THE CURE FOR WHAT AILS:
A REALISTIC REMEDY
FOR THE MEDICAL MALPRACTICE "CRISIS"

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INTRODUCTION

Doctors hate lawyers.¹ Whether previously subjected to a medical malpractice lawsuit or simply apprehensive that a claim may someday be filed, physicians blame lawyers for what they view as a medical liability system run amok.² Physicians believe they should be immune from medical malpractice lawsuits, that only specialized health courts should hear medical malpractice cases, that a no-fault compensation system should be established for all medical

¹. Prior to becoming a law professor, as a practicing medical malpractice defense attorney the author would meet with defendant physician clients to begin the process of mounting a defense to the plaintiff’s medical malpractice claim; in that initial meeting between defense counsel and defendant physician, invariably the first words out of the defendant physician’s mouth were, “I know you’re defending me and, no offense, but I hate all lawyers.” See also George J. Annas, Doctors and Lawyers and Wolves, 371 LANCET 1832, 1832 (2008) (noting that physicians “often view lawyers as predators”); Peter D. Jacobson & M. Gregg Bloche, Improving Relations Between Attorneys and Physicians, 294 JAMA 2083, 2083 (2005) (noting “physician antipathy toward attorneys”); Sherry Karabin, Lawyers and Doctors, CHI. L. AW., July 30, 2010, available at http://www.chicagolawymagazine.com/Archives/2010/08/Lawyers-and-doctors.aspx (noting the relationship between physicians and attorneys is “highly adversarial”).

². See, e.g., Eli Engel & Edward H. Livingston, Solving the Medical Malpractice Crisis, 145 ARCH. SURG. 296, 296 (2010) (“Physicians consider the current state of the medical malpractice problem a crisis.”); Jill Barton, Many Doctors Decide to Practice Without Insurance, USA TODAY, June 6, 2004 (“While doctors blame the trial lawyers and frivolous lawsuits, they acknowledge patients will suffer the most if the system remains broken.”); Editorial, Malpractice and Health Care Reform, N.Y TIMES, June 16, 2009, at A26 (“The current medical liability system, based heavily on litigation, has a spotty record.”).
malpractice claims, that a higher standard of proof should be required in medical malpractice trials, or, at a minimum, that damages caps should severely restrict the amount plaintiffs may recover in medical malpractice cases that proceed to verdict. 3 Physicians complain of a medical malpractice “crisis” infecting America, causing physicians to retire early, relocate their practices, change practice specialties, accept fewer high-risk patients, or practice “defensive medicine” in an effort to fend off possible malpractice lawsuits. 4

Physicians, along with healthcare industry representatives, proponents of tort reform, and conservative lawmakers, allege America’s medical malpractice crisis fuels exorbitant malpractice insurance premiums, causes younger physicians to migrate away from high-risk specialties, and adds to the sharp escalation of healthcare costs, all resulting from medical malpractice lawsuits flooding the civil justice system. 5 These groups view the likelihood of being sued as simply a random event wholly unrelated to the quality of medical care ren-


5. See, e.g., Alec Shelby Bayer, Looking Beyond the Easy Fix and Delving into the Roots of the Real Medical Malpractice Crisis, 5 HOUS. J. HEALTH L. & POL’Y 111, 116 (2005) (noting that physicians blame plaintiffs lawyers, frivolous lawsuits and multi-million-dollar judgments for increased malpractice insurance premiums); News Release, Am. Coll. of Obstetrics & Gynecologists, Medical Liability Survey Reaffirms More Ob-Gyns Are Quitting Obstetrics, (July 16, 2004), http://www.acog.org/from_home/publications/press_releases/nr07-16-04.cfm (stating that one in seven ACOG fellows has ceased practicing obstetrics based on medical malpractice concerns, that the number of medical students entering obstetrics declined for the third year in a row, and that “[w]omen’s health is in jeopardy as new doctors turn away from our specialty”); Stephen Langel, GOP Pushing Malpractice Reform, ROLL CALL (July 6, 2009, 12:00 AM) http://www.rollcall.com/issues/55.1/-/36429-1.html (“Republicans have long argued that the system is weighted against doctors” and “say that limitless damage awards lead to crushing insurance costs for doctors, who pass them along to patients, and that physicians are practicing defensive medicine, which drives up healthcare costs through unnecessary treatments”).
ordered. They rail against the tort system, pleading for an end to a perceived medical malpractice crisis they view as destroying both the healthcare profession and the delivery of quality medical care.

Conversely, the plaintiffs bar, patient advocacy groups, and liberal lawmakers claim the problem is not too much litigation; rather, that America suffers from an unacceptable level of negligent medical care plaguing our healthcare system. They cite studies and statistics in arguing that medical negligence causes as many as 98,000 deaths each year, that hospitals are dens of infection, disease and substandard medical care, and that all medical malpractice litigation costs combined only amount to 2% of total U.S. healthcare spending. Plaintiffs’ lawyers and patient advocacy groups complain that states are unconstitutionally restricting access to the courts by enacting legal hurdles to commencing medical malpractice claims, and by capping damages, both economic and non-economic. The plaintiffs bar loathes evidentiary rules that prohibit the use at trial of otherwise damning admissions offered by a physician subsequent to an adverse medical incident. Plaintiffs—patients—are being squeezed out of a system designed to offer them redress, say plaintiffs’ lawyers, relying on studies estimating that each year three times as many Americans die from preventable medical errors as die in automobile accidents.

7. See, e.g., Paul J. Barringer et al., Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again, 33 J. HEALTH POL’Y & L. 725, 748 (2008) (noting that “most quarters of organized medicine would prefer a fault-based administrative health court” but, in the alternative, both the hospital community and physician organizations support “federal tort reforms that would limit non-economic damages”); Bayer, supra note 5, at 116 (noting that physicians blame plaintiffs lawyers, frivolous lawsuits and multi-million-dollar judgments for “hindering the practice of medicine” by causing a medical malpractice crisis); Physicians’ Opinions on Healthcare Reform, JACKSON HEALTHCARE (November 4, 2009), http://www.jacksonhealthcare.com/media-room/healthcare-research/ (follow “Physicians on Healthcare Reform”) (finding that in a 2009 survey of 1,978 physicians, 92% of responding physicians desire tort reform).
8. See CONG. BUDGET OFFICE, CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (2009), available at http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf (noting that the costs from settlements, awards, and administrative expenses related to medical malpractice suits total roughly two percent of total health care expenditures); Tom Baker, The Medical Malpractice Myth 22 (2005); INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al. eds., 2000) (concluding that an estimated 98,000 patients die each year from preventable medical errors); see also Darius N. Lakdawalla & Seth A. Seabury, The Welfare Effects of Medical Malpractice Liability 1, 4 (Nat’l Bureau of Econ. Research, NBER Working Paper Series, 2009), available at http://www.nber.org/papers/w15383 (concluding that a 10% reduction in malpractice costs would reduce total healthcare expenditures by, at most, 1.2%).
Who is right? If there is a disease, what exactly is it, and what is the remedy? Countless academicians and policymakers have weighed in on the issue, opining fixes that simply have not gained enough traction for implementation or even testing.\textsuperscript{10} State legislatures have applied band-aids, but nothing has come close to remediying the problem.\textsuperscript{11} The answer resides in what the “problem” truly is. Identify that, and the solution becomes clear. This article defines the actual problem afflicting the current medical liability system and explains why previously suggested fixes have not and/or will not work. Then, this article breaks new ground by proposing a realistic remedy for the real world of medical malpractice claims, as opposed to previous recommendations that have failed to consider either the political aspects of the issue or the necessity of physician “buy-in” regarding any proposed reform. As the Patient Protection and Affordable Care Act\textsuperscript{12} (PPACA) currently awaits its ultimate fate—mostly likely at the hands of the Supreme Court of the United States sometime in 2012—now is the perfect time to propose a realistic federal remedy to standardize medical malpractice claims nationwide.\textsuperscript{13}

Part I of this article provides a brief history of the medical malpractice “crisis” and the current landscape of medical negligence from the various parties’ perspectives. Part II explains the political aspects surrounding the problem. Part III reviews states’ attempts to address medical malpractice through conventional tort reform and alternative legal systems. Part IV describes efforts by medical institutions to approach medical malpractice via a reduction of medical errors strategy. Part V summarizes non-traditional approaches to the issue of liability for medical errors. And, finally, Part VI proposes a comprehensive solution that, if implemented nationally, may fully address the competing challenges of medical malpractice liability.

\textsuperscript{10} See infra pp. 118-26 for a discussion of previous remedies proposed by legal scholars.

\textsuperscript{11} See infra pp. 118-22 for a discussion of state medical malpractice reform efforts.


\textsuperscript{13} When tort reform is undertaken on an ad hoc basis state-by-state, the result is a patchwork of conflicting laws forcing physicians to choose where to practice based on what state has enacted—or is contemplating enacting—the most physician-friendly statutes. See, e.g., Mary Coombs, \textit{How Not to Do Medical Malpractice Reform: A Florida Case Study}, 18 \textit{Health Matrix} 373, 401, 425 (2008) (arguing that Florida’s 2004 citizen initiatives resulting in three substantive changes to Florida’s medical malpractice statutes did not produce the desired outcomes).
A. The “Crisis”

The concept of America facing a medical malpractice crisis is not new. Between the 1950s and 1980s, medical malpractice filings increased by 1000%. During that time, the dollar amounts awarded by juries to medical malpractice plaintiffs rose by more than 275%. Medical malpractice insurance premiums rose in response to these increases, driving some physicians to retire, change practice areas to a less risky specialty, or refuse to accept high-risk patients. In response, many states enacted tort reform legislation in an effort to curb the number of lawsuits and/or decrease the amounts awarded by juries and to reduce what were perceived to be exorbitant medical malpractice insurance premiums. Medical malpractice reforms enacted from the mid-1970s to the mid-1980s, however, resulted in neither a decrease in claims filed nor a decrease in the rates charged for medical malpractice insurance premiums. In fact, malpractice premiums actually rose—the law of unintended consequences. These legislative changes resulted in an extended time period be-
tween the adverse medical incident and resolution of the claim, approximately four and a half years.\textsuperscript{21} Other analysts have concluded the insurance time lag in medical malpractice claims may be as much as nine years.\textsuperscript{22} This time lag resulted in insurance companies being forced to utilize premiums paid in later years to pay claims incurred in earlier years because the insurance model was unable to account for such a time lag.\textsuperscript{23} Therefore, insurance companies incurred losses they did not expect and consequently increased premiums, both to make up the difference and to show a profit to investors.\textsuperscript{24}

During the late 1980s and early 1990s, approximately 70\% of medical malpractice claims resolved with no payment made, so new insurance companies entered the market and began competing for the now-lucrative business of medical malpractice insurance by offering low premiums.\textsuperscript{25} The cycle then began—insurance companies facing greater competition, reducing premiums to gain more market share, resulting in not collecting sufficient premiums to cover losses, and then raising premiums in subsequent years to cover claims paid for negligent medical care occurring years earlier.\textsuperscript{26} During this rollercoaster cycle of premium increases and decreases, insurance companies experienced a sharp decline in their investment returns, further compounding the problem. Physician advocacy groups claimed that individual physicians paid the price—through increased medical malpractice insurance premiums and excess judgments—for failures not entirely of their own creation.\textsuperscript{27} Now, many reflect back to view the 1990s not as a medical malpractice crisis, but rather as an insurance company accounting and investment crisis resulting in damage to the healthcare profession.\textsuperscript{28} Even today, medical malpractice insurance companies continue to price premiums based almost solely on a physician’s specialty and caps, only 10.5\% experienced flat or declining premiums, while 18.7\% of states without damages caps experienced stable or declining premiums; see also Baker, supra note 8, at 51-58.

\begin{itemize}
\item \textsuperscript{21} ALAN G. WILLIAMS, PHYSICIAN, PROTECT THYSELF 34 (2007).
\item \textsuperscript{22} See Baker, supra note 8, at 52-53.
\item \textsuperscript{23} Baker, supra note 8, at 47-48.
\item \textsuperscript{24} Id. at 51-52.
\item \textsuperscript{25} David M. Studdert, Michelle M. Mello & Troyen A. Brennan, Medical Malpractice, 350 NEW ENG. J. MED. 283, 285 (2004).
\item \textsuperscript{26} See Bayer, supra note 5, at 115-16.
\item \textsuperscript{27} A joint study funded by the Agency for Healthcare Research and the Harvard Risk Management Foundation concluded that individual physicians were assessed liability in excess of their negligence in cases where injuries were incurred due to a combination of individual and system failures. See Michelle M. Mello & David M. Studdert, Deconstructing Negligence: The Role of Individual and System Factors in Causing Medical Injuries, 96 GEO. L.J. 599, 614 (2008).
\item \textsuperscript{28} See, e.g., Michael Foster, No-Fault Medical Injury Compensation: Hoofbeats or Pipe Dreams?, 68 ST. JOHN’S L. REV. 727, 729 (1994) (noting that frequency and severity of claims were the primary factors controlling medical malpractice insurance premium increases).
\end{itemize}
geographic location, resulting in small yet volatile risk pools vulnerable to huge
premium spikes subsequent to a handful of large payouts in a particular loca-

tion or practice specialty. 29 Unlike automobile insurance premiums—which in-
crease when drivers cause or are involved in an accident—medical malpractice
insurance premiums are rarely based on a physician’s professional medical rec-
ord. 30

In the mid-2000s, with a Republican Congress and George W. Bush in the
White House, there was a strong push to enact tort reform on a national level.
Arguing that frivolous medical malpractice claims were contributing to the rise
in healthcare costs, 31 President Bush himself proposed a $250,000 cap on non-

economic damages in medical malpractice lawsuits, as well as to reduce the
statute of limitations in such cases and to allow judges to review the contingen-
cy fee agreements of plaintiffs’ lawyers. 32 Such recommendations were in re-
sponse to a spike in medical malpractice insurance premiums beginning in
2001. The premium increases were due to a combination of factors unrelated to
the number of medical malpractice claims filed or the amount of jury awards. 33
Subsequent to 2008, with a change in congressional composition and a different
party controlling the White House, the din of the call for medical malpractice
reform has quelled but not abated. 34 Physicians are still angry, conservative
legislators still aggressive in their trumpeting that America’s healthcare costs
could be contained by curbing frivolous medical malpractice lawsuits. But is
America experiencing a crisis and, if so, of what type?

