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CBO

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Limiting Tort Liability for Medical Malpractice

The past few years have seen a sharp increase in premiums for medical malpractice liability insurance, which health care professionals buy to protect themselves from the costs of being sued *(see Figure 1 on page 2)*. On average, premiums for all physicians nationwide rose by 15 percent between 2000 and 2002—nearly twice as fast as total health care spending per person. The increases during that period were even more dramatic for certain specialties: 22 percent for obstetricians/gynecologists and 33 percent for internists and general surgeons.[1] (For a definition of malpractice and other terms used in this brief, *see Box 1 on page 3*).

The available evidence suggests that premiums have risen both because insurance companies have faced increased costs to pay claims (from growth in malpractice awards) and because of reduced income from their investments and short-term factors in the insurance market. Some observers fear that rising malpractice premiums will cause physicians to stop practicing medicine, thus reducing the availability of health care in some parts of the country.

To curb the growth of premiums, the Administration and Members of Congress have proposed several types of restrictions on malpractice awards. Bills introduced in the House and Senate in 2003 would impose caps on awards for noneconomic and punitive damages, reduce the statute of limitations on claims, restrict attorneys' fees, and allow evidence of any benefits that plaintiffs collect from other sources (such as their insurance) to be admitted at trial. Limits of one kind or another on liability for malpractice injuries, or "torts," are relatively common at the state level: more than 40 states had at least one restriction in effect in 2002.[2]

Evidence from the states indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise. But even large savings in premiums can have only a small direct impact on health care spending—private or governmental—because malpractice costs account for less than 2 percent of that spending.[3] Advocates or opponents cite other possible effects of limiting tort liability, such as reducing the extent to which physicians practice "defensive medicine" by conducting excessive procedures; preventing widespread problems of access to health care; or conversely, increasing medical injuries. However, evidence for those other effects is weak or inconclusive.

1. The figure for all physicians comes from survey data from the Centers for Medicare and Medicaid Services; the figures for various specialties come from annual surveys conducted by *Medical Liability Monitor* newsletter. Both sets of surveys collect data on base rates charged by insurers and thus do not reflect discounts or additional charges applied to individual policies. Moreover, the latter surveys do not incorporate the relative market shares of insurers, so the averages are not weighted. (Note that most of the numbers reported in this issue brief are for physicians; less information is available for other types of health care providers, but trends appear to be similar for them.)

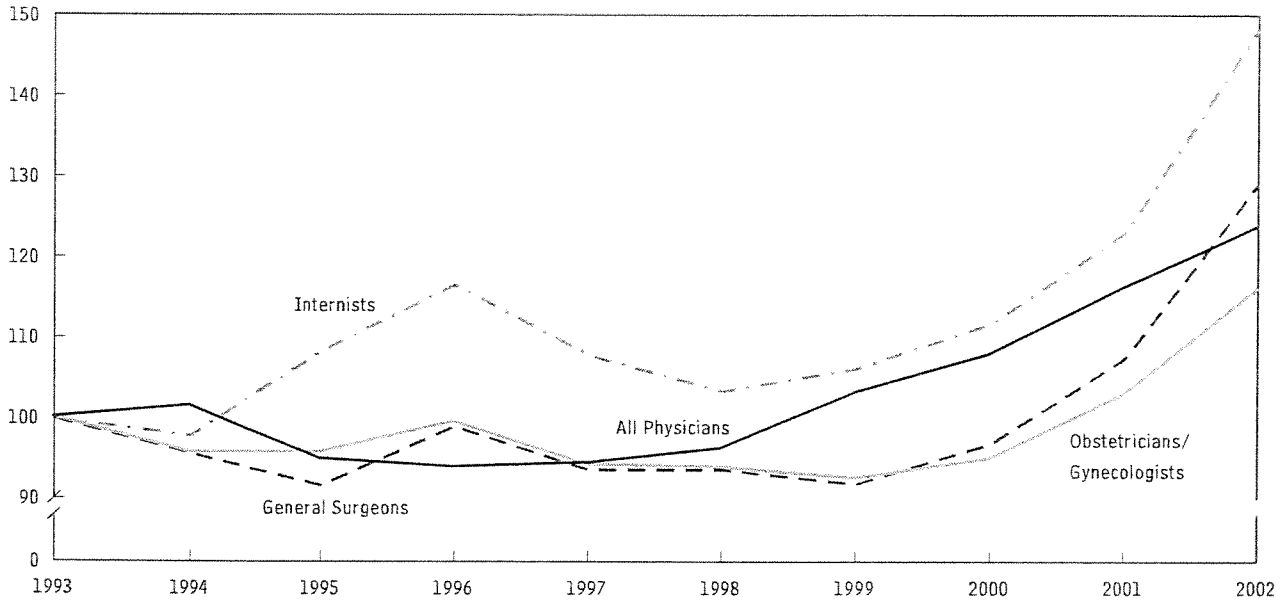
2. That number comes from the Congressional Budget Office's database of state laws on medical malpractice torts. The database includes information from the National Conference of State Legislatures, the American Tort Reform Association, and the law firm of McCullough, Campbell, and Lane. For a discussion of whether tort liability issues are better addressed at the federal or the state level, see Congressional Budget Office, *The Economics of U.S. Tort Liability: A Primer* (October 2003).

3. The 2 percent figure is a CBO calculation based on data from Tillinghast-Towers Perrin (an actuarial and management consulting firm) and the Office of the Actuary at the Centers for Medicare and Medicaid Services.

Figure 1.

Trends in Premiums for Physicians' Medical Malpractice Insurance, by Type of Physician, 1993 to 2002

(Index, 1993 = 100)



Source: Congressional Budget Office based on data from the Office of the Actuary at the Centers for Medicare and Medicaid Services (data for all physicians) and from annual premium surveys conducted by *Medical Liability Monitor* newsletter (data for physicians by specialty).

The Goals and Pitfalls of Tort Liability for Medical Malpractice

Issues surrounding the effects of the malpractice system and of possible restrictions on it can be viewed as questions of economic efficiency (providing the maximum possible net benefits to society) and equity (distributing the benefits and costs fairly).

Fairness is ultimately in the eye of the beholder. But the common equity-related argument for malpractice liability is that someone harmed by the actions of a physician or other medical professional deserves to be compensated by the injuring party.

The efficiency argument is that, in principle, liability (as a supplement to government regulations, professional oversight, and the desire of health care providers to maintain good reputations) gives providers an incentive to control the incidence and costs of malpractice injuries. In practice, however, the effect on efficiency depends on the standards used to distinguish medical negligence from appropriate care and on the accuracy of malpractice judgments and awards. If malpractice is judged inaccurately or is not clearly defined, doctors may carry out excessive tests and procedures to be able to cite as evidence that they were not negligent. Likewise, if malpractice is defined clearly but too broadly or if awards tend to be too high, doctors may engage in defensive medicine, inefficiently restrict their practices, or retire. Conversely, if doctors face less than the full costs of their negligence—because they are insulated by liability insurance or because malpractice is unrecognized or undercompensated—they may have too little incentive to avoid risky practices. For all of those reasons, it is not clear whether trying to control malpractice by means of liability improves economic efficiency or reduces it.

Box 1.

Definitions of Some Common Tort Terms

Collateral-source benefits: Amounts that a plaintiff recovers from sources other than the defendant, such as the plaintiff's own insurance.

Economic damages: Funds to compensate a plaintiff for the monetary costs of an injury, such as medical bills or loss of income.

Joint-and-several liability: Liability in which each liable party is individually responsible for the entire obligation. Under joint-and-several liability, a plaintiff may choose to seek full damages from all, some, or any one of the parties alleged to have committed the injury. In most cases, a defendant who pays damages may seek reimbursement from nonpaying parties.

Malpractice: "Failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss or damage to the recipient of those services or to those entitled to rely upon them."[1]

Negligence: A violation of a duty to meet an applicable standard of care.

Noneconomic damages: Damages payable for items other than monetary losses, such as pain and suffering. The term technically includes punitive damages, but those are typically discussed separately.

Punitive damages: Damages awarded in addition to compensatory (economic and noneconomic) damages to punish a defendant for willful and wanton conduct.

Statute of limitations: A statute specifying the period of time after the occurrence of an injury—or, in some cases, after the discovery of the injury or of its cause—during which any suit must be filed.

1. Bryan A. Garner, ed., *Black's Law Dictionary*, 6th ed. (St. Paul, Minn.: West Group, 1990), p. 959.

The costs of court-imposed awards and out-of-court settlements for malpractice are reflected in the premiums charged for malpractice insurance. If those costs are inefficiently high (or low), premiums will tend to be too, on average. But premiums can also be a source of inefficiency themselves. The amounts that physicians pay for malpractice coverage are generally based on broad aggregates, which reflect factors such as doctors' medical specialties and locations but neglect relevant differences in the quality of their services. Thus, even if premiums are correct on average, they may be too high for the large majority of physicians and too low for a minority who are less careful or competent.

Why Have Malpractice Premiums Risen So Sharply?

Premiums for malpractice insurance are set so that over time, insurers' income from those premiums equals their total costs (including the cost of providing a competitive return to their investors) minus their income from investing any funds they hold in reserve. In the short term, however, premiums may be above or below that equilibrium level, with profits fluctuating or reserves rising or falling as a result.

A full analysis of the reasons for the recent rise in premiums is beyond the scope of this brief. But the available evidence suggests that higher costs for insurers (particularly from increases in the size of malpractice awards), lower investment income, and short-term factors such as cyclical patterns in the insurance market have all played major roles.

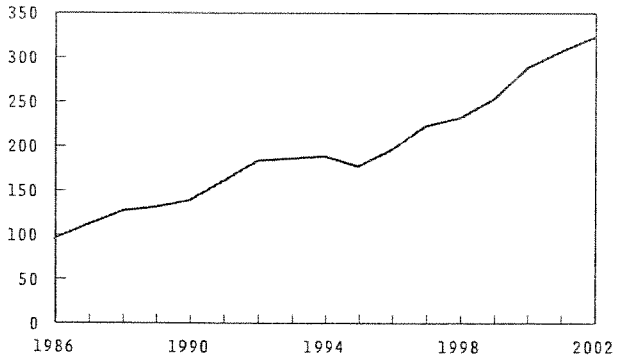
Increased Costs

Payments of claims are the most significant costs that malpractice insurers face, accounting for about two-thirds of their total costs. The average payment for a malpractice claim has risen fairly steadily since 1986, from

Figure 2.

Average Insurance Payment for Closed Malpractice Claims, 1986 to 2002

(Thousands of dollars)



Source: Physician Insurers Association of America.

Note: These averages exclude closed claims that did not result in payments.

about $95,000 in that year to $320,000 in 2002 *(see Figure 2)*. That increase represents an annual growth rate of nearly 8 percent—more than twice the general rate of inflation.[4]

Although the cost per successful claim has increased, the rate of such claims has remained relatively constant. Each year, about 15 malpractice claims are filed for every 100 physicians, and about 30 percent of those claims result in an insurance payment.[5]

The other one-third of malpractice insurers' costs comprise legal costs for policyholders who are sued and underwriting and administrative expenses. Those types of costs have also increased. Like claims payments, legal-defense costs grew by about 8 percent annually during the 1986-2002 period, from around $8,000 per claim to more than $27,000.[6] In addition, the many malpractice insurers who buy reinsurance to protect themselves from large losses have seen that part of their underwriting costs rise significantly over the past decade. (Those increases are not related solely to medical malpractice but reflect a general tightening of the reinsurance market in the wake of such catastrophic events as Hurricane Andrew in 1992, the Northridge earthquake in 1994, and the terrorist attacks of September 11, 2001.)[7]

Reduced Investment Income

Insurers generally base the malpractice premiums they charge in a given year on the future payments they expect to make for claims filed in that year. On average, claims are settled five years after the premiums for them were collected, and the income that insurers earn from investing premium receipts in the meantime is an important source of funds for them.

Insurance companies' investment yields have been lower for the past few years, putting pressure on premiums to make up the difference. According to the General Accounting Office (GAO), annual investment returns for the nation's 15 largest malpractice insurers dropped by an average of 1.6 percentage points from 2000 to 2002—enough to account for a 7.2 percent increase in premium rates.[8] That figure corresponds to almost half of the 15 percent increase in rates estimated by the Centers for Medicare and Medicaid Services.

Short-Term Factors

Premium increases in recent years may also reflect temporary adjustments in the reserve levels and profit rates of insurance companies. Premiums rose sharply for a few years in the late 1980s because of insurers' expectations of

4. Those figures are based on data collected by the Physician Insurers Association of America. Malpractice claims typically include a component to compensate plaintiffs for additional medical costs they incur because of their injuries, so one factor contributing to the growth in the average value of claims since 1986 has been increases in health care spending—which, on a per-person basis, has risen at an average rate of 6.9 percent a year during that period.

5. Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms" (paper presented at the Council on Health Care Economics and Policy conference, "Medical Malpractice in Crisis: Health Care Policy Options," Washington, D.C., March 3, 2003); and CBO calculations based on data from the Physician Insurers Association of America.

6. Claims that did not lead to payments incurred average defense costs of $22,000 in 2002, compared with $39,000 for claims that did result in payments.

7. For a discussion of the dynamics of the reinsurance market, see Congressional Budget Office, *Federal Reinsurance for Disasters* (September 2002).

8. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (June 2003), p. 27.

future claims, which proved to be too high. The result was an accumulation of reserves, which were drawn down in the 1990s during a period of relative stability in premiums. If insurers' current expectations of future claims also turn out to be too high, the same thing could happen again.

The recent increases may also be a self-limiting response to insurers' low profits. In some states, premiums have been significantly affected when major insurers have decided to withdraw from the malpractice market, either locally or nationally. For example, in West Virginia and Nevada, the St. Paul Company had market shares of 43 percent and 36 percent, respectively, when it stopped renewing policies in August 2001 and then left the market entirely.[9] Such a reduction in the supply of malpractice insurance can help drive premiums up sharply in the short run. But those higher premiums encourage other malpractice insurers to expand their insurance offerings in those markets and thus tend to moderate future price increases (all other things being equal).

Potential Effects of Some Restrictions Under Consideration

In theory, the kinds of limits on malpractice liability that are being considered in the Congress could either enhance or detract from economic efficiency, depending on the current state of the liability system. For example:

- Capping or otherwise restricting awards for noneconomic losses and punitive damages might improve efficiency if such awards are now frequently arbitrary or excessive. It would do so by reducing the extent to which disproportionate awards distort the incentives for providers to practice medicine safely. Conversely, that change might undermine incentives for safety and reduce efficiency if current awards are generally appropriate.
- Allowing evidence of benefits that patients receive from collateral sources to be presented at trial might improve efficiency if today judges or juries sometimes wrongly find health care providers negligent out of (perhaps subconscious) concern that plaintiffs would otherwise be in dire financial straits. Or again, it might reduce efficiency if it encouraged carelessness by providers.
- Capping "contingent" fees (those set by a plaintiff's attorney as a percentage of any damages awarded to the plaintiff) could improve efficiency by reducing nuisance suits. Conversely, such a change could reduce efficiency by making it harder for some patients with legitimate but difficult claims to find legal representation.

Evidence About the Effects of Restricting Malpractice Liability

Several studies have found that various types of restrictions on malpractice liability can indeed reduce total awards and thereby lead to lower premiums for malpractice insurance. By themselves, however, such changes do not affect economic efficiency: they modify the distribution of gains and losses to individuals and groups but do not create benefits or costs for society as a whole. The evidence for indirect effects on efficiency—through changes in defensive medicine, the availability of medical care, or the extent of malpractice—is at best ambiguous.

Effects on Malpractice Premiums

In 1993, the Office of Technology Assessment issued a report summarizing the first wave of studies on the experience of states that set limits on malpractice liability in the 1970s and 1980s. The report concluded that caps on damage awards consistently reduced the size of claims and, in turn, premium rates for malpractice insurance. Further, it found that limiting the use of joint-and-several liability, requiring awards to be offset by the value of collateral-source benefits, and reducing statutes of limitations for filing claims were also effective in slowing the growth of premiums.[10]

More-recent studies have reached similar conclusions. A 2003 study that examined state data from 1993 to 2002 found that two restrictions—a cap on noneconomic

9. The St. Paul Company had been the largest or second-largest malpractice insurer in nine other states as well; see Thorpe, "The Medical Malpractice 'Crisis'."

10. Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs* (September 1993), p. 66.

damages and a ban on punitive damages—would together reduce premiums by more than one-third (all other things being equal).[11] And based on its own research on the effects of tort restrictions, the Congressional Budget Office (CBO) estimated that the provisions of the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 (H.R. 5) would lower premiums nationwide by an average of 25 percent to 30 percent from the levels likely to occur under current law. (The savings in each state would depend in part on the restrictions already in effect there.)

Savings of that magnitude would not have a significant impact on total health care costs, however. Malpractice costs amounted to an estimated $24 billion in 2002, but that figure represents less than 2 percent of overall health care spending.[12] Thus, even a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small.[13]

Effects on Defensive Medicine

Proponents of limiting malpractice liability have argued that much greater savings in health care costs would be possible through reductions in the practice of defensive medicine. However, some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients. On the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small.

A comprehensive study using 1984 data from the state of New York did not find a strong relationship between the threat of litigation and medical costs, even though physicians reported that their practices had been affected by the threat of lawsuits.[14] More recently, some researchers observed reductions in health care spending correlated with changes in tort law, but their studies were based on a narrow part of the population and considered spending for only a few ailments. One study analyzed the impact of tort limits on Medicare hospital spending for patients who had been hospitalized for acute myocardial infarction or ischemic heart disease; it observed a significant decline in spending in states that had enacted certain tort restrictions.[15] Other research examined the effect of tort limits on the proportion of births by cesarean section. It also found savings in states with tort limits, though of a much smaller magnitude.[16]

However, when CBO applied the methods used in the study of Medicare patients hospitalized for two types of heart disease to a broader set of ailments, it found no evidence that restrictions on tort liability reduce medical spending. Moreover, using a different set of data, CBO found no statistically significant difference in per capita

11. Thorpe, "The Medical Malpractice 'Crisis'."

12. U.S. health care spending totaled about $1.4 trillion in 2002 (excluding spending on public health and capital improvements), according to data from the Office of the Actuary at the Centers for Medicare and Medicaid Services.

13. Moreover, one of the restrictions in H.R. 5—changing the rules for collateral-source benefits—would in some cases merely shift costs from malpractice insurers to providers of such collateral benefits (who in most cases are health insurers) rather than reduce costs overall. As a result, the total dollar impact on health insurance premiums would be smaller than the impact on malpractice premiums. Conversely, the total benefit to the federal Treasury would be larger than the savings in federal spending on health care, because tax revenues would increase to the extent that employers passed on part of their savings in health insurance premiums to their workers in the form of higher taxable wages.

14. Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Boston: Harvard University School of Public Health, 1990), Chapter 10, pp. 2-3.

15. Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics* (May 1996), pp. 353-390. Specifically, the study estimated that states with any of four restrictions (caps on noneconomic or total damages, prohibitions on punitive damages, no automatic addition of prejudgment interest, and offsets for collateral-source benefits) lowered spending for inpatient care by between 5 percent and 9 percent in the year following the patients' initial admission for either diagnosis. However, the study also found that a second set of tort restrictions (caps on contingent fees for plaintiffs' attorneys, deferred payment of some or all damages, restrictions on joint-and-several liability, and public compensation funds for patients) tended to increase spending by between roughly 2 percent and 3 percent, at least in the short run. Those results were unexplained.

16. Lisa Dubay, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics*, vol. 18 (August 1999), pp. 518-519. Estimated cost savings were 0.27 percent.

health care spending between states with and without limits on malpractice torts. Still, the question of whether such limits reduce spending remains open, and CBO continues to explore it using other research methods.

