The Tort of Medical Malpractice:
Is It Time for Law Reform in North Carolina?

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The Tort of Medical Malpractice

Is It Time for Law Reform in North Carolina?

North Carolina, like other states, is currently considering important modifications to its Common Law of tort, and especially to that subset of tort known as medical malpractice. This is because malpractice insurance premiums for North Carolina physicians are apparently increasing at a rapid rate, which allegedly imperils the quality of medical care for North Carolinians. Proponents of tort reform insist that such reform is the only way to ensure that quality medical care remain affordable in the Tarheel State. Opponents of tort reform respond that fluctuations in interest rates, and the "insurance cycle" in general, account for premium changes, and that tort reform would imperil the health of North Carolinians by "subsidizing" negligent physicians. As with many political debates, there is some truth to all these claims, and the task at hand is to understand the nature of tort law, of insurance, and of the incentives provided by increasing claims.

In this study of current and proposed North Carolina med-mal law, then, it's important to begin by grasping how tort law (of which "med-mal" is a branch) fits in the legal order of a society of free and responsible individuals. Only through an understanding of the nature and function of tort does the discussion of whether there is "too much" or "too little" med-mal liability become fully intelligible. To understand the nature of tort law, one must appreciate the difference between two basic types of legal rules in a free society: rules of private ordering and of public ordering. After clarifying this distinction, the study proceeds to examine in detail the nature of America's medical malpractice system, paying particular attention to the field of obstetrics, where vastly increased insurance premiums have both been most severe and have arguably resulted in the highest social cost through wasteful and perhaps dangerous "defensive medicine."

North Carolina's own particular med-mal situation is then examined in detail. Although not yet in "acute crisis" stage, the malpractice situation is clearly worsening in North Carolina, and the time for reform is ripe. The study examines the various reforms currently proposed in the North Carolina legislature, and finds that at various points they either go too far or not far enough. In conclusion, a blueprint is discussed for the kind of med-mal reform North Carolina should contemplate if it wishes to further the role of tort law in private ordering and reduce the tremendous transaction costs of medical malpractice.

Introduction

"A billion here, a billion there, and pretty soon you're talking about real money." When the late Sen. Everett M. Dirksen from Illinois offered that famous quip about government spending 40 years ago, no one imagined that the same words might be used today to describe the American tort system. Yet last year a Florida jury conjured up punitive damages of $145 *billion* for a class of plaintiffs. The year before, a California jury recommended a $28 *billion* treasure trove for one single claimant. And in 1998 four major cigarette companies agreed to the mother of all awards—a quarter-trillion-dollar settlement supposedly to reimburse states for the Medicaid costs of smoking-related illnesses, though in fact designed to cartelize an industry for the mutual profit of plaintiffs and states alike.[1]

So it goes. Not just tobacco; but guns, asbestos, and a cross section of American industry that has morphed into the Mass Tort Monster: "DDT, Bendectin, DES, swine flu vaccine, Copper-7, PCBs, the Dalkon Shield, Shiley heart valves, heart catheters, pickup-truck fuel tanks, blood products, silicone breast implants, pedicle screws, penile implants, intraocular lenses, … lead pigment, latex, dietary supplements, fen-phen, Rezulin, L-tryptophan, Duract, Parlodel, Synthroid, Propulsid and so forth almost *ad infinitum*."[2] The manufacturers of these products, and those (such as physicians) who recommended them, are targeted.