B. Negligent Medical Care

A medical error is “the failure of a planned action to be completed as in-
tended (i.e., error of execution) or the use of a wrong plan to achieve an aim

29. E.g., Robert B. Leflar & Futoshi Iwata, Medical Error as Reportable Event, as
30. See, e.g., Kara M. McCarthy, Doing Time for Clinical Crime: The Prosecution of
Incompetent Physicians as an Additional Mechanism to Assure Quality Health Care, 28
SETON HALL L. REV. 569, 582 (1997).
31. David M. Studdert et al., Claims, Errors, and Compensation Payments in Medical
32. David A. Hyman & Charles Silver, Medical Malpractice Litigation and Tort Re-
33. See Bayer, supra note 5, at 118 (noting that six factors contribute to higher premi-
ums: increased medical costs, prior losses by insurers, insurers’ prior inadequate reserves
resulting in increased current premiums to show a profit to investors, decline in insurers’ in-

vestment income, pressure on insurers’ to raise premiums—despite damages caps—simply
to establish security in the market, and the decrease in malpractice insurers allows those re-
main to set higher prices).
34. See, e.g., Langel, supra note 5.
(i.e., error of planning).”\textsuperscript{35} A much cited report conducted by the Institute of Medicine concluded that as many as 98,000 people die in American hospitals each year as a result of preventable medical errors.\textsuperscript{36} By way of contrast, in 2009, 33,808 Americans died in automobile accidents.\textsuperscript{37} Other studies have concluded that nearly half of all patients endure some type of medical error at some point while receiving medical care,\textsuperscript{38} and as many as 18% of hospital patients incur a medical injury caused by their healthcare provider.\textsuperscript{39} Empirical research indicates that medical negligence committed in hospitals imposes an additional cost of approximately $1246 per patient admission.\textsuperscript{40} The Institute of Medicine’s study concluded that preventable medical errors cost the country as much as $29 billion annually.\textsuperscript{41} Contrary to what most physicians believe, the total amount paid out in medical malpractice claims in 2009 was the same as 1991,\textsuperscript{42} and the number of paid claims dropped 34% from 1991 to 2009.\textsuperscript{43} Although physicians generally support efforts to improve patient safety,\textsuperscript{44} they traditionally resist any measures that might lead to a lower degree of professional autonomy.\textsuperscript{45}

Some commentators argue that medical malpractice lawsuits promote patient safety by identifying dangerous conditions at hospitals or risky medical

\textsuperscript{35} INST. OF MED., supra note 8, at 28.

\textsuperscript{36} Id. at 1.


\textsuperscript{39} Jennifer Arlen, Contracting Over Liability: Medical Malpractice and the Cost of Choice, 158 U. Pa. L. Rev. 957, 971 (2010) (“Studies have found that between four and eighteen percent of hospital patients are the victims of medical errors, many of which cause serious injuries.”); see also, Troyen A. Brennan et al., Incidence of Adverse Events and Negligence in Hospitalized Patients, 324 New Eng. J. Med. 370, 376 (1991).

\textsuperscript{40} See Michelle M. Mello et al., Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement, 4 J. EMPIRICAL LEGAL STUD. 835, 847 (2007).

\textsuperscript{41} INST. OF MED., supra note 8, at 27.


\textsuperscript{43} In 1991, there were 53.1 paid claims per one million people in the United States; in 2009, there were 35.1. Id. at 10 (citing the National Practitioner Data Bank and the U.S. Census Bureau).

\textsuperscript{44} See, e.g., Barringer et al., supra note 7, at 747; Mello, Caring for Patients, supra note 4, at 49.

\textsuperscript{45} See, e.g., Barringer et al., supra note 7, at 747.
practices employed and that lofty premiums may improve patient safety. The problem is not too many medical malpractice lawsuits, they say, but, rather, not enough lawsuits to incentivize physicians and hospitals to improve care and reduce the number of medical errors plaguing our healthcare system.

C. Most Patients Injured by Medical Negligence Do Not Sue

In general, most patients harmed by medical negligence do not file medical malpractice claims. Various studies have examined the problem, reaching consistent conclusions. In a California study, 1% of patients were injured by medical negligence, but statewide only 10% of injured patients sued. A Harvard Medical Practice Study found that, in fifty-one New York hospitals, 1% of patients were injured by negligent treatment yet the number of negligent injuries was 6.7 times greater than the number of malpractice claims filed statewide. In a study conducted in Colorado and Utah, approximately 1% of patients were injured by medical negligence, yet, in Colorado the number of negligent injuries was 5.1 times greater than the number of malpractice claims filed statewide and, in Utah, 6.7 times greater. Similarly, in Florida over a three-year period, there were 6.3 times more negligently injured patients than the number of malpractice claims filed. Other more limited studies found that only 1.2% of negligently injured patients in a Chicago hospital sued, and of 220 women whose babies suffered serious injuries or death during the birth process, only twenty-three consulted an attorney and none ever brought suit. Based on the volume of studies regarding medical malpractice claim filings, it would appear that any

46. See, e.g., Baker, supra note 8, at 99-105 (detailing four cases where negligent medical care resulted in medical malpractice lawsuits, which then resulted in medical institutions improving quality of care).

47. See id. at 108-09 (explaining how, in response to soaring malpractice insurance premiums in the 1980s, the American Society of Anesthesiologists (ASA) launched a study to determine the causes of claims filed against their members and, after analyzing over a thousand claims, concluded that at least a third of anesthesiology errors involved severe but preventable “adverse respiratory events”). The ASA formulated new practice guidelines and encouraged the design of new equipment, resulting in a sharp decrease in anesthesiology errors—it is the only health sector with fewer than four deaths per million patient exposures—and a drastic reduction in malpractice premiums. See id.

48. See, e.g., Hyman & Silver, supra note 32, at 1089-92, 1131 (arguing that too few patients injured by medical negligence sue their healthcare providers; and stating, “When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.”).

49. Id. at 1089-90.

50. Id. at 1090.

51. Id.

52. Id.

53. Id. at 1091.

54. Id.
suggestion that the current medical malpractice system is overrun with frivolous litigation is patently false.\textsuperscript{55}

D. Defensive Medicine

The plaintiffs’ bar and many commentators believe the fear of being sued forces physicians to practice better medical care and commit fewer errors.\textsuperscript{56} However, the civil justice system’s adversarial process is foreign to physicians, who view the improvement of medical care as emanating from a non-punitive, cooperative approach—such as peer review discussions and morbidity and mortality conferences—in a systemic process seeking increased patient safety.\textsuperscript{57} Therefore, many physicians’ response to the perceived threat of medical malpractice litigation is not to practice a higher level of medical care but to practice “defensive medicine.”\textsuperscript{58}

There is no set definition of defensive medicine, but it usually takes the form of a physician practicing in a manner to avoid a medical malpractice claim, as opposed to practicing in a manner best for the patient and/or according to accepted standards of care.\textsuperscript{59} Ordering medically unnecessary tests or studies,\textsuperscript{60} inappropriate referrals to consultants or specialists, and performing procedures that should not otherwise be performed—all with the goal of reducing the chances of being sued—are forms of defensive medicine.\textsuperscript{61} Similarly,

\textsuperscript{55} Studdert et al., supra note 31, at 2031. Statistics show that, in general, large jury awards are rendered only in cases where injuries are severe, and median jury awards for temporary injuries are drastically less than in cases resulting in permanent injury or death. See also Hyman & Silver, supra note 32, at 1105 (citing a Bureau of Justice Statistics study finding that the median jury award in death cases was $837,000, in permanent injury cases $412,000, and in temporary injury cases just $77,000).

\textsuperscript{56} See, e.g., Baker, supra note 8, at 93-139; Ian Barney, Medical Malpractice Reform: A Silver Bullet for the Healthcare Crisis?, 15 PUB. INT. L. REP. 1, 3 (2009).

\textsuperscript{57} See, e.g., Studdert, supra note 25, at 287.

\textsuperscript{58} See, e.g., Mello, Impact of Crisis, supra note 4, at 5-6.

\textsuperscript{59} David M. Studdert et al., Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, 293 J. AM. MED. ASS’N. 2609, 2609-10 (2005) (defining “defensive medicine” as a “deviation from sound medical practice that is induced primarily by a threat of liability”).

\textsuperscript{60} One of the most dangerous forms of defensive medicine is ordering unwarranted radiographic studies, unnecessarily exposing patients to dosages—possibly repeated dosages—of radiation; however, one of the most frequent defensive medicine tests ordered is a radiographic study (i.e., X-ray, ultrasound, MRI, CT scan, PET scan).

\textsuperscript{61} See, e.g., WILLIAMS, supra note 21, at 59-60 (warning that a physician practicing defensive medicine may one day be forced to explain, on the witness stand subject to penalty of perjury, why the physician ordered a particular test or made a specific referral. That physician will then either have to lie under oath or admit practicing defensive medicine because the physician feared being sued. If such testimony would not result in a jury verdict in favor of a medical malpractice plaintiff, it is hard to imagine what would).
refusing to accept high-risk patients, limiting the scope of practice, or restricting high-risk procedures are also forms of defensive medicine.

One study reported that 93% of responding physicians admitted practicing some form of defensive medicine: 59% ordered more diagnostic tests than medically necessary; 52% referred patients under unnecessary circumstances; 43% employed imaging technology in clinically unnecessary situations; 42% restricted their practices by refusing high-risk patients or procedures; 33% prescribed additional medication medically unnecessary; and 33% recommended invasive procedures medically unnecessary.\(^62\) Another study concluded that 83% of Massachusetts physicians practiced some form of defensive medicine in an effort to avoid a medical malpractice claim.\(^63\)

Estimates of how much, dollar-wise, defensive medicine costs the healthcare system are quite disparate, with the American Medical Association quoting figures as high as $126 billion annually\(^64\) but a team of Harvard researchers concluding that hospitals expend $38.8 billion each year on defensive medicine costs and individual physicians $6.8 billion.\(^65\) Regardless of the actual costs of defensive medicine, there is no dispute that reducing—drastically reducing—defensive medicine will not only benefit patients but will decrease total costs of American healthcare.

E. The Physician Perspective

As early as 1833, American physicians complained that medical malpractice lawsuits force physicians to abandon their practices.\(^66\) Today, many physicians think that the public considers them the “wealthy class and has little sympathy for their economic plight.”\(^67\) Physicians firmly believe frivolous medical malpractice lawsuits cause their malpractice insurance premiums to rise, fear they will be the target of a malpractice claim sometime soon, feel pressured in their day-to-day medical practice by the threat of a malpractice claim, and

\(^{62}\) Studdert, supra note 59, at 2610-11.


\(^{65}\) Michelle M. Mello et al., National Costs of the Medical Liability System, 29 HEALTH AFF. 1569, 1573-74 (2010).

\(^{66}\) BAKER, supra note 8, at 140.

\(^{67}\) Engel, supra note 2, at 296. However, empirical research regarding jury verdicts in medical malpractice cases shows “that juries treat physicians very fairly, perhaps with too much deference” based on the actual level and degree of medical negligence. Philip G. Peters, Jr., Doctors & Juries, 105 MICH. L. REV. 1453, 1495 (2007).
sometimes order unnecessary tests or inappropriately refer patients to consultants based on a fear of being sued. \textsuperscript{68} Surveys reveal that physicians’ malpractice concerns are unrelated to their states’ legislative malpractice protections, including caps on non-economic and punitive damages, \textsuperscript{69} and that physicians’ perception of malpractice risk is three times greater than the actual risk of incurring a malpractice claim. \textsuperscript{70} Physicians do not consider medical errors a “problem” when compared to the “problem” of frivolous medical malpractice lawsuits: one-third of surveyed physicians named medical malpractice lawsuits and medical malpractice insurance as the two biggest problems in healthcare, but only 5\% listed medical errors resulting in patient injuries as the biggest problem in healthcare. \textsuperscript{71}

Other surveys reveal that the vast majority of physicians believe most medical malpractice lawsuits are frivolous and that attorneys and patients should be fined or assessed some other type of financial penalty for commencing them. \textsuperscript{72} Most physicians are unaware medical negligence is responsible for more deaths each year than automobile accidents and workplace accidents combined. \textsuperscript{73} However, medical malpractice insurance premiums are only 5\% of the premiums charged for automobile insurance and workplace insurance. \textsuperscript{74}

F. Physician Supply

America needs more doctors. A study conducted by the Association of American Medical Colleges Center for Workforce Studies (AAMC) concluded that, if physician supply and use patterns remain the same, America will experience a shortage of 124,000 full-time physicians by 2025. \textsuperscript{75} American medical

\textsuperscript{68} See, e.g., Emily R. Carrier et al., Physicians’ Fears of Malpractice Are Not Assuaged by Tort Reforms, 29 HEALTH AFF. 1585, 1587 (2010).
\textsuperscript{69} Id. at 1589.
\textsuperscript{71} Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 N. ENG. J. MED. 1933, 1940 (2002).
\textsuperscript{72} See, e.g., Physicians’ Opinions on Healthcare Reform, supra note 7, at 27 (referencing a 2009 survey of 1978 physicians in which 92\% responded that tort reform should include a damages cap and “a deterrent for ‘junk’ lawsuits”).
\textsuperscript{73} See, e.g., Baker, supra note 8, at 63.
\textsuperscript{74} Id.
schools are increasing their enrollment as recommended by the AAMC, but the study found the increase will be insufficient to meet future patient demands and that action beyond increasing the supply of physicians will be needed. Complex changes such as improving efficiency, reconfiguring healthcare delivery, and making better use of both physicians and other healthcare professionals will also be necessary.