Effects on the Availability of Physicians' Services

Some observers argue that high malpractice premiums are causing physicians to restrict their practices or retire, leading to a crisis in the availability of certain health care services in a growing number of areas. GAO investigated the situations in five states with reported access problems and found mixed evidence. On the one hand, GAO confirmed instances of reduced access to emergency surgery and newborn delivery, albeit "in scattered, often rural, areas where providers identified other long-standing factors that affect the availability of services." On the other hand, it found that many reported reductions in supply by health care providers could not be substantiated or "did not widely affect access to health care."[17]

Effects on Malpractice

Defenders of current tort law sometimes argue that restrictions on malpractice liability could undermine the deterrent effect of such liability and thus lead to higher rates of medical injuries. However, it is not obvious that the current tort system provides effective incentives to control such injuries. One reason for doubt is that health care providers are generally not exposed to the financial cost of their own malpractice risk because they carry liability insurance, and the premiums for that insurance do not reflect the records or practice styles of individual providers but more-general factors such as location and medical specialty.[18] Second, evidence suggests that very few medical injuries ever become the subject of a tort claim. The 1984 New York study estimated that 27,179 cases of medical negligence occurred in hospitals throughout the state that year, but only 415—or 1.5 percent—led to claims.[19]

In short, the evidence available to date does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency. Thus, choices about specific proposals may hinge more on their implications for equity—in particular, on their effects on health care providers, patients injured through malpractice, and users of the health care system in general.

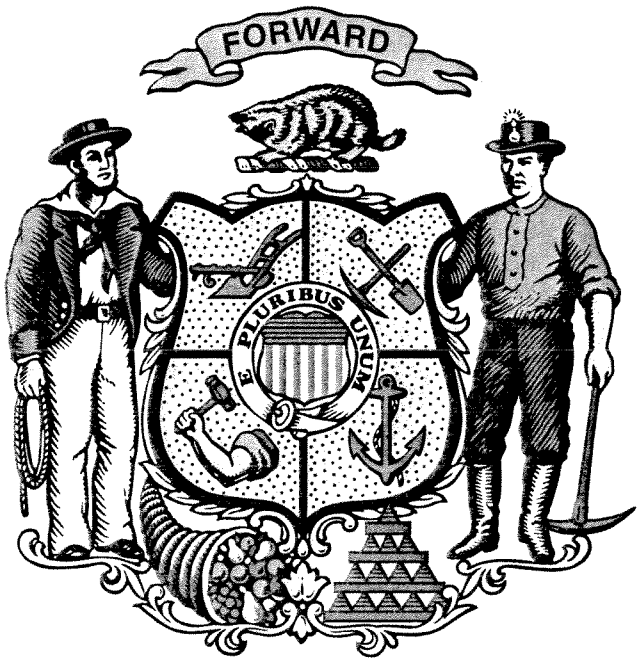
Related CBO Publications: *The Economics of U.S. Tort Liability: A Primer* (October 2003) and *Cost Estimate for H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003* (March 10, 2003), available at www.cbo.gov.

This policy brief was prepared by Perry Beider of CBO's Microeconomic and Financial Studies Division and Stuart Hagen of CBO's Health and Human Resources Division.

17. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (August 2003), unnumbered summary page ("What GAO Found") and p. 5. GAO's study also included a comparison group of four states without reported access problems.

18. However, providers incur other financial and psychic costs (in time, loss of reputation, and so on) when they are sued for malpractice. Moreover, in some cases, they lose their insurance coverage.

19. A. Russell Localio and others, "Relation Between Malpractice Claims and Adverse Events Due to Negligence," *New England Journal of Medicine*, vol. 325, no. 4 (July 25, 1991), pp. 245-251. Many acts of negligence are undoubtedly too minor to justify filing a tort claim. But the 27,179 estimated cases of negligence in 1984 included 5,396 with strong evidence that the negligence contributed to patient disabilities of six months or more—and the estimated 415 claims actually filed correspond to just 7.7 percent of that smaller number of cases.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TRENDS

The Medical Malpractice 'Crisis': Recent Trends And The Impact Of State Tort Reforms

Do recent events constitute a crisis or merely the workings of the insurance cycle?

by Kenneth E. Thorpe

ABSTRACT: By many accounts, the United States is in the midst of its third medical malpractice "crisis." Physicians in several states are facing high and rising premiums. The largest national medical malpractice carrier and some large multistate physician-backed liability firms have recently left the market. Rising premiums are traced largely to increases in claims severity. Capping malpractice payments has been advanced as one approach to slowing the growth in premiums. This analysis finds that premiums in states that cap awards are 17.1 percent lower than in states that don't cap. At issue, however, is whether these stopgap solutions promote the goals of the U.S. liability system.

BY MANY ACCOUNTS, the United States is in the midst of its third "crisis" in medical malpractice. The medical malpractice "crises" in the mid-1970s and 1980s occurred during times of rapid growth in insurance premiums. In the 1970s rising claims frequency and severity resulted in the exit of many malpractice carriers.[1] Some for-profit liability carriers were replaced by a new wave of physician-owned malpractice companies. Medical liability premiums increased sharply again during the 1980s, leading several states to adopt reforms designed to limit malpractice insurers' costs. Indeed, the events of the 1980s led to proposals for broader, more fundamental reforms of the liability system.

Both rising premiums and a reduction in the number of firms offering coverage characterize the most recent medical malpractice crisis. Depending on the specialty and state, the median increase in malpractice premiums ranged from 15 to 30 percent. Rate increases in other states, such as Pennsylvania, ranged from 26 to 73 percent in 2003.[2] The St. Paul Companies, the largest insurer throughout most of the 1990s, stopped writing policies during 2002. Other large, regional carriers have also exited the market. Overall, these insurers accounted for nearly 14 percent of the national market prior to the crisis.[3] In several states facing the most acute crises, carriers exiting the market accounted for a substantial (up to 40 percent) share of premiums written.

While premiums have risen sharply over the past three years, there is much variation across states. The premium spikes have resulted in physician strikes in West Virginia, work slowdowns in New Jersey, and some temporary closings of hospital services (such as trauma care at the University of Nevada Medical Center). Physicians in other states, such as Connecticut, are staging rallies at their state capitol, demanding "tort" reform. A recent analysis by the American Medical Associ-

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ation (AMA) reports that twelve states face crises in their medical liability systems, with problem signs appearing in another thirty.[4] However, there does not appear to be a crisis in the remaining states, as growth in insurance premiums has been low.

The spike in premiums has created much tension within the physician community. Prospects for federal tort reform limiting payments from malpractice suits have been improved by support from President George W. Bush and a lobbying campaign by the AMA. The House of Representatives recently passed the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003 (H.R. 5), which would limit payments from malpractice claims. However, similar legislation has not passed in the Senate.

The crux of the debate focuses on the underlying causes of the most recent rise in premiums. Providers point to a rise in jury awards and rising costs of defending malpractice claims (rising severity). They also highlight the role that contingency fees paid to attorneys play in creating incentives for "frivolous" suits. Some consumer groups, however, believe that rising rates can be traced to lower returns on investments received by the medical malpractice carriers and a downturn in the economy. Such disagreements have led to a contentious debate over what, if any, changes should occur in medical malpractice liability law. This paper examines recent trends in the medical malpractice industry and estimates the impact that tort reforms could have on premiums.

Trends In Key Medical Malpractice Premiums And Financial Ratios

The past four years have seen rising medical malpractice premiums, declining profits, and a reduction in the number of liability carriers offering insurance (Exhibit 1). According to data collected by the National Association of Insurance Commissioners (NAIC), total medical malpractice premiums earned (those retained by malpractice insurance carriers) increased by 23 percent in 2002.

These averages mask variation in the growth in premiums across states. Premium increases in several states, including Florida (more than a 50 percent premium increase for internists) and Ohio (more than a 60 percent premium increase for some internists), were substantial. However, other states such as California saw very small premium increases.

The most important drivers of recent rate increases are (1) severity (awards, settlements, and defense and administrative costs); frequency (claims per insured physician); and (3) changes in investment income. In combination, these factors largely determine expenses and, when compared with premiums earned and investment income, are an indication of overall profitability.

One widely used profit measure is the loss ratio (awards, settlements, and defense costs as a percentage of premium). Exhibit 2 presents data concerning the combined loss ratio, a broader measure that also includes dividends paid to policyholders and corporate income

EXHIBIT 1
Trends In Medical Malpractice Premiums, As Percentage Change, 1998–2002

Year	Premiums earned (%)	OB-GYN premiums (%)	Internal medicine premiums (%)	General surgery premiums (%)
1998	9.1	0.3	-2.9	1.0
1999	3.9	2.1	5.1	1.1
2000	5.3	4.8	7.3	7.0
2001	14.1	10.3	9.9	12.0
2002	23.2	14.2	20.0	21.9

SOURCES: Premiums earned: National Association of Insurance Commissioners data; and premium increases for physician specialties: tabulations from the Medical Liability Monitor, 8 October 2002.
NOTE: OB/GYN is obstetrician/gynecologist.

EXHIBIT 2
Trends In Medical Malpractice Financial Ratios, 1995–2002

Year	Broad combined ratio[a] (%)	Loss ratio[b] (%)	Investment insurance ratio[c] (%)	Net income[c] (%)
1995	126	95	49	23
1996	124	91	44	20
1997	124	91	45	21
1998	126	92	43	17
1999	122	91	34	12
2000	129	103	33	4
2001	141	113	31	-10
2002	129	111	18	-11

SOURCES: Senate Committee on Health, Education, Labor, and Pensions hearing, 11 February 2003; and Tillinghast-Towers Perrin tabulations using the National Association of Insurance Commissioners filings of Physician Insurers Association of America (PIAA) companies for 2002.

[a] Awards, settlements, and defense costs plus dividends, administrative costs, and corporate income taxes as a percentage of premium.

[b] Awards, settlements, and defense costs as percentage of premium.

[c] As a percentage of premiums.

taxes, as well as investment income as a share of premium. Net income is the difference between the broad combined ratio and investment income.[5]

Several important trends appear in these data. First, the broad combined ratio, which measures claims payments, reserves for potential future awards settlements, and defense and administrative costs as a percentage of earned premiums, has risen since 1999. Thus, by 2002 every premium dollar collected resulted in $1.29 in total expenses, awards, and settlements. Historically, malpractice carriers have offset these underwriting losses with earnings from investment income. Starting in 1995, investments as a share of premiums decreased sharply, falling thirty percentage points by 2002. All combined, these trends reduced carriers' overall net after-tax income from 23 percent to -11 percent by 2002.

What Accounts For The Deteriorating Financial Condition Of Malpractice Carriers?

Several factors likely account for medical malpractice carriers' deteriorating financial condition.[6] At issue is whether the most recent trends reflect the traditional underwriting cycle that will eventually regress to mean profits in the industry, or a permanent upward increase in average losses and premiums. Factors influencing these trends include the following.

■ **Traditional insurance cycle trends.** Although all lines of insurance have underwriting cycles, the medical malpractice market experiences wider swings in profitability. Malpractice claims face a long lag from the time an event occurs and a claim is filed to the actual payout date. Premiums established in a given year are designed to cover the claims and defense costs associated with claims filed during the same year. However, it may take several years before claims and premiums can be reconciled to a given year, which adds much uncertainty in setting premiums. Unpublished data from one large carrier revealed that nearly 70 percent of claims were paid within five years of being filed. However, nearly 12 percent took at least eight years to resolve.

Firms' policies for setting aside reserves also influence calendar-year profits.[7] Reserves are treated as an expense and, other things constant, reduce profits. During the early 1990s actual claims payments turned out to be lower than projected, and reserves set aside to pay future claims were too high.[8] Over time,

loss reserves were reduced (thus reducing expenses), resulting in rising profits (lower loss ratios) during the early 1990s. The combination of relatively high investment returns and overreserving in the early and mid-1990s resulted in rising profits that encouraged some firms to hold the line on rates. With declining profits and a projected rise in costs, medical malpractice companies have increased their reserves by drawing down surplus, resulting in lower profits (higher loss ratios).

■ **High investment returns.** The net investment yield for malpractice firms increased to nearly 8 percent by 1998 and has since declined to approximately 6 percent.[9] The growth in returns produced a high investment income ratio through 1998 but has decreased since then. Higher investment returns offset the need to raise premiums. A one-percentage-point increase in expected returns is associated with a reduction in premiums of two to four percentage points.[10]

■ **Rising severity.** Median malpractice awards (including both jury awards and settlements) per paid claim have doubled in real terms between 1990 and 2001.[11] The data indicate that severity has increased approximately 9 percent per year since 1990 (other estimates tracking the market are similar; see, for instance, data in National Practitioner Data Bank annual reports). Several factors may account for the rise in severity. (1) Rising economic costs (future medical expenses, lost wages) appear to be rising slightly faster than overall indemnity payments (the sum of noneconomic and economic awards).[12] (2) Severity of injury per paid claim is also rising. (3) The share of million-dollar awards is also rising. The rise in payments over time is particularly high among cases with grave permanent injury. The Physician Insurers Association of American (PIAA) reports that nearly 8 percent of all awards now exceed $1 million—double the share just five years ago.[13] Data from Illinois reveal that average indemnity of paid claims for an adult with grave permanent injuries has risen from $960,100 (during 1990–1994) to nearly $1.6 million (1995–1999).[14]

(4) Defense and administrative costs are also rising. Data from PIAA and several state insurance departments (such as Ohio and Illinois) show a sharp rise in defense and administrative costs per paid claim. Defense costs have greatly increased in the most severe cases (major and grave permanent injury).

■ **Rising costs of reinsurance.** The rise in claims severity flows through to the reinsurance market. Rising severity, coupled with the events of 11 September 2001, has led reinsurers to add to their reserves and increase reinsurance rates to medical malpractice companies.

■ **Reduced capacity.** The structure of the insurance market has changed dramatically in some of the states facing the sharpest rise in premiums (such as Nevada, West Virginia, Pennsylvania, and Ohio). Several years of underwriting losses led the St. Paul Companies, one of the largest national carriers, to increase its reserves by $600 million in 2001 alone. It was the largest carrier in several states that are now facing sharp increases in medical malpractice premiums.[15] For example, it was the second-largest insurer in Nevada by 1996, accounting for 32 percent of all written premiums.[16]

In addition to The St. Paul, several physician-owned companies—most notably, PHICO (in Pennsylvania) and PIE Mutual (in Ohio)—expanded their medical malpractice business outside their state of domicile. In virtually every case, these companies generated large operating losses outside their home states. By 1996 PHICO wrote medical malpractice policies in twenty states, while PIE Mutual entered about a dozen states. PIE Mutual had the largest market share—nearly a third of premiums written in West Virginia in 1996 alone. However, it was declared insolvent in 1998 and ceased operations. The Commonwealth of Pennsylvania declared PHICO insolvent in 2002. As a result, nearly a third of the physicians in West Virginia changed carriers. The St. Paul largely filled the void in West Virginia between 1996 and 2001. However, by 2001 it ceased writing new business, again placing West Virginia's physicians in a precarious position looking for new medical malpractice insurance coverage. The St. Paul announced in December 2001 that it would exit

the medical malpractice market altogether.[17] The company's exit left more than 36 percent of Nevada's physicians looking for new coverage. More than a third of Ohio's physicians have changed liability carriers over the past five years as well.[18]

These recent changes in market structure have strained the underwriting capacity of medical malpractice companies in several states. Nearly 15 percent of the entire medical malpractice book of business nationally (highly concentrated in several states) has switched, or attempted to switch, malpractice companies since 1998. The issue here concerns liability companies' ability to write the new business. The remaining companies are drawing down surplus and increasing reserves in anticipation of rising claims payments. At the same time, the entire St. Paul book of business is seeking new coverage. Thus, an emerging issue is how much new business the remaining carriers can underwrite. Regulators and rating agencies (such as A.M. Best) use metrics such as the premium-to-surplus (PS) ratio for guidance regarding underwriting capacity, with PS ratios less than 1 preferred. In some cases, the PS ratios have been rising sharply, raising concerns about the (short-run) capacity of the remaining carriers to absorb the new business.

"Certainly to the physicians facing 40–60 percent increases in their premiums, the recent spike in premiums is a crisis."

■ **Rising frequency.** While the number of claims per physician rose sharply between 1956 and 1990 (from 1.5 claims per 100 covered physicians in 1956 to approximately 15 per 100 in 1990, as reported by The St. Paul), the trends appear relatively flat nationally over the past couple of years. In some states (such as Missouri) reported frequency has declined.[19] However, other states have reported a rise in frequency, particularly states with caps on noneconomic damages and no process for discouraging claims frequency (such as an affidavit or certificate of merit)—for instance, Louisiana reports approximately thirty-one claims per physician, double the national average.[20]

Is This A Crisis, Or Simply The Workings Of The Insurance Cycle?

Certainly to the physicians facing 40–60 percent increases in their premiums, the recent spike in premiums is a crisis. With respect to the broader functioning of the market, however, the jury is out. Rising claims costs may reflect a rise in underlying negligence. If true, the system may be functioning as designed, and the spike in premiums may provide stronger incentives for physicians to improve the quality of care provided (the deterrence function of medical liability law). On the other hand, we may be observing a permanent rise in claims payments and costs unrelated to trends in physician negligence. At issue is the extent to which the underlying factors generating higher premiums are following a traditional cyclical insurance pattern, or whether a structural change has occurred in severity and frequency.

The 2000 "crisis" does differ in several key respects from earlier ones. The substantial disruption in market supply in several states—traced to a handful of multistate physician-backed firms and the experience of The St. Paul—are new and, it is hoped, transitory events. It appears that a substantial share of the multistate, physician-owned companies have refocused their effects on their state of domicile. With The St. Paul now out of the market, both trends should eventually bring some stability into states that have been adversely affected. Thus, these substantial disruptions may not signal long-term structural problems of competition or capacity.

Second, many physicians also feel squeezed by rising insurance premiums and declining Medicare reimbursement. Indeed, the rise in premiums has occurred just as Medicare payments to physicians decreased 5.4 percent in 2003.[21]

With respect to broader structural changes, data from PIAA (along with some selected state data) reveal a long-term rise in claims severity.

In Illinois, for example, million-dollar awards accounted for 4 percent of all claims and nearly 42 percent of all indemnity payments between 1985 and 1989. By 1995–1999, 12 percent of all claims exceeded a million dollars, accounting for 52 percent of all indemnity payments.[22] The PIAA data show a similar long-term trend. During 1990, 1.5 percent of all paid claims exceeded a million dollars. By 2001 the percentage had risen to 8 percent.[23]

Policy Options For Addressing Medical Malpractice

The goals of the liability system are to provide financial incentives to deter substandard medical care and to compensate those injured by such care. There is some evidence that the current system performs poorly on both counts.[24] First, program administration—defense and underwriting costs—accounts for approximately 60 percent of total malpractice costs, and only 50 percent of total malpractice costs are returned to patients.[25] These costs are high even when compared with other tort-based systems, such as automobile litigation or airplane crashes, that determine fault and compensate victims.[26] Moreover, most patients that receive negligent care never receive any compensation. The Harvard Medical Practice Study found that only one malpractice claim was filed for every eight negligent medical injuries.[27] Second, deterring substandard medical care is a major rationale for using a tort-liability system for medical malpractice.[28] There is a considerable theoretical literature examining the potential of a tort-based system for optimally promoting safety.[29] Several empirical studies have also been conducted to evaluate whether the tort system deters medical errors. Overall, the literature is mixed.[30]

The recent spike in premiums has renewed state and national interest in limiting claims payments. Several states adopted such limits in response to the spike in premiums in the 1970s and 1980s. More recent interest has been expressed by President Bush, the AMA, and others, in the form of supporting federal legislation capping award payments and reducing "frivolous" claims.[31] Congressional Democrats have advanced their own approach, aimed at curbing an exemption from antitrust laws provided under the McCarran-Ferguson Act. A key issue in the debate is whether state tort reforms slowed the growth in premiums and improved malpractice insurance firms' profitability. To address this question, the final section examines the impact of existing state tort reforms on malpractice premiums and profits through 2001.[32]

Impact Of Traditional Tort Reforms

Using new data from the NAIC, I examined trends in premiums earned and loss ratios, by state, for 1985–2001.[33] I estimated two versions of the premium model. The first entered total earned premiums as the dependent variable, with total nonfederal physicians as an explanatory variable. The second model entered earned premiums divided by nonfederal physicians as the dependent variable. The key explanatory variables used in the regression are the state tort reforms and other factors (outlined below) influencing claims payments, claims frequency, and insurer costs. I also examined the impact of competition on premiums and profitability over time.