According to the U.S. Chamber of Commerce, the tort system is wrecking our economy. It is not disputed that, since 1930, growth in litigation costs has been four times the growth of the overall economy. The Chamber reports that federal class actions have tripled over the past 10 years, while similar filings in state courts ballooned by more than 1,000 percent.[3] The estimated aggregate cost of the tort system in 2002 was $233 billion, or roughly $1,000 for every man, woman and child in America, according to Tillinghast-Towers Perrin, a respected actuarial firm that works for many insurance companies. The share of this cost going to trial (i.e., plaintiffs') lawyers—roughly $40 billion in 2002—is 150% of the annual revenues of Microsoft or Intel, and twice those of Coca-Cola.[4] The cost of our tort system represented 2.23 percent of the nation's gross domestic product, or the equivalent of a 5 percent tax on wages.[5] This cost of nearly $1,000 per American in 2002 compares to a cost of $12 per person in 1950.[6] Even adjusting for inflation, the cost of tort has increased by more than 900 percent over fifty years.[7] The Tillinghast firm predicts that, over the next 10 years, the total "tort tax" will be $3.6 trillion.[8]

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On the other hand, reputable scholarship maintains that there have traditionally been too *few* tort suits, and that litigation is only now beginning to catch up to the harms wrongfully inflicted on some Americans by others. One respected 1991 study, for example, has concluded that for every *eight* instances of medical negligence causing harm in America, only *one* malpractice suit is filed—and that one suit, likely as not, was launched in a case without merit….[9]

In this study of current and proposed North Carolina med-mal law, it's important to begin by grasping how tort law (of which "med-mal" is a branch) fits in the legal order of a society of free and responsible individuals. Only through an initial understanding of the nature and function of tort does the discussion of whether there is "too much" or "too little" tort liability become fully intelligible.

To understand the nature of tort law, one must appreciate the difference between two basic types of legal rules in a free society: rules of *private ordering* and of *public ordering*. After clarifying this distinction, the Introduction will close with a brief overview of the constitutional separation of powers as it applies to tort (and especially to med-mal) reform. Then the nature of North Carolina med-mal will be examined in some detail.

I. Why Have Tort Liability Anyway?

Public Ordering v. Private Ordering

Public law, that subset of our legal system that regulates relationships between citizens and government, is, in a word, sexy. Constitutional litigation (where citizens sue governments for breach of our higher law) makes headlines, as it should.[10] Criminal trials (where governments sue citizens for breach of conduct) are front-page and prime-time fodder. Notwithstanding the valid interest in public ordering, however, it is interesting that in a free society like ours, *private law* issues are not more widely recognized as vital.[11]

What we must realize is that private law (roughly, rules regulating the allocation of rights and obligations, or (in other words) the sharing of risks *among citizens*) and private ordering (the possibility for people to "self-determine" through interaction amongst themselves) are arguably what distinguishes free societies from totalitarian ones.[12] All countries have public law institutions—prisons and police and legislatures, for example. But only in free countries does the private law of contract, property, tort and family law dominate the acquisition and exchange of rights and obligations.

Private law does this by allowing citizens to transfer entitlements (i.e., to assume risks) voluntarily (through contract law) or involuntarily (for one of two reasons: when one's choices wrongfully cause harm to another (tort law), and when family ties impose duties). Most of us will never have a serious run-in with the police or with any government agency. But all of us interact daily in the private law legal forum—we work, we buy, we sell, we parent families, and sometimes we "collide" with others who are doing the same thing.

What Tort Is Not

Tort law, which assigns private obligations to wrongdoers who cause harm to others in these "collisions," is an essential component of private ordering. What is the essence of tort?[13] This important question is perhaps best broached by sketching what tort law is *not*:

• *Tort law is not insurance against unfortunate losses*. Tort law does not exist in order to provide protection against risks. Free societies have a very "thick" (i.e., competitive) contractual market for insurance policies that do just that.[14] Most losses that we suffer happen without any tort—lightning may strike us, we may get sick and miss work, or a medical procedure may fail through no fault of the physician. Homeowners' insurance, health insurance and life insurance (commonly called "first party insurance" because they protect the insured party against loss to herself) are available to protect against these hazards. If, however, the loss is the result of a wrongful act by a third party, the victim may recover from the tortfeasor.[15] If insurance against loss is the desired goal, contract law and the competitive insurance market is the answer. If "free insurance" (otherwise known as "social insurance") for the poor, or for all, is the desired goal, then public law, not tort law, is the appropriate vehicle for the creation of what is in essence a welfare plan. Public law can socialize risk, and remove it from the realm of private ordering. But tort law is not insurance, nor is it a welfare plan.