Physicians argue that because of medical malpractice claims, good doctors are retiring early and, more importantly, quality would-be doctors are choosing other professions before even entering medical school. America is experiencing a severe shortage of primary care physicians and has fewer and fewer medical students and residents training to be primary care physicians.76 In a 2011 survey of 15,794 physicians, only 43% of primary care physicians would choose the same specialty—the lowest percentage of all physician categories.77 Any remedy enacted to address the medical malpractice issue should encourage both physicians and would-be physicians to practice medicine instead of retiring or selecting another profession.

II. POLITICAL REALITIES

A. Congress

An issue pushed by Republican lawmakers during the 2010 healthcare debate was tort reform, specifically, medical malpractice reform. Although some commentators predicted medical liability reform would be included in the PPACA,78 the final bill paid lip service to that issue—an issue that is near and dear to the hearts of conservative lawmakers and their constituency, particularly physicians—by not incorporating any proposed tort reforms but instead merely allocating funds to study the problem on a state level.79 As Republicans continue to challenge the PPACA, a sticking point for them remains the lack of

approximately 952,000 active physicians by 2020, and the growth and aging of the population will contribute to a 22 percent increase in demand for physician services between 2005 and 2020; the national physician shortage is likely driven by such factors as U.S. population growth, aging population and doctors, and increased physician visits).

76. See DILL & SALSBERG, supra note 75, at 7-8.

77. Medscape Physician Compensation Report: 2011 Results (April 28, 2011) (on file with the author), available at http://www.medscape.com/sites/public/physician-comp/2011. The two specialties with the highest percentage of physicians who would choose the same specialty were dermatology (93%) and plastic surgery (82%). Only 61% of pediatricians and 56% of emergency medicine physicians would choose the same specialty.

78. Michelle M. Mello & Troyen A. Brennan, The Role of Medical Liability Reform in Federal Health Care Reform, 361 N. ENG. J. MED. 1, 3 (2009).

tort reform. Appeasing Republicans on this issue would be no small victory, and may remove one criticism they have of the PPACA.

Stereotypically, conservatives favor limiting the liability of—or even shielding from liability—physicians who allegedly commit medical malpractice.80 Conversely, liberals generally favor allowing allegedly injured patients to sue their healthcare providers in the same manner any tort victim could.81 Physicians support conservative lawmakers in hopes tort reform will ensue. The trial bar supports liberal lawmakers so that tort liability will remain a viable business. This may tend to oversimplify the issue, but in general the stereotyping is accurate. Conservative politicians need to show physicians and other advocates/lobbyists for tort reform that some success was achieved. Liberal lawmakers likewise would like to accomplish goals they can tout to their constituents. Therefore, any remedy to the medical malpractice “crisis” must also incorporate the political realities of our society.

If a federal remedy can be fashioned that allows conservative politicians to brag they achieved many of the demanded tort reforms—a cap on non-economic damages, a cap on punitive damages, and evidentiary prohibitions against the use at trial of a physician’s statement of regret, remorse or fault and anything emanating from the peer review process—those politicians’ physician constituents certainly would acknowledge success, to some degree, of their original goals. If that same remedy can satisfy constituents of liberal politicians by protecting the most vulnerable of plaintiffs, enacting damages caps that are far from onerous and are tied to the rate of inflation, and encouraging the very behavior studies prove have the most positive effect on an injured patient or patient’s family, then an agreeable solution to the problem certainly will have been reached. Both sides can claim victory.

B. Physician “Buy-In”

It is imperative any medical malpractice reform enacted be acceptable to physicians.82 Otherwise, they will continue to practice defensive medicine, causing harm to patients and incurring additional healthcare costs. Similarly, it is essential any medical liability reform result in a more satisfied physician workforce than we currently have. Medical liability concerns and malpractice insurance premiums affect both physicians’ satisfaction and the quality of medical care they render.83 Dissatisfied physicians perform more poorly than satisfied physicians, committing more medical errors and negatively impacting the

80. See, e.g., Langel, supra note 5.
81. Id.
82. See, e.g., Mello, supra note 78, at 2.
83. See, e.g., Mello, Caring for Patients, supra note 4, at 48-49.
healthcare system. Dissatisfied physicians are more likely to relocate their practices or leave clinical practice altogether, which disrupts the continuity of care while putting patients in underserved geographic areas at risk for losing access to medical care. Satisfied physicians are “more attentive to patients and . . . have higher levels of satisfaction among their patients,” and patients of satisfied physicians more stringently adhere to prescribed medical treatments. Clearly, physicians are the most important actors, and most important resource, within the entire medical malpractice system, so whatever remedy is finally implemented must be acceptable to physicians.

At a minimum, physicians desire: (1) stable, affordable malpractice insurance premiums, (2) tort reform that caps non-economic damages to prevent what they consider shockingly aberrant jury awards that exceed their malpractice insurance policy limits, (3) evidentiary rules that protect as privileged from disclosure—and thus inadmissible at a medical malpractice trial—any explanations and/or apologies physicians make to a patient or family subsequent to an adverse medical incident, (4) evidentiary rules that protect as privileged any peer review discussions and/or documentation subsequent to an adverse medical incident, and, (5) a nationwide level playing field so physician relocations and geographic practice preferences are unrestrained by whether an area is considered hostile or friendly to physician defendants.

Physicians typically enter the profession with the best of intentions. As the nation benefits from a dedicated, quality physician workforce, any changes to the current medical malpractice system must encourage and foster qualified candidates to enter medical school, medical school graduates to enter the specialty of their choice not based on malpractice considerations, resident physicians selecting practice locales to do so based on personal or professional preference and not malpractice considerations, and the attending physician workforce to remain where they are and practice until retirement age without feeling forced out by malpractice considerations. Physicians must “buy into” and invest in any changes made to the current malpractice system or the most important actors in the American healthcare system may, either consciously or subconsciously, sabotage the effort to improve both the medical malpractice landscape and the provision of quality medical care.

Unless the American Medical Association and a majority of physicians view a proposed remedy as satisfactory, those professionals responsible for provid-

84. Id. at 43.
85. Id. at 44.
86. Id. at 43.
87. Id.
88. Id. at 51 (concluding that “physicians’ behavior is a critical policy focus”).
89. Absent achieving blanket tort immunity from medical malpractice claims, it is likely those groups will have to be convinced any compromise remedy provides the protections, and result, they seek.
ing medical care to the American population will continue to complain, change practice specialties, relocate or retire based on malpractice fears, and practice defensive medicine. And, would-be physicians will continue to think twice about entering medical school.

C. Federalization

Healthcare regulation and tort law—including medical malpractice law—have traditionally been within the province of state law and regulation. However, as healthcare and its associated costs have become national issues, and with the 2010 enactment of the PPACA, legal scholars have advocated full federalization of medical malpractice law. These well-reasoned arguments are based on the federal government’s partial funding of the states’ healthcare costs through Medicare, Medicaid and other federal programs and the resulting externalization onto the federal government of states’ medical malpractice costs. The federal government is responsible for approximately 30% of nationwide healthcare spending, and thus, by extrapolation, the federal government directly pays for approximately 30% of “malpractice-induced inefficient utilization (both ‘defensive medicine’ and follow-up care after injury).”

As other commentators have so thoroughly explained, the federal government could pass national medical malpractice reform—as Congress almost accomplished in 2003 with the HEALTH Act—and such federal action “seems necessary” to replace the states’ patchwork of varied and disparate medical malpractice statutes and rules. In 2009, during the debate regarding national healthcare reform, two of the leading medical malpractice legal scholars—professors Michelle M. Mello and Troyen A. Brennan—argued that federal medical malpractice reform could be accomplished either by Congress declaring “its intent to completely preempt state regulation of the field . . . [or by] . . .

90. Physician organizations and the hospital community, however, desire tort reform on the federal level. See, e.g., Barringer et al., supra note 7, at 748.

91. See, e.g., Mello, supra note 78, at 1-2 (arguing that medical malpractice reform should be included in federal healthcare reform); Abigail R. Moncrieff, Federalization Snowballs: The Need for National Action in Medical Malpractice Reform, 109 COLUM. L. REV. 844, 856-57, 879 (2009) (arguing that federal healthcare reform may reduce national medical liability costs). Subsequent to a ruling on the PPACA by the Supreme Court of the United States, successful federalization of medical malpractice should defeat any state constitutional challenges—including the successful state constitutional challenges to damages caps employed in some states—that exist when attempting to reform medical malpractice within a state’s legislature.

92. See, e.g., Moncrieff, supra note 91.

93. Id. at 848 (arguing that the approximation is even greater based on the federal tax code’s allowance for the federal government’s subsidization of private healthcare expenditures—an additional 10% of healthcare costs).

94. Id. at 889.
conditioning states’ receipt of federal health funds . . . on their willingness to adopt changes to their tort systems.”

The PPACA currently faces constitutional challenges in numerous federal courts, resulting in uncertainty of the law’s full implementation and permanency until the challenges are ultimately resolved by the Supreme Court of the United States. If the PPACA is ruled constitutional, then there should be no legal impediment to enacting a federal law addressing medical malpractice on a national level. To do so on the federal level, without a patchwork of states attempting to do so, would be ideal. However, if the Supreme Court rules the PPACA unconstitutional, then incorporating the remedy herein proposed into any future federal healthcare bill certainly would improve the bill’s bi-partisan appeal and thus chances for passage and widespread acceptance. Or, individual states can certainly enact the remedy proposed in this article without any federal legislative attempt.

III. FIXES THAT DON’T FIX

A. Conventional Tort Reform

Proposals by academicians and policymakers to address the perceived medical malpractice crisis typically fall into the realm of conventional tort reform under one of three categories. The first is limitation on access to courts, which includes shortening statutes of limitations, enacting statutes of repose, and establishing screening panels. The second category is modification of li-
ability rules, which includes eliminating joint and several liability rules, imposing higher standards for proving breaches of informed consent, and eliminating *res ipsa loquitur*. The third category is damages reform, consisting of caps on economic, punitive and/or non-economic damages, limiting attorney’s fees, mandating collateral source offsets, and requiring periodic payments instead of allowing lump sum payouts.

Many states enacted elements of the first and second categories from the 1970s through the 1990s, but the actual effectiveness of any of these band-aids has, at worst, been disproven by empirical research and regressive analyses, or, at best, is still debated based on conflicting studies results. And, although caps on damages certainly have resulted in a decrease in average jury award in those states with caps, a reduction in the frequency/number of claims cannot similarly be deduced.

In general, there are three types of damages available in medical malpractice claims: compensatory damages for economic loss, such as past and future medical costs, lost wages, and any other out-of-pocket expenses related to the injuries caused by the alleged medical negligence; non-economic damages, sometimes referred to as “pain and suffering” damages; and punitive damages.

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98. See, e.g., Studdert et al., supra note 25, at 288.

99. Id.


102. Some studies have found a 20-30% reduction in average award amounts. See, e.g., Mello, supra note 97, at 4.

103. Studies measuring medical malpractice claim frequency based on data reported to the National Practitioner Data Bank—to which the Health Care Quality Improvement Act requires all medical malpractice payouts be reported—have concluded that there is no evidence non-economic damages caps are effective in reducing frequency of claims. See, e.g., Durrance, supra note 4, at 590. California was the first state to cap damages in medical malpractice suits, when, in 1975, it enacted a $250,000 cap on noneconomic damages—not tied to the rate of inflation or any other indices—in an effort to reduce the number of medical malpractice claims and reduce medical malpractice insurance premiums. After the cap was enacted, the number of medical malpractice claims actually rose, as did insurance premiums. See Mark A. Finkelstein, *California Civil Section 3333.2 Revisited: Has It Done Its Job?*, 67 S. CAL. L. REV. 1609, 1611 (1994); see also Geri O’Brien, *Medical Malpractice—$250,000 Cap on Pain and Suffering—Cal. Civ. Code §3333.2—Does the Statute Meet Its Constitutional Burden and Legislative Goals?*, 8 Whittier L. REV. 601, 618 (1986).