■ **State tort reforms.** *Damage caps.* Damages in medical malpractice cases fall into three general categories: noneconomic damages (pain, suffering, anguish), economic damages (lost wages and medical care expenses), and punitive damages, if conduct is viewed as malicious or in reckless disregard of plaintiffs' rights (these are rarely awarded). Only five states cap both economic and noneconomic damages, so I combined states that cap noneconomic damages or both noneconomic and economic damages into a composite "award cap" measure (twenty-four states by 2001). The empirical analysis was designed to assess the impact that award caps and caps on punitive damages, or not allowing punitive damages, have on profits and premiums.

Joint and several liability. Joint and several liability is the ability to collect the entire award from any liable defendant, independent of the degree of fault. This allows the plaintiff to collect from the group, or any individual provider,

the entire amount of the award. Tort reforms have limited this so that the defendant is not liable for more than his or her degree of fault and is not jointly liable with any other person for damages attributed to them.

Statutory caps on attorneys' fees. Attorneys in malpractice cases are generally paid a percentage of the award received by the plaintiff. These reforms limit the contingency fees attorneys may receive, which reduce the financial incentives to file a claim.

Collateral offset rule. This rule states that a plaintiff could recover the full amount of the reward even if the plaintiff received money from other sources such as health insurance or worker's compensation. Some states have adopted mandatory and discretionary offsets that reduce the award by the amount the plaintiff will receive from other sources, while other states allow the information on collateral sources to be entered as evidence before an award amount is determined. I use two measures in the analysis—one indicating whether the state had a mandatory offset for collateral sources, and a second for states that permit an offset for collateral sources.

In addition to state tort reforms, the analysis included other factors found by previous research to influence premiums and profits.[34] These include factors affecting the frequency of claims, including attorneys per capita, percentage of population in an urban area, unemployment rate, and the number of welfare recipients per 100,000 population. Factors affecting the severity of awards, such as surgical procedures performed per 100,000 population and per capita income, were also included. Finally, I examined the impact of competition on premiums and profits using the Hirschman-Herfindahl Index (HHI).[35]

The final data set included all fifty states and the District of Columbia (cross-sectional) over seventeen years (time series). Using both random and fixed-effects models, I regressed the (log) loss ratio and earned premiums on state dummies indicating whether the state had adopted each reform, and if so in what year.[36] The key results are presented in Exhibit 3. The model was estimated using both fixed- and random-effects models.[37]

■ **Empirical results.** The empirical results indicate that the caps on awards adopted by several states were associated with lower loss ratios and lower premiums (Exhibit 3). However, other than states with discretionary offsets, other tort reforms were not associated with lower premiums or improved profits. Loss ratios in states capping awards were 11.7 percent lower than in states without caps.[38] In addition, loss ratios were 13.3 percent lower in states with discretionary collateral offsets. Loss ratios were 25 percent lower in states that adopted both reforms. The impact of states with mandatory offsets on loss ratios was not significantly different from zero.

Premiums in states with a cap on awards were 17.1 percent lower than in states without such caps. When using earned premium per physician as the dependent variable, the caps were associated with a 12 percent reduction in

EXHIBIT 3
Impact Of State Medical Malpractice Tort Reforms On Loss Ratios And Premiums, Relative To No Tort Reforms

Performance measure	Awards caps	No punitive damage or punitive cap	Mandatory collateral offset rule	Discretionary collateral offset	Attorney fee caps
Loss ratio	−11.7% ($p = .06$)	NS	NS	−13.3% ($p \leq .10$)	NS
Total earned premium	−17.1% ($p < .05$)	NS	NS	NS	NS
Earned premium per physician	−12.7% ($p < .05$)	NS	NS	NS	NS

SOURCE: Author's analysis (regression results available upon request).
NOTES: Statistical findings denote difference from zero. NS is not significantly different from zero.

premiums. The analysis found no association between the adoption of other state tort reforms on loss ratios, premiums, joint liability, caps on attorneys' fees, or collateral offsets.

The results also highlight the effect of competition on premiums and loss ratios. Competition varies in the industry across states as well as over time. The results indicate that a 10 percent increase in the index (less competitive) is associated with a 2 percent increase in premiums ($p < .05$). Several states have seen considerable changes (both increases and decreases) in market competition during the past two decades. Some states, such as West Virginia, have become less competitive since 1996, while competition in other states has increased. The regression results indicate that the 20 percent rise in the HHI in West Virginia between 1996 and 2001 was associated with a 4 percent increase in premiums. The HHI increased by 80 percent during this period in Minnesota (associated with a 16 percent increase in premiums) but declined by 40 percent in Idaho. So at least in some states, the rise in market concentration has contributed to higher medical malpractice premiums. The impact of market concentration on loss ratios was not statistically significant.

"At least in some states, the rise in market concentration has contributed to higher medical malpractice premiums."

Conclusions

Physicians in several states are facing sharp increases in their medical liability premiums. As a result, some facilities have temporarily shut down; physicians in some states are reluctant to perform high-risk procedures; and early physician retirements appear to be on the rise.[39] These physicians, and their patients, are facing an important short-term crisis. A major part of the policy debate concerns the factors generating the large increases in premiums in some states. Rising severity is now a two-decade-old phenomenon in the industry. Several malpractice firms with substantial market shares in some of the hardest-hit states—Ohio, West Virginia, Pennsylvania, and Nevada—either left the market, became insolvent, or refocused their underwriting in their state of domicile. These trends caused substantial disruption in the medical malpractice marketplace in these states. Thus, a major part of the crisis in these states concerns both severity and the resulting impact on underwriting capacity among firms remaining in the market.

The analysis indicates that capping payments from malpractice carriers was associated with lower premiums.[40] Yet how should we interpret these results? At issue is whether we should adopt short-term, stopgap solutions to slow the growth in premiums, or use the recent experience to more fundamentally evaluate and perhaps reform the liability system. The recent spike in medical malpractice insurance premiums allows us an opportunity to reexamine whether the tort system is achieving its goals. If it isn't, what changes in the system would improve the dual goals of deterrence and compensation? The results suggest that capping awards may improve the profitability of malpractice carriers and reduce premiums. Whether this is socially desirable or improves the goals of deterrence and compensation remains an open question.[41]

Another key question is the extent to which the most recent premium spike simply reflects the insurance cycle and changes in market structure and competition. Alternatively, do the recent trends also reflect a structural and secular rise in the severity of awards that, absent reforms, will permanently change the traditional insurance premium cycle? In this case, physicians could face several more years of rising premiums. Although experience varies across states, the data do indicate a long-term increase in awards and settlements per paid claim. At issue are the factors that underlie these trends. Do they reflect increases in the incidence of negligent adverse events and substandard physician care? If so, simply capping awards will ultimately result in lower growth in premiums but will leave unchanged

the fundamental problem of rising substandard care.

Surprisingly, we know very little about trends in the rates of negligent adverse events over time. The two most cited studies, from California in the 1970s and New York in the 1980s, suggest that these rates have been constant. More recent studies from Colorado and Utah conducted in the 1990s produced similar results.[42] Clearly, more work in this area is required.

STOPGAP REFORMS (caps on awards) of our current liability system would ultimately result in lower premiums (relative to their levels without the caps). On the other hand, it is also important to evaluate any such reforms in the context of their ability to further the dual policy objectives of deterrence and compensation.

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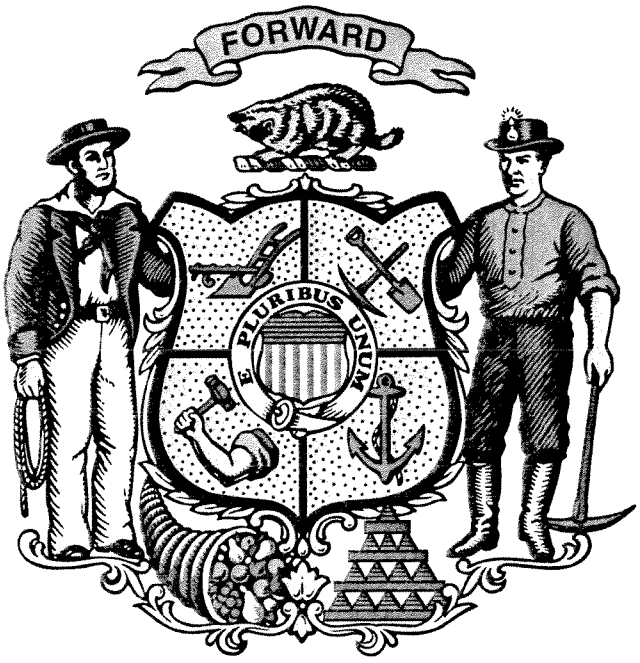
NOTES

1. See, for example, R. Bovbjerg, "Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card," *University of California, Davis, Law Review* 22, no. 2 (1989): 499–556.
2. As reported by *Medical Liability Monitor*, October 2003.
3. Tabulations from National Association of Insurance Commissioners, *Market Share Report—Medical Malpractice*, 1997–2001 (Kansas City: NAIC, various years).
4. American Medical Association, "AMA Analysis: A Dozen States in Medical Liability Crisis" (Chicago: AMA, 17 June 2002).
5. This broader combined loss ratio combined with the investment income ratio produces a measure of net income. This is a standard measure used by actuaries in medical malpractice firms to measure changes in calendar-year profitability.
6. See, for example, Jim Hurley, Tillinghast–Towers Perrin, testimony before the House Energy and Commerce Subcommittee on Health, "Harming Patient Access to Care: The Impact of Excessive Litigation," 17 July 2002. Much of the discussion in this section is based on my analysis of data from the NAIC. In addition, I benefited greatly from the analyses of Jim Hurley from his testimony and a recent study from the U.S. General Accounting Office, *Medical Malpractice Insurance, Multiple Factors Have Contributed to Increased Premium Rates*, Pub. no. GAO-03-702 (Washington: GAO, June 2003).
7. Actuaries use a variety of methods for establishing reserves for medical malpractice firms. Reserves are generally posted on a claim filed within ninety days of the date an expected loss is reported. Reserves depend on the number of claims filed, the firms' expectation of the percentage of claims that will result in a payment, expenses (defense costs), and the expected payout. Reserves are reported as part of the loss expenses incurred in each firm's statement of income. If reserves turn out too high (that is, expected payouts were lower than actual payouts), a credit on the income statement is taken in a later year. Therefore, expenses on an income statement reflect both actual benefit and loss payments during a year (for events that occurred in a prior year) and reserves for claims filed this year expected to result in a future payment. They also show up on the balance sheet as a liability.
8. Hurley, "Harming Patient Access to Care."
9. A.M. Best, *Aggregates and Averages*, 1997–2002 editions (Oldham, N.J.: A.M. Best, various years).
10. The precise impact will depend on the length of time it takes to resolve a claim. Some states with fast-track laws resolve claims faster than other states. The shorter the tail, the less impact a one-percentage-point change in investment returns will have on premiums.
11. Median jury awards plus median settlements per paid (awards plus settlements) claim, derived from the Physician Insurers Association of America (PIAA) data-sharing project. See L. Bartholomew, "Using PIAA Data: A Valuable Resource" (Washington: PIAA, 17 May 2002).
12. Missouri Department of Insurance, *Medical Malpractice Insurance in Missouri* (Jefferson City: Missouri Department of Insurance, February 2003). These data also indicate a rise in severity of injury per paid claim.
13. Bartholomew, "Using PIAA Data."
14. Illinois Department of Insurance, *Medical Malpractice Claims Study* (Springfield: Casualty Actuarial Section, 2001).
15. The St. Paul Companies, "The St. Paul Announces Fourth-Quarter Actions to Improve Profitability and Business Positioning," Press Release, 12 December 2001.

16. Market share data are from NAIC, *Market Share Reports*, 1994–2001.
17. Tabulations by author from NAIC, *Market Share Report by Line of Business—Medical Malpractice, 1995–2001* (Kansas City: NAIC, 2003).
18. Ibid.
19. However, the number of liability companies with closed claims still flowing through the system that report claims has likely declined here as well. For instance, the 2001 totals do not include claims from PHICO. So it is not clear whether the reports of falling claims frequency are real or simply an artifact of exiting companies' failure to report closed claims to the state.
20. See, for example, LAMMICO, "The Letter" (no date provided), www.lammico.com/letter/article.asp?letter_article_id=294&letter_id=35 (23 July 2003).
21. The scheduled 4.5 percent additional cut was recently replaced by a 1.5 percent increase in payments in 2004. See H.R. 1, *The Medicare Prescription Drug Improvement Act of 2003.*
22. Illinois Department of Insurance, *Medical Malpractice Claims Study.*
23. Bartholomew, "Using PIAA Data."
24. P.C. Weiler et al., *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (Cambridge, Mass.: Harvard University Press, 1993).
25. J.S. Kakalik and N. Pace, *Costs and Compensation Paid in Tort Litigation* (Santa Monica, Calif.: RAND, 1986).
26. Weiler et al., *A Measure of Malpractice*, 77–109.
27. Ibid., 70.
28. W.B. Schwartz and N.K. Komesar, "Doctors, Damages, and Deterrence: An Economic View of Medical Malpractice," *New England Journal of Medicine* 298, no. 23 (1978): 1282–1289.
29. See, for example, S. Shavell, "A Model of the Optimal Use of Liability and Safety Regulation," *RAND Journal of Economics* 15, no. 2 (1984): 271–280.
30. See, for example, L. Dubay et al., "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics* 18, no. 4 (1999): 491–522; F. Sloan et al., "Effects of the Threat of Medical Malpractice Litigation and Other Factors on Birth Outcomes," *Medical Care* 33, no. 7 (1995): 700–714; and Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Cambridge, Mass.: Harvard University, 1990), chaps. 8 and 10. For additional discussion concerning the paucity of published empirical work linking the threat of suit to lower rates of negligent adverse events (or a reduction in substandard medical care), see M. Mello and T. Brennan, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," *Texas Law Review* 80, no. 7 (2002): 1595–1637.
31. In some states plaintiffs can file a claim with its initial adjudication completed by a medical review panel. Plaintiffs can use this process for discovery, and if concurrence is received from the panel, the claim may proceed. Plaintiffs in other states must receive an expert (outside) validation or certificate of merit before the claim proceeds. Limited expenses are incurred under the first approach, while the latter approach provides some financial incentive not to file a claim with low likelihood of receiving a positive verdict.
32. The two most recent studies were conducted by W.K. Viscusi and P. Born, "Medical Malpractice Insurance in the Wake of Liability Reform," *Journal of Legal Studies* 24 (June 1995): 463–490, which evaluated the impacts through 1991; and by S. Zuckerman, R.R. Bovbjerg, and F. Sloan, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," *Inquiry* 27, no. 2 (1990): 167–182, which tracked the impact of state reforms through 1986.
33. NAIC, *Profitability Report* (Kansas City: NAIC, 2003).
34. See, for example, Viscusi and Born, "Medical Malpractice Insurance"; and Zuckerman et al., "Effects of Tort Reforms." Also see F. Sloan, P.M. Mergenhagen, and R.R. Bovbjerg, "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis," *Journal of Health Politics, Policy and Law* 14, no. 4 (1989): 663–689.
35. This is a standard measure of market concentration. It is simply the square of each firm's market share summed. Data on market shares were derived from the NAIC and from unpublished data from the Congressional Budget Office.
36. Data on state tort reform laws were initially developed using information from the Web site of a specialty law firm, McCullough, Campbell, and Lane, www.mcandl.com/states.html (30 July 2003). When information from this site was not clear, state insurance departments were asked for clarification. Finally, I compared these results with those used by the CBO to develop its estimates in developing H.R. 5, as seen at CBO, "H.R. 5: Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003," 10 March 2003, www.cbo.gov/showdoc.cfm?index=4091&sequence=0 (30 July 2003). The classification used in the analysis was identical to that used by the CBO.
37. I ran both fixed- and random-effects models for the premium and loss-ratio regressions. The results from the Hausman Test do not allow us to

reject the null hypothesis that coefficients estimated using random and fixed effects are the same. The fixed-effects estimate indicated that state award caps were associated with premiums that were 17.1 percent lower, and the random-effects estimate produced the same result. Thus, while the random-effects results are displayed, the fixed-effects results were the same for the tort-related variables. J.A. Hausman, "Specification Tests in Econometrics," *Econometrica* 46, no. 6 (1978): 1251–1271. Regression to the mean could also be an issue if states with high premiums adopting the award caps tended to return to the average over time. Thus, caps in high-premium states experiencing regression to the mean would appear more effective than laws in average- or low-premium states. Using 1985 data on states that had no award cap (about forty-five states), I estimated the premium regression (absent the tort variables). I estimated a second regression using the residuals (from the 1985 regression) as the dependent variable, a dummy set to 1 if the state ultimately adopted an award cap, as well as the other independent variables outlined in the text. If regression to the mean were an issue, the coefficient on the dummy variable would be positive and significant (that is, high-premium states adopted caps). The t-statistic on the dummy variable in this regression was −0.22. Since there was no apparent relationship here, there would be minimal (if any) bias due to regression to the mean. For a related test, see D. Dranove and K. Cone, "Do State Rate Setting Regulations Really Lower Hospital Expenses?" *Journal of Health Economics* 4, no. 2 (1985): 159–165.