Tort law assigns private obligations to wrongdoers who cause harm to others. It is an essential component of private ordering.

• *Being an innocent victim does not entitle one to tort recovery.* Many innocent people suffer losses for which there is no tort recovery. Indeed, the vast majority of good people to whom bad things happen have no proper recourse in tort. The pedestrian struck by lightning, the merchant who loses everything she owns to a more efficient business competitor; the baby born with a congenital birth defect, the unintelligent or unattractive person; and many, many others, can and should find no solace in tort law. Just because something sad has happened does not mean tort law should provide a remedy. Tort law is not an equalizer. Only a horrific use of public law could equalize everyone's chances and outcomes.[16]

Tort's essence, then, is not the compensation of "casualties," although of course tort does compensate some innocent victims in certain circumstances. Rather, the essence of tort law is to reallocate risks when one person has *wrongfully* and *without consent* caused harm to another.[17]

Tort Versus Contract

It is of the essence of private ordering that tort be properly subjugated to the contractual transfer of risks. If I assume a risk voluntarily, through contract, I cannot sue my contract partner in tort if the risk materializes. If I purchase a home in a one-industry town, I may not blame my seller two years later after the factory has shut down and my house has lost most of its value. I have assumed this risk through contract, by buying the house. Taking a seat as a passenger in a car one knows is being driven by a drunk driver is a different kind of implied contractual assumption of risk.[18] When a victim expressly or implicity assumes a risk of loss through contract, tort must decline to shift the risk elsewhere. Medical procedures are inherently risky—the mere fact that an operation is not successful is not sufficient basis for a tort remedy.

Tort Law Doesn't Involve the Public

Tort suits are adjustments of risks between private parties. They are very different from public legislation, criminal and regulatory, in several important ways.

• Significantly, an obligation under tort law arises *without state intervention*. Government is not a party to a tort suit—unless, of course, the government (through one of its employees, say) has committed a tort or has suffered wrongful damage in its private capacity (as when a motorist negligently runs into government property).

• Tort suits are about private adjustments of risks—they are not a mechanism to express public outrage. Vindication of public offense is the province of criminal law, a principal component of *public* ordering.[19] Criminal law doesn't even need individual victims, by the way; torts do. "Traditional" crimes like attempted murder and treason[20] produce no individualized, non-consenting victim. Nor do more "victimless" crimes such as prostitution[21] and sodomy.[22] These may be the province of criminal law—but tort law does not exist to cure societal ills.

• Tort law is not about punishment. Criminal adjudication punishes the culprit: common law torts require *compensation* only.[23]

Tort suits are about private adjustments of risks – they are not a mechanism to express public outrage.

• Common law tort suits are not properly concerned with the enactment of "public policy," which is of course a quintessential yield of public ordering. Every citizen has the right to intervene in the legislative process that produces public policy, but only the parties directly involved in a tort suit can intercede in that suit. Our legislative process, which guarantees all the right to voice their views, is the only constitutional forum for policy-making. But common law judges don't, and must not, make public policy.

• Finally and crucially, tort suits were not designed as, and are inappropriate vehicles for, coerced redistribution of resources. Redistribution is the province of tax and welfare law, which are components of public ordering. Coerced transfer through public ordering is typically based on conceptions of *distributive* justice—the view that certain classes have "too much," and others "not enough."[24] In tort law, however, forced transfers are based on notions of *corrective* justice (this defendant wrongfully caused a loss to this plaintiff, and must make good that loss). These notions of corrective justice have no distributive punch: that is, if a defendant, however poor and pitiful, wrongfully[25] harms a victim, however rich and powerful, compensation is absolutely owing in tort.