104. It is important to note that non-economic damages—which tort reformers target as providing “a windfall for undeserving plaintiffs”—represent not only purely pain and suffering damages, but also some of the true expenses “of adapting the plaintiff to pursue whatever
es in cases where a defendant acted far outside the bounds of ordinary medical negligence. Punitive damages are rarely, if ever, awarded in medical malpractice cases, and oftentimes are not even allowed to be pled for fear they might unduly influence the jury.105

Of the conventional tort reform fixes, physicians and hospital groups most embrace damages caps,106 most likely because they can point to statistics supporting a decrease in the total amount of damages recovered by plaintiffs107 and a slight increase in the number of practicing physicians in states that have enacted damages caps.108 Currently, 28 states impose a cap on non-economic damages and six states impose a cap on total damages, although some view these caps as draconian based on their low levels: the non-economic damages cap in eight states is only $250,000.109

professor or avocation gave the plaintiff’s life meaning before the injury.” Todres, supra note 70, at 694 (quoting David N. Hoffman, The Medical Malpractice Insurance Crisis, Again, 35 HASTINGS CTR. REP. 15, 18 (2005)).

105. See, e.g., Durrance, supra note 4, at 576 (“Punitive damages are rarely awarded in medical malpractice cases.”); Theodore Eisenberg et al., The Predictability of Punitive Damages, 26 J. LEGAL STUD. 625, 633-37 (1997) (concluding that juries only rarely award punitive damages and are most reluctant to do so in products liability and medical malpractice cases); Mello, supra note 65, at 1571 (estimating that, based on reported cases studied, punitive damages comprise only 3% of total medical malpractice damages awarded nationally).

106. See, e.g., The Medical Liability Crisis and Its Impact on Patient Care: Hearing Before the S. Comm. on the Judiciary, 108th Cong. 2d Sess. (2004) (statement of Dr. George Lee of the American Hospital Association); Durrance, supra note 4, at 575 (noting that the American Tort Reform Association’s “ideal package” for medical malpractice reform includes a non-economic damages cap of $250,000); Engel, supra note 2, at 300 (“[T]he approach to tort reform . . . pursued most vigorously by physician groups has been limitations of damage awards.”).

107. See, e.g., J. Clark Kelso & Kari C. Kelso, Jury Verdicts in Medical Malpractice Cases and the MICRA Cap, INST. FOR LEGIS. PRAC. 17, 18 (August 5, 1999) (finding a 74% reduction in non-economic damage awards and a 25% decrease in total judgments). Of course, juries award what they determine is appropriate, and the court later reduces the amount if the award exceeds the state’s damages cap. Therefore, no reduction in the amount a jury thinks is warranted has actually occurred; rather, that the amount of the judgment entered is reduced to the statutory cap amount. A jury still concluded that the plaintiff was harmed to a particular monetary extent.

108. Daniel P. Kessler, William M. Sage, & David J. Becker, Impact of Malpractice Reforms on the Supply of Physician Services, 293 J. AM. MED. ASS’N 2618 (2005) (concluding that states with direct tort reform—i.e., damages caps—experienced a 2.4% greater increase in the number of physicians compared to states without damages caps, but that direct tort reform has a greater effect on physician retirement and entry into the profession than on physicians relocating state-to-state).

109. For example, California’s 1975 non-economic damages cap of $250,000 has never been increased and is not tied to the rate of inflation. In April 2011, the Virginia General Assembly overrode the Republican governor’s veto of a bill that would increase that state’s total (economic damages and non-economic damages combined) medical malpractice recovery cap of $2 million by $50,000 each year until a maximum of $3 million in 2031. Anita Kumar, Legislature Overrides McDonnell’s Veto on Medical Malpractice Awards, WASH. POST, April 6, 2011, available at http://www.washingtonpost.comblogs/virginia-
Damages caps, however, have had little effect on medical malpractice insurance premiums, and the empirical evidence reveals damages caps do not discourage the filing of frivolous medical malpractice claims. To date, damages caps are the subject of the most rigorous moral challenge to any of the proposed fixes, as non-economic damages caps “effectively force the most seriously injured patients to take on a disproportionate share of the costs of medical errors.” Studies show that damages caps “exacerbate existing inequities in compensation for medical injuries by disproportionately affecting the most severely injured plaintiffs.” As such, six state supreme courts have ruled damages caps unconstitutional under their states’ constitutions. And

10. See, e.g., Mitchell S. Berger, Following the Doctor’s Orders—Caps on Non-Economic Damages in Medical Malpractice Cases, 22 RUTGERS L.J. 173, 187 (1990) (stating that the National Association of Insurance Commissioners reported that caps do not affect premiums); Jerome M. Staller, Simplicity Can Be Devastating, 22 MED. MALPRACTICE L. & STRATEGY 1 (2005) (noting that a Texas malpractice insurer increased premiums 19%—even though a damages cap was enacted—because non-economic damages are a small part of total losses paid; Texas’s damages cap estimated to result in just a 1% reduction in malpractice premiums); Zeiler, supra note 19, at 392-94; Zeiler, supra note 101, at 681.

11. See, e.g., Mello, Impact of Crisis, supra note 4, at 15 (concluding that damages caps “disproportionately burden the most severely injured patients” instead of “discouraging ‘frivolous’ litigation”).

12. Many allege caps on non-economic damages further victimize vulnerable plaintiffs—children, women and minorities—because those plaintiffs do not qualify for high economic damages awards based on either their income or reduced life expectancy. Legal scholars argue that monies otherwise awarded to these plaintiffs are limited by statutory caps, such caps benefitting the most negligent physicians by reducing liability in the most egregious cases. See, e.g., Amanda Edwards, Recent Development: Medical Malpractice Non-Economic Damages Caps, 43 HARV. J. ON LEGIS. 213 (2006); Lucinda Finley, The Hidden Victims of Tort Reform: Women, Children, and the Elderly, 53 EMORY L.J. 1263 (2004); Mitchell J. Nathanson, It’s the Economy (and Combined Ratio) Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform, 108 PENN. ST. L. REV. 1077 (2004).

13. Todres, supra note 70, at 694.


the gaping hole in any argument for non-economic damages caps is the case resulting in a low economic damages award yet the true “pain and suffering” loss is significant: the death of a child.\textsuperscript{116}

In general, conventional tort reform fixes have not operated to decrease the number of medical malpractice claims filed, the severity of the claims, or the rates charged for malpractice insurance premiums.\textsuperscript{117} However, even if these familiar fixes were implemented nationwide in some combination, the effects would not be the result physicians and hospital groups desire. The Congressional Budget Office estimates medical malpractice insurance premiums would only be reduced by approximately 10\% even if federal tort reform incorporated a $250,000 cap on non-economic damages, a punitive damages cap of $500,000 or twice the economic damages award, collateral-source offsets, a one-year statute of limitations for adult claimants and a three-year statute of limitations for child claimants, and joint and several liability reform.\textsuperscript{118} Some commentators argue that damages caps punish innocent victims—yet reward both the bad actors and insurance companies\textsuperscript{119}—while doing nothing to decrease medical errors or punish incompetent doctors.\textsuperscript{120} And, economic damages are what they are—the medical care necessary to treat the patient for the remainder of her life expectancy.\textsuperscript{121} A cap on economic damages further injures plaintiffs in that

\textsuperscript{116} See, for example, Blankenship v. St. Louis Univ., No. 052-07195, 2009 WL 3802413 (22d Mo. Cir. Aug. 17, 2009), wherein a six-month-old child was mistakenly diagnosed with a simple virus and discharged home yet was suffering from meningococcemia. The boy died days later and in the subsequent medical malpractice lawsuit a jury awarded the boy’s parents $80,000 in economic damages and $6 million in non-economic damages. Although it is doubtful the parents feel as if they were made whole by the non-economic damages award, hopefully their pain and suffering was somewhat assuaged by the jury finding the loss of their son was worth more than a mere $80,000.


\textsuperscript{118} See, e.g., supra note 97, at 5.

\textsuperscript{119} See, e.g., Mary Alexander, Corporate Greed, 38 TRIAL 10 (2002); McCarthy, supra note 30.

\textsuperscript{120} See, e.g., Kevin J. Gfell, The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions, 37 IND. L. REV. 773 (2004); Elliot Klayman & Seth Klayman, Punitive Damages: Toward Torah-Based Tort Reform, 23 CARDOZO L. REV. 221, 249 (2001).

\textsuperscript{121} Two recent illustrations are: (1) Stanziano v. Miami Valley Hosp., No. 2006-CV-05798, 2009 WL 2137061 (Ohio, Com. Pl. Jul. 2, 2009) where a child was born with permanent brain damage, cerebral palsy and hypoxic ischemic encephalopathy due to medical negligence; the jury awarded the child economic damages of $25,983,217 based on what it would take to care for the child for the rest of his life, Interview with Jill Gustafson, Plaintiffs’ Attorney (March 16, 2011); and (2) Johnson v United States, No. CV 07-7973 GAF PJWX, 2009 WL 3520125 (C.D. Cal. Oct. 23, 2009). In a bench trial, a United States Dis-
they are thus unable to recover their actual economic loss even though a jury found the healthcare provider negligent and awarded compensatory damages in an effort to make the plaintiff “whole.”

Other commentators unfamiliar with the real world of medical malpractice lawsuits have recommended fixes not grounded in the realities of such lawsuits\textsuperscript{122} or have suggested remedies wholly unappealing to the essential group who must “buy into” the proposed remedy—physicians.

\begin{quote}
 Magnuson v. United States, 441 U.S. 50, 55 (1979) (arguing that because hospitals are special facilities which are the “site” where a large number of medical errors occur, providing incentives to hospitals to reduce medical errors would be an effective fix for the problems associated with the current medical liability system; this is the same argument some employ when advocating enterprise liability). Although hospital-based medical system reforms may impact the number and nature of medical malpractice claims as a by-product of their goal to improve medical care, such an argument in the legal realm commits a fundamental flaw in that, although hospitals may be the physical location where many medical errors occur, physicians, either individually or in their capacity as the “captain of the ship,” are legally responsible for medical negligence (other than nursing or hospital staff negligence). As the majority of hospitals neither employ physicians nor retain them as independent contractors but instead simply grant them hospital privileges, the hospital is not legally responsible for most physicians’ medical negligence unless there is an allegation of negligent credentialing (i.e., the hospital should never have granted the physician hospital privileges). The physicians, and thus their malpractice insurance carriers, are legally responsible for the vast majority of medical negligence claims. Unless the physician is an employee of the hospital, the hospital is only responsible for the nursing and hospital staff care rendered, such care not typically being the target of a medical malpractice lawsuit even though the savvy plaintiffs’ attorney always names the hospital as a defendant in an attempt to access its deep pocket and thus, perhaps, obtain a quick settlement for nuisance value to bankroll the real medical malpractice claim against the physician(s). Even in those few states that allow plaintiffs to allege hospitals are legally responsible for physician negligence based on an agency theory when physicians serve as independent contractors, a seasoned defense attorney easily draws the distinction for the jury—as the author has successfully done in several cases. More medical care is rendered in physician offices than in rendered in hospitals, and statistics reflect that as few as 18\% of medical malpractice insurance claims involve hospitals, with the remainder emanating from individual physicians and healthcare providers. Other studies show that medical and healthcare institutions only pay 35\% of all medical liability indemnity costs. Additionally, providing damages caps for hospitals but not for individual physicians would simply encourage defendant physicians to “dump” on the hospital (i.e., testify that the medical error was caused by nursing/hospital negligence rather than physician negligence) because the defendant physician would know that the hospital’s liability was capped but the physician’s was not. Any such incentive program implemented by a hospital would thus rely on legislation to alter tort liability from physician to hospital, which means such a recommended fix is simply another way of saying legislated tort reform. See, e.g., Fletcher v. S. Peninsula Hosp., 71 P.3d 833 (Ak. 2003) (refusing to extend liability to hospital for alleged malpractice of independent contractor physician under theories of either vicarious liability or apparent agency); Malanowski v. Jabamoni, 688 N.E.2d 732 (Ill. App. Ct. 1997) (holding that, as physician was not an employee of hospital, the hospital was not legally responsible
\end{quote}
Proposals to address medical malpractice under the auspices of “system reform” fall into four categories. The first is alternative dispute resolution, consisting of the creation of health/medical courts (similar to that in the United Kingdom), the use of private contracts to control any disputes, early offer programs to encourage prompt settlement prior to the filing of a claim, and compensating claims through a fault-based administrative system. The second category is alternatives to the negligence standard, which include compensating claims through a no-fault administrative system and implementation of pre-designated compensable events. The third category is relocation of legal responsibility, which basically shifts liability from individuals to organizations via “enterprise liability,” while the fourth category frequently discussed is the creation of enterprise insurance. Enterprise insurance obviates the need for individual physicians—who either have hospital privileges or are hospital employees/independent contractors—to maintain medical malpractice insurance but instead requires the enterprise insurance carrier to cover any and all claims occurring at the covered institution regardless which healthcare professional was responsible for the allegedly negligent care.
Despite this array of recommended fixes, significant scholarly debate still exists as to which of these proposed remedies to attempt, and there is little agreement, much less a consensus, if any of these academic proposals will work. Subsequently, none of the fixes has garnered sufficient political/legislative support for enactment and implementation. One could argue that if a fix were attractive enough, a state legislature would at least experiment with it. The PPACA included funding for pilot projects incorporating some aspects of these recommended fixes, so there may yet be evidence of success or failure of one or more of these methods. However, this article recommends a comprehensive remedy based on the competing desires of those on all sides of the debate—physicians, patients, politicians, and the public at large—while retaining the structure of America’s civil justice system’s resolution of tort claims.