38. The percentage changes reported here took each dummy variable from the log model and transformed them to a percentage change using the methods outlined in P. Kennedy, "Estimation with Correctly Interpreted Dummy Variables in Semi Logarithmic Equations," *American Economic Review* 71, no. 4 (1981): 801.
39. In a recent Georgia survey of physicians, a third of obstetrician/gynecologists and a fifth of family practitioners stated that they would stop performing high-risk procedures. Another 12 percent noted that they would not cover the emergency room in the future. *BNA's Health Care Policy Report* 11, no. 5 (2003): 162.
40. This means that premiums are lower than they would be in the absence of award caps. It does not imply that the premiums decline. Premiums in states with award caps have risen over time, but they are lower than they would be absent the award caps.
41. At issue is whether the reforms would reduce deadweight loss associated with defensive medicine and costs of administering the system and improve deterrence and compensation. Some commentators are dubious about the prospects. See P. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (Cambridge, Mass.: Harvard University Press, 1985). However, any such analysis must also consider the impact that high premiums have on the availability of and access to medical care services.
42. California Medical Association and California Hospital Association, *Report on the Medical Insurance Feasibility Study*, ed. D.H. Mills (San Francisco: CMA/CHA, 1977); and D. Studdert et al., "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care* 38, no. 3 (2000): 250–260. These studies have generally concluded that approximately 3.7 percent of hospital admissions are associated with an adverse event and that approximately a quarter of these are due to negligence.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Comments

*759 ADDRESSING THE IMPROPRIETY OF STATUTORY CAPS ON PAIN AND SUFFERING AWARDS IN THE MEDICAL LIABILITY SYSTEM

Elizabeth Stewart Poisson

Introduction

In the mid-1970s, legislators responded to a decrease in the availability of affordable health care that many constituents blamed on a "crisis" in the medical malpractice insurance market. [FN1] A second surge in medical malpractice premiums in the mid-1980s encouraged *760 many legislators to again introduce legislation designed to reduce malpractice premium rates. [FN2] Today, in the throes of yet another inhospitable insurance market, national sentiment again asks for a solution. [FN3] These three liability insurance "crises" share the same basic features: cancellation of malpractice insurance policies, increasing medical malpractice insurance premiums, and fewer insurers willing to cover doctors. [FN4] In the mid-1980s, insurance companies blamed "'frivolous lawsuits' and 'out of control' juries" just as insurance companies did in the 1970s and continue to do today. [FN5]

When responding to public concern over a perceived medical malpractice crisis, legislators continue to favor statutory caps as a panacea for elevated insurance premiums and physician attrition. [FN6] Caps, however, are a unilateral solution that fails to address each of *761 the three parties involved in the malpractice debate adequately--the legal community, the medical profession, and the insurance industry. Efforts to place caps on pain and suffering awards [FN7] at the state and federal levels threaten to sacrifice an injured patient's right to just compensation in exchange for a potentially ineffective solution to rising malpractice premiums. Many factors make caps an unattractive and infeasible means for solving the current malpractice insurance crisis. The cyclical nature of insurance premium fluctuations, the current state of confusion in the jury's methodology for determining pain and suffering awards, and the vital role that pain and suffering awards play in plaintiff compensation, all reinforce the need for more

comprehensive solutions to this crisis.
Part I.A of this Comment explores how reports of rising health care costs, physician attrition from certain regions and practice areas, and increasing malpractice premiums make constituents believe in the existence of a malpractice crisis that threatens to impair the medical profession severely. Part I.B describes pain and suffering damages and their function in medical malpractice cases. Part II identifies the major players in this debate on medical malpractice reform--the medical profession, the legal community, and the insurance industry--and shows how each blames the others for increasing medical malpractice premiums. [FN8] Part III illustrates that thus far, the favored solution addresses only the legal community's role in medical malpractice by enacting statutory limits, or caps, on pain and suffering damages in such suits. Part IV discusses how caps on pain and ***762** suffering awards sacrifice an injured patient's right to just compensation in exchange for an inadequate solution to a perceived crisis. [FN9] Part V suggests an alternative, three-pronged response that addresses each player's role in effecting a solution that would control medical malpractice insurance costs while preserving the opportunity for just patient compensation.

I. Defining the Issue

A. The Medical Malpractice Insurance Market

When the cost of malpractice coverage for physicians increases, a common belief surfaces that health care costs will follow suit. [FN10] Due to the consistently poor underwriting performance of medical malpractice insurance, such coverage is already one of the more expensive types of insurance available. [FN11] Some commentators also hypothesize that physician and hospital earnings suffer when ***763** malpractice premiums increase. [FN12] Such financial pressure may induce physicians, particularly specialists, to go on strike, retire early, change to other areas of practice, or relocate to states with lower premiums. [FN13]
Insurers generally assign malpractice premiums by evaluating the amount of risk that they think each applicant poses. [FN14] Insurance providers may consider any number of physician risk factors in their analyses. [FN15] They calculate total risk based on this physician risk analysis as well as on outside economic factors. [FN16] Sometimes, insurers decide to take a broader approach and set premium rates for each practice area in each region of a state. [FN17] For the same reasons, ***764** premium rates also vary between states. [FN18]
This process of assigning premiums reflects the general practice common to all liability insurers--putting applicants into specific groups that each represent various levels of risk. [FN19] For example, neurosurgeons frequently perform specialized, high-risk surgery, while general practitioners rarely engage in surgery at all. Neurosurgeons, therefore, will likely have a higher probability of facing large malpractice claims than general practitioners. [FN20] As a result, insurers tend to assign higher premiums to neurosurgeons. [FN21]

B. Pain and Suffering Awards

In contrast with this objective assessment of risk lies the subjective determination of pain and suffering awards. These awards serve a vital role in compensating injured patients. The purpose of pain and suffering awards, as of all compensatory damages, is to restore an injured patient to her pre-injury condition. [FN22] The egregiousness of the defendant's negligence does not factor into the jury's calculation of compensatory damages because the focus rests on making the injured patient whole rather than punishing the defendant's culpability. [FN23]
Every jurisdiction in the United States "recognize[s] an injured person's right to recover damages for pain and suffering" associated ***765** with a physical injury. [FN24] Adequate compensatory malpractice damages, therefore, must include an award for pain and suffering that compensates an injured patient for the past and future physical and mental suffering associated with his injury. [FN25] The numerous intangible injuries that

a patient suffers in conjunction with a physical injury receive recognition through this broad concept of a pain and suffering award. [FN26] Courts recognize the legitimacy of these more subjective injuries, even though the injuries are not objectively quantifiable or considered in economic damages. [FN27] Non-economic damages, therefore, must act as the vehicle for compensating pain and suffering. [FN28]

The intangible nature of these injuries makes it difficult for jurors to assign a dollar value to pain and suffering awards. [FN29] The subjectivity of such injuries is unavoidable: "[T]he victim alone experiences and can accurately describe each intangible harm; hence, how she feels or perceives the injury is most relevant to a determination of compensatory damages." [FN30] The jury must in turn rely on its perception of the plaintiff's pain and suffering to determine damages, and jurors may grant pain and suffering awards subjectively based on the credibility of the victim and other witnesses. [FN31] This ***766** reliance on descriptive testimony, juror perception, and the severity of the plaintiff's injury cause jury awards for pain and suffering to vary. [FN32]

Lack of guidance from the legal community further increases the variability of pain and suffering awards. Trial courts often give jurors only vague guidance as to how to evaluate pain and suffering. The standard jury instructions for determining pain and suffering damages ask each juror to use his own common sense, experience, and fairness to guide him in deciding on a number to represent the value of the injured patient's intangible losses. [FN33] Jurors may rely heavily on attorney presentations in determining pain and suffering awards because the guidelines that the court presents are not helpful during deliberations. [FN34] Attorneys may then further confuse jurors by employing tactics during closing arguments that while designed to aid jurors in the determination of a suitable award, actually complicate the process. [FN35]

***767** Other factors impede any attempt to obtain consistency in pain and suffering awards. In trying to discern the "correct" number to represent a patient's pain and suffering, jurors further confuse the process of determination. [FN36] They often consider factors that may be irrelevant in determining just compensation for pain and suffering. [FN37] These variables in juror consideration lead to a distinct fluctuation in the size of pain and suffering awards, largely because jurors from case to case fill in the gaps in the guidelines that they receive in different ways. [FN38]

II. The Three Players: Lawyers, Insurers, and Doctors

In order to understand this clash between medical malpractice insurance and pain and suffering damages completely, it is important to comprehend all of the perspectives surrounding the debate. President George W. Bush, insurance providers, and physician groups, such as the American Medical Association ("AMA"), publicly blame lawyers and the medical malpractice liability system for the current rise in malpractice insurance premiums. [FN39] This ***768** popular argument targets attorney contingent fees as a major source of increasing premiums. [FN40] Opponents of this fee arrangement cast sizeable contingent fees as an inducement for attorneys to "cash in" on medical malpractice cases. They argue that the size of medical malpractice verdicts and, hence, of attorney contingent fees is on the rise, which in turn leads to an increase in the number of medical malpractice cases filed by plaintiffs' attorneys. [FN41]

Trial attorneys and consumer protection groups, such as Public Citizen, blame the insurance industry and its response to the recent economic downturn for the increase in malpractice premiums. [FN42] These groups argue that the insurance industry's lack of economic foresight and the current bear market caused the recent premium hikes. [FN43] Statistics show a four percent reduction in medical malpractice cases from 1995 to 2000. [FN44] Data collection beginning in ***769** 1975 also suggests that insurance premiums generally rise only during recessions, whereas insurance industry payouts follow medical inflation rates. [FN45] This information leads opponents of caps to believe that the insurance industry is at fault for rising malpractice premiums.

When the insurance industry uses income from investments to pay claims, and investment returns dwindle, insurers must increase premiums to make up the difference. [FN46] Insurance companies profited from the stock market boom in the late

1990s and later miscalculated their needs. [FN47] This miscalculation induced insurance carriers to keep premiums low in order to draw new revenue to increase their market investments. [FN48] In recent years, however, the absence of stock market gains prevents insurers from subsidizing low rates for premiums. [FN49]

***770** A few critics blame the medical profession for the increase in malpractice insurance premiums. [FN50] A small percentage of the total number of physicians caused the majority of the medical malpractice payouts made over the past decade. [FN51] By regulating its physicians more strictly, the medical profession could reduce incidences of malpractice and improve patient treatment. Better disciplinary practices within the profession could identify offending physicians, remove them from practice, and prevent their negligence from driving up medical malpractice premiums.

Implicit, yet rarely recognized, in this debate over the cause of increasing malpractice insurance premiums is the understanding that none of these three groups is solely to blame for the current state of the liability insurance market. One important reason to look at this problem as a shared responsibility, rather than as a crisis created by a single group, is the unfortunate truth that information on this subject is sparse and inconclusive. [FN52] The very players involved in this debate--insurers, doctors, and lawyers--largely constitute the membership of the groups collecting the information. [FN53] For example, groups such as the AMA offer statistics about ballooning jury awards, while consumer groups on the other side of the debate provide evidence that payouts continue to rise only gradually. [FN54] This difficulty ***771** in finding cohesive empirical data on medical malpractice issues illustrates the hesitancy of each of these three major players to realistically assess and report their role in the debate. The resulting uncertainty in data emphasizes the importance of analyzing the various theories of blame to determine how the active players can adjust their practices to address the perceived liability insurance crisis. [FN55]

III. Statutory Caps: A Unilateral Solution

A. An Overview of Caps

Variance in the size of pain and suffering awards and increasing insurance premiums induce legislators to provide predictability to non-economic awards by imposing statutory caps. [FN56] The popularity of caps in state and federal legislatures creates the impression that legislators consider caps the most effective means for curbing malpractice insurance premiums. [FN57] In jurisdictions with statutory caps, the jury will often determine damages according to the general rules governing the award of damages, and then the judge will modify the jury's award to conform to the maximum amount allowed under ***772** the statutory cap. [FN58] Although patients have challenged such caps on equal protection, due process, and independent state constitutional bases, appellate courts have generally upheld statutory caps on non-economic damages as constitutional. [FN59]

Proponents of statutory caps limiting non-economic damages cite multiple arguments in favor of their position. One argument alleges that pain and suffering awards by their nature are too intangible to allow jurors to make any legitimate pecuniary evaluation and, therefore, require standardization through fixed statutory caps. [FN60] Proponents of caps also argue that upholding the overarching goal of lowering insurance costs and preventing a windfall recovery to plaintiffs requires statutory caps on damages. [FN61] A third rationale posits that statutory caps are necessary because unlimited pain and suffering awards have the potential to take on an unfairly punitive nature. [FN62] These arguments, when coupled with the less restrictive nature of non-economic caps as compared to other types of caps, encourage legislators to enact statutory limits to solve insurance crises.

It is difficult, however, to discern the methodology that legislators use in assigning a specific dollar amount to these statutory ***773** caps. Sometimes the legislators voting on caps claim that they do not understand the numbers themselves. [FN63] One method that legislators have used in the past looks at previous medical malpractice payouts and

sets a number in sync with those prior awards. [FN64] The AMA and other interested parties can also propose numbers for these caps. [FN65] Other legislators may simply "pull [a number] out of the air." [FN66] However, a general public policy rationale does pervade most of this legislation, as legislators seemingly tend to choose a number that they believe will best achieve their stated purpose of reducing jury awards to alleviate the cost of insurance premiums. [FN67]

The $250,000 figure that frequently appears in proposed caps enjoys widespread use largely because it is the amount of California's seminal statutory cap on non-economic damages. [FN68] Pro-cap legislators in other states perceive California's law as a successful attempt at lowering medical malpractice premiums, so they propose to adopt the same parameters. [FN69] One glaring problem with this $250,000 amount is that California's legislature selected the figure as a fair cap in 1975. Adjusted for nearly thirty years of inflation, a $250,000 cap today is the equivalent of about a $72,000 cap in 1975. [FN70]

***774** Though information illuminating the rationale behind adopting the $250,000 figure for today's non-economic damages is sparse, what little explanation that is available does not discuss valuation in terms of just patient compensation. [FN71] Rather, proponents of this figure fail to consider what amount will allow just patient compensation for non-economic injuries and focus solely on finding a figure that will hopefully drive insurance costs for physicians down to an acceptable level. [FN72] This omission of the injured patient's perspective ignores the primary function of non-economic awards: just compensation of patients for the intangible injuries associated with medical negligence. [FN73]

Partisan politics also come into play in this debate generally with Republicans supporting caps and Democrats opposing them. [FN74] Commentators view Democrats, plaintiffs' attorneys, and consumer rights groups as trying to thwart caps and preserve the rights of the common person. [FN75] On the other end, President Bush and the Republican majority appear to rally behind insurers and doctors, the very groups pouring money into Republican fundraising efforts. [FN76] The debate morphs into corporate America versus the little guy, with legislators at both ends refusing to compromise on the form and substance of any medical malpractice legislation. [FN77] The most obvious indicator of this stalemate appears in the failure of these proposed ***775** caps to pass through both houses of Congress. [FN78]

B. MICRA: A Case Study

Notwithstanding this stalemate at the federal level, many states have enacted statutory caps in response to steep increases in medical malpractice insurance premiums. [FN79] Assessing the effectiveness of prior attempts to solve medical malpractice crises through statutory caps is helpful in evaluating the merits of enacting new caps today. These early caps continue to serve as models for much of Congress's recent legislation. [FN80] Prior legislation also provides the impetus for continuing to explore the potential of caps to curb malpractice insurance premiums. [FN81]

In 1975, California enacted the Medical Injury Compensation Reform Act ("MICRA") to alleviate the insurance crisis of the mid-1970s. [FN82] At the time, medical malpractice insurance premiums were increasing rapidly and physicians had begun to feel the effects. [FN83] Some physicians allegedly limited their practice areas, while others ***776** began practicing without insurance. [FN84] In response, California legislators attempted to reform the medical malpractice liability system by capping non-economic damages at $250,000. [FN85] Immediately following MICRA's passage, malpractice premiums for California physicians declined by about twenty-five percent. [FN86] Data compiled by the United States General Accounting Office show that direct losses incurred by insurers in California also fell between 1975 and 1981. [FN87]

In the mid-1980s, however, direct losses incurred by California's medical malpractice insurers increased to beyond pre-MICRA levels before again declining in the late 1980s. [FN88] Similarly, incurred losses nationwide rose to a high of almost seven billion dollars in 1986 before dropping to a low of about four billion dollars in 1991. [FN89] Trends in

direct losses incurred in California and across the nation mirrored one another from 1975 to 2001. [FN90] Data indicate that after the first fifteen years, MICRA had little effect on trends in California premiums, as they continued to fluctuate in accord with the national average. [FN91] Some groups further argue that the rates only fell to such a low price after 1988 due to the passage of Proposition 103, which regulated the insurance industry and required approval from the insurance commissioner for rate changes. [FN92] The medical profession, however, credits MICRA with the drop in rates in the early 1990s. [FN93]

***777** Proponents of MICRA argue that evidence that trends in the nation and California mirror one another does not prove that MICRA did not work. [FN94] Rather, they focus on the notion that MICRA prevented California's premiums from rising at the same rate as the nation's premiums, even if the two sets of numbers followed the same trends. [FN95] In California, the average highest premium increase in 2002 was twenty percent, while in North Carolina it was fifty percent, and in Georgia it was thirty-seven percent. [FN96] Other statistics indicate, however, that premiums in California rose about thirty-seven percent over the last four years, while the national average increased only a little over five and a half percent. [FN97] Ultimately, these variances in data show that a reliable assessment MICRA's efficacy may not be possible. With such uncertainty surrounding caps and what, if any, effect they may have to lower malpractice premiums, it is important to remember that any small difference in physician payment comes at the cost of inadequate patient compensation. [FN98]

C. Statutory Caps in Other States

Other states have enacted caps similar to California's with varying degrees of success. West Virginia enacted a one million dollar cap on non-economic damages in 1986. [FN99] In 2003, however, ***778** West Virginia legislators reduced this cap to $250,000. [FN100] Physicians in West Virginia complained that medical insurance premiums continued to rise because the statutory limit on non-economic damages enacted in 1986 was not aggressive enough to limit the growing number of excessive jury verdicts. [FN101] Opponents of caps contend that malpractice payouts in West Virginia stayed steady over the past decade and that premium inflation directly tracked the path of the national economy. [FN102]

Alabama enacted legislation in 1987 that limited all non-economic damages, including pain and suffering and punitive damages, to $400,000. [FN103] As a result, Alabama's medical malpractice awards are significantly lower than those in most states. [FN104] Even so, many physicians and health care providers saw a marked increase of forty to fifty percent in their malpractice insurance premiums in 2001. [FN105] This increase indicates that the size of malpractice payouts that insurance companies make in Alabama does not necessarily determine the size of malpractice premiums for physicians in the state. [FN106]

Both West Virginia and Alabama experienced the same patterns in the size of malpractice premiums following tort reform as California experienced, ultimately seeing an increase in the amount of ***779** medical insurance premiums notwithstanding the enactment of statutory caps. [FN107] Although analysis of the effects of these states' statutory limits varies according to the source of the analysis, both sides of this debate challenge the efficacy of past statutory caps. Supporters of caps feel that premiums have increased in these states because the original legislation did not impose sufficiently strict limits. [FN108] Cap opponents, on the other hand, argue that these laws did not achieve their desired effect because the correlation that exists between the size of malpractice insurance premiums and the size of malpractice payouts is insufficient to counter the variety of other factors that influence the size of insurance premiums. [FN109] The preceding analysis indicates that such fixed caps are not sufficiently successful in controlling malpractice premium costs to justify denying patients just compensation for their intangible injuries.

IV. Balancing an Effective Solution with the Needs of Patients

A. Static Caps Versus Subjective Awards

Legislators complain that jury awards for pain and suffering damages become arbitrary and unpredictable without caps. [FN110] Ironically, assigning rigid caps to such an undefined process as that used in determining pain and suffering awards makes the numbers chosen for these caps even more arbitrary than the numbers that jurors assign to an injured patient's pain and suffering. [FN111] Caps are static limits that apply regardless of the variety of facts that may exist in specific medical malpractice cases. [FN112] The current state of ***780** ambiguity surrounding jury determinations of pain and suffering awards creates an unworkable environment for such uniform caps. In order to enable legislators to assign valid numbers to these caps, courts need to better define the rules for determining pain and suffering awards. [FN113] Until judges, legal scholars, and attorneys clarify the proper methods for jurors to use, legislators are in no better position than jurors to decide what constitutes a just pain and suffering award. Legislators, in fact, may find themselves in a worse position than jurors when attempting to enumerate caps. As actors far removed from the courtroom, legislators do not have the benefit of a judge's guidance or a case's facts to guide then in assigning these caps. When jurors make their award of damages, they presumably have the judge, specialized jury instructions, and the facts of the case aid them. Legislators would likely not have the benefit of any of these tools in determining what would be an appropriate cap to apply to non-economic damages in such suits. Granted, legislators would have the benefit of testimony and statistics in their deliberations, but the partisan nature of these sources discredits strong reliance on the information that they present. [FN114]

However, public policy concerns, specifically a focus on the welfare of the national health care system and the national insurance system as a whole, may dictate that legislators are in a better position than jurors to assign values to pain and suffering awards. [FN115] This public policy rationale considers the greater good of the medical liability system over the fact-specific situation of each individual plaintiff. Jurors look solely at the injured patient in the case at hand, and legislators consider the good of the greater malpractice system when assigning a number to represent an adequate pain and suffering award. [FN116] This difference in focus between legislators and jurors indicates that the two groups likely have very different agendas when valuing pain and suffering.

