VA	1976	1.5M total	
WV	1986	250K	
WI	1979	350K	

State Consideration in 2005[169]

Review Panels	**Changes or Implementation of Noneconomic Damage Caps**
Connecticut	Alaska
Kansas	Arizona

[169] Natl. Conf. of State Legis., *State Medical Malpractice Reform 2005 Number at a Glance*, http://www.ncsl.org/standcomm/sclaw/medmalataglance.htm.

Louisiana	Connecticut
Maine	Georgia
Mississippi	Hawaii
Nevada	Illinois
New Hampshire	Indiana
New Jersey	Iowa
North Carolina	Kentucky
Pennsylvania	Maine
South Carolina	Maryland
Tennessee	Massachusetts
Wyoming	Minnesota
	Missouri
	Montana
	Nevada
	New Hampshire
	New Jersey
	New York
	North Carolina
	Oklahoma
	Pennsylvania
	South Carolina
	South Dakota

	Tennessee
	Vermont
	Virginia
	Washington

The central question in the medical liability tort reform debate is whether these "patchworks set up by the states make any sense in terms of driving physicians from state to state who might otherwise stay in one state if there was a uniform standard across the [U.S.]"[170]

Under the present legal framework each state determines what limits, if any, it places on noneconomic damage caps in medical liability lawsuits. Clearly, national uniformity is untenable under this approach. Further, this state-by-state patchwork must be evaluated by comparing each state's attempt on equal footing. For example, a "hard cap," like the $250,000 cap found in California's MICRA, is not comparable to the "soft cap" provided in the Missouri law as such a cap increases with inflation.[171] Originally set at $350,000 in 1986, the cap on noneconomic damages in Missouri was $565,000 as of February 1, 2004.[172] Other states have enacted "soft caps" like Missouri,[173] but many states such as Alaska,[174] Mississippi,[175] and Nevada[176] have recognized their ineffectiveness, have

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[170] A.C. Hoffman, *Governmental Studies on Medical Malpractice: The Implications of Rising Premiums for Healthcare and the Allocation of Health Resources*, 24 Med. & L. 297, 299 (June 2005) "Medical malpractice is a bigger problem than most people want to admit." *Id.* at 298.

[171] Medical Liability Reform—NOW!, *supra* n. 97, at 23.

[172] *Id.*

[173] Florida has a separate cap on noneconomic damages for practitioners ($500,000) and non-practitioners ($750,000). Fla. Stat. § 766.118 (2004). The cap, however, increases to $1 Million for practitioners and $1.5 Million for non-practitioners if the negligence results in death or a permanent vegetative state or if the court finds a manifest injustice would occur if the cap was not increased. Medical Liability Reform—NOW!, *supra* n. 97, at 24. Also, the $500,000 cap on noneconomic damages in Massachusetts does not apply if the court finds the patient's injury resulted in substantial disfigurement or permanent loss or impairment, or if the court determines that other special circumstances warrant a finding that such limitation would deprive the plaintiff of just compensation for the injuries sustained. *Id*.

[174] Signed into law by Governor Murkowski on June 7, 2005, Senate Bill 67 strengthens Alaska's existing cap on noneconomic damages by establishing a $250,000 cap on noneconomic damages awarded in a personal injury cause of action, and a $400,000 cap on noneconomic damages awarded in a cause of action involving wrongful death or a severe permanent physical impairment that is more than seventy percent disabling. Alaska Stat. § 09.55.549(c) & (d) (2005). A single cap applies "regardless of the number of health care providers against whom the claim is asserted" or the number of causes of action filed. *Id.* at § 09.55.549(e).