Although the civil tort system is considered “inefficient” in compensating medical malpractice claims—with 54 cents of every dollar paid for victim compensation actually going to administrative expenses such as attorney’s fees, court costs, and expert witness fees instead of a greater share going to the victim—in general the current medical malpractice system works quite well to pay legitimate claims and weed out frivolous ones. A study conducted by Harvard researchers concluded that, “the malpractice system performs reasonably well in its function of separating claims without merit from those with merit and compensating the latter . . . [t]he vast majority of resources go toward resolving and paying claims that involve [medical] errors.” Other studies have

patients’ emotional healing subsequent to an adverse medical incident); supra note 122 (explaining why such a theory will not work in the real world of medical malpractice litigation).

127. See, e.g., Moncrieff, supra note 127, at 856.

128. Id. at 856–57.


130. Studdert, supra note 31, at 2031.

131. Id.; see also, Thomas H. Cohen & Kristen A. Hughes, Medical Malpractice Insurance Claims in Seven States, U.S. DEPT. OF JUSTICE BUREAU OF STATISTICS (March 2007) (concluding that medical malpractice insurance payouts were higher for severe/major injuries than for temporary or emotional injuries); Todres, supra note 70, at 681 (noting that one medical malpractice insurance company’s statistics revealed only 0.9% of claims filed resulted in a jury verdict for the plaintiff, with 27.4% of claims settling, 67.7% of claims being dropped, and 4% of claims resulting in a defense verdict).

132. Studdert, supra note 31, at 2031–32. The study, found that, in a sampling of 1452 closed medical malpractice claims from five malpractice insurance companies: 63% of claims involving medical error; 72% of claims not involving medical error were denied compensation; 73% of claims involving medical error resulted in compensation paid; when claims not involving medical error were compensated, payments were 40% lower than for claims involving medical error; claims without evidence of medical error or injury to the patient accounted for only 13% of total litigation costs; non-payment of claims involving medical error or patient injury occurred more frequently than payment of claims not involving medical error or patient injury. Id.
found that plaintiffs prevail at trial in 10-20% of cases expert reviewers believe they should lose; in 20-30% of cases expert reviewers thought were close calls; and in approximately 50% of cases expert reviewers believed showed strong evidence of medical negligence.133 In fact, if jury trials are any indication, the medical malpractice litigation system favors healthcare providers over patients: physicians prevail at trial in 50% of cases expert reviewers believed the physician should lose and 70-80% of cases in which expert reviewers found either unclear or ambiguous evidence of medical negligence.134

Some legal scholars have noted that the current medical malpractice liability system creates a social benefit for medical negligence victims not only by providing compensation but by providing other forms of “corrective justice” that produce psychological benefits for medical negligence victims.135 One of the goals of the current medical malpractice system is “to deter healthcare professionals from practicing negligently and committing medical errors.”136

Combining corrective justice with this deterrence aspect equates to a stronger argument for maintaining medical malpractice claims within the current tort system, rather than entertaining alternative systems.137 The deterrence aspect of the medical malpractice system has similarly been embraced by other legal scholars: “Malpractice liability is potentially one of the most effective mechanisms for reducing medical error. Well-designed malpractice liability can optimally deter error by giving medical providers direct financial incentives to make cost-effective investments in patient safety. This benefits patients and medical providers alike.”138

Medical liability leads medical providers to make

133. Peters, Jr., supra note 67, at 1454.
134. Id. at 1492.
135. Mello, supra note 65, at 1570.
136. McCarthy, supra note 30, at 576; see also, Mello, supra note 65, at 1570 (arguing that the current medical liability system “reduces future injuries by signaling to healthcare providers that they will suffer sanctions if they practice negligently and cause injury”).
137. Some commentators have even lauded the few instances where physicians faced criminal liability for providing negligent medical care and, in fact, advocate increased criminal liability for certain types of medical errors. See, e.g., McCarthy, supra note 30, at 618 (arguing that the “current mechanisms of civil sanctions and disciplinary actions are insufficient to punish adequately healthcare professionals who intentionally harm patients or consciously disregard a substantial and unjustifiable risk” and therefore “the prosecution of healthcare professionals presents an effective additional mechanism to assure quality healthcare”).
138. Arlen, supra note 39, at 959 (however, Professor Arlen does argue that the current medical malpractice system must be reformed). Medical liability risk has almost certainly led to increased institutional investment in risk management. See, e.g., Mello, supra note 65, at 1572. For example, the captive insurance company for Harvard-associated hospitals developed a risk management system that employs past medical malpractice claims in a proactive effort to reduce future errors and improve patient safety. RMF Strategies, http://www.rmfstrategies.com/patientsafety/ (last visited 4/24/11).
expensive and durable investments in safety that benefit all of their patients.>139

IV. MEDICAL SYSTEM REFORMS

In addition to approaching medical malpractice as a legislative or civil justice system issue, some believe improving medical care should be a companion goal.140 Therefore, some commentators have suggested medical system reforms that would hopefully lead to both improved medical care and a reduction in the number of potential medical malpractice claims. They have also recommended those reforms be implemented through entities such as hospitals and healthcare systems because institutional level reforms may represent the best opportunity to reduce medical errors.141 This article does not seek to discount the value of medical system reforms in reducing medical errors and improving care. The healthcare community should do all it can through medical system reforms to accomplish those goals; however, medical system reforms do nothing to address the issue of patient compensation subsequent to an adverse medical incident. Therefore, medical system reforms alone cannot address the issue of medical malpractice reform.

A. Peer Review

The term “peer review” generally describes an array of processes created by hospitals, medical groups, and other healthcare entities to verify that competent physicians provide quality medical care.142 Hospitals began formalizing the peer review process in 1952 after the Joint Commission on Accreditation of Hospitals began requiring hospitals to create peer review procedures in order to obtain accreditation.143 Prior to granting hospital privileges to physicians to allow them to treat patients at its hospital, or prior to hiring physicians as hospital employees, a panel of physicians at the hospital undertakes a review of the edu-

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140. See, e.g., Studdert, supra note 25, at 288.
141. See, e.g., Mello, supra note 27, at 620.
143. Susan O. Scheutzow, State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?, 25 AM. J. L. & MED. 7, 13 (1999). Additionally, Congress promoted professional peer review in 1986 by enacting the Health Care Quality Improvement Act, which protects peer review participants from liability for damages; however, even though proposed and debated, the Act ultimately did not create an evidentiary privilege. 42 U.S.C. § 11101 (2010).
cation, training, and experience of potential hires. When colleagues review a physician’s care of a specific patient subsequent to an adverse medical incident, this is also considered a “peer review,” although if the review occurs at a generalized meeting where other adverse medical incidents are discussed, the meeting may also be called a “morbidity and mortality conference.” In general, physicians are told these reviews are confidential, hoping to inspire candor. Such “[p]eer review confidentiality is rooted in public policy to support physicians in their self-regulatory efforts to monitor the competency and conduct of their peers.”

Effective peer review is considered imperative to ensuring quality medical care is rendered in the hospital setting.

Recognizing the importance of peer review, each of the 50 states enacted some form of statute or evidentiary rule to protect as privileged and/or confidential the peer review process, although legislative changes and judicial opinions have since eroded—and in some cases eviscerated—some states’ protections of the privilege. In general, the “peer review privilege” seeks both to prohibit the discoverability of records generated during the peer review process and to rule as inadmissible the discussions/statements made during the peer review process. Underlying the peer review privilege is the theory that tremendous educational and experiential benefits result from allowing physicians a protected environment in which to answer truthfully and candidly colleagues’ questions—and perhaps even admit other actions should have been undertaken or that the physician believes he or she committed a medical error from which the entire hospital can learn—without the fear that in a subsequent medical malpractice lawsuit the physicians’ statements will be admitted at trial as an

148. See, e.g., Sisters of Charity Health Sys. v. Raikes, 984 S.W.2d 464 (Ky. 1998) (holding that Kentucky’s peer review privilege does not extend to medical malpractice lawsuits); FLA. CONST. art. X, § 25. Over eighty percent of Floridians casting ballots in the 2004 general election voted in favor of a constitutional amendment allowing patients access to any record related to “any adverse medical incident,” effectively discarding Florida’s previously strong peer review privilege. See Fla. Hosp. Waterman, Inc. v. Buster, 984 So. 2d 478, 481 n.1 (Fla. 2008). In Buster, the Florida Supreme Court subsequently affirmed that the constitutional amendment was not only valid, but also was self-executing. Id. at 481.
149. See, e.g., Whitney Foster, Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians, 31 U. ARK. LITTLE ROCK L. REV. 321, 334 (2009) (noting that such statutes/rules: “(1) stipulate that the information obtained during peer review is privileged and inadmissible in court; (2) grant participants, and sometimes the hospital, immunity from suit; and (3) require that the information be kept confidential”).
admission against interest or the critique offered by another physician serving on the peer review panel will be offered against the defendant physician.\footnote{MacCourt, \textit{supra} note 3, at 552 (“Physicians are scared that identification and remediation of medical error—whether of their own or of their colleagues’—will expose them to a lawsuit.”); Scheutzow, \textit{supra} note 143, at 18.}

In jurisdictions that fully protect the peer review privilege, hospitals and medical institutions are free to establish monitoring systems to identify “at risk behavior” or “at risk physicians” and address those concerns with an intervention system. For example, Vanderbilt Medical Center created its Patient Advocacy Reporting System (PARS), resulting in approximately sixty-six percent of at risk physicians demonstrating improved indexes of care subsequent to intervention.\footnote{Moore, \textit{supra} note 142, at 1203.}

Researchers studying PARS concluded that, when protected by the peer review process, such programs can “identify physicians at increased risk of malpractice claims and have an impact on improving their patient complaint profile.”\footnote{\textit{Id.} at 1205.} In the case of Vanderbilt Medical Center, the PARS program resulted in a reduction of medical malpractice claims and lawsuits.\footnote{\textit{Id.} at 1204.}

When protected by statutory privilege, peer review operates as a quality improvement and risk management tool by providing a safe forum in which physicians evaluate other physicians’ work to ensure it complies with the standard of care.\footnote{See, \textit{e.g.}, Nijm, \textit{supra} note 144, at 542.} When shielded by privilege, the majority of physicians trust that the peer review process serves to raise awareness and increase physicians’ ability to anticipate future problems and thus prevent similar medical errors.\footnote{See, \textit{e.g.}, \textsc{Atul Gawande}, \textsc{Complications: A Surgeon’s Notes on an Imperfect Science} 57, 62 (2002).}

Numerous scholars and commentators have discussed the importance of a strong peer review privilege, either federally or state-by-state, as one of the best mechanisms to improve medical care and reduce medical errors.\footnote{See, \textit{e.g.}, Teresa L. Salamon, \textit{When Revoking Privilege Leads to Invoking Privilege: Whether There is a Need to Recognize a Clearly Defined Medical Peer Review Privilege} in \textsc{Vermani v. Novant Health Inc.}, 47 \textsc{Vill. L. Rev.} 643 (2002); \textit{see also} Foster, \textit{supra} note 149; Leflar, \textit{supra} note 29; Kohlberg, \textit{supra} note 145, at 162; Moore, \textit{supra} note 142; Nijm, \textit{supra} note 144; Scibetta, \textit{supra} note 146.}

V. NON-TRADITIONAL REMEDIES

Some legal scholars have argued that approaching medical malpractice from a legislative perspective injects politics, and a great time lag, into the equation. Therefore, they have posited innovative remedies to be implemented
by healthcare institutions and liability insurers. Some of these fixes focus on early disclosure of medical errors and offers of compensation prior to patients filing claims or even retaining legal counsel, while others have proposed alternate means to pay for the damages caused by the alleged medical negligence.

Enterprise liability/insurance has been touted by some as the panacea for medical malpractice litigation, with proponents arguing that it would encourage medical institutions to reduce medical errors by punishing them financially when they don’t. However, such a system ignores the fundamental issue of physician negligence—hospitals, in general, do not control physicians through employment or independent contractor status. Therefore, enterprise liability/insurance cannot adequately address the issue of physician negligence, especially considering the incidence of medical negligence occurring outside the hospital setting.

A. No-Fault Compensation Schemes

Just as workers’ compensation operates as a no-fault insurance vehicle to protect businesses from litigation when a worker is injured—while providing the worker a means of efficient redress without a requirement he prove negligence by the employee—two distinct no-fault medical malpractice systems have been implemented, with varying degrees of success.

In response to soaring medical malpractice insurance premiums for physicians practicing obstetrics and gynecology, in the 1980s Virginia enacted the Birth-Related Injury Compensation Program (BIP) and Florida enacted the Birth-Related Neurological Injury Compensation Association (NICA). Both programs were designed to compensate infants and the families of infants born

158. See, e.g., Baker, supra note 8, at 174 (“[E]nterprise insurance . . . is my answer to the medical malpractice insurance crisis.”); Mello, supra note 27, at 618 (in advocating enterprise liability, stating that “tort deterrence is best targeted at the institutional, not individual, level in medical malpractice law”); Peters, supra note 123, at 278-86 (advocating enterprise liability over health courts as the solution to the medical malpractice issue).
159. See, e.g., MacCourt, supra note 3, at 521 (arguing that enterprise insurance is not “practical or reflective of reality”); see also supra notes 46 and 122 (arguing that the biggest threat to physician autonomy is enterprise liability).
160. The National Vaccine Injury Compensation Program and states’ no-fault automobile legislation similarly operate as no-fault programs akin to workers’ compensation. In 1989, a national healthcare commission chaired by former Presidents Nixon, Ford and Carter suggested a national no-fault medical malpractice compensation systems as one of its recommendations to address medical malpractice claims. The recommendation was never given serious consideration. Barringer, supra note 7, at 733.
162. FLA. STAT. § 766.301 (2011).
with significant neurologic impairment incurred during the birthing process.\textsuperscript{163} All physicians in the state pay into the fund, with OB/GYNs and delivery hospitals choosing whether to be a “participant.” If they so choose, they pay a “premium,” and thus are covered if a patient or family files a medical malpractice lawsuit alleging negligence in the birth process, or, if the patient petitions the fund. If the facts of the incident fit within the statutory definition as determined by an administrative law judge, the fund accepts the claim (and any medical malpractice lawsuit filed is dismissed). The programs prescribe an administrative process through which an administrative law judge awards statutory damages without regard to fault.