A more cynical view of the push to place valuation of these awards in the hands of legislators emerges with this public policy ***781** argument in favor of caps. Some skeptical legislators see the push to enact caps as a move to take the role of jurors and put it in the hands of elected officials. [FN117] In usurping this power, pro-cap legislators implicitly claim that they are wiser than jurors and, therefore, will do a better job valuing pain and suffering. [FN118] The irony of this position appears when legislators remind one another that the very jurors that they seem to deem incapable of rendering just awards are trusted to elect them to office every term. [FN119]

The Supreme Court of New Hampshire addressed the issue of reconciling the rigid nature of statutory caps on damages and just pain and suffering awards in Carson v. Maurer. [FN120] The rationale that the court applied in its decision embraces many of the common criticisms of caps. The court determined that the New Hampshire legislature's cap on non-economic damages in medical malpractice cases did not eliminate frivolous suits and instead prevented deserving plaintiffs from receiving just compensation. [FN121] The court further reasoned that it would be unfair to impose the burden of solving the problem of exorbitant insurance premiums solely on injured patients, the persons most in need of just compensation. [FN122] Due to the fact that no economic formula existed for calculating pain and suffering damages, the court decided that remittitur would be a better means of resolving excessive damage awards. [FN123] The court concluded that partial recovery cannot equal total compensation. [FN124] These arguments addressing the infeasibility of reconciling caps and pain and suffering awards indicate that current processes for valuing pain do not mesh with the rigidity of statutory

caps.

*782 B. Recent Cases

A complete analysis of the relationship between statutory caps and patient compensation must illustrate the true impact of statutory caps on an injured patient's ability to gain just compensation. Many of the statutes that state and federal legislatures have considered recently have used MICRA's cap level of $250,000. [FN125] It is informative to consider examples of how caps work in practice. Several recent medical malpractice cases illustrate some of the difficulties in reconciling caps and just compensation.

Critics of statutory caps on damages cite the injustice of applying a rigid cap to patients with a variety of injuries and losses in support of their position. [FN126] Take the case of Ben Johnson, a sixty-seven year old diabetic who received the statutory limit of $250,000 as compensation for non-economic injuries resulting from the medical malpractice of his thoracic surgeon. [FN127] While Johnson did not contest the amount of damages awarded him for this injury, a patient with different attributes might act differently. For example, imagine that Johnson, rather than a sixty-seven year old diabetic, is actually a twenty-four year old diabetic in the same situation. In this hypothetical, Johnson, a younger adult who receives negligent post-operative care for an operation on his leg, must also be compensated for the pain and suffering associated with facing the rest of his life without the use of that limb. [FN128] The only variance in this hypothetical involves the duration of Johnson's life. To compensate the younger Johnson to the same extent as the elder Johnson, the life expectancy that the jury used in determining the sixty-seven year old Johnson's future pain and suffering must be increased by a number of years.

A statutory cap, however, would prevent the younger Johnson *783 from receiving additional compensation for his additional years of suffering. The problems of such a proposition are evident. A subjective evaluation of the degree of pain will often conflict with the objective duration of another patient's life. For instance, when a jury awards the maximum statutory award for pain and suffering to a more mature patient, a younger patient with exactly the same injury will necessarily be slighted in his award by a statutory cap. The issue does not involve a variation in the degree of pain and suffering; rather, it involves a difference in the duration. Under the common sense approach to just compensation, the twenty-four year old Johnson should recover an amount several times larger than the amount of the elder Johnson's future pain and suffering award because the younger Johnson's life expectancy is several times longer. [FN129]

Another criticism of statutory caps on pain and suffering damages examines just compensation for severely injured patients in conjunction with the stated goals of statutory caps on damages. Statutory caps generally propose to "stabilize insurance risks and reduce malpractice insurance rates." [FN130] Limits on damages reduce such risks by ensuring that insurance providers will never have to pay more than the statutory maximum. [FN131] Though this minimization of risk serves a public policy role by providing more predictability in medical malpractice awards, it shifts the focus away from the individual malpractice victim by assigning a maximum value to non-economic awards without looking at the facts of each case. Due to this shift in focus, many severely injured patients will likely receive inadequate awards for pain and suffering because the severity of their injuries does not factor into legislators' designation of caps on damages. These severe injuries cost insurers a great deal of money in incurred losses, but they cost severely injured patients even more in the long run. [FN132]

In one of the largest jury awards of 2001, an injured boy received *784 a $107.8 million judgment for severe brain damage that he suffered at birth. [FN133] The New York jury awarded the boy a total of $72 million to compensate him for his past and future pain and suffering. [FN134] The attending physicians that delivered the plaintiff were negligent in observing him after birth, and this negligence allowed him to contract meningitis, which in turn caused cerebral palsy. [FN135] This boy, now twelve, remains

confined to a wheelchair, requires twenty-four-hour care, and cannot speak or use his hands. [FN136]

Although this boy's experience sounds incredibly compelling, an award of $72 million for total pain and suffering is staggering. The fact that the boy suffers from a type of cerebral palsy that cripples his body while leaving his mind untouched may justify the award. [FN137] Rather than focusing on this extraordinary figure, however, imagine what this boy's award would be under some of the caps recently in front of legislators. An injury that a New York jury valued at $72 million would be compensated at only $250,000. While $72 million may be excessive, this lower amount, the statutory maximum allowed under MICRA and its progeny, surely would not compensate this boy for sixty-four years of such torment. A more acceptable cap might work on a sliding scale to provide an amount for pain and suffering that varies in proportion to the severity of the injury and the length of time that the victim must live with that injury. [FN138]

Often, less severely injured patients will find adequate compensation notwithstanding such statutory limits because their total damages will already be less than the cap. [FN139] Patients with more severe injuries, however, will likely need greater compensation to deal with the greater emotional trauma, greater amount of pain, and the general greater impact on their lives. If only a fraction of medical malpractice cases involve severely injured patients, then these caps would cut awards in only a small number of cases each year. The imposition of such caps would deprive severely injured patients most ***785** in need of compensation in exchange for little overall economic benefit to the medical profession. [FN140]

Limiting the amount that an injured patient may receive in compensation for pain and suffering before the patient ever enters the courtroom contradicts the principle that pain and suffering awards are a necessary component of total compensation in a medical malpractice action. [FN141] Both society and the legal system recognize pain and suffering as a legitimate personal injury. [FN142] In naming pain and suffering a legitimate injury, the legal system recognizes that an award compensating this injury should correspond directly to the severity of the plaintiff's past and future pain and suffering. [FN143] The inclusion of pain and suffering awards under the heading of compensatory damages further supports this recognition because the goal of compensatory damages is to return the plaintiff to pre-injury status. [FN144] Caps necessarily shift part of the focus of pain and suffering awards from fully compensating the injured patient to the welfare of the greater medical liability system. [FN145] Setting such a limitation on pain and suffering awards indicates to injured patients that the court will ensure full compensation for their pain and suffering as long as they did not suffer more than the statutory limit.

Other arguments against capping pain and suffering awards cast these awards as a means of reparation for the other injustices that injured patients suffer. Litigating medical malpractice actions carries an enormous financial burden. Some opponents of caps argue that large pain and suffering awards allow injured patients to recover ***786** attorney expenses indirectly. [FN146] In accord with this theory is the idea that pain and suffering awards provide an injured patient with the opportunity to retaliate against the defendant in the event that other damages do not adequately compensate her injuries. [FN147] While such reasoning does not support the traditional purpose of pain and suffering awards, it does voice public sentiment that defendants in medical malpractice actions get off too easily and that plaintiffs do not receive adequate compensation. [FN148] Scholars, however, recognize this type of argument to be the weakest advanced in opposition to caps because it strays from the true purpose of pain and suffering awards. [FN149]

V. A Trilateral Approach to a Trilateral Issue

Legislators have repeatedly offered statutory caps on damages as a solution to insurance crises over the past three decades. [FN150] Statutory caps, rather than yielding the significant relief that legislators promise, seem to have their major impact

on the rights of injured patients. [FN151] The cyclical fluctuation of insurance premiums, confusion in the jury's methodology for determining pain and suffering awards, and the vital role that these awards play in plaintiff compensation all reinforce the need for alternative solutions to increasing insurance premiums. The debate over medical malpractice insurance involves ***787** three major players--the legal community, the medical profession, and the insurance industry. [FN152] Any meaningful attempt to curtail the costs of malpractice premiums while protecting an injured patient's opportunity for just compensation must address problems in all three areas and offer reform across the board.

A. Solutions in the Legal Community

While ample room for reform exists in the legal liability system, statutory caps on damages are not the best way to achieve the important objectives of reducing malpractice premiums and ensuring adequate patient compensation. Rather, the legal community should make substantive and procedural changes to provide jurors with more guidance in determining pain and suffering awards. These solutions involve judges, jurors, attorneys, and legislators in the endeavor of compensating only meritorious claims and legitimately proven injuries with reasonable pain and suffering awards.

A possible solution that at least one commentator suggests involves a system of "no-fault" judgments to deal with medical malpractice issues. [FN153] This system would discard malpractice insurance and instead ask patients and health care providers to contribute to a patient compensation fund. [FN154] Under this regime, physicians would be responsible for reporting their own mistakes. [FN155] A benefit of no-fault judgments would be that physicians would avoid high malpractice insurance premiums and liability. [FN156] In practice, however, physicians may find themselves just as hesitant to come forward for fear of losing their licenses, suspension, or generally drawing attention to their own mistakes.

A less radical, and perhaps more feasible, approach would focus on refining the current medical liability system. Within the current system, judges in medical malpractice trials should police attorneys to ensure that evidence irrelevant to the determination of pain and suffering awards is not admitted in conjunction with proof of that aspect of the patient's injury. [FN157] Studies show, for example, that jurors ***788** are prone to improperly consider evidence of wrongdoing when making compensatory damage findings. [FN158] Judges, therefore, must prevent attorneys from tying such evidence into arguments designed to aid the jury in determining pain and suffering damages. [FN159]

Courts must also ensure that jurors receive proper instruction as to the purpose of pain and suffering damages in their jurisdiction. [FN160] Specifically instructing jurors on what they may and may not consider in deliberations, on what the award purports to compensate, and on proper valuation methods would give jurors greater guidance in determining pain and suffering awards and would lessen large variances between awards. [FN161] Similarly, courts must give jurors ***789** proper instructions on the methods used to estimate pain and suffering awards in their jurisdictions.

As part of offering greater specificity in instruction as to the purpose of pain and suffering damages, judges, attorneys, and legal scholars should take steps to arrive at a consensus as to the proper methods for determining these damages. [FN162] This consensus would clarify the process for jurors and ensure more predictability in jury awards among the states. [FN163] Although different jurisdictions employ different methods, currently jurisdictions allow attorneys to argue for pain and suffering damages in three main ways. [FN164] Some courts allow attorneys to ask for a single, total sum for pain and suffering; some allow attorneys to ask for a total sum and a per diem sum; and some disallow attorneys from asking for any specific sum of money altogether. [FN165]

Making the effort to come to a consensus in the legal community as to the best methods for valuing pain and suffering damages would set the stage for federal legislators to follow suit and propose justifiable statutory limits on pain and suffering damages.

[FN166] Admittedly, different jurisdictions employ different methods for valuing pain and suffering in their courts. When state legislators undertake the process of promulgating statutory caps, however, they should look to the laws of their jurisdiction and employ the proper methods to ensure fairness. This application will be difficult because legislators will not have the factual specifics of a case to consider in ***790** making such determinations, but some legal guidance is better than none at all.

Legislators often accompany caps on damages with limits on the contingent fees that plaintiffs' attorneys charge in medical malpractice actions. [FN167] Many members of the defense bar and other critics outside of the legal community continue to see contingent fees as a windfall for plaintiffs' attorneys. [FN168] However, important policy considerations help to justify contingent fees in malpractice cases. Attorneys litigating medical malpractice cases incur great expense. [FN169] Also, litigating against the insurance industry, which has larger resources than most injured plaintiffs or their attorneys, requires a significant amount of capital. Contingent fees allow plaintiffs' attorneys to take cases for indigent clients by relying on sizeable fees from other successful cases, by taking a risk up front that successful litigation will cover the costs of the trial, and by providing a fee that creates further incentive for attorneys to continue to take cases on a contingent fee basis. [FN170]

Placing reasonable limits on contingent fees, limits that take these policy considerations into account, would provide injured patients with greater opportunities for compensation. [FN171] Many ***791** injured patients bringing suits against medical providers are indigent and unable to pay attorneys' fees and litigation expenses. By charging for their services on a contingency basis, attorneys allow low-income plaintiffs to seek justice despite the client's personal lack of capital. Severely restricting or eliminating contingent fees would cut off access to the medical liability system for those indigent plaintiffs. Such a policy would sacrifice the rights of patients without exploring other avenues of relief in the legal community.

B. Solutions in the Medical Profession

Statistics from the National Practitioner Data Bank ("NPDB") show that since 1990, five percent of doctors in the United States accounted for over half of all malpractice payouts. [FN172] Greater policing of this minority of negligent doctors would eliminate repeat offenders and reduce the incidence of medical malpractice. [FN173] Currently, some efforts to curb malpractice are in place. For example, Congress created the NPDB as a federal initiative designed to improve the quality of medical care. [FN174] This discrete monitoring system should alert state medical boards to problems in the ranks and in turn reduce the number of injured patients and subsequent malpractice payouts. [FN175] NPDB's anonymity, however, prevents the public from knowing about medical errors. In the absence of greater public access to information about problem physicians, more self-regulation is needed to protect both patients and physicians from the negligence of a few bad actors.

Encouraging state medical boards to increase enforcement of state medical practice acts and to discipline offending physicians ***792** would improve the chances of preventing future malpractice. [FN176] While states require continuing medical education, [FN177] this type of education should be more extensive. Physicians with numerous malpractice payouts, not simply physicians with allegations of malpractice pending, should have their licenses to practice medicine suspended or lose their licenses altogether. [FN178] Eliminating these repeat offenders would help the medical profession reduce premiums by policing their own ranks and would protect patients from injury. [FN179]

Greater access to information regarding physicians and a general increase in the free flow of communication between physicians, patients, and governing bodies would further help to identify problem doctors. [FN180] Insurers list a good bedside manner and a willingness to answer patient questions as effective ways to reduce the odds of facing a malpractice suit. [FN181] Further, doctors and medical staff are in the best position to recognize which physicians are having repeated problems with negligence. [FN182] Encouraging health care providers to report such problems would bring these matters to

the attention of the governing bodies so that further investigations can take place. [FN183] Allowing patients to have access to databanks, such as the NPDB, would encourage patients to take a proactive role in investigating *793 their physicians and would add to informed patient consent. [FN184]
Periodic recertification of physicians by state medical boards would also help to detect physicians with repeated malpractice problems. [FN185] This type of recertification would put medical boards in the position to identify physicians struggling with drug and alcohol problems, physicians with disabling physical or mental health problems, and generally negligent physicians. [FN186] In addition, initial licensing processes could focus more on preventing medical errors than they currently do. [FN187] These prophylactic procedures would not only benefit the great majority of physicians in the medical profession by reducing the number of malpractice payouts, but they would also protect patients from having to enter the courtroom in the first place. Such self-regulation places power and accountability in the appropriate place, with the physicians who bear the brunt of increased malpractice premiums. [FN188]

C. Solutions in the Insurance Industry

The periodic insurance crises over the past three decades have generally followed the ups and downs of the economy. [FN189] More conservative financial management in the investments of insurance companies would help to lessen the severity of future insurance crises. [FN190] In order to deal with the problem of the size of current malpractice premiums, however, members of the insurance industry *794 can adjust certain practices and thereby reduce the burdens on members of the medical profession, while still allowing for adequate patient compensation. [FN191]
A possible means for equalizing the size of premiums for non-offending physicians would be to alter the current system of assigning premiums to physicians. Currently, insurance carriers assign premiums largely according to the level of risk that each physician encounters due to her specialty or lack thereof. [FN192] A better system might distribute the costs of insurance premiums equally throughout the medical profession. [FN193] This practice would protect insurance carriers from the temptation to exaggerate the risks associated with one specialty area to justify charging them more than physicians in lower-risk areas of medicine. [FN194]
The current methods of assigning rates to physicians focus on legitimate concerns of the insurance industry, namely risk associated with the daily activities of specialists. Insurance carriers could better address this concern and provide an incentive for problem physicians to leave practice by charging higher rates to such physicians. [FN195] This practice, called "experience loss rating," would prevent physicians in good standing from paying the same malpractice premiums as physicians with repeated malpractice payouts on their records. [FN196] Statistics indicate that the same few physicians repeatedly subject *795 insurance carriers to liability for malpractice. [FN197] Carriers could reduce the risk of payouts by better policing this offending group of physicians.
Insurers could also create an additional safety incentive for physicians by offering lower rates to physicians willing to undergo periodic health and competency exams. These periodic exams would allow an insurance carrier to detect risky physicians by identifying problems with drug use and physical and mental incapacity. [FN198] Such prophylactic measures would help insurance carriers police their physician clients in an attempt to charge physicians according to the actual payout risk each physician creates. This practice would also serve to protect patients of these physicians from potential injury due to both mental and professional incompetence.

Conclusion

The current crisis has numerous causes and, therefore, demands a multi- faceted response. Tort reform by way of statutory caps focuses only on changing the legal liability system. Such a superficial response ignores other actors responsible for the current state of malpractice insurance, namely the medical profession and the insurance industry. Any

chance of remedying the current insurance crisis must address the shortcomings of all three parties rather than simply attacking one. Past reform for similar insurance markets in the 1970s and 1980s committed this error of singling out the legal liability system. The repeated recurrence of marked increases in malpractice premiums over the past three decades indicates that such a solution is ineffective.
Additionally, while tort reform in the legal liability system is a necessary component of any solution for relieving physicians of exorbitant malpractice premiums, empirical evidence indicates that statutory limits on pain and suffering damages are ill-advised and premature. Rather than significantly reducing malpractice premiums, such caps have their greatest impact on patients by preventing just compensation for pain and suffering in many situations. The undefined, "analytically impenetrable" [FN199] process that jurors currently use to determine pain and suffering awards precludes such legislation. ***796** Until the legal community reforms this substantive portion of the medical liability system, any statutory cap imposed on pain and suffering damages will be arbitrary at best and fundamentally unjust at worst.

[FN1]. Patricia J. Chupkovich, Comment, Statutory Caps: An Involuntary Contribution to the Medical Malpractice Insurance Crisis or a Reasonable Mechanism for Obtaining Affordable Health Care?, 9 J. Contemp. Health L. & Pol'y 337, 337 (1993); Mark A. Finkelstein, Note, California Civil Section 3333.2 Revisited: Has It Done Its Job?, 67 S. Cal. L. Rev. 1609, 1609 (1994). This insurance crisis consisted mainly of an increase in premiums for medical malpractice insurance. See Hoffman v. United States, 767 F.2d 1431, 1434 (9th Cir. 1985). This Comment does not evaluate whether a crisis exists today or has existed in the past. Rather, this Comment functions under the premise that the existence of medical malpractice insurance crises is a contested issue. The arguments presented in this Comment address solutions appropriate either to alleviating the perception of a crisis or to alleviating actual crisis conditions should a consensus develop that they exist.

[FN2]. .Ams. for Ins. Reform, Medical Malpractice Insurance: Stable Losses/Unstable Rates 2, 5 exhibit 2 (2002), at http://www.insurance-reform.org/StableLosses.pdf (Oct. 10, 2002) [hereinafter Stable Losses] (indicating that there have been two major periods where malpractice premiums have spiked, both in conjunction with economic downturns in the 1970s and 1980s) (on file with the North Carolina Law Review); see also J. Robert Hunter & Joanne Doroshow, Ctr. for Justice & Democracy, Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices 3 (2002) (discussing "skyrocketing" liability insurance premiums in the late 1980s), http:// www.insurance-reform.org/PremiumDeceit.pdf (on file with the North Carolina Law Review). See generally George J. Church, Sorry, Your Policy Is Canceled, Time, Mar. 24, 1986, at 16 (naming physician attrition and expensive insurance premiums as part of the impetus causing legislators to propose caps).