[175] On June 3, 2004, the Mississippi Legislature enacted House Bill 13 a civil justice reform bill that further strengthens Mississippi's medical liability reform laws. Miss. Code Ann. § 11-1-60 (2005). Most importantly the bill creates a hard $500,000 cap on noneconomic damages for medical liability causes of

abandoned soft-caps and have enacted legislation to strengthen their existing caps.[177]

While studies of various aspects of the liability crisis in states that have implemented legislative reforms reveal the value of such efforts,[178] several states have had reforms overturned by the courts, while others' state constitutions prohibit caps on damages.[179] This confusing and inconsistent tort liability scheme that varies from state to state can only drive physicians from state to state in search of optimal working conditions.[180]

The answer lies in tort reform on the federal level. Another benefit in federal tort reform is health care savings in various health care programs.[181] The Congressional Budget Office ("CBO") estimates of health care savings show that federal tort reform makes sense from the government expenditure perspective.[182] The CBO estimates, for example, that direct spending, not to mention payments for indirect costs, for federal health insurance programs would be reduced by $14.9 billion over a ten-year period with federal tort reform.[183] In addition to the federal savings, state and local governments would save about $6 billion over ten years as a result of lower premiums for health care benefits they provide to their employees.[184] Medicaid costs to states would decrease by $2.5 billion over that period.[185] The benefits are many, but the political opposition is steep to federal tort reform.

D. *Direct Reforms Improve the Quality of Health Care*

Because of the mixed results tort reform efforts have had in

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action filed against a health care provider. *Id.* This provision significantly strengthens Mississippi's existing cap, which was enacted into law in 2002, by deleting the exceptions to the cap and increases that were scheduled to occur in 2011 and 2017. *Id.*

[176] As the result of passage of the Keep Our Doctors in Nevada initiative in 2004, Nevada has a $350,000 cap on noneconomic damages in medical liability cases. Nev. Rev. Stat. § 41A.035 (2005).

[177] *See* Medical Liability Reform—NOW!, *supra* n. 97, at 23-26.

[178] Palmisano, *supra* n. 34, at 377.

[179] *Id.* at 379-80.

[180] A.C. Hoffman, *supra* n. 170, at 299.

[181] Cong. Budget Off., Congressional Budget Office Cost Estimate: Cost Estimate for H.R. 5: The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, http://www.cbo.gov/showdoc.cfm?index=4091& sequence=0&from=6 (accessed Nov. 29, 2005).

[182] Proposed federal medical tort reform legislation would "lower the cost of malpractice insurance for physicians, hospitals, and other health care providers and organizations. That reduction in insurance costs would, in turn, lead to lower charges for health care services and procedures, and ultimately, to a decrease in rates for health insurance premiums." *Id.* In addition, since "employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and other fringe benefits. As a result, CBO estimates that enacting H.R. 5 would increase federal revenues by $15 million in 2004 and by $3 billion over the 2004-2013 period." *Id.* Further, "[e]nacting H.R. 5 also would reduce federal direct spending for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits ("FEHB") program, and other federal health benefits programs. CBO estimates that direct spending would decline by $14.9 billion over the 2004-2013 period." *Id.*

[183] *Id.*

[184] *Id*.

[185] *Id.*

different states, critics have concluded that legislative reform will not solve the medical liability crisis.[186] A closer look at various reform efforts, however, indicates otherwise. In states such as Florida and Missouri, tort reform legislation has instituted "soft caps" on damages, which are subject to a variety of exceptions, can increase annually with inflation or other economic indicators, or apply individually to every defendant or plaintiff, thereby allowing several caps for a single claim.[187] Further, some states like New York have enacted reforms in piecemeal fashion and did not include a cap on damages.[188] Consequently, malpractice damage awards have eluded reductions, and insurance premiums remain overwhelming.