Just as it is difficult to imagine a free society without the right to hold and to contractually exchange property, free nations have always also had rules of tort liability, transferring property following wrongfully caused private losses. Tort law, in other words, is essential to private ordering. To see this, imagine that tort was replaced by social insurance: i.e., that every

loss was deemed a public loss, because government provided total protection against all risks. Imagine also that government proceeded to sue (i.e., to prosecute) all those who caused "claims" on its resources. *In such a society there would be no need for tort law*: government recovery of its payouts would proceed, typically using tax or criminal law. *There would also be no meaningful contract law in such a world*—if all risks are borne by government, then private individuals could not really own property (because to own property is to assume the risk of its loss).[26] Socialization of risks substitutes public for private ordering.

*In other words, socialization of risk substitutes regulations and criminal statutes for contract and tort***.** The things that constitute wrongs against persons in a free society become offenses against the state in a collectivized polity. Political processes, not private conduct, determine who gets entitlements and who loses them in a publicly ordered society. The vibrancy of private ordering is the vibrancy of freedom: if tort is abused and is replaced by public policy, private ordering recedes, and freedom is replaced by collectivism.

The Constitution and Tort Reform

Federal legislation that would cap med-mal awards and limit attorney fees passed the U.S. House of Representatives 229 to 196 on March 13, 2003.[27] HR 5 was the seventh attempt at federal malpractice reform since Republicans took over the House in 1995.[28]

In the face of GOP pressures to federalize tort law, our constitutional principles must be recalled and enforced. The general principle cannot be repeated often enough: *Our federal government is one of limited and enumerated powers.* The making of tort law is not one of those powers. President Bush is a former governor who says he is committed to principles of federalism. Yet he defends the attempted federalization of malpractice law: "People say, well, is [med-mal] a federal responsibility?" "It's a national problem," he responds, "that requires a national solution. The federal government ought to set a minimum federal standard to reform the medical liability system."[29] However, the fact that a problem exists in more than one state does not make it a *federal* responsibility.

The current administration's legal strategy in defense of federal med-mal (and, generally, tort) intervention appears to be twofold.[30] First, federal limitations on med-mal suits are supposedly warranted because the federal government spends money on health care, and the Constitution's spending power[31] presumably allows Congress to impose conditions on parties that benefit from those expenditures. Not only does the federal government fund Medicare and Medicaid, it also provides direct care to members of the armed forces, veterans, and patients served by the Indian Health Service, as well as tax breaks to the great majority of workers, who obtain health insurance through their employers. The administration projects government savings of at least $25 billion a year if its proposed med-mal reforms are put in place. "[A]ny time a malpractice lawsuit drives up the cost of health care, it affects taxpayers. It is a federal issue," the president declared in a North Carolina speech.[32]

In essence, the argument is that Washington pays for *a lot* of health care; therefore Washington can compel state malpractice reform, which would affect how *all* health care money is

spent. But the Supreme Court has invalidated conditions imposed on the recipients of federal spending unless, among other things, the conditions are unambiguous and reasonably related to the aim of the expenditure.[33] In this instance, Congress has not linked the receipt of federal health funding to malpractice reform, nor has the federal government shown that the goals of Medicare and Medicaid depend on such reforms. Moreover, the scope of proposed federal malpractice intervention extends, though it need not logically do so, to all health care lawsuits—the federal reforms do not apply only to suits brought by or against parties who receive federal funds.

As a subsidiary argument to its weak Spending Clause contention, the administration posits a *Commerce Clause* claim.[34] Physicians are allegedly "forced" to move to another state, or to retire from practice altogether (thus removing their services from the "stream of interstate commerce"), by recent hikes in malpractice premiums, which themselves are allegedly due to overly generous state med-mal rules.[35] This chilling of interstate commerce warrants, it is said, federal intervention.

The lack of any need for federal intervention is eloquently proven by state med-mal reform being ubiquitous. More than three dozen states have passed damage caps. All 50 states have either passed or are currently considering some kind of med-mal reform.