[FN3]. See 149 Cong. Rec. H1834-35 (daily ed. Mar. 13, 2003) (statement of Rep. Sensenbrenner) (urging medical liability reform); 149 Cong. Rec. E434 (daily ed. Mar. 12, 2003) (extension of remarks of Rep. Linder) (same); Joseph B. Treaster, Malpractice Rates Are Rising Sharply: Health Costs Follow, N.Y. Times, Sept. 10, 2001, at A1 (indicating that insurers blame the legal system for this insurance crisis).

[FN4]. Hunter & Doroshow, supra note 2, at 1; see Treaster, supra note 3. See generally Fred J. Hellinger & William E. Encinosa, Ctr. for Org. & Delivery Studies, U.S. Dep't of Health & Human Servs., The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians (2003) (discussing the effects of caps on physician populations), http:// www.ahcpr.gov/research/tortcaps/tortcaps.pdf (on file with the North Carolina Law Review).

[FN5]. .Hunter & Doroshow, supra note 2, at 3; see also Church, supra note 2, at 16-20,

23-26 (describing the aspects of the legal system that insurers blame for increasing premiums).

[FN6]. See, e.g., Patients First Act of 2003, S. 11, 108th Cong. §4(b) (2003) (proposing a $250,000 statutory cap on non-economic damages in medical malpractice actions), http://thomas.loc.gov (on file with the North Carolina Law Review); Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. §4(b) (2003) (same), http:// thomas.loc.gov (on file with the North Carolina Law Review); H.B. 809, 2003 Gen. Assem., Reg. Sess. §1(b) (N.C. 2003) (same), http:// www.ncga.state.nc.us/html2003/bills/AllVersions/House/H809v1.html (on file with the North Carolina Law Review).

[FN7]. When speaking about this type of cap, legislators use the terms "pain and suffering awards" and "non-economic damages" interchangeably. Such awards encompass "damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature." Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002, H.R. 4600, 107th Cong. §9(15) (2002), http://thomas.loc.gov (on file with the North Carolina Law Review). Along with economic damages, these non-economic awards comprise the broader concept of compensatory damages. Margaret C. Jasper, The Law of Medical Malpractice 28 (2d ed. 2001) (noting that economic damages, also called "special damages," are characterized as monetary losses that the plaintiff can objectively prove, and they generally include medical expenses, lost wages, and diminished earning capacity); see David W. Leebron, Final Moments: Damages for Pain and Suffering Prior to Death, 64 N.Y.U. L. Rev. 256, 263 (1989) (indicating that non-economic damages, also called general damages, include pain and suffering awards and awards for injuries not covered by special damages).

[FN8]. For the purposes of this Comment, the medical profession includes all health care providers; the legal community includes judges, attorneys, legal scholars, and to some extent legislators; and the insurance industry includes all medical malpractice insurance providers.

[FN9]. While caps on punitive awards often accompany caps on pain and suffering awards, the two types of damages achieve very different purposes. Punitive awards punish the defendant for wrongdoing, while pain and suffering awards compensate the plaintiff for the intangible aspects of her injury that can be inferred from the facts of the case. 1 Jerome H. Nates et al., Damages in Tort Actions §1.01, at 1-6 to 1-8 (2003). This Comment focuses specifically on the effects of statutory caps on just patient compensation and does not address additional caps that legislators place on punitive damages.

[FN10]. James B. Auden & Gerald Glombicki, Fitch Ratings, Medical Malpractice Insurance: In Intensive Care 1 (2003), http:// www.fitchratings.com/corporate/reports/report.cfm?rpt_id=169844 (on file with the North Carolina Law Review); Office of the Assistant Sec'y for Planning & Evaluation, U.S. Dep't of Health & Human Servs., Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care 11 (2003) [hereinafter Reforming Medical Litigation], http://aspe.hhs.gov/daltcp/reports/medliab.pdf (on file with the North Carolina Law Review); Treaster, supra note 3 (indicating that some physicians believe a rise in malpractice premiums contributes to an increase in health care costs); Robert P. Hartwig & Claire Wilkinson, Medical Malpractice Insurance, Ins. Issues Series, June 2003, at 1, 5-6, at http://server.iii.org/yy_obj_ data/binary/729103_1_0/Medmal.pdf (on file with the North Carolina Law Review). But

see Cong. Budget Office, Cost Estimate for H.R. 4600, at 4 (2002) ("Malpractice costs account for a very small fraction of total health care spending...."), ftp://ftp.cbo.gov/38xx/doc3815/hr4600ec.pdf (on file with the North Carolina Law Review); Public Citizen, Medical Misdiagnosis in North Carolina: Challenging the Medical Malpractice Claims of the Doctors' Lobby, Congress Watch, Apr. 2003, at 1, 24, 25 fig.12 [hereinafter Medical Misdiagnosis] (noting that of the fifteen states with the worst access to health care according to Health and Human Services, nine have statutory caps ostensibly designed to curb malpractice premiums), at http:// www.citizen.org/documents/Medical_Misdiagnosis_NC.pdf (on file with the North Carolina Law Review).

[FN11]. Auden & Glombicki, supra note 10, at 2 (explaining that medical malpractice insurance underperforms, tends to follow different trends, and is more volatile than other segments of the total insurance market); Treaster, supra note 3.

[FN12]. Treaster, supra note 3.

[FN13]. See Hellinger & Encinosa, supra note 4, at 13 ("Between 1970 and 2000, the supply of physicians per capita increased at a faster rate in those States that passed tort reform laws that capped damage payments in malpractice cases."); Troy Goodman, Malpractice Premiums May Cost Utah's New Moms Their OB-GYN Care, Salt Lake Trib., July 12, 2002, at A1, 2002 WL 4263919; Rachel Zimmerman & Christopher Oster, Insurers' Missteps Helped Provoke Malpractice 'Crisis', Wall St. J., June 24, 2002, at A1; Tanya Albert, West Virginia Supreme Court Upholds Limits on Malpractice Awards, Amednews.com, at http:// www.amednews.com/2001/prl20205 (Feb. 5, 2001) (quoting the West Virginia Board of Medicine as stating that the number of physicians in that state decreased by 5.8% in six years) (on file with the North Carolina Law Review).

[FN14]. U.S. Gen. Accounting Office, Liability Insurance: Effects of Recent "Crisis" on Businesses and Other Organizations 12 (1988) (Sup. Doc. No. GA 1.13:HRD-88-64) [hereinafter Liability Insurance], available at http:// archive.gao.gov/d16t6/136658.pdf.

[FN15]. See U.S. Gen. Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates 7 (2003) (Sup. Doc. No. GA 1.13:GAO-03-702) [hereinafter Multiple Factors] (citing claims history and participation in risk-management programs as factors that insurers consider in giving discounts or adding surcharges), http:// www.gao.gov/new.items/d03702.pdf (on file with the North Carolina Law Review); Advertisement, Bruce R. Swicker, Welcome to Insurance4docs.com, at http:// www.insurance4docs.com (last visited Sept. 3, 2003) (naming factors such as nature of practice, board certification, teaching credits, continuing education, claims history, and length of practice) (on file with the North Carolina Law Review).

[FN16]. Multiple Factors, supra note 15, at 7 (explaining that insurers also consider anticipated investment income and desire to earn a decent profit in assigning premiums). Most states have regulatory boards that may deny insurers' proposed changes in premium rates. Id.; see, e.g., N.C. Dep't of Ins., About North Carolina Department of Insurance, at http:// www.ncdoi.com/Home/About.asp (last visited Dec. 24, 2003) (outlining the responsibilities of the North Carolina Department of Insurance, which include reviewing premium rates) (on file with the North Carolina Law Review).

[FN17]. See Multiple Factors, supra note 15, at 7. Insurers may do this because they can hypothesize what the risk for these groups may be based on these general characteristics. For instance, physicians in metropolitan areas tend to pay higher premiums than those in more rural parts of the country. Id. at 13 (noting that physicians in Philadelphia receive quotes for medical malpractice insurance premiums that are approximately eighty-three percent higher than quotes that physicians outside of the city

receive). One reason proposed for these variations involves the perception that certain geographic areas historically see greater losses than others. Id. Differences in loss rates may arise from variables such as the incidence of malpractice and the attitudes of jurors in medical malpractice cases toward defendants. This latter idea is supported by the theory that plaintiffs' attorneys "venue shop" because juries in certain areas of the country tend to award more money or produce a favorable verdict in trials. See generally Kimberly Jade Norwood, Shopping for a Venue: The Need for More Limits on Choice, 50 U. Miami L. Rev. 267 (1995) (exploring the effects of venue shopping on public perception of justice).

[FN18]. See Multiple Factors, supra note 15, at 7, 13.

[FN19]. Liability Insurance, supra note 14, at 12.

[FN20]. U.S. Gen. Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984, at 54 (1987) (illustrating that while about one-half of the total number of neurosurgeons faced a suit in a given year, only about one-sixth of general practitioners were involved in such claims), available at http://archive.gao.gov/d2t4/132815.pdf.

[FN21]. See Multiple Factors, supra note 15, at 13 (reiterating that high-risk specialists often have higher premiums).

[FN22]. See 1 Nates et al., supra note 9, §3.01, at 3-4 to 3-7. When malpractice results in the loss of a limb, the goal of restoring the patient to pre-injury condition would obviously be frustrated. Jasper, supra note 7, at 27 (noting that regardless of the court's actions, sometimes full restoration is impossible). In such a situation, the goal of compensatory damages becomes to pay the difference between the patient's pre-injury and post-injury conditions. Id. at 28.

[FN23]. See 4 Nates et al., supra note 9, §40.02, at 40-26.

[FN24]. 1 Nates et al., supra note 9, §4.01, at 4-5; see also Edward C. Martin, Limiting Damages for Pain and Suffering: Arguments Pro and Con, 10 Am. J. Trial Advoc. 317, 317-18 (1986) (observing that every American jurisdiction recognizes the reality of pain and suffering injuries).

[FN25]. See Victor E. Schwartz & Leah Lorber, Twisting the Purpose of Pain and Suffering Awards: Turning Compensation into "Punishment", 54 S.C. L. Rev. 47, 68 (2002); see also 1 Nates et al., supra note 9, §4.01, at 4-5 (explaining that pain and suffering awards encompass both mental and physical anguish).

[FN26]. Schwartz & Lorber, supra note 25, at 68. Pain and suffering awards compensate physical pain suffered during injury and in recovery; anguish and terror suffered due to fear of impending injury or death; immediate emotional distress and long-term loss of love and companionship resulting from the injury or death of a close family member; enduring loss of enjoyment of life; denial of pleasures from normal personal and social activities because of injury; curtailment of life expectancy; and finally, disfigurement. 2 Am. Law Inst., Reporters' Study: Enterprise Responsibility for Personal Injury 199-200 (1991); see Frank M. McClellan, Medical Malpractice 112-20 (1994); supra note 7 and accompanying text.

[FN27]. See Martin, supra note 24, at 318.

[FN28]. See Jasper, supra note 7, at 27.

[FN29]. Schwartz & Lorber, supra note 25, at 60; see also McClellan, supra note 26, at

112 ("Since there is no market for the sale and purchase of pain and suffering, no source other than the legal process exists for determining whether the awards made for pain and suffering are reasonable or unreasonable.").

[FN30]. Leebron, supra note 7, at 264.

[FN31]. See id.; see also McClellan, supra note 26, at 103-04 (indicating that many factors influence juror perception of the plaintiff's injuries, including the trial judge's rulings on evidentiary matters and the socio-economic values of the jury itself).

[FN32]. See McClellan, supra note 26, at 103-04.

[FN33]. See id. at 115. For example, the Fifth Circuit's Pattern Jury Instruction for determining pain and suffering damages reads:
You may award damages for any bodily injury that the plaintiff sustained and any pain and suffering, [disability], [disfigurement], [mental anguish], [and/or] [loss of capacity for enjoyment of life] that the plaintiff experienced in the past [or will experience in the future] as a result of the bodily injury. No evidence of the value of intangible things, such as mental or physical pain and suffering, has been or need be introduced. You are not trying to determine value, but an amount that will fairly compensate the plaintiff for the damages he has suffered. There is no exact standard for fixing the compensation to be awarded for these elements of damage. Any award that you make should be fair in the light of the evidence.
** Modern Federal Jury Instructions 5-101 (2002).

[FN34]. Randall J. Bovbjerg et al., Valuing Life and Limb in Tort: Scheduling "Pain and Suffering", 83 Nw. U. L. Rev. 908, 913-14 (1989); see infra notes 164-65 and accompanying text.

[FN35]. .McClellan, supra note 26, at 113-16. Some of these methods include suggesting a total sum for pain and suffering and asking jurors to compute a per diem sum and a total sum for damages. Id. A total sum argument asks jurors to consider awarding the plaintiff a certain amount for pain and suffering. See, e.g., Watson v. Chicago, 464 N.E.2d 1100, 1102 (Ill. App. Ct. 1984) (illustrating that an attorney can ask a jury to award $49,000 for forty-nine years of pain and suffering). A per diem argument asks jurors to use a formula that multiplies a time unit by a unit that puts a price on pain to come to generate a total number for pain and suffering. See, e.g., Caley v. Manicke, 182 N.E.2d 206, 208-10 (Ill. 1962) (holding that such mathematical formulations are unreliable and thereby ruling that counsel may not use them to lead jurors). The lack of a consensus in the legal community regarding the best method for determining pain and suffering awards has caused at least one scholar to label the jury's process for arriving at a number as "analytically impenetrable." Leebron, supra note 7, at 265.
The closing argument also allows a lawyer the chance to obfuscate the case for the jury. In order to avoid some of these juror-clouding tactics, the American Bar Association provides guidelines to show practitioners which methods they can ethically use in their closing arguments. Criminal Justice Standards Comm., Am. Bar Ass'n, ABA Standards for Criminal Justice 4-7.8 (1993). Practitioners argue that some of these methods used in closing help rather than hinder juries. See Steve Lubert, Modern Trial Advocacy 443 (2d ed. 1997) (emphasizing that the closing argument is an attorney's only chance to tell his client's story without interruption).

[FN36]. The notion that there could be a "correct" number at which jurors should arrive when awarding pain and suffering damages is diametrically opposed to the concept that "there is no rule of certainty with reference to the amount of recovery permitted for any particular type of emotional distress; the only limit is such an amount as a reasonable person could possibly estimate as fair compensation." Restatement (Second) of Torts

§905 cmt. i (1979).

[FN37]. Schwartz & Lorber, supra note 25, at 60 (arguing that the indefinite guidance that courts offer jurors in calculating pain and suffering damages allows improper factors, such as the degree of culpability of the defendant, to influence awards).

[FN38]. See id. An example of this variance in the size of awards appears in one study that applied the National Association of Insurance Commissioners' Severity of Injury Scale to unpublished jury verdict data compiled by the Urban Institute/Vanderbilt University project. See Bovbjerg et al., supra note 34, at 920-24. This study showed that juries determining damages for injuries of like severity in multiple cases returned with numbers ranging from $147,000 to just over $18 million. See id. at 923. This type of disparate result not only provides ammunition to advocates for the reform of the medical liability system, but it also erodes general public confidence in the overall justice of pain and suffering awards. See id. at 924.

[FN39]. See State of the Union Address, 2003 U.S.C.C.A.N. D10, D11-12; Auden & Glombicki, supra note 10, at 3 ("[M]edical malpractice and other casualty lines have experienced a greater frequency of high-severity losses due to higher litigation costs and continuing expansion of jury settlementsover the past five years ...."); Press Release, American Medical Association, The Medical Liability Crisis: AMA Talking Points, at http://www.ama- assn.org/ama/pub/article/6282-7225.html (last updated Apr. 28, 2003) (identifying jury awards as the problem causing the medical liability crisis) (on file with the North Carolina Law Review).

[FN40]. See Zimmerman & Oster, supra note 13.

[FN41]. See id.

[FN42]. See Press Release, American Bar Association, Health Care Accountability: Medical Malpractice, at http:// www.abanet.org/poladv/priorities/medmal.html (last updated Nov. 6, 2002) (illustrating attorneys blaming the insurance industry's response to a decline in investment income) (on file with the North Carolina Law Review); Press Release, Joan Claybrook, President, Public Citizen, Medical Errors, Not Lawsuits, Are Real Cause of Rising Malpractice Insurance Premiums, at http:// www.citizen.org/pressroom/print_release.cfm?ID=1297 (Jan. 9, 2003) [hereinafter Claybrook] (showing consumer groups blaming insurers) (on file with the North Carolina Law Review).

[FN43]. Treaster, supra note 3.

[FN44]. .Press Release, Public Citizen, Quick Facts on Medical Malpractice Issues, at http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=9125 (last visited Oct. 29, 2003) (noting that patients filed 90,212 claims in 1995 and 86,480 claims in 2000 (citing Nat'l Ass'n of Ins. Comm'rs, Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001))) (on file with the North Carolina Law Review). A spokesperson for the National Association of Independent Insurers ("NAII") took issue with this statistic, noting instead that "total industry payouts to cover losses and legal expenses jumped 52 percent--from $4.5 billion in 1995 to $6.9 billion in 2000." Press Release, National Association of Independent Insurers, Medical Liability Talking Points, at http:// www.naii.org/sitehome.nsf/IndustryIssuesMedMal-TalkingPoints?OpenPage (last visited Oct. 19, 2003) [hereinafter NAII Press Release] (on file with the North Carolina Law Review). Taken together, the NAIC data and the NAII data suggest that though the number of claims did not increase, jury verdict size and legal fees for the defense likely did. However, a third set of statistics analyzing the size of individual payouts from 1991 to 2001 shows a steady increase in the size of the average

medical malpractice payout. Laurie Woellert, A Second Opinion on the Malpractice Plague, Bus. Wk., Mar. 3, 2003, at 98, 98 (reporting data from the National Practitioner Data Bank as indicating that from 1991 to 2001 the average malpractice payout increased by an average of 6.2% per year to $135,941 in 2001). If in fact payouts did increase incrementally from 1991 to 2001, this would indicate that the "jump" in insurer payouts that the NAII cites must be linked directly to attorney fees that insurers incurred in litigating medical malpractice cases. See id.; NAII Press Release, supra. Caps on damages do not address defense costs in medical malpractice litigation; therefore, this type of legislation would not be likely to cause this figure to decline or have any effect in slowing premium growth.

[FN45]. Stable Losses, supra note 2, at 6-7. One government study of the insurance industry supports this interpretation and further explains that in the short-term, insurers can keep premiums at a low rate while losses continue to increase. See Multiple Factors, supra note 15, summary. Insurers do this because they collect premiums immediately, but they do not generally have to make payouts for quite some time. Id. The spike in premiums occurs when the insurers ultimately have to make these payouts, and due to the fact that they have overextended themselves by keeping premiums low and have seen poor returns on their investments, they make large rate changes. See id.

[FN46]. See Hunter & Doroshow, supra note 2, at 4.

[FN47]. See Treaster, supra note 3.

[FN48]. Id.