Both NICA and BIP are considered successful,\textsuperscript{164} although NICA more significantly so, as BIP has been plagued by financial solvency problems.\textsuperscript{165} However, the programs are limited in scope in that they only cover OB/GYNs and delivery hospitals, and only for a very specific type of injury occurring during a very specific timeframe.\textsuperscript{166} And, under NICA, other than a $10,000 death benefit and up to a $100,000 one-time family benefit, non-economic damages are not available.\textsuperscript{167} Families faced with caring for a severely neurologically impaired infant certainly may need money fast without waiting for a costly and lengthy civil case to resolve with no guarantee of recovery, but the bereaved parents of an infant killed by medical negligence committed during the birthing process may hardly be satisfied with $10,000 and no assurance the exact same thing will not happen to some other family.\textsuperscript{168}

\begin{thebibliography}{9}
\bibitem{163} For example, Florida’s NICA statute defines a “birth-related neurological injury” as an “injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscita\-tion in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.” \textsc{Fla. Stat.} \textsection 766.302(2) (2011).
\bibitem{164} \textit{See, e.g.}, Barringer, \textit{supra} note 7, at 739.
\bibitem{165} Conversely, NICA is more than financially stable. Since the program’s inception, NICA has paid out over $96,000,000 in claims. In fiscal year 2010, NICA received 722 cases, accepting 278. Any case rejected by NICA via an administrative law judge’s ruling may then proceed to the tort system. Telephone Interview with Kenney Shipley, Exec. Dir., Fla. Neurological Birth Injury Comp. Ass’n (Feb. 24, 2011).
\bibitem{166} In Florida, a statewide commission was created to determine whether expanding NICA to brachial injuries is prudent, but currently the NICA model has only worked for the limited class of cases prescribed.
\bibitem{167} \textsc{Fla. Stat.} \textsection 766.31 (2011).
\bibitem{168} Having litigated dozens of NICA cases, the author knows firsthand both the utility of such a program and its drawbacks, and has seen the families thus affected.
\end{thebibliography}
Commentators and policymakers have recommended implementation of no-fault systems such as NICA and BIP for all medical malpractice claims, but no serious attempt to enact such a recommendation has ever been undertaken and political opposition is strong. No-fault compensation systems deprive the negligent healthcare provider “of meaningful feedback on faulty practices” while supplying no deterrence effect. No-fault systems certainly result in a measure of economic recovery paid quickly to injured persons or their families, but the problem with no-fault compensation systems is the same as with damages caps—negligent behavior is not punished in any way, the negligent actor has no incentive to reduce negligent behavior in the future, and recovery of non-economic damages is severely limited. Financially penalizing negligent behavior through the tort system, weak as that punishment may be, remains the greatest judicial deterrent to healthcare providers rendering negligent medical care. Any proposed medical malpractice remedy must build on such penalties, while recognizing the need for medical system reform to further improve medical care and reduce medical errors.

B. Medical Apology Laws

When physicians are asked why patients sue, typically they respond that it is for either money or revenge, or both; however, studies clearly indicate that, in general, patients sue for much different reasons, including feeling as if their physician abandoned them, as if their physician was not being truthful with them, as if their concerns were not being addressed by their physician, or, as if their physician was trying to cover something up. As a defense attorney, the

169. For a more definitive exploration of the NICA and BIP programs, see, for example, Gil Siegal, Michelle M. Mello and David M. Studdert, Adjudicating Severe Birth Injury Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation, 34 AM. J.L. & MED. 489 (2008).

170. See, e.g., Barringer, supra note 7, at 740-41 (describing New York’s experience in the 1990s with such a recommendation to then-Governor Mario Cuomo by state health commissioner Dr. David Axelrod).

171. Id. at 752.

172. MacCourt, supra note 3, at 530. See also Richard A. Epstein, Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice, 54 DePaul L. Rev. 503, 519-20 (2005) (noting three criticisms of no-fault insurance schemes within the medical malpractice context: difficulty in determining what incidents will be covered; the financial problems associated with Virginia’s BIP; patients might not want a no-fault system).

173. See, e.g., Todres, supra note 70, at 701 (stating that a no-fault compensation system for medical malpractice claims “would not provide any deterrance of negligent acts by physicians”).

174. See, e.g., Heidi P. Forster et al., Commentary, Reducing Legal Risk by Practicing Patient-Centered Medicine, 162 ARCH. INTERN. MED. 1217 (2002); Gerald B. Hickson et al., Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal
author certainly experienced depositions, mediations, arbitrations, and trials where the patient clearly desired revenge against the physician for the injuries the patient suffered,\textsuperscript{175} but such anecdotal recitations are belied by the volume of studies showing why patients in fact sue their physicians.

When an adverse medical incident occurs, however, physicians often fear even discussing the incident with the patient\textsuperscript{176} because of: 1) a natural aversion to confronting angry people; 2) concerns that discussing the matter may alert the patient she has a viable medical malpractice claim; 3) anxiety the discussion might negatively impact the physician’s defense to a malpractice claim; and, 4) fear the discussion may result in higher medical malpractice insurance premiums or the physician losing his insurance altogether.\textsuperscript{177} The typical physician response to a fear of litigation is to remain silent, whether based on human instinct or a defense attorney’s instruction not to discuss or admit anything.\textsuperscript{178} This response is exactly opposite from what a patient or patient’s family needs after an adverse medical incident. Patients need answers, an explanation. But physicians, fearing both litigation and making an admission against interest that may later be used against them in a medical malpractice lawsuit, clam up. Patients then sue, to get the answers in court that the physician deprived them of in the hospital.

Two studies—one by the University of Michigan in conjunction with the Massachusetts Institute of Technology and the other by Harvard researchers—concluded that once a lawsuit’s discovery process revealed to the patient the answers the patient sought and showed that the physician did not commit negligence, the patient tended to drop the lawsuit.\textsuperscript{179} Research from patient surveys indicates medical malpractice claimants desire apologies and might not have filed suit if one had been given,\textsuperscript{180} and since prompt disclosure, explanation of


175. One such incident involved a patient who previously suffered from priapism (a perpetual erection) for over 20 years, a condition the patient stated neither he nor his wife minded one bit. The patient consulted a urologist for an unrelated condition, and subsequent to undergoing the urologist’s recommended treatment for the unrelated condition, the patient was rendered permanently impotent. The patient sued, and for months his only demand was that the urologist also be rendered permanently impotent. Thankfully the case settled prior to trial—for a monetary amount.

176. See, e.g., Carrier, supra note 68, at 1585.


178. See, e.g., Carrier, supra note 68, at 1585.


the facts, and apology are really what the patient seeks, such communication from physician to patient actually reduces liability.\textsuperscript{181}

Concerns regarding patient safety and physicians’ ethical obligations support prompt disclosure to patients of an adverse medical incident and/or a medical error.\textsuperscript{182} Disclosing such information is not only appropriate,\textsuperscript{183} it can improve and strengthen patients’ trust in their physicians, a vital component in the physician-patient relationship.\textsuperscript{184} However, physicians, risk managers, and defense attorneys fear that disclosing a medical error (and apologizing for committing that error) may invite a medical malpractice claim and/or ensure a plaintiff’s victory in any such claim based on the evidentiary “admission against interest” made by the physician when disclosing and apologizing for the medical error.\textsuperscript{185} Concerned an apology by a physician will later be used at trial and viewed by jurors as an admission of liability,\textsuperscript{186} malpractice defense attorneys routinely advise physicians not to apologize or make any statement admitting fault, remorse, or regret.\textsuperscript{187} Although, in general, defense attorneys preach “deny and defend” to their physician clients,\textsuperscript{188} studies indicate that a majority of physicians desire to apologize to a patient or patient’s family subsequent to an adverse medical incident and that approximately 90% of physicians think the chances they will be sued for medical malpractice are decreased if the pa-

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\item \textsuperscript{182} Kachalia, supra note 181, at 213. Most medical ethicists agree that it is a physician’s duty to disclose any medical error to the patient/family.

\item \textsuperscript{183} Id. Some states (for example, Pennsylvania, New Jersey, Nevada and Florida) require physicians to disclose medical errors to the patient/family. Florida’s mandatory disclosure statute is typical: “An appropriately trained person designated by each licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgment or admission of liability, nor can it be introduced as evidence.” FLA. STAT. § 395.1051 (2010).

\item \textsuperscript{184} Kachalia, supra note 181, at 213.

\item \textsuperscript{185} Id.

\item \textsuperscript{186} See, e.g., Robbennolt, supra note 180, at 461.


\item \textsuperscript{188} See, e.g., Boothman, supra note 177, at 129 (stating “[t]he ‘deny and defend’ strategy was born of” physicians’ fears); Lucinda E. Jesson & Peter B. Knapp, \textit{My Lawyer Told Me to Say I’m Sorry: Lawyers, Doctors, and Medical Apologies}, 35 WM. MITCHELL L. REV. 1410, 1418 (2009) (noting the deny and defend strategy “was alive and well at the turn of this century”).
\end{itemize}
tient or patient’s family is offered an apology. Additionally, legal scholars posit that apologies carry crucial benefits for both plaintiffs and defendants and increase the chances of settling a case. An apology prior to the filing of a claim may avoid a lawsuit altogether, but even if it does not the resulting litigation may be more efficient because tension, anger, and antagonism might be diffused or reduced.

Other commentators have suggested a federal evidentiary rule prohibiting the use at trial of a full apology in any civil case. The Federal Rules of Evidence—and most state evidentiary codes—deem admissible as an exception to the rule against hearsay any statements made by a party, and under evidentiary rules, an admission against interest is admissible against the party making the statement. Physicians appear to know this, too, whether upon instruction from attorneys, risk managers, or insurance personnel, or simply from their own experience or knowledge. The author has frequently lectured at teaching hospital and medical school Grand Rounds, instructing attending and resident physicians to confer with their risk manager or hospital attorney prior to discussing an adverse medical incident with a patient or patient’s family for fear any apology the physician offers may include an admissible admission against interest. However, if an evidentiary rule excluding medical apologies from admissibility were in effect, physicians nationwide could provide the explanations and apologies patients and their families so desperately need and want.

Empirical evidence derived from extensive studies suggests apologies favorably influence the resolution of claims. Studies measuring the restoration of trust—in the patient-physician relationship, a vital element in providing quality medical care—conclude that where a wrongdoer was at fault it was best to apologize, but where there was no evidence of guilt it was best to provide the explanations and apologies patients and their families so desperately need and want.

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189. Wei, supra note 181, at 121-22.
190. See, e.g., Robbennolt, supra note 180, at 463.
191. Id.
192. Id.
195. Williams, supra note 21, at 93-96.
196. Robbennolt, supra note 180, at 515. Professor Robbennolt’s studies involved participants reading an accident scenario, assuming the role of accident victim, and evaluating a settlement offer from the responsible party; some offers included a full or partial apology. The studies found that 73% of participants would likely accept the settlement offer accompanied by a full apology, while only 53% would likely accept the settlement offer not accompanied by a full apology. The partial apology resulted in the injured party feeling ambivalent and increasing the uncertainty whether to accept the offer.
deny wrongdoing. In general, an apology is offered by an alleged wrongdoer as an “acknowledgement of the legitimacy of the violated rule, admission of fault and responsibility for its violation, and the expression of genuine regret and remorse for harm done.”

In the medical malpractice context, apologies can be separated into two categories: partial apologies and full apologies. A partial apology expresses remorse or regret for an incident; a full apology does the same, with the added dimensions of an expression admitting fault and a promise not to commit the same mistake again. Commentators suggest that only a full apology accepting responsibility for the incident by acknowledging fault can have the intended effect on the patient or patient’s family. Simply put, there is a difference between: “I’m so sorry you lost your husband after the surgery I performed” and, “I’m so sorry for your loss. We made a mistake counting the number of sponges and unfortunately we left one inside your husband. That caused an infection and before we could correct the problem it was too late. I know it’s no consolation, but we are implementing new procedures to ensure this doesn’t happen to anyone else. Again, I can’t tell you how sorry I am for our mistake.” Not only does the latter represent a full apology, it provides the patient or family the explanation so desperately needed. But how does the legal system view the latter?

Statements, including those admitting fault, made during settlement negotiations are generally inadmissible at trial to prove liability pursuant to evidentiary rules. Thus, a physician may apologize to an injured patient or family during mediation or a settlement conference. However, by the time either or

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198. Robbennolt, supra note 187, at 352.
199. There is no true definition of a partial apology versus a full apology, and different legal scholars define them differently (for instance, one paper reports eight states enacted statutes protecting full apologies, while another paper reports only five states have full apology laws).
200. An example of a partial apology is, “I am so sorry this happened to you.” An example of a full apology is, “I am sorry I did this to you.” Edward A. Dauer, Apology in the Aftermath of Injury: Colorado’s “I’m Sorry” Law, 34 COLO. LAW. 47, 49 (2005).
201. Colorado’s medical apology law, which protects full apologies, reads: “In any civil action brought by an alleged victim of an unanticipated outcome of medical care... any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a healthcare provider or an employee of a healthcare provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.” COLO. REV. STAT. § 13-25-135 (2011).
202. FED. R. EVID. 408(a)(2).
those events occur, significant litigation costs most likely have already been incurred, and feelings on both sides might have escalated during the course of discovery. Protecting a medical apology prior to a claim ever being filed is the best way to maximize the effectiveness of medical apologies.