At the margin, malpractice abuse has surely steered some patients across state lines to find better health care, and it has surely influenced young physicians' choice of specialties and of geographic locations . But intrastate regulation of in-state conduct is simply *not* interference with interstate commerce — if I am wrong on this count, then there is no area immune from federal jurisdiction, and we don't live in a federal republic. Naturally, there's an *effect* on commerce when any individual or company withdraws from a state. But if a move from one state to another is the result of unfriendly in-state negligence claims, then as long as there is no discrimination against out-of-state parties, the effect is not uniquely related to the *interstate* aspect of commerce.

In objecting to President Bush's assertion of federal med-mal jurisdiction, I do not dismiss potential problems associated with excessive malpractice awards. Fear of undue malpractice liability probably does lead doctors to order redundant and expensive diagnostic tests[36] and operations, as will be illustrated below.[37] High malpractice insurance premiums may encourage competent physicians to retire prematurely, or to restrict their practice to high-paying, low-tort-risk patients, or to refuse to take on any new patients, leaving whole geographic or socioeconomic sectors underserved.[38] On the other hand, it should be noted again that some well-respected academic sources suggest that there may currently be too *little* med-mal liability.[39]

But I need not enter the substantive debate on med-mal reform at this juncture. Tort reform may well be appropriate—it is sufficient here to show that *federal* intervention to affect med-mal is neither necessary nor proper. Here, in a nutshell, is why. The two litigants in a med-mal suit are typically a local (in-state) plaintiff and a local (in-state) physician. As a re-

sult, any insufficient or excessive tort liability would be directly felt in the local state, where it will translate (in the case of excessive liability) into high insurance premiums for local doctors and concomitant high costs for patients.[40] Doctors held liable too often can retire from practice or relocate to other states if they find liability too onerous. That will lower supply of physician services, increase prices, and exert pressure on in-state legislatures, and indirectly also on juries, to temper their excesses.

The lack of any need for federal intervention is eloquently proven by the fact that state med-mal reform is ubiquitous.[41] More than three dozen states have passed damage caps. All 50 states have either passed or are currently considering (North Carolina is in the latter category) some kind of med-mal reform.[42] If a state legislature chooses not to enact med-mal reform—and if it suffers an increase in the cost or a decline in the quantity of medical care, as a result of excessive liability—that would most assuredly not create a federal crisis. Rather, that would be a matter for the state's legislators and voters to resolve. The tort regime applicable to North Carolina's health care providers is, therefore, an issue for North Carolina law.

Is there, then, a med-mal problem in the nation and in North Carolina? If there is, how should North Carolina fix it? The remainder of this report addresses these two questions.

II. The General Medical Malpractice Problem

The Med-Mal "Crisis"

Medical malpractice has been even more prone to cries of "crisis" than most other areas of tort law. Manifestations of the alleged med-mal crisis are, among others:

• *Relatively brutal increases in tort liability*. Since 1975, when insurers first began to itemize tort costs attributable to med-mal, med-mal costs have grown at a compound annual rate of 11.9 percent, which is fully 25 percent more rapidly than the 9.5 percent annual increase already bemoaned for all U.S. tort costs.[43] These costs have been translated into uneven, sometimes drastic, increases in med-mal premiums, as liability insurers periodically hemorrhage money—for every dollar of premium earned in 2001, for example, insurers paid out $1.38. In addition, the much-publicized decision by St. Paul, the biggest single insurer in the market, to cease writing new med-mal policies contributed to a drop of approximately 15 percent of the premium-writing capacity of the industry[44];

• *An increase in mammoth claims*. According to one database, the percentage of payments over $1 million doubled, to slightly more than 7 percent of med-mal claims, from 1995 to 2001 alone. Today over 10 percent of med-mal payments are over $1 million nationally, while in North Carolina nearly one fifth of all medical liability claims are over $1 million.[45] In some specialties, such as OB-GYN, the *average* claim is now over $1 million. Mammoth claims impact on med-mal insurance rates, and insurability, much more than do smaller claims, as they drastically increase risk for insurers and greatly increase their desire to engage in "nuisance settlements" of invalid claims (in order to avoid the small risk of an unjustified massive award).