[FN49]. Id. Statistics comparing the frequency and the amount of medical malpractice payouts, the ebb and flow of the national economy, and the rise and fall of malpractice insurance premiums over the years, indicate a strong inverse correlation between the strength of the economy and the cost of medical insurance premiums. See generally Stable Losses, supra note 2 (studying medical malpractice payout and premium data compiled for the Americans for Insurance Reform coalition by A.M. Best, the leading provider of statistics on the insurance industry, in conjunction with data on the economy and the frequency of malpractice payouts). For instance, from 1967 to 2001, the economy performed well around 1972, 1978, 1988, and 1997, and it bottomed out in 1975, 1985, 1992, and 2001. See id. at 3. Similarly, medical malpractice premiums spiked in the mid-1970s, in the mid-1980s, and in the early millennium. See Multiple Factors, supra note 15, at 5, 9; Press Release, Rep. Peter DeFazio, House Votes on Medical Malpractice: DeFazio Points at Real Problem--the Insurance Industry, at http://defazio.house.gov/031303HCRelease.shtml (Mar. 13, 2003) (pointing out that "[e]ach of these 'crises' happens to coincide with recessions, stock market downturns, and insurance industry investment losses") (on file with the North Carolina Law Review). Interestingly, statistics indicate that insurers continue to make a profit during these downswings in their cycle, even though profits do decrease slightly. See, e.g., A.M. Best Comp., First Professionals Insurance Company, Inc., Best's Co. Reports, July 14, 2003 (indicating that profits for malpractice providers went down due to market swings, but improved with an increase in premium costs), LEXIS, Legal, Area of Law--By Topic, Insurance, Company & Financial Information, Best's Company Reports file (on file with the North Carolina Law Review).

[FN50]. See generally Medical Misdiagnosis, supra note 10 (blaming doctors and insurers).

[FN51]. According to data from the National Practitioner Data Bank, 5.1% of physicians account for 54.2% of the number of malpractice payouts since 1990. Press Release, Sidney M. Wolfe, MD Director, Health Research Group, Public Citizen, Statement on

Medical Malpractice, at http:// www.citizen.org/pressroom/release.cfm?ID=1298 (Jan. 9, 2003) (interpreting data from the public use files of the National Practitioner Data Bank) (on file with the North Carolina Law Review).

[FN52]. See Zimmerman & Oster, supra note 13 (noting that the insurance industry relies heavily on Jury Verdict Research for statistics, yet this service admittedly does not report on all verdicts, excluding those in which physicians and health care providers are absolved of guilt). Few sources collect data on medical malpractice, and those that do, such as the Medical Liability Monitor, charge for access to their information. E.g., Medical Liability Monitor, Subscription Page, at http:// www.medicalliabilitymonitor.com/subscribe.html (last visited Oct. 29, 2003) (charging $399 for a year's subscription) (on file with the North Carolina Law Review).

[FN53]. See, e.g., Ga. Trial Lawyers Ass'n, Medical Malpractice--Situation Analysis, at http://gtla.org/public/justice-preservation/legpacket/toc.html (last visited Oct. 29, 2003) (representing attorneys providing data) (on file with the North Carolina Law Review). A recent report to Congress addressed this problem by suggesting that "Congress may want to consider encouraging NAIC and state insurance regulators to identify and collect additional data necessary to evaluate the frequency, severity, and causes of losses on medical malpractice claims." Multiple Factors, supra note 15, at 6 (footnotes omitted).

[FN54]. Compare Albert, supra note 13 (noting increased jury awards), and Donald J. Palmisano, President-elect, American Medical Association, The Crisis in American Medicine: The Death of a Noble Profession or a Call to Action?, Speech in New Orleans, Louisiana, at http://www.ama-assn.org/ama/pub/article/1752-7256.html (Jan. 30, 2003) ("According to Jury Verdict Research, the median jury award reported by lawyers increased 43 percent between 1999 and 2000. More than half of these jury awards topped $1 million, and the average jury award increased to $3.5 million.") (on file with the North Carolina Law Review), with Ralph Nader, The Malpractice Crisis, Common Dreams News Ctr., Jan. 6, 2003, at http:// www.commondreams.org/views03/0106-06.htm ("Malpractice cases filed and actual payments in constant dollars have been level for many years....") (on file with the North Carolina Law Review).

[FN55]. See Zimmerman & Oster, supra note 13 (emphasizing that no single group is entirely responsible for the problem).

[FN56]. See, e.g., 148 Cong. Rec. H6731 (daily ed. Sept. 26, 2002) (statement of Rep. Bilirakis) (arguing that legislation capping non-economic damages "will help bring stability and predictability to the medical liability insurance market"); see also Schwartz & Lorber, supra note 25, at 60 (noting a sentiment among legislators that statutory caps would stabilize the insurance market by making jury awards more predictable). The most common statutory caps limit either all damages other than economic damages, the total damages recoverable in malpractice actions, or solely pain and suffering damages. See, e.g., Cal. Civ. Code §3333.2 (West 1997) (imposing a $250,000 cap on non-economic damages, such as pain and suffering, in medical malpractice cases); La. Rev. Stat. Ann. §40:1299.42(B)(1) (West 2001) (limiting all damages except medical expenses in medical malpractice cases); S.D. Codified Laws §21-3-11 (Michie Supp. 2003) (capping total general damages in medical malpractice cases). Overall, legislators have embraced caps on non-economic damages over other types of statutory limits on damages, possibly because courts tend to find them to be constitutional. See Jasper, supra note 7, at 107-13 (summarizing state statutory limits on damages in medical malpractice cases); infra note 59 and accompanying text.

[FN57]. See Bovbjerg et al., supra note 34, at 958 (commenting on the popularity of caps).

[FN58]. See, e.g., Carter v. United States, 333 F.3d 791, 797 (7th Cir. 2003) (affirming the district court judge's reduction of non-economic damages to Maryland's statutory maximum of $530,000 after the jury awarded $15.5 million); Schiernbeck v. Haight, 9 Cal. Rptr. 2d 716, 724 (Cal. Ct. App. 1992) (recommending that jury not be told of the cap and that the amount and timing of damages should be tailored by the trial court if jury's award exceeds the cap).

[FN59]. See, e.g., Davis v. Omitowoju, 883 F.2d 1155, 1158 (3d Cir. 1989) (upholding caps on non-economic damages under equal protection and due process scrutiny); Hoffman v. United States, 767 F.2d 1431, 1437 (9th Cir. 1985) (upholding caps on non-economic damages under the Equal Protection Clause); Vincent v. Johnson, 833 S.W.2d 859, 862 (Mo. 1992) (upholding the constitutionality of caps on non-economic damages under the Missouri Constitution). The general consensus among courts indicates that statutory caps must pass only rational basis review because these claims implicate neither a fundamental right nor a suspect class. See, e.g., Fein v. Permanente Med. Group, 695 P.2d 665, 679-84 (Cal. 1985) (upholding California's cap on non-economic damages in medical malpractice actions under rationale basis review); Robinson v. Charleston Area Med. Ctr., Inc., 414 S.E.2d 877, 885-87 (W. Va. 1991) (upholding a cap on non-economic damages using rationale basis review). But see Carson v. Maurer, 424 A.2d 825, 838 (N.H. 1980) (holding that a statutorily imposed cap on non-economic damages violated the New Hampshire Constitution on equal protection grounds under a heightened standard of review).

[FN60]. Martin, supra note 24, at 329-30 (noting that courts do not generally support this argument because it would prevent injured patients from receiving full compensation for malpractice).

[FN61]. Id. at 330, 332-33.

[FN62]. Id. at 331-32. See generally Schwartz & Lorber, supra note 25 (offering an analysis of the tendency of jurors to use pain and suffering awards to punish defendants in order to circumvent caps on punitive damages).

[FN63]. See, e.g., 148 Cong. Rec. H6729 (daily ed. Sept. 26, 2002) (statement of Rep. Jackson-Lee) ("I am also confused about where this arbitrary cutoff of $250,000 for non-economic damages comes from. It happens to be the same number used in similar legislation passed 27 years ago in California, with no adjustment for inflation or changes in costs of living.").

[FN64]. See Emily Townsend Black Grey, Comment, The Medical Malpractice Damages Cap: What Is Included?, 60 La. L. Rev. 547, 548 (2000) (explaining that Louisiana legislators chose a $500,000 cap on total damages in the Medical Malpractice Act of 1975 because there had never been a medical malpractice judgment or settlement above that amount in Louisiana).

[FN65]. See David G. Warren, The Politics of Medical Malpractice Reforms: Governmental Responses to Affected Groups, 10 Am. J. Trial Advoc. 257, 273-74 (1986) (discussing some of the numbers applied to various types of caps). It does not appear that the AMA has taken advantage of this opportunity to participate in the debate by offering its own number for future caps.

[FN66]. Edward W. Taylor & William G. Shields, The Limitation on Recovery in Medical Negligence Cases in Virginia, 16 U. Rich. L. Rev. 799, 810 (1982) (noting that empirical evidence relating to past pain and suffering payouts does not support the $750,000 cap on total damages that the Virginia legislature chose).

[FN67]. See, e.g., 148 Cong. Rec. H6705 (daily ed. Sept. 26, 2002) (demonstrating that legislators frequently focus on reducing premiums). This focus may induce legislators to simply borrow numbers from other jurisdictions. See infra note 69 and accompanying text.

[FN68]. See Cal. Civ. Code §3333.2 (West 1997); infra Part III.B.

[FN69]. See Governor's Select Task Force on Healthcare Prof'l Liab. Ins., Final Report 212, 219-21 (2003) (illustrating the Task Force's belief that the $250,000 figure will work in Florida because it worked in other states), http://www.doh.state.fl.us/myflorida/DOH-Large-Final%20Book.pdf (on file with the North Carolina Law Review).

[FN70]. One dollar in 1975 has the same buying power as $3.44 in 2003. Bureau of Labor Statistics, United States Department of Labor, Inflation Calculator, at http://data.bls.gov/cgi-bin/cpicalc.pl (last visited Dec. 24, 2003) (on file with the North Carolina Law Review). This means that a $250,000 pain and suffering award in 1975 would have to be inflated to a $860,000 award today to compensate the injured patient to the same extent. Thus, what was worth $250,000 in 1975 is worth only $72,675 today. But see Governor's Select Task Force on Healthcare Prof'l Liab. Ins., supra note 69, at 220 n.850 (crediting testimony from Dr. Richard E. Anderson as saying that in California a rise in indemnity payments due to increasing economic awards has more than made up for the neglected inflation rate).

[FN71]. See id. at 219-21.

[FN72]. See id.

[FN73]. See supra notes 24-28 and accompanying text.

[FN74]. For example, President Bush has repeatedly asked Congress to send him legislation that he can approve to enact caps. See, e.g., State of the Union Address, 2003 U.S.C.C.A.N. D10, D12 (urging Congress to pass legislation to curb excessive medical malpractice litigation). Many Democrats in Congress oppose such legislation. See, e.g., 149 Cong. Rec. S9080 (daily ed. July 9, 2003) (statement of Sen. Leahy) (arguing that a $250,000 cap on non-economic damages will take away patient rights).

[FN75]. Jim Vandehei, Medical Malpractice Sparks Partisan Battle, Wash. Post, Feb. 17, 2003, at A4.

[FN76]. Id.

[FN77]. See, e.g., 148 Cong. Rec. H6705 (daily ed. Sept. 26, 2002) (depicting the discussion that takes place in the House when legislators propose caps on damages in medical malpractice cases).

[FN78]. See, e.g., Patients First Act of 2003, S. 11, 108th Cong. §4(b) (2003) (proposing a $250,000 statutory cap on non-economic damages in medical malpractice actions), http://thomas.loc.gov (on file with the North Carolina Law Review); Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. §4(b) (2003) (same), http:// thomas.loc.gov (on file with the North Carolina Law Review).

[FN79]. See Jasper, supra note 7, at 107-13. But cf. S. 802, 2003 Gen. Assem., Reg. Sess. §1.9 (N.C. 2003) (proposing not to enact a statutory cap but rather to enact other safeguards such as a new procedure to discipline attorney misconduct in medical malpractice cases), http:// www.ncleg.net/hmtl2003/bills/CurrentVersion/Senate/Sbil0802.full.html (on file with the

North Carolina Law Review).

[FN80]. Compare, e.g., Cal. Civ. Code §3333.2 (West 1997) (capping non-economic damages at $250,000), with, e.g., Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002, H.R. 4600, 107th Cong. §4(b) (2002) (proposing to cap non-economic damages at $250,000), http:// thomas.loc.gov (on file with the North Carolina Law Review).

[FN81]. See supra notes 68-70 and accompanying text.

[FN82]. Finkelstein, supra note 1, at 1609. The stated purpose of MICRA proclaimed:
The Legislature finds and declares that there is a major health care crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state.
Medical Injury Compensation Reform Act, ch. 2, §12.5, 1975 Cal. Stat. 2d Ex. Sess. 3949, 4007 (codified at Cal. Civ. Code §3333.2). Commentators also blamed an increase in the number of malpractice suits and the size of awards in these suits for this crisis. Finkelstein, supra note 1, at 1612.

[FN83]. See Hoffman v. United States, 767 F.2d 1431, 1434 (9th Cir. 1985) (describing the climate that bore MICRA).

[FN84]. Id.

[FN85]. .Cal. Civ. Code §3333.2 (defining damages for non-economic losses to include damages that "compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage"). MICRA did not impose caps on economic damages. See id.; see also Finkelstein, supra note 1, at 1610 n.8 (noting that such a cap on economic damages would likely violate an injured patient's due process rights).

[FN86]. Finkelstein, supra note 1, at 1618.

[FN87]. .Multiple Factors, supra note 15, at 59 fig.10 (indicating graphically that direct losses incurred fell from about $500,000,000 to about $200,000,000 in 2001 dollars during this time).

[FN88]. Id. (showing that direct losses incurred peaked at approximately $650,000,000 in 1986 before falling to about $100,000,000 in 1991).

[FN89]. Id. at 17.

[FN90]. Compare id. (national data), with id. at 59 (California data).

[FN91]. Press Release, Foundation for Taxpayer and Consumer Rights, MICRA Did Not Lower Insurance Premiums in California, at http:// www.consumerwatchdog.org/insurance/fs/fs002695.php3 (Aug. 22, 2002) ("Premiums [in California] grew 191 percent through 1988, when they began to fall, dropping 20 percent by 1991. The same pattern emerged in the nation: premiums grew 331 percent through 1989, then fell 5 percent by 1991.") (on file with the North Carolina Law Review).

[FN92]. E.g., Press Release, Foundation for Taxpayer and Consumer Rights, Cal. Medical

Malpractice Caps Don't Hold Down Doctors' Premiums, According to Cal. Doctor, at http://www.consumerwatchdog.org/insurance/pr/pr002964.php3 (Jan. 6, 2003) ("Premiums did not drop until after the passage of Proposition 103....") (on file with the North Carolina Law Review).

[FN93]. See Hundreds of Florida, Mississippi Doctors Skip Work to Protest Malpractice Insurance Costs, Jefferson City News Trib. Online Edition, Jan. 28, 2003, at http://www.newstribune.com/stories/012803/wor_0128030911.asp (indicating that doctors believe that MICRA caused California's rates to grow at a slower pace than rates across the nation as a whole) (on file with the North Carolina Law Review).

[FN94]. See id.

[FN95]. See id. (reporting the President of the Florida Medical Association as saying that malpractice insurance rates for California doctors have only risen 167% since 1975 compared to a fivefold increase nationwide).

[FN96]. .Office of the Assistant Sec'y for Planning & Eval., U.S. Dep't of Health & Human Servs., Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care 23 (2003) (comparing percentage increases in premiums in 2001 and 2002 in states with caps and states without caps). But see Hunter & Doroshow, supra note 2, at app. C., exhibit 3 (illustrating that in 1997, California's earned medical malpractice premiums were $629,000,000, North Carolina's earned premiums were $117,000,000, and Georgia's premiums were $179,000,000).

[FN97]. Martin Ramey, Comment, Putting the Cart Before the Horse: The Need to Re-Examine Damage Caps in California's Elder Abuse Act, 39 San Diego L. Rev. 599, 628 n.181 (2002).

[FN98]. See id. at 628-29 (noting that MICRA's cap would be worth only about $72,000 after adjusting for inflation); infra notes 125-49 and accompanying text.

[FN99]. Act of March 8, 1986, ch. 106, §55-7B-8, 1986 W. Va. Acts 796, 796 (amended 2003).

[FN100]. Act of March 8, 2003, 2003 W. Va. Acts 147 (codified at W. Va. Code §55-7B-8) (Michie Supp. 2003).

[FN101]. See Loch Adamson, Testimony: Surgical Strike, N.Y. Times, Feb. 2, 2003, §6 (Magazine), at 18, 18 (reporting that two dozen surgeons recently staged a "walk-out" because they felt that medical insurance premiums were too high under the one million dollar cap). Notably, six of the physicians that participated in the strike allegedly had committed serious medical errors themselves. Joe McLeod, A Malpractice Crisis, All Right, News & Observer (Raleigh, N.C.), Jan. 16, 2003, at 13A. These alleged errors include "operating on the wrong knee, failing to remove a clip on an artery which resulted in the need for a liver transplant, and killing a patient by inadvertently cutting into the patient 's [sic] stomach." Id. These instances of malpractice are a reminder that physicians play a significant role in increasing the number and amount of malpractice payouts.

[FN102]. See Ams. for Ins. Reform, Medical Malpractice Insurance: Stable Losses/Unstable Rates in West Virginia 7 exhibit 3, at http://www.insurance-reform.org/StableLossesWV.pdf (Jan. 2003) (reporting that from 1991 to 2001, the paid loss per doctor in West Virginia decreased from $14,652 to $12,955) (on file with the North Carolina Law Review).

[FN103]. Alabama Medical Liability Act of 1987, §5, 1987 Ala. Acts 189, 261 (codified at

Ala. Code §6-5-544 (1993)).

[FN104]. Kelly McClurg, Malpractice Rates Starting to Rise in Alabama, Birmingham Bus. J., Sept. 28, 2001, http:// birmingham.bizjournals.com/birmingham/stories/2001/10/01/story8.html (on file with the North Carolina Law Review).

[FN105]. Id.

[FN106]. See id.

[FN107]. See id; Jim Wallace, Tort Reform on Legislative Front Burner, Charleston Gazette & Daily Mail (W. Va.), Jan. 2, 2003, at 1A, 2003 WL 5438802.

[FN108]. See Adamson, supra note 101, at 18 (depicting surgeons who staged a walk-out to encourage legislators to introduce a lower cap on non-economic damages). "Strict limits" would mirror MICRA's statutory cap of $250,000 on pain and suffering damages. See Cal. Civ. Code §3333.2 (West 1997).

[FN109]. See Hunter & Doroshow, supra note 2, at 15-18; McClurg, supra note 104; see also Multiple Factors, supra note 15, at 7 (listing investment return among the multiple factors that affect premium size).

[FN110]. See, e.g, 148 Cong. Rec. H6705 (daily ed. Sept. 26, 2002) (depicting the concerns of many legislators regarding pain and suffering awards).

[FN111]. See supra notes 63-69 and accompanying text (indicating that most legislators have no set formula for arriving at a number for caps on non-economic damages, and thus that these numbers often are arbitrary).

[FN112]. See, e.g., Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. §12 (2003) ("This Act shall apply to any health care lawsuit brought in a Federal or State court...."), http:// thomas.loc.gov (on file with the North Carolina Law Review).

[FN113]. See Carson v. Maurer, 424 A.2d 825, 837 (N.H. 1980) (noting that no formula exists for calculating pain and suffering damages); infra notes 160- 65 and accompanying text.

[FN114]. See supra notes 52-55 and accompanying text.

[FN115]. See, e.g., 149 Cong. Rec. H1829 (daily ed. Mar. 13, 2003) (statement of Rep. Shays) (contending that legislators must set caps in order to protect health care and insurance availability for Americans).

[FN116]. See id. (statement of Rep. Shays).

[FN117]. See id. (statement of Rep. Baca) (expressing his horror at the idea of taking away the jury's role in malpractice litigation).

[FN118]. See id. (statement of Rep. Baca).

[FN119]. Id. (statement of Rep. Weiner) (indicating that his colleagues believe that jurors cannot be trusted and are not smart enough to render proper awards).