In other states that have instituted *direct* reforms, damage caps have contributed to insurance rate reductions, enabling providers to continue to practice without limitation.[189] *Direct* reforms are statutory limits on malpractice awards such as caps on total or noneconomic damages, collateral source rule reforms (which require damages to be reduced by all or part of the value of collateral sources payments to the plaintiff), abolition of punitive damages, or abolition of mandatory prejudgment interest.[190] Such reforms statistically attract and retain physicians,[191] and improve productivity in health care by reducing the prevalence of defensive medicine practices through their effect on claim rates and on compensation conditional on a particular claim.[192]

Specifically, physician supply rose by two to three percent more in states that adopted direct liability reforms during a two-year research study.[193] However, reforms have a larger effect on physician supply three or more years after their adoption; in other words, it takes time for the effects of tort reform to become apparent.[194] The U.S. Department of Health and Human Services "found that between 1970 and 2000 states with malpractice damage caps have approximately 12% more physicians per capita than states without such restrictions over the thirty-year period."[195] Moreover, insurance premiums in states that cap awards are 17.1 percent lower than in

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[186] *See* Symposium, *supra* n. 61; *see also* Liang & Ren, *supra* n. 32. at 505.
[187] Palmisano, *supra* n. 34, at 380.
[188] American Academy of Actuaries, *supra* n. 118, at 3.
[189] Liang & Ren, *supra* n. 32, at 502.
[190] Kessler & McClellan, *supra* n. 12, at 941 (indirect reforms include impositions of mandatory periodic payments, caps on attorneys' contingency fees, and abolition of joint-and-several liability for total or noneconomic damages).
[191] Jonathan Klick & Thomas Stratmann, *Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter?* 17 (unpublished, Am. Enter. Inst. September 11, 2003) (available at http://www.aei.org/docLib/200310091_klick.pdf).
[192] Kessler & McClellan, *supra* n. 12, at 952.
[193] Kessler et al., *supra* n. 36, at 2618.
[194] *Id*.
[195] Liang & Ren, *supra* n. 32, at 515.

states that do not cap awards.[196] But in no other state has tort reform had a greater effect on the medical liability crisis than in California; thus MICRA is the prototype for proposed federal tort reform legislation, designed to provide a uniform safety net to all American doctors and the citizens they serve in our fifty states.

E. *Federal Medical Malpractice Tort Reform Legislation*

1. The Constitutional Power of Congress to Enact Tort Reform Legislation and Federal Authority for Preemption of State Medical Liability Reform

While federal tort reform legislation is necessary to provide uniformity to the tort reform arena, some have questioned the power of the federal government to become involved in tort law, which they claim has been traditionally relegated to the states. It is true that the federal government is a government of enumerated powers. Thus, if Congress wishes to enact legislation on any subject, it must find authority for that legislation in some provision of the Constitution.[197] While Article I, Section 8 enumerates a list of powers, by far the most influential of these is the power "[t]o regulate [c]ommerce . . . among the several [s]tates."[198] In 1824, Justice Marshall and the Supreme Court explained that commerce comprises every species of commercial intercourse.[199] That broad sweeping standard of the Commerce Clause only intensified with the Court's finding that activity that has a cumulative substantial effect on interstate commerce can be regulated by the federal government.[200]

A limitation on Congress' sweeping legislative authority under the Commerce Clause came into question in the 1995 case of *United States v. Lopez*.[201] Congress had passed a statute that made it "a federal offense for 'any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone.'"[202] In *Lopez*, the Court invalidated the statute as in excess of Congress' power under the Commerce Clause, holding that the act neither regulated a commercial activity nor contained a requirement that the possession was connected to interstate commerce. The Court further held that Congress' Commerce Power was valid only when 1) regulating channels of commerce; 2) regulating the instrumentalities of commerce; and 3) regulating activities

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[196] Thorpe, *supra* n. 54, at 1.
[197] Michael C. Dorf, *Does Federal Tort Reform Unduly Infringe on State Sovereignty?*, http://writ.corporate.findlaw.com/scripts/printer_friendly.pl?page=/dorf/20030430.html (accessed Nov. 29, 2005).
[198] U.S. Const. art. I, § 8, cl. 3.
[199] *Gibbons v. Ogden*, 22 U.S. 1, 68 (1824).
[200] *Wickard v. Filburn*, 317 U.S. 111, 125 (1942).
[201] 514 U.S. 549 (1995).
[202] *Id.* at 551.