In a jurisdiction that has not enacted an evidentiary rule prohibiting from use at trial a full apology, the physician offering the latter apology will hear his words again at trial, and the plaintiffs’ attorney will claim this is an admission of liability. The jury would have little choice but to return a verdict finding the physician liable. In a jurisdiction, however, that has enacted an evidentiary rule prohibiting the use at trial of a full apology, that latter apology could not come back to haunt the physician. If the volumes of research on the issue are accurate, that physician might never even experience a medical malpractice claim because the physician was unrestrained in his ability to offer an explanation and full apology. If physicians are aware they can offer full apologies on the spot while the adverse medical incident is still fresh and bitter in the minds and hearts of the patient and family, that full apology might have its most productive impact.

In 1986, Massachusetts became the first state to enact a statute protecting some types of apologies from later use at trial as an admission against interest. No other state enacted an “apology law” until 1999, but since that time 35 more states have done so. Some statutes—such as California’s, Massachusetts’s, Florida’s, Tennessee’s, Texas’s, and Washington’s—protect general apologies, while other states’ statutes protect only apologies offered by healthcare providers. Some legal scholars have advocated federal protection of full apologies in all civil cases, while other legal scholars oppose apology

203. Whether it is the defendant physician undergoing deposition cross-examination by the plaintiffs’ attorney or the patient being cross-examined by the defense attorney, being subjected to deposition cross-examination can engender bitter feelings and/or exacerbate any previously existing ill will.

204. In a jurisdiction without a medical apology law, such a case would most likely settle favorably for the plaintiff prior to trial based on the damning admission. As the vast majority of medical malpractice claims resolve prior to any trial, the plaintiffs have a strong argument for a large settlement if they are armed with an admissible apology that includes a statement admitting fault.

205. Unfortunately, there is a dearth of reported appellate court and/or state supreme court cases regarding the exclusion or admission of medical apologies in states that have enacted medical apology laws. However, in Airasian v. Shaak, a Georgia appeals court had occasion to affirm a trial court’s order ruling inadmissible, pursuant to Georgia’s medical apology law (GA. CODE ANN. § 24-3-37.1(c) (West 2008)), a physician’s statement to the patient’s wife (“This was my fault”) subsequent to an adverse medical incident. 657 S.E. 2d 600 (Ga. App. 2008).


208. See, e.g., Runnels, supra note 193.
laws, arguing that protecting an apology from use at trial robs the apology of its weight and effectiveness.\textsuperscript{209}

C. Disclosure and Offer Programs

Several medical institutions have commenced their own programs to deal with adverse medical incidents. The process is similar at the institutions that have enacted these “disclosure and offer” programs. Subsequent to the incident, the institution undertakes an investigation to determine what, if anything, was done wrong by the healthcare providers.\textsuperscript{210} If the investigation reveals a medical error of some type, the next step is a physician-patient meeting at which the physician discloses the medical error and offers an apology (if the state has a medical apology law) and a promise to implement a change to reduce or eliminate the possibility of a recurrence. At the meeting, an offer of compensation may be made to the patient or family.

The University of Michigan Health System (UMHS) pioneered a disclosure and offer program,\textsuperscript{211} and a number of other institutions have enacted similar programs.\textsuperscript{212} The stated goals of the UMHS program are three-fold: (1) compensate patients quickly and fairly when inappropriate medical care causes injury; (2) defend appropriate medical care vigorously; and, (3) reduce patient injuries (and therefore medical malpractice claims) by learning from adverse medical incidents.\textsuperscript{213}

Subsequent to an adverse medical incident, UMHS and medical institutions with similar programs approach the patient and acknowledge what occurred, provide answers to any questions the patient has, establish a follow-up procedure with the patient, offer a full apology for any inappropriate medical care resulting in injury, and study the patient’s experience in hopes of improving fu--

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\item[209] See, e.g., Lee Taft, Apology Subverted: The Commodification of Apology, 109 YALE L.J. 1135 (2000); Brent T. White, Say You’re Sorry: Court-Ordered Apologies as a Civil Rights Remedy, 91 CORNELL L. REV. 1261, 1294 (2006) (arguing that apologies lose their moral underpinnings if protected from admissibility, which undermines their sincerity and thus their healing attributes); see also Lee Taft, Apology Within a Moral Dialectic: A Reply to Professor Robbennolt, 103 MICH. L. REV. 1010 (2005).
\item[210] See, e.g., Kachalia, supra note 181, at 214.
\item[211] Mello, supra note 78, at 2.
\item[212] For example, the University of Illinois Medical Center in Chicago, the Lexington (Kentucky) Veterans Affairs Medical Center, and Catholic Healthcare West have implemented successful disclosure and offer programs. CAROL B. LIEBMAN & CHRIS STERN HYMAN, THE PROJECT ON MEDICAL LIABILITY IN PENNSYLVANIA, MEDICAL ERROR DISCLOSURE, MEDIATION SKILLS AND MALPRACTICE LITIGATION 53-56 (2005), available at http://www.pewcenteronthestates.org/uploadedFiles/wwwpewtrustsorg/Reports/Medical_Liability/LiebmanReport.pdf.
\item[213] Boothman, supra note 177, at 137-38.
\end{footnotes}
Compensation is offered when deemed appropriate, with the patient receiving funds in an expedited manner compared to what could be effectuated by the filing of a formal claim. Studies show UMHS’s program has reduced the number of medical malpractice claims filed by nearly 36% and reduced litigation costs by more than 50%. COPIC—a private, physician-led medical malpractice insurance company in Colorado—implemented a disclosure and offer program subsequent to Colorado’s enactment of a medical apology law; COPIC’s “3Rs” program has been highly successful and is regarded as a model in the medical malpractice insurance industry.

Some of the disclosure and offer programs, however, have their drawbacks, as they may be limited to more minor medical errors with smaller potential damages, typically $25,000.00 or less. Most plaintiffs’ lawyers would not accept a medical malpractice case where the potential recovery was less than $100,000, as the costs to prosecute a medical malpractice claim typically run from $50,000 to $100,000. Also, a disclosure and offer program may achieve less stellar results in healthcare organizations that operate differently than the self-insured UMHS, which employs its physicians, pays for their malpractice coverage, and accepts responsibility for claims on a system-wide basis.

The University of Florida College of Medicine-Shands Hospital system (UF-Shands) implemented a disclosure and mediation program in 2008 that has

214. Id.
216. Id. The mean monthly rate of new claims — including those never filed in court — per 100,000 patient encounters decreased from 7.03 claims before the advent of the disclosure-and-offer program to 4.52 claims after full implementation. The average monthly rate of lawsuits decreased from 2.13 to 0.75 per 100,000 patient encounters. Median time from claim reporting to resolution decreased from 1.36 to 0.95 years.
217. Id. The study also compared how much UMHS spent on liability costs, which included fees for attorneys and experts, as well as amounts paid to patients and their families. As a percentage of monthly operating revenue, those costs declined from a median 0.084% before the disclosure-and-offer program to 0.04% after it was fully implemented. Id.
218. As a practicing medical malpractice defense attorney for fifteen years prior to becoming a law professor, this information comes from the author’s personal knowledge and extensive experience in the field.
219. Kachalia, supra note 181, at 221. Other than state health systems, county hospitals serving the indigent population, and teaching hospitals employing resident physicians, most hospitals do not “employ” physicians. Physicians are granted privileges to admit patients to hospitals but in actuality are non-employees, or occasionally independent contractors. Regardless, unless a hospital negligently granted a physician privileges when it should not have (i.e., the physician had some disciplinary action against him), the hospital is not liable for the negligent acts of the physician. The physician—or his malpractice insurance carrier—bears the financial responsibility for the physician’s defense and any settlement or judgment. See supra note 122 and accompanying text.
220. The University of Florida College of Medicine-Shands Hospital system operates medical facilities throughout Northeast Florida.
yielded positive results. The Florida Patient Safety and Pre-Suit Mediation Program at UF-Shands requires a physician disclose any medical error and offer the patient the opportunity to participate in a mediation process if the patient desires to pursue a medical malpractice claim. If the patient foregoes the mediation process, the average time to litigate the claim is 2.8 years (and there is no guarantee of recovery). Should the patient choose mediation, the average length of time until the patient receives compensation is 6 months. In general, patients receive the same, if not slightly more, compensation when opting for mediation rather than litigation; however, the total costs to UF-Shands are significantly decreased because of the savings in litigation costs (i.e., attorneys’ fees, expert witnesses, etc.), which, of course, reduces medical malpractice insurance premiums.

VI. THE REMEDY

Recommended medical system reforms aimed at improving medical care (and thus, if effective, reducing malpractice claims by reducing the number of medical errors committed) should be implemented. This article in no way suggests the goal of improved medical care can be reached solely by the remedies herein proposed. And, medical system reforms are a better way to achieve the goal of reduced medical errors than the remedies proposed by this article. This article simply seeks to recommend a legislative remedy to be implemented through the civil justice system that does not deprive or in any significant way negatively impact a patient’s constitutional right to redress through the courts.

As a single rotten apple may spoil the entire barrel, statistics from the National Practitioner Data Bank reveal that relatively few physicians are responsible for a disproportionate percentage of medical malpractice claims payouts. For example, over a twelve-year period, 2774 physicians (fewer than 1% of American physicians) incurred five or more medical malpractice claim payouts—jury awards against them or settlements paid on their behalf—and just

221. In response to the Harvard Medical Practice Study III (which found that the highest frequency of malpractice claims emanated from patients who felt their physicians rushed them or felt they received inadequate explanations or just brief attention during physician interactions), Medicare implemented a pre-suit mediation program with positive results. Interview with Randall Jenkins, Esq., UF-Shands Assoc. Dir. of Patient Safety Research & Educ., at UF-Shands Jacksonville (Feb. 23, 2011).

222. As Florida does not have a “full apology law,” (i.e., only statements of sympathy, not statements of fault, are deemed inadmissible in a civil action), the UF-Shands program does not incorporate a full apology into the disclosure process. Id.

223. Average litigation costs per claim dropped from a high of $92,997.80 in 2003 to $6,446.33 in 2009, the year UF-Shands’s disclosure and mediation program was instituted. Id.

5% of all American physicians were responsible for 54% of all medical malpractice payouts. Any legislative remedy should reward physicians for never previously being the target of a medical malpractice claim; however, current non-economic damages caps reward all physicians with a cap on potential damages, no matter how many prior instances of medical negligence they may have committed. Therefore, any cap on damages should apply only to physicians with no previous substantial medical malpractice payouts rendered on their behalf within the seven years preceding the filing of the claim regarding the adverse medical incident at issue. Likewise, any cap on damages should not apply to any hospital or medical institution with more than one substantial medical malpractice payout in the twelve months preceding the filing of the claim regarding the adverse medical incident at issue.

Limiting monetary awards by imposing a cap on economic damages defeats the purpose of allowing an aggrieved plaintiff to petition for redress in the court system. If a child injured by medical negligence must be on a ventilator for the remainder of her life yet her life expectancy is not reduced, the economic damages resulting from the medical negligence will dwarf any cap on economic damages; however, in those states with economic damages caps, such a plaintiff will not receive the necessary medical care because there will be no funds from which to pay for it. This remedy purposefully omits any cap on economic damages.

For defendant physicians, non-economic damages should be capped at $1 million for an individual plaintiff and $3 million for all claimants, indexed to

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226. Unfortunately, the medical disciplinary system is not effective in addressing the issue of negligent physicians. Of nearly 35,000 American physicians with two or more medical malpractice payouts, only 8% were disciplined by a medical board. One physician incurred 24 medical malpractice payouts in an eight-year period, totaling more than eight million dollars, yet that physician was never disciplined by any medical board. National Practitioner Data Bank, supra note 225; see also, Sidney M. Wolfe, Bad Doctors Get a Free Ride, N.Y. TIMES, Mar. 4, 2003, at A27.
227. As hospitals and medical entities often decide to pay “nuisance value” to extinguish liability in cases where it is determined to be financially beneficial to settle early on, such defendants should not be punished for employing this litigation strategy that actually reduces overall litigation costs. Therefore, only cases where the hospital or medical entity pays out in excess of $100,000 should count toward the damages cap exclusion. Additionally, such a provision might encourage more settlements under the $100,000 threshold and similarly might encourage plaintiffs lawyers to accept more small dollar cases where liability appears clear.
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The rate of inflation. Such a cap would prohibit those isolated yet publicized exorbitant payouts that so shock the public and outrage physicians but would still allow for sufficient damages in cases where economic damages are minimal but the emotional and/or pain and suffering loss is severe. As most physician malpractice insurance policies carry “$1/$3” limits ($1 million per claim/$3 million annual aggregate), if a physician is found liable and a jury awards high non-economic damages, the physician has his personal assets protected. However, the non-economic damages caps should be inapplicable to a “bad doctor” who previously incurred a substantial medical malpractice payout anytime in the previous seven years; his insurer would pay the policy limits to satisfy an award under the typical $1 million/$3 million policy limits, but then the physician’s personal assets could be accessed to pay any excess award, thus punishing the “bad doctor” for prior medical errors but rewarding the “good doctor” for a lack of prior errors. If the physician is “going bare” (carries no medical malpractice insurance), then the physician would be responsible for the entire award, whether protected by the cap—because the physician incurred no more than one substantial medical malpractice payout within the previous seven years—or not. The proposed cap may actually encourage

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229. For example, if a wife/mother dies due to medical negligence and leaves behind a husband and four minor children, even though each survivor has a claim, as does the estate of the deceased (which thus totals six plaintiffs), the maximum amount of non-economic damages that could be awarded under this proposal would be $3 million.