Nuisance claims are therefore a direct function, to some extent, of the likelihood of a mammoth claim.

• *Widespread anecdotal allegations of resulting grave social harm*. These include stories of massive "early retirement," of restriction of practice to existing (and new low-risk) clientele, and of reduction in supply of certain specialty fields, especially OB-GYN, in many states;

• *Exacerbation of medical inflation*. This is said to occur not only because high liability awards are factored into insurance premiums, which are factored into doctors' fees, and not only because a lower supply of medical services increases prices, but also because redundant and expensive tests and procedures are now said to be required by malpractice insurers as inefficient prophylactics against med-mal liability. One telling example of this is highlighted immediately below.

An Illustration of the Crisis: Obstetrics

A two-volume study from the National Institute of Medicine (NIM—an arm of the National Academy of Science) in 1990 illustrated the med-mal crisis in striking detail (though many practitioners would contend that matters have gotten worse since then…). The study, entitled *Medical Professional Liability and the Delivery of Obstetrical Care*, contained the findings of an interdisciplinary committee that investigated the effects of litigation on the practice of obstetric medicine. The study, which had no institutional bias for physicians or patients, commissioned over 20 research papers and reviewed more than 50 existing surveys, as well as other scholarly research.[46]

According to one database, the percentage of payments over $1 million doubled, to slightly more than 7 percent of med-mal claims, from 1995 to 2001… In North Carolina nearly one fifth of all medical liability claims are over $1 million.

The study found that over seven in 10 obstetricians had been sued at least once. Suits in modern times invariably followed "imperfect" births, which constitute (depending on one's definition of "imperfect") upwards of 5 percent of all births today. Plaintiffs usually claim that had the obstetrician delivered the baby earlier, by caesarian section, the baby would have been "perfect." Claims like this are rampant today—the NIM committee found, for instance, that in Massachusetts fully 80 percent of obstetrical malpractice claims included a charge of failure to peform a caesarian-section. Such comparatively vacant claims, in the absence of any individualized evidence of wrongdoing or causation, never would have reached a jury in early times—but of late they are indeed allowed to go to juries, who know full well that the defendant physician is insured against liability. Knowledge of this, and fear of mammoth awards of "free money" to parents, leads insurers to propose hefty settlements and substantial increases in med-mal premiums even when the physician has done nothing wrong.

As a result of this development, the National Institutes of Medicine committee documented a startling increase in the number of caesarian-section births, which by 1990 accounted for 25

percent of all deliveries, easily the highest rate in the world and a fivefold increase from the 5 percent rate in 1970. The nationwide cost of these caesarian-section deliveries was estimated at $750 million per year in 1990 dollars, not including the costs of negative side-effects of surgery. The study found a distinct relationship between the med-mal system and caesarian-sections.

The desire for a perfect baby is overwhelming, yet about 5 percent of babies are handicapped in some way, usually neurologically. This tragedy has been with us from time immemorial, except that in earlier days relatively primitive medical equipment meant that the survival rates for these "bad babies" was relatively low. A stillborn baby was quickly buried, and the grief from the death slowly faded. Today very few babies die at birth, and babies with neurological problems have high maintenance costs and limited prospects for earning a high income when they reach adulthood. Whereas in the past parents were wont to conclude that divine will, or in some cases the parents' own misbehavior during pregnancy, was likely the cause of their child's "defect," today large amounts of money are at stake, and many feel someone else must be found to blame.