which have a substantial relation to interstate commerce, i.e., substantially affecting interstate commerce.[203] Thereafter, in *United States v. Morrison*,[204] the Court invalidated a portion of the Violence Against Women Act by applying *Lopez*. The Court concluded that the activity regulated by the Act could not be classified as "economic activity," and therefore the cumulative substantial effects test laid out in *Wickard* was inapplicable.[205]

With *Lopez* and *Morrison*, the Supreme Court has established the test to determine whether a regulated activity has a substantial effect on interstate commerce. The Court must consider four factors: (1) whether the regulated activity is commercial or economic in nature; (2) whether an express jurisdictional element is provided in the statute to limit its reach; (3) whether Congress made express findings about the effects of the proscribed activity on interstate commerce; and (4) whether the link between the prohibited activity and the effect on interstate commerce is attenuated.[206]

Congressional legislative authority is proper in the federal regulation of medical liability reform.[207] Excessive malpractice litigation results in increases in malpractice premiums, which in turn force physicians and patients to cross state lines. Responding to the problem, the United States Department of Human Health and Services ("HHS") issued a Service Report finding that "the litigation crisis . . . has made insurance premiums unaffordable or even unavailable for many doctors."[208] The excesses of the current litigation system are a crucial element to "defensive medicine—the costly use of medical treatments by a doctor for the purpose of avoiding litigation."[209] Patients, who most need doctors, are at risk of not being able to find one because the doctor has "given up practice, limited the practice to patients without health conditions that would increase the litigation risk, or *moved to a state* with a fairer legal system where insurance can be obtained at a lower price."[210] The results have been profound, with patients being forced to drive hundreds of miles across state lines to receive health care. The sum total of this activity has a *substantial effect* on interstate commerce, thus falling into federal jurisdiction and ultimately justifying federal

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[203] *Id.* at 558-59.
[204] 529 U.S. 598 (2000).
[205] *Id.* at 609-10.
[206] *Id.* at 610-12.
[207] The HEALTH Act of 2005, includes specific findings that the current civil justice system adversely affects patients access to quality health care, that the health care and insurance industries affect interstate commerce, that the health care liability systems affect commerce by contributing to higher health costs, as well as having a significant effect on the amount, distribution and use of Federal funds. H.R. 5, 109th Cong. §2(a) (Jul. 21, 2005).
[208] U.S. Dept. of Human Health & Servs., *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, http://aspe.hhs.gov/daltcp/reports/litrefm.htm (accessed Nov. 29, 2005).
[209] *Id.*
[210] *Id.* (emphasis added).

preemption of state medical liability laws.

Federal authority to legislate on medical liability reform is also justified by Congress' Spending Power. The Constitution's Spending Power authorizes Congress to "provide for the . . . general welfare of the United States."[211] The power is utilized by Congress as authority over virtually all expenditures of federal funds. The Supreme Court in *Dole v. South Dakota* held that incident to this power, Congress may attach conditions on the receipt of federal funds and has repeatedly employed the power "to further broad policy objectives by conditioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives."[212]

The Supreme Court in *Dole* set out four general restrictions on the Spending Power:

> In considering whether a particular expenditure is intended to serve general public purposes, courts should defer substantially to the judgment of Congress. Second, we have required that if Congress desires to condition the States' receipt of federal funds, it "must do so unambiguously . . . , enabling the States to exercise their choice knowingly, cognizant of the consequences of their participation." Third, our cases have suggested (without significant elaboration) that conditions on federal grants might be illegitimate if they are unrelated "to the federal interest in particular national projects or programs." Finally, we have noted that other constitutional provisions may provide an independent bar to the conditional grant of federal funds.[213]