230. As the median award—economic and non-economic damages combined—in a medical malpractice case resulting in death is $837,000, and in a permanent injury case $412,000 (Hyman, supra note 32, at 1105), if the proposed cap is applicable it should affect only a minority of jury awards.

231. See, e.g., Williams, supra note 21, at 118; George Peterson, Malpractice Insurance: What Are the Limits?, AM. SOC’Y OF ANESTHESIOLOGISTS NEWSL., Aug. 2007 (concluding that, for anesthesiologists, $1/$3 million medical malpractice insurance policy limits are standard); Timothy R. Bone, What Policy Limits Should a Florida Physician Buy?, ORLANDO MED. NEWS (Sept. 10, 2010, 12:11 pm), http://orlandomedicalnews.com (noting that it is recommended physicians maintain $1/$3 million medical malpractice insurance policy limits).

232. For example, if the jury awards $5 million in non-economic damages, the cap reduces that award to $1 million, which the defendant physician’s insurer pays to the plaintiff pursuant to the policy (most likely a $1 million/$3 million policy). Additionally, studies show that nearly all medical malpractice payouts are less than $1 million. For example, for the 7,328 closed claims studied within a 2007 insurance database, less than 3% resulted in payouts in excess of $1 million. AM. SOCIETY OF ANESTHESIOLOGISTS CLOSED CLAIMS PROJECT, http://depts.washington.edu/asaecp/ASA/index.shtml; see also supra note 55 and accompanying text.

233. Just as hospitals and medical entities may opt to settle a case early on for nuisance value, so too might a physician or the physician’s insurer (if the physician is insured via a “consent policy,” the physician ultimately decides whether to settle the case; however, as most policies these days are not consent policies, the insurer could settle a case without the physician’s permission). If such a settlement is less than $100,000, the physician would still have the protections of the damages cap. See discussion supra note 227.
physicians who do not currently carry malpractice insurance to purchase it, thus providing patients a potential source from which to recover for negligent medical care.

Some states that have enacted non-economic damages caps allow—in egregious cases—awards to exceed the non-economic damages cap, in the discretion of trial court. States with statutes allowing the exceeding of the state’s non-economic damages cap have instituted an absolute limit the trial judge may award in excess of the non-economic damages cap. Therefore, the remedy proposed in this article also includes an exception to the $1 million/$3 million non-economic damages cap as part of the remedy—the trial judge may increase the amount of the non-economic damages award only in egregious cases involving death or severe permanent injury. However, the absolute maximum the trial judge could award would be nine times the economic damages awarded. This multiplier is derived from the Supreme Court of the United States’ “single digit multiplier” limit for the maximum punitive damages award. If the trial judge is not satisfied that, under the facts of the case and considering the severity of the plaintiff’s injuries, a non-economic damages award of $1 million/$3 million is sufficient, then the trial judge may institute a non-economic damages award not to exceed nine times the economic damages.

As previously discussed, punitive damages in medical malpractice cases are almost never allowed to be pled, and they are rarely awarded. However, to protect against a grossly extreme punitive damages award and to provide a further compromise to physicians and tort reformers, punitive damages should be capped at $1 million for an individual claimant and $3 million for all claimants, while allowing the trial judge—when the facts warrant the awarding of

234. See, e.g., Fla. Stat. Ann. § 766.118 (West 2011) (noting that if the medical negligence resulted in a permanent vegetative state or death, noneconomic damages may exceed the state’s $1 million non-economic damages cap if the trial court determines that a manifest injustice would occur unless increased non-economic damages are awarded, based on a finding that because of the special circumstances of the case, the non-economic harm sustained by the injured patient was particularly severe).


236. The “single digit multiplier” cap created by the Supreme Court for punitive damages awards simply serves as an appropriate benchmark to determine if a “pain and suffering” award is excessive under the proposed remedy. The author well knows non-economic damages and punitive damages serve separate and distinct purposes; the single digit multiplier is merely employed as a benchmark to set an absolute maximum of non-economic damages.

237. See supra note 105.

238. Mississippi’s statutory limit on punitive damages comes in the form of caps based on the net worth of a defendant. For example, an individual physician defendant who has a
punitive damages—the discretion to award up to nine times compensatory damages per Supreme Court precedent.

Because disclosure and offer programs are so successful addressing many patients’ needs subsequent to an adverse medical incident, for hospital/medical entity defendants the $1 million/$3 million damages caps should be applicable only if the defendant has in place an appropriate disclosure and offer program and the defendant has not incurred a substantial medical malpractice payout within the twelve months preceding the filing of the claim at issue.\(^\text{239}\) The $1 million/$3 million cap would also be applicable to any malpractice insurer that implements an acceptable disclosure and offer program. The requirements for a disclosure and offer program may be prescribed in a fashion similar to COPIC’s and/or the University of Michigan Health System’s. If the entity defendant does not have in place a disclosure and offer program that meets the requirements, the entity may not avail itself of the damages caps protections. Such a requirement will encourage hospitals, medical systems and insurers to implement these highly beneficial programs. If the claim cannot be resolved within the disclosure and offer program, the entity is “rewarded” for having such a program by having the damages cap in place should a medical malpractice claim result.

Considering their tremendous benefits in both preventing medical malpractice claims from being filed and contributing to potential claimants’ emotional and psychological healing following an adverse medical incident, full apologies should receive full protection: if a healthcare provider offers a full apology to a patient or patient’s family, nothing regarding that apology may ever be offered against the healthcare provider in a subsequent medical malpractice lawsuit.

Also included in this proposed remedy is a federal peer review privilege in medical malpractice litigation protecting from admission into evidence any statement, document or other evidence associated with any investigation, review or analysis conducted by a hospital, medical facility or its committees, agents or employees subsequent to an adverse medical incident, as well as any review of a physician’s performance, whether regarding a specific incident or a more generalized performance review.

\(^{239}\) Most hospitals are self-insured up to a pre-determined limit, typically around $10 million. Any judgment or settlement in excess of the hospital’s self-insured limit is paid by the hospital’s excess medical malpractice insurance carrier. Under this proposed remedy, if a hospital has in place a prescribed disclosure and offer program, then the premiums the hospital pays for its excess malpractice insurance should be greatly reduced, as the chances the excess coverage will ever be invoked are severely diminished (i.e., only in cases where the hospital has incurred a significant medical malpractice payout in the twelve months preceding the filing of the claim at issue).
If the plaintiff prevails in a medical malpractice action, the plaintiffs’ attorney’s fees should be paid directly by the defendant, as opposed to reducing the amount awarded to the plaintiff. In a case where only economic damages are awarded (or minimal non-economic damages are awarded), a plaintiff cannot be made whole when the award is reduced by 33%-40% to pay the plaintiff’s attorney. The trial judge should conduct a hearing to decide how much to award in attorney’s fees (which should please physicians and tort reformers), but the trial judge should be guided by a generalized fee schedule. 240

To summarize, the remedy herein proposed consists of:

1. a $1 million/$3 million non-economic damages cap—indexed to the rate of inflation—for physicians who have incurred no more than one substantial medical malpractice payout in the previous seven years, and for hospitals/medical entities that have implemented an acceptable disclosure and offer program and that have incurred no more than one substantial medical malpractice payout in the previous twelve months (trial judge may exceed in egregious cases but an absolute limit of nine time economic damages);
2. a $1 million/$3 million non-economic damages cap—indexed to the rate of inflation—for malpractice insurers that have implemented an acceptable disclosure and offer program (trial judge may exceed in egregious cases but an absolute limit of nine time economic damages);
3. a $1 million/$3 million cap—indexed to the rate of inflation—on punitive damages awards (trial judge may exceed in egregious cases but an absolute limit of nine time economic damages);
4. full protection for medical apologies;
5. full protection for peer review/morbidity and mortality processes;
6. prevailing plaintiffs lawyers’ fees to be paid directly by defendant (not from jury award proceeds) as determined by the trial judge guided by a generalized fee schedule.

This remedy cannot solve all the problems associated with the current medical liability system. However, as opposed to other proposed fixes, this remedy includes provisions that attempt to address each of the major problems of the

240. For example, Connecticut has a legislatively imposed sliding scale—fees may not exceed one third of the first $ 300,000; 25% of the next $ 300,000; 20% of the next $ 300,000; 15% of the next $ 300,000; and 10% of damages exceeding $ 1.2 million. Conn. Gen. Stat. §52.251C (2011). The Supreme Court of Florida has ruled unreasonable attorney’s fees in excess of 40 percent of any recovery up to $1,000,000; 30 percent of any recovery between $1,000,000 and $2,000,000; 20 percent of any excess over $2,000,000. Fla. Rules of Prof’l Conduct R. 4-1.5(f)(4)(B).
current system and offers a compromise between the competing parties involved.

Patients are guaranteed access to the civil justice system instead of being forced into specialized health courts, a no-fault compensation system, or a civil justice system restricted by draconian damages caps and/or a higher burden of proof. The proposed remedy’s disclosure and offer component means more patients will receive compensation and sooner, and plaintiffs lawyers most likely will accept more low-dollar-damages cases, which benefits patients/plaintiffs. More patients and families will receive the apologies and explanations so crucial to the healing process, and to the prevention of the filing of malpractice claims. All these benefits should satisfy plaintiffs’ lawyers, patient advocacy groups and liberal lawmakers, as will the continuation of the deterrence effect against negligent medical care present when the resolution of medical malpractice claims remain within the civil justice system. Patients and their families will benefit from no reduction in jury awards to pay their attorneys’ fees, and plaintiffs’ lawyers will benefit from a generalized fee schedule that outlines exactly what they can expect to earn. This proposed remedy is a “win” for patients and plaintiffs’ lawyers.

Physicians are guaranteed a level playing field nationwide, with the resolution of medical malpractice claims uniform across the country. As opposed to the current patchwork of individual states’ damages caps, physicians should be pleased with a nationwide damages cap, considering that restriction continues to be the most important goal sought by physicians. A greater number of qualified individuals should apply to medical school, and a greater number of practicing physicians continue to treat patients, based on the uniformity and definitiveness of medical malpractice as a known, defined quantity. Simply put, physician fear will decrease—and physician satisfaction increase—which also will lead to a reduction in defensive medicine. Physicians will receive protection for peer review and medical apologies, two processes they so value. Additionally, peer review protection will operate as a benefit to patients, as the result of effective peer review is reduction of medical errors (which will lead to fewer malpractice claims). Physicians, medical entities and malpractice insurers will enjoy tremendous benefits from this proposed remedy, and conservative lawmakers certainly would view its enactment as a “win” for their constituents.

CONCLUSION

Although there certainly are problems with it, the tort system generally provides compensation to plaintiffs injured by substandard care and denies compensation to plaintiffs who received appropriate care; for those plaintiffs whose care was in question, about half receive compensation.\textsuperscript{241} Thus, when

\textsuperscript{241} See, e.g., Hyman, supra note 32, at 1097.
patients sue, the result is generally what it should be. Although the medical malpractice system does not resolve cases perfectly, many experts agree that it does a fair job compensating the truly injured while also serving, to some degree, as a deterrent to negligent medical care.\textsuperscript{242} If we can increase the number of disclosure and offer programs, an even greater number of injured patients will receive compensation and receive it faster.

Enacting comprehensive reform of what works best in the present system—while recognizing the political necessity of including some reforms to appease the issue’s most important actors—presents the best opportunity to correct the flaws in the present system without losing any benefits. Medical system reforms certainly may address issues of quality control, but the goals of patient compensation, deterrence, reduction of both medical errors and defensive medicine, and the maintenance of constitutional access to the court system equate to but one result: remedying the current system with an approach such as herein proposed.

Reformers may never convince physicians that the problem lies with medical errors, but it is essential physicians invest in a remedy for such remedy to be effective. The remedy must give them something they want even if the bulk of studies conclude what they want will not work. Give physicians the damages caps they so want, and explain to them why the levels are, in general, set at $1 million/$3 million.\textsuperscript{243} Give physicians federalization of medical malpractice claims so that they know wherever they practice the rules are the same. Give physicians a strong federal peer review privilege and a federal “full apology” law so they can, within the confines of the physician-patient relationship they so value, conduct frank, complete disclosure of medical errors along with full apologies expressing both remorse and, if warranted, fault in an effort to fulfill the ethical obligations of their profession. But also give physicians the tort incentive to practice better medical care. And give plaintiffs—patients—what, constitutionally, they’re entitled to: access to the civil justice system as a means of redress for a perceived harm that allows them a full and fair opportunity to recover appropriate damages. Politically, realistically, this remedy will heal.

\textsuperscript{242} Id.

\textsuperscript{243} Although physicians in states that have enacted low damages caps ($250,000 to $750,000) may argue that any malpractice claim filed against them subsequent to enactment of the proposed remedy will then be governed by a higher damages cap, this remedy acts as a compromise to the medical profession—hundreds of thousands of physicians currently practice in states with no damages caps of any kind.
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