Plaintiffs' lawyers are most anxious to get before a jury and ask for "compensation" for the innocent baby from the doctor insured by the big, bad, med-mal insurer. Infant neurological damage accounted for the absolute majority of suits against OB-GYN's in many states by the time the NIM study was published, and was second (to breast cancer claims against gynecologists) in other states. Typically, OB-GYN med-mal suits run into millions and often the tens of millions (the cost of rearing a "defective" child); and classically the plaintiff's claim is that the obstetrician failed to monitor the fetus adequately, which in turn led to his/her failure to perform the caesarian section.

In the past, parents were wont to conclude that divine will, or in some cases their own misbehavior during pregnancy, was likely the cause of their child's "defect." Today large amounts of money are at stake, and many feel someone else must be found to blame.

What led to this rapid expansion of med-mal, to the detriment of physicians and of patients? In a word, technology. Electronic fetal monitoring, or EFM, was developed in 1972. The idea was that by monitoring the fetus the doctor could detect distress and intervene (typically by caesarian section) to ensure a normal birth. Cerebral palsy claims became "failure to monitor" claims. But even by 1990 the NIM knew that most cases of fetal brain damage were *not* due to delivery events. *It turns out that massive, and expensive, use of fetal monitoring strips has not reduced the incidence of cerebral palsy, because of rampant "false positive" results of the test strips.* The NIM report concluded that overwhelming evidence establishes that "EFM [and caesarian section] has not reduced neonatal morbidity and death, and… it has not reduced the frequency of developmental disability." Yet EFM not only remains in (costly) use, but is still considered standard procedure if an obstetrician hopes to defend him or herself against charges of negligence.

This author examines very closely, as a case study in his Torts class at George Mason Law School, the largest med-mal case in Connecticut history, *Sabia v Humes*, where, despite a total lack of evidence of any causal negligence, an OB-GYN and her insurer were led to a multi-million dollar settlement of a "bad baby" case.[47] Nothing unique about Connecticut law allowed *Sabia* to happen—the state's common law of med-mal is essentially identical to North Carolina's. Indeed, *Sabia* happens writ large across the country every year.

The NIM committee found that, *in every state*, sizeable numbers of family practitioners had eliminated OB-GYN from their practice by 1990. They were compelled to do so, because the huge discrepancy in liability insurance premium made the obstetric part of their practice non-profitable.[48] Obstetrical specialists, for their part, also reduced or eliminated their services to high-risk women. One common way for OB-GYNs to screen out high-risk pregnancies is to cut their Medicaid caseloads, since Medicaid patients are more likely to have engaged in poor pre-natal care, and since the *pro-rata* cost of malpractice insurance all by itself is often greater than Medicaid reimbursement for the delivery.

The purpose of private ordering is not achieved by transferring a risk from a possibly innocent parent to a doctor who almost certainly did nothing wrong. What is *achieved by this forced insurance is a frustration of many doctors' idealistic career goals.*

This is clearly perverse. The purpose of private ordering is surely not achieved by transferring a risk from a possibly innocent parent to a doctor who almost certainly did nothing wrong. What *is* achieved by this forced insurance is a frustration of many doctors' idealistic career goals. The doctor who has been sued (and, recall, an absolute majority of OB-GYN's have now been sued) learns to treat his or her patients as future adversaries. Overuse of knowingly needless and expensive procedures (like EFM's) is just one way in which med-mal's costs filter down to the entire population. Demoralization of the healing arts is another way this misdeed is done.

In general, advances in technology constantly provide new ammunition for those "in search of a reason" for a bad medical result. ("Why didn't you use this device? It might have made a difference.") The ubiquity of insurance eases jurors' pain, as they decide that the doctor won't really "feel" the tort award, which will be paid by a faceless corporation. The real payers, of course, are the doctors and patients alike, who suffer a decline in supply and an increase in the price of medical services. In ways similar to that afflicting obstetrics, other specialties and even general practice have been afflicted by this desire of juries to turn tort law into future health insurance. This is a perversion of private ordering, and only tort reform can cure it.

III. Medical Malpractice in North Carolina

Facts Indicating There Is a Crisis