In the case of medical liability reform laws, it is clear that Congress has the authority to legislate pursuant to its Spending Power. Federal funds are consistently expended on health care as the federal government provides direct care to members of the armed forces, veterans, and patients served by the Indian Health Service, not to mention the funding of Medicare and Medicaid. Further, the federal government provides tax breaks to workers who obtain health insurance through their employers.[214] Applying these facts to the Court's holding in *Dole* suggests that the federal government is justified in attaching strings to the funds it provides for health care since

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[211] U.S. Const. art. I, § 8, cl. 1.
[212] 483 U.S. 203, 206 (1987) (quoting *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980) (opinion of Burger, C.J.)).
[213] *Id.* at 207-08 (citations omitted).
[214] It is estimated that the federal government would save at least $25 billion a year in taxpayers' money if its proposed medical malpractice reforms were put into place. Andrea D. Stailey, *The Health Act's Same Old Story, Different Congress Dilemma: Overhauling the HEALTH Act and Unifying Congress as a Remedy for Tort Reform*, 40 Tulsa L. Rev. 187, 201-02 (Fall 2004).

requiring state compliance would be reasonably related to the purpose of the expenditure itself.

2. Attempting to Provide Medical Malpractice Tort Reform at the Federal Level

A brief overview of the attempts to enact federal tort reform illustrates that passing federal legislation to cap noneconomic damages has proven to be an arduous task. In 1997 and again in 1999, members of the House of Representatives introduced initial attempts at health care liability reform.[215] Each of the proposed bills contained provisions that capped noneconomic damages at $250,000. Although each bill was referred to a House Committee,[216] both died in committee and were never reintroduced in the House for a vote.

On April 25, 2002, the Help Efficient, Accessible, Low Cost, Timely Health Care Act of 2002 ("HEALTH Act of 2002") was introduced in the House of Representatives in order to improve "accessibility to health care and the quality of medical care by reducing the burden of medical liability."[217] The HEALTH Act of 2002, among other things, would have limited noneconomic damages at $250,000, regardless of the number of defendants a plaintiff sues and preempted certain state laws.[218] Like its predecessor, the HEALTH Act of 2002 died in committee.

The HEALTH Act of 2003 was proposed in the House on March 21, 2003 and stated the same goals as its predecessor.[219] Although it passed in the House, the Senate failed to act on the bill after two readings. In that same Congress, Senate Republicans made yet another attempt to pass health care liability reform by introducing the Patients First Act of 2003. Although this bill was nearly identical to the HEALTH Act of 2003 in many important respects,[220] Senate Democrats refused to debate the measure.

House Republicans tried again to revive the failed bills by

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[215] On March 18, 1997, the House introduced the revised Health Care Liability Reform Act of 1997. H.R. 1091, 105th Cong. (March 8, 1997). On June 16, 1999, the House introduced the Medical Malpractice Rx Act. H.R. 2242, 106th Cong. (June 16, 1999).

[216] The Health Care Liability Reform Act of 1997 was referred to the House Committee on the Judiciary. The Medical Malpractice Rx Act was referred to the subcommittee on Health and Environment.

[217] Melissa C. Gregory, *Capping Noneconomic Damages in Medical Malpractice Suits is Not the Panacea of the "Medical Liability Crisis"*, 31 Wm. Mitchell L. Rev. 1031, 1040 (2005); R. Bruce Josten, *Letter to the House of Representatives, H.R. 4600, the HEALTH Act of 2002*, http://www.uschamber.com/issues/letters/2002/.020925hr4600.htm (accessed September 25, 2005).

[218] H.R. 4600, 107th Cong. § 4(c) (Apr. 25, 2002).

[219] H.R. 5, 108th Cong. (2003). Those goals included improving access to health care as well as improving medical care by reducing the burden the liability system weighs on the health care system. This bill also had $250,000 cap on noneconomic damages.