[FN120]. 424 A.2d 825, 836 (N.H. 1980) (striking the statutory cap because it violated

the Equal Protection Clause of New Hampshire's constitution).

[FN121]. Id. at 837.

[FN122]. Id.

[FN123]. Id. Remittitur is "[t]he process by which a court reduces or proposes to reduce the damages awarded in a jury verdict." Black's Law Dictionary 1298 (7th ed. 1999). This topic is quite controversial itself. For an excellent discussion of remittitur as applied to pain and suffering damages, see generally David Baldus et al., Improving Judicial Oversight of Jury Damages Assessments: A Proposal for the Comparative Additur/Remittitur Review of Awards for Nonpecuniary Harms and Punitive Damages, 80 Iowa L. Rev. 1109 (1995).

[FN124]. See Carson, 424 A.2d at 838.

[FN125]. See, e.g., Act of March 8, 2003, 2003 W. Va. Acts 147 (codified at W. Va. Code §55-7B-8) (Michie Supp. 2003) (capping non-economic damages at the greater of $250,000 or three times economic damages up to $350,000 per plaintiff); Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003, H.R. 5, 108th Cong. (2003) (using a $250,000 cap).

[FN126]. See Martin, supra note 24, at 333-34, 337.

[FN127]. Ben Johnson v. Alan Malki, M.D. & Steve Cardenas, P.A.C., Cal. Jury Verdicts Wkly., Apr. 10, 2001, LEXIS, Legal, States Legal-U.S., California, Jury Instructions & Verdicts, CA Combined Jury Verdicts and Settlements File. The surgeon's negligent post-operative care of Johnson resulted in a massive infection that ultimately required the amputation of Johnson's leg. Id. Johnson alleged that his health care providers knew of his problems with diabetes and peripheral vascular disease prior to deciding to operate, and accordingly, they had a duty to take additional measures to protect against post-operative infection. Id.

[FN128]. See supra note 26 and accompanying text (outlining the variables that pain and suffering damages compensate).

[FN129]. See 4 Nates et al., supra note 9, §36.01, at 36-3 to 36-13 (explaining that life expectancy factors into damage awards in tort claims). The same premise should apply to an evaluation of damages for loss of consortium for the younger Johnson's wife. See 2 id., §11.02, at 11-4 to 11-7 (describing loss of consortium).

[FN130]. Carson v. Maurer, 424 A.2d 825, 836 (N.H. 1980); see also Medical Injury Compensation Reform Act, ch. 2, §12.5, 1975 Cal. Stat. 2d Ex. Sess. 3949, 4007 (codified at Cal. Civ. Code §3333.2 (West 1997)).

[FN131]. See Finkelstein, supra note 1, at 1619 (describing how MICRA helped reduce perceived risk of exorbitant pain and suffering awards for insurers).

[FN132]. See supra note 26 and accompanying text (describing the losses that non-economic damages compensate).

[FN133]. Amy Johnson Conner, Med-Mal Lawyer Breaks Personal Record with $107 Million Verdict, Law. Wkly. USA, Jan. 7, 2002, at B19 (reporting verdict in Ballinas v. N.Y. City Health & Hosps. Corp., No. 7709/94 (N.Y. Sup. Ct. 2001)).

[FN134]. Seven million dollars of this total amount compensated his past suffering, and

sixty-four million compensated his future pain and suffering for the next sixty-four years. Id.

[FN135]. Id.

[FN136]. Id.

[FN137]. Id.

[FN138]. Bovbjerg et al., supra note 34, at 959 (indicating that reasonable limits could be discovered through assessing past jury awards).

[FN139]. See, e.g., Grier v. Lermand, No. 14548/01, N.Y. J.V. Rep 21, 2003 WL 21754728 (N.Y. Sup. Ct. June 23, 2003).

[FN140]. See Martin, supra note 24, at 337 (reasoning that severely injured patients comprise the distinct minority of plaintiffs in medical malpractice cases, so the effects of reducing compensation for the severely injured will be "minimal at best").

[FN141]. See id. at 333-34.

[FN142]. See Hatahley v. United States, 351 U.S. 173, 182 (1956) (acknowledging pain and suffering as legitimate damages to factor in awarding compensation); McDermott v. Severe, 202 U.S. 600, 611-12 (1906) (allowing the consideration of future mental anguish in determining damages for the loss of a limb); Martin, supra note 24, at 333-34.

[FN143]. See Martin, supra note 24, at 334. This focus on the severity of the patient's injury ignores the fact that pain and suffering awards depend on more than the patient's degree of pain. Such a focus does, however, provide a means to implement a more discernable method of measuring pain and suffering awards. See id.

[FN144]. See supra notes 22-23 and accompanying text. Although returning plaintiffs to pre-injury status is not always possible, courts acknowledge the worthiness of the pursuit by allowing patients to receive monetary compensation for their injuries. See 1 Nates et al., supra note 9, §3.01, at 3-4 to 3-7 ("While a pecuniary award will not eradicate the plaintiff's injury in these cases, an economic recovery may assuage damaged feelings or make the suffering of the plaintiff more bearable.").

[FN145]. See supra notes 115-16 and accompanying text.

[FN146]. Martin, supra note 24, at 335-36. This argument ignores the fact that one of the very improprieties that caps propose to eliminate is using damages for compensation of extraneous losses. See id. To clarify, pain and suffering awards should not attempt to compensate plaintiff attorney's fees when correctly applied. See supra note 26 and accompanying text.

[FN147]. Martin, supra note 24, at 336.

[FN148]. See Nader, supra note 54 (indicating that the argument surrounding medical malpractice damages should focus more on injured patients who are receiving "neither justice nor compassion nor compensation"); Press Release, AARP-NC, Key Advocates for Elderly Condemn Proposals to Strip Away Right of Nursing Home Residents 1-2, at http://www.nc-cpr.org/file_depot/010000000/010000/9208/folder/22129/AARPSeniorsRally.pdf (May 13, 2003) (voicing condemnation of proposed medical malpractice caps in North Carolina because of rampant nursing home negligence) (on file with the North Carolina Law Review); Press

Release, Public Citizen, Editorials and Columns Opposing Anti-Consumer Medical Malpractice Legislation 1-6, at http:// www.citizen.org/documents/Editorials_Oppose.pdf (May 22, 2003) (compiling editorials voicing public opposition to statutory caps on non-economic damages) (on file with the North Carolina Law Review).

[FN149]. See Martin, supra note 24, at 335-36; Schwartz & Lorber, supra note 25, at 49.

[FN150]. .See, e.g., Alabama Medical Liability Act of 1987, §5, 1987 Ala. Acts 189, 261 (codified at Ala. Code §6-5-544 (1993)) (imposing a cap of $400,000 on all damages in medical malpractice actions); Medical Injury Compensation Reform Act, ch. 1, §24.6, 1975 Cal. Stat. 3949, 3969 (codified at Cal. Civ. Code §3333.2 (West 1997)) (imposing caps on non-economic damages in medical malpractice cases in the mid-1970s).

[FN151]. See discussion supra notes 56-109 and accompanying text.

[FN152]. See discussion supra notes 39-55 and accompanying text.

[FN153]. Dan Shapiro, Beyond the Blame: A No-Fault Approach to Malpractice, N.Y. Times, Sept. 23, 2003, at F6. Dr. Shapiro is a clinical psychologist who works with health care providers to help them cope with lingering guilt over malpractice through physician wellness seminars. Id.

[FN154]. Id.

[FN155]. Id.

[FN156]. See id. Dr. Shapiro notes that statutory caps on damages do not address the current problem that doctors hesitate to come forward and admit their mistakes. Id.

[FN157]. Schwartz & Lorber, supra note 25, at 68.

[FN158]. Id.; see supra notes 36-38 and accompanying text. Mr. Schwartz and Ms. Lorber cite "the Propulsid case" as a prime example of such conflagration. See Schwartz & Lorber, supra note 25, at 65. They note that in that case, the plaintiffs' counsel included arguments involving the egregiousness of the defendant's culpable conduct, and jurors in turn awarded all of the plaintiffs, even the minimally injured, the same amount in compensatory damages. See id. at 66-67. The trial court later reduced the award and decided not to hold a hearing for punitive damages. See id. at 67.

[FN159]. Id. at 68. Judges could police attorneys by reprimanding them when they make improper suggestions in closing arguments and by imposing fines on attorneys who repeatedly commit these infractions.

[FN160]. Id.; see supra note 33 and accompanying text (quoting the Fifth Circuit's instruction). Empirical evidence shows that jurors assign different awards when they receive different instructions from the court in the same case. See Edward J. McCaffery et al., Framing the Jury: Cognitive Perspectives on Pain and Suffering Awards, 81 Va. L. Rev. 1341, 1342, 1372 (1995) (concluding that an instruction telling jurors to consider "how much one would have to be paid to subject herself to an injury in the first place" produces an award twice as large as an instruction telling jurors to make the plaintiff whole). But cf. Bovbjerg et al., supra note 34, at 913 (noting that jurors generally may not consider what amount someone would demand prospectively before volunteering to undergo the same injury). This information on juror influence emphasizes the impact of the jury instruction on pain and suffering awards in medical malpractice trials.

[FN161]. Schwartz & Lorber, supra note 25, at 68-69. Mr. Schwartz and Ms. Lorber

propose specificity in instructions from the court to steer jurors away from considering the guilt of the defendant. Id. Such instructions would explain the purpose of pain and suffering awards, outline the elements of these damages as described in state law, and define the proper and improper issues to consider in coming to a decision on the awards. Id. Specific instructions would also prohibit jurors from personalizing the plaintiff's injury and considering what they would accept were they in the plaintiff's position. Id. at 69. Other commentators suggest implementing a scheduling system such as that used in worker compensation statutes and avoiding the conundrum of instructing jurors on determining pain and suffering awards altogether. See Bovbjerg et al., supra note 34, at 930 (citing Patricia M. Danzon, Medical Malpractice Liability, in Liability: Perspectives and Policy 101, 122-23(Robert E. Litan & Clifford Winston eds., 1988)). Problems with such a system include under-compensation of severely injured patients and the elimination of awards as a deterrence mechanism for medical malpractice. See id. Further, such a shift in the administration of compensation awards in medical malpractice suits would radically change the concepts and purposes surrounding the liability system. Worker compensation schedules, for instance, are designed to provide prompt and sure relief for injured workers. See generally Peter M. Lencisis, Workers Compensation: A Reference and Guide 9 (1998) (noting that injured workers give up full compensation for the assurance of this efficient and certain system). Deterrence does not play a role in such a system, and it is unclear that the medical liability system could, or that the public would want it to, function without such a deterrence mechanism.

[FN162]. .See McClellan, supra note 26, at 116 (indicating that members of the legal community believe that the methods for determining pain and suffering damages that attorneys discuss in closing arguments have substantial impact on pain and suffering awards).

[FN163]. See id. at 115.

[FN164]. Id. at 113.

[FN165]. Id. A fourth method, the "golden rule argument," asks jurors to put themselves in the plaintiff's shoes, but most jurisdictions do not allow its use. Id. at 113-14.

[FN166]. The static nature of caps on damages as they stand now further obstructs the process of determining proper pain and suffering awards, but caps would gain more legitimacy if there were an accepted method of valuation used by the entire legal community that legislators could adopt in evaluating caps. See Press Release, Senator Edward M. Kennedy, Statement of Senator Edward M. Kennedy in Opposition to the Medical Malpractice Amendment, at http://www.senate.gov/~kennedy/statements/02/07/2002730306.html (July 26, 2002) (expressing Senator Kennedy's opinion that caps are arbitrary and do not take into consideration the severity of the injury or the age of the victim) (on file with the North Carolina Law Review).

[FN167]. See, e.g., Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2002, H.R. 4600, 107th Cong., §5 (2002) (proposing a graduated limit on contingency fees in medical malpractice cases), http://thomas.loc.gov (on file with the North Carolina Law Review).

[FN168]. .Auden & Glombicki, supra note 10, at 7-8 (discussing high contingent fees in medical malpractice cases); Sylvia Law & Steven Polan, Pain and Profit: The Politics of Malpractice 81 (1978) ("'The contingent legal fee... has become the golden calf of the legal profession."' (alteration in original) (quoting Norman S. Blackman, Medical Malpractice Suits: The Lawyers' Stakes, N.Y. Times, Apr. 7, 1975, at 30 (letter to the Editor from the President of the Kings County Medical Society))); see also Michael

Horowitz, Making Ethics Real, Making Ethics Work: A Proposal for Contingency Fee Reform, 44 Emory L.J. 173, 178 (1995) (describing the complaints of such critics).

[FN169]. .McClellan, supra note 26, at 102 (noting that "[t]he cost of evaluating and litigating medical malpractice cases compels plaintiffs' attorneys to reject some meritorious cases because the money that could be recovered does not justify the cost of the suit or the risk of losing"). Some of the costs involved include paying expert witnesses and conducting discovery.

[FN170]. See id. See generally Ruth Bader Ginsburg, In Pursuit of the Public Good: Access to Justice in the United States, 7 Wash. U. J.L. & Pol'y 1 (2001) (describing the origins of the contingent fee system in the United States as grounded in theories of philanthropy and self-interest); Horowitz, supra note 168 (discussing some of the ethical problems with contingent fees in the bar, specifically pointing to the inflation of the standard fee from one-third to forty and sometimes even fifty percent of the total settlement); Peter Karsten, Enabling the Poor to Have Their Day in Court: The Sanctioning of Contingency Fee Contracts, a History to 1940, 47 DePaul L. Rev. 231, 238-42 (1998) (extolling the contingent fee system as allowing the impoverished to have access to the courts).

[FN171]. For instance, some commentators recommend that attorneys gauge contingent fees as a function of the amount of risk that a case poses. See, e.g., Lester Brickman, ABA Regulation of Contingency Fees: Money Talks, Ethics Walks, 65 Fordham L. Rev. 247, 248 (1996) (arguing that it may be unethical for attorneys to engage in the practice of charging a standard contingent fee regardless of the monetary loss or time spent).

[FN172]. Wolfe, supra note 51. The NPDB is federally funded, and its contents are kept confidential from the general public. Div. of Quality Assurance, U.S. Dep't of Health & Human Servs., National Practitioner Data Bank Guidebook A-2 to A-3 (2001) (Sup. Doc. No. HE20.9308:D26), http://www.npdb-hipdb.com/pubs/gb/NPDB%20Guidebook.pdf (on file with the North Carolina Law Review).

[FN173]. See Wolfe, supra note 51.

[FN174]. Div. of Quality Assurance, supra note 172, at A-1 to A-3. In its legislation, Congress acknowledged that the medical malpractice problem had grown to such a level that states could not handle it without federal help. See Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, §402, 100 Stat. 3784, 3784 (codified as amended at 42 U.S.C. §11101 (2000)).

[FN175]. See Div. of Quality Assurance, supra note 172, at A-3.

[FN176]. See Wolfe, supra note 51 ("Only 7.6% of those doctors who have had two or more malpractice payouts against them have been disciplined in the last 12 years.").

[FN177]. E.g., N.C. Admin. Code tit. 21, r. 32.0101(b) (June 2002) ("Each person licensed to practice medicine in the State of North Carolina shall complete no less than 150 hours of practice relevant CME every three years in order to enhance current medical competence, performance or patient care outcome."). More extensive education could include specific requirements that a portion of the required hours pertain to practice, a portion to patient relations, and a final portion to preventing malpractice.

[FN178]. See Wolfe, supra note 51 (indicating that 1,192 physicians in the United States have five malpractice payouts on their records). Even if these payouts involve minor injuries, state boards should implement a policy of suspending or revoking licenses to police even the smallest payouts when physicians have them in significant numbers.

[FN179]. See Claybrook, supra note 42 ("Prevention is the cheapest remedy.").

[FN180]. See id. (discussing the benefits of encouraging the medical profession to self-regulate).

[FN181]. See SCPIE Indem. Co., Keys to Reducing Risk: Meaningful Physician-Patient Interactions, Safe Prac., Aug. 2000, at 1, 1-2, http:// www.scpie.com/general/publications/safe_practice/200008.pdf (on file with the North Carolina Law Review). The United States Medical Licensing Examination in fact has a new section that assesses "clinical and communication skills." Press Release, United States Medical Licensing Examination, Americans Overwhelmingly Support New Medical License Test, at http:// www.usmle.org/news/cse/newsrelease2503.htm (Feb. 5, 2003) (noting that "[p]oor clinical and communications skills have been linked to a higher incidence of malpractice suits") (on file with the North Carolina Law Review).

[FN182]. See Claybrook, supra note 42; see also Shapiro, supra note 153 (noting that a doctor would typically be in a better position to recognize a mistake than a patient).

[FN183]. See Claybrook, supra note 42.

[FN184]. See id. Currently, patients can access state databases through their state medical board websites, but these sites only indicate whether the physician has an active license or not. E.g., North Carolina Medical Board, Lookup a Physician, Physician Assistant, or Nurse Practitioner, at http:// www.ncmedboard.org/database/search.asp (last visited Oct. 13, 2003) (providing database searches by name and profession) (on file with the North Carolina Law Review).

[FN185]. See Claybrook, supra note 42.

[FN186]. See Law & Polan, supra note 168, at 32 (indicating that these problems are the most common reasons for disciplining physicians).

[FN187]. See Comm. on Quality of Health Care in Am., Inst. of Med., To Err Is Human: Building a Safer Health System 11-12 (Linda T. Kohn et al. eds., 1999) (recommending health professional licensing bodies focus more on safety and performance skills).

[FN188]. One proponent of reform in the medical profession references The Bible in support of his position. McLeod, supra note 101 ("As the Bible tells us in Luke 4:23 'Physician, heal thyself."').

[FN189]. See generally Stable Losses, supra note 2 (comparing malpractice premiums and payouts with the economic cycle and frequency of malpractice awards).

[FN190]. See Treaster, supra note 3. Though conservative investment would likely increase premiums slightly in times of prosperity, an increase that is better distributed would prevent such volatile swings in the size of premiums. Cf. supra notes 45-49 and accompanying text (discussing the cyclic effect of insurers' investment income on premiums).

[FN191]. Some of the practices that insurers could adjust include their means of assigning premiums, their method of using investments to offset the cost of premiums, and their lack of a means to police physicians with numerous malpractice payouts. See supra notes 14-21 and accompanying text (describing the process of assigning premiums); supra note 45 and accompanying text (addressing the use of investments to assuage premium rates).

[FN192]. See supra notes 14-21 and accompanying text.

[FN193]. See Nader, supra note 54. In a study of the distribution of malpractice premiums throughout the medical profession, Nader observes that premiums for physicians would be quite manageable if distributed differently: "If physicians would total the entire amount of premiums they paid last year and divide it evenly by all the physicians practicing in the United States, these average premium is less that $10,000 per doctor per year." Id.; see also Stable Losses, supra note 2, at 6 exhibit 3 (calculating that the average premium in 2001 was $9,719). A problem with this system, however, is that specializing physicians tend to make more money than general practitioners, so it hardly seems equitable to force them to pay the same amount in insurance premiums.

[FN194]. See Nader, supra note 54. Some critics allege that insurance carriers purposefully charge popular specialists, such as obstetricians, higher rates in the hope that the public outcry over a decrease in the number of these specialists will encourage legislators to push harder for insurer-friendly tort reform. E.g., id. (alleging that insurers use this process to charge specialists $50,000 to $100,000 more than general practitioners).

[FN195]. "Problem" physicians would include doctors who have a history of drug and alcohol problems as well as doctors who have been held liable in more than one medical malpractice suit. See Law & Polan, supra note 168, at 32.

[FN196]. Nader, supra note 54.

[FN197]. See Wolfe, supra note 51.

[FN198]. CMEs should currently ensure physicians are up to date on the availability of new medical practices and the dangers of certain risky procedures. See supra note 177 and accompanying text.

[FN199]. Leebron, supra note 7, at 265.
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