[220] Both bills would have imposed a $250,000 cap on noneconomic damages in health care lawsuits. *See* Kathryn Zeiler, *Turning from Damage Caps to Information Disclosure: An Alternative Tort Reform*, 5 Yale J. Health Pol'y, L. & Ethics 385 at fn 1 (Winter 2005), citing to S.B. 11, 108th Cong. (2003).

proposing the HEALTH Act of 2004 on May 5, 2004.[221] In principle, the Act was identical to the previous HEALTH Acts,[222] and the bill successfully passed through the House.[223] History repeated itself yet again, and the bill died in the Senate without a vote.[224]

On July 28, 2005, the U.S. House of Representatives passed the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2005 ("HEALTH Act of 2005") which, among other things, effectively caps noneconomic damages in medical malpractice litigation to $250,000, limits attorneys fees, and restricts the circumstances in which plaintiffs may seek punitive damages.[225] Upon introduction in the House, the bill's sponsor, Representative Phil Gingrey,[226] described the bill's purpose as "to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system."[227] The bill preempts state law only to the extent that such law prevents the application of any provision of the proposed federal law.[228] The bill does not preempt state law on any provision not addressed in the bill, nor does it preempt or supersede any state or federal law that imposes greater procedural or substantive protections for health care providers from any loss or damages.[229] The bill is expected to face substantial opposition in the Senate, as the bill's predecessors have failed to pass muster on the Senate floor.

In addition to limiting noneconomic damages, and following the California model, the bill:

- Limits the liability of manufacturers, distributors and providers of drugs and medical devices whose products comply with Food and Drug Administration standards;

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[221] Carly N. Kelly, Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. Med. & Ethics 515, 518 (Fall 2005).

[222] The limit on noneconomic damages was set at $250,000, a recurring number throughout each proposed bill.

[223] House successfully passed the bill by a vote of 229-197.

[224] For an explanation of this Congressional impasse, one need look no further than the stranglehold that Plaintiffs' attorneys have placed on Democratic politicians through focused and lavish political donations. For example, in 2002, a non-presidential year, the American Trial Lawyers Association ("ATLA") was the largest PAC contributor to the Democratic party, donating over $2.5 million dollars. *The Best Friends Money Can Buy: A Report On the Lawsuit Industry in America*, 2003, http://www.triallawyersinc.com/html/part10.html (accessed December 18, 2005). This contribution paled in comparison, however, to the ninety-nine percent that the Democrats have received of the $470 million in political donations to federal campaigns alone by trial lawyers in America since 1990. *Id.*

[225] H.R. 5, 109th Cong. The bill, passed 230-194, largely along party lines, just before Congress adjourned for summer recess.

[226] A Republican from Georgia.

[227] Carly N. Kelly, Michelle M. Mello, *Are Medical Malpractice Damage Caps Constitutional? An Overview of State Litigation*, 33 J.L. Med. & Ethics 515, 527 n. 21 (Fall 2005). House Democrats have objected that the bill sped through the approval process without having to go to any committees.

[228] H.R.5, 109th Cong. at § 11(a).

[229] *Id.* at §11(a)(1)-(2).

- Authorizes the award of punitive damages only where there is clear and convincing evidence that a person acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury to the claimant;
- Allows the court to restrict the payment of attorney contingency fees by limiting the fees to a decreasing percentage based on the increasing value of the amount awarded;
- Allows the introduction of collateral-source benefits, such as health insurance payouts, and the amount paid for those benefits as evidence; and
- Sets a three-year limitations period for bringing suit after the date of the manifestation of an injury or one year after discovery of the injury.[230]

Following the familiar pattern, the measure is awaiting consideration in the Senate Committee on the Judiciary and, to the dismay of many, the HEALTH Act of 2005 may face the same fate as previous bills that died before even coming to the floor for debate. Nearly unanimous Democratic opposition means that the Senatorial votes necessary to pass the measure are not likely to materialize until 2007 at the earliest.[231] Further, the Plaintiffs' attorneys group, ATLA, not only actively opposes the legislation, but it has been raising millions of dollars to combat bill passage and has hired additional congressional lobbyists to continue to squeeze lawmakers into opposing these tort reform efforts.[232] It is not surprising then that, despite Senate Majority Leader Bill Frist's efforts to compromise and effect a bipartisan solution to the malpractice tort reform crisis by means of tort reform at the federal level, there has been no momentum to effect bill passage.[233] Special interests rather than public interest seem to prevail in Washington, D.C. on the tort reform issue.

IV. CONCLUSION

A recent risk management study concluded that malpractice loss costs are growing annually at a trend rate of eight percent.[234] Hospitals and physicians can no longer maintain a reasonable level of practice, while

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[230] *Id*.; *see also* Brandon Van Grack, *The Medical Malpractice Liability Limitation Bill*, 42 Harv. J. on Legis. 299 (Winter 2005).
[231] *Congressional Roundup: No Medical Malpractice Legislation Will Be Enacted This Year, Senator Predicts*, Health L. Rptr. Vol. 14, No. 40 (Oct. 13, 2005).
[232] J.H. Birnbaum, & J.F. Harris, Wash. Post A05 (Apr. 3, 2005).
[233] *See Congressional Roundup*, *supra* n. 231.
[234] Aon: Healthcare Risk Consulting, *Hospital Professional Liability & Physician Liability: 2004 Benchmark Analysis Executive Summary*, 4, http://www.aon.com/us/busi/risk_management/risk_consulting/wp_2004_hpl_report_highlights_oct04.pdf (accessed Dec. 26, 2005).

retaining professional autonomy and financial security. As a result, physicians are reducing their hours or leaving practice altogether "at the peak of their diagnostic powers,"[235] and thus, diminishing the level of medicine in many areas of the country.[236]

> In addition to patient safety and quality improvement, the fear of litigation stifles the advancement of new medical treatments and medications, encourages physicians to practice defensive medicine, overwhelms the healthcare system with paperwork—leaving less time for patient care, and discourages qualified candidates from pursuing a career in medicine or from moving to a state with a bad liability climate.[237]

Furthermore, the medical liability crisis is expanding beyond patient care into other areas such as the biomedical industry.[238]

However, several states have enacted medical liability tort reforms to combat the deleterious effects on patient care. MICRA continues to provide health care providers in California with a shield of protection that is out of reach in many other states. Consequently, the American Academy of Actuaries recommends a national tort reform package of measures, including a cap on noneconomic awards and a mandatory collateral offset rule, in order to achieve savings in malpractice losses and insurance premiums.[239]

It is axiomatic that quality of health care improves when there is greater access to physicians and healthcare services.[240] If our goal as a nation is to promote a "culture of safety," then it will be necessary to create a legal environment that encourages professionals and organizations to work in unison to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients.[241] Without a change in the process of resolving claims for medical injury, the liability crisis will continue to kill the *golden goose*, harming not only our health care providers, but also our own access to adequate and affordable medical care.

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[235] Senate HELP Committee Statement, *supra* n. 58, (citing The Times (Gainesville), July 17, 2002);
[236] *Id.* (citing Scranton Times, Nov. 20, 2002) (Mercy Hospital Chief of Surgery Charles Bennon, M.D. proclaimed, "[i]t will take generations to get back the quality of medicine in Philadelphia.").
[237] Judiciary Committee Testimony, *supra* n. 69.
[238] *See* Subrata Saha & Pamela Saha, *The Biomedical Industry and the Need for Tort Reform*, 22 IEEE Engr. in Med. & Biology Mag. 154 (July/August 2003) (explaining the effects on biomedical research and development).
[239] American Academy of Actuaries, *supra* n. 118, at 4.
[240] Palmisano Small Business Testimony, *supra* n. 77, at 8.
[241] *Id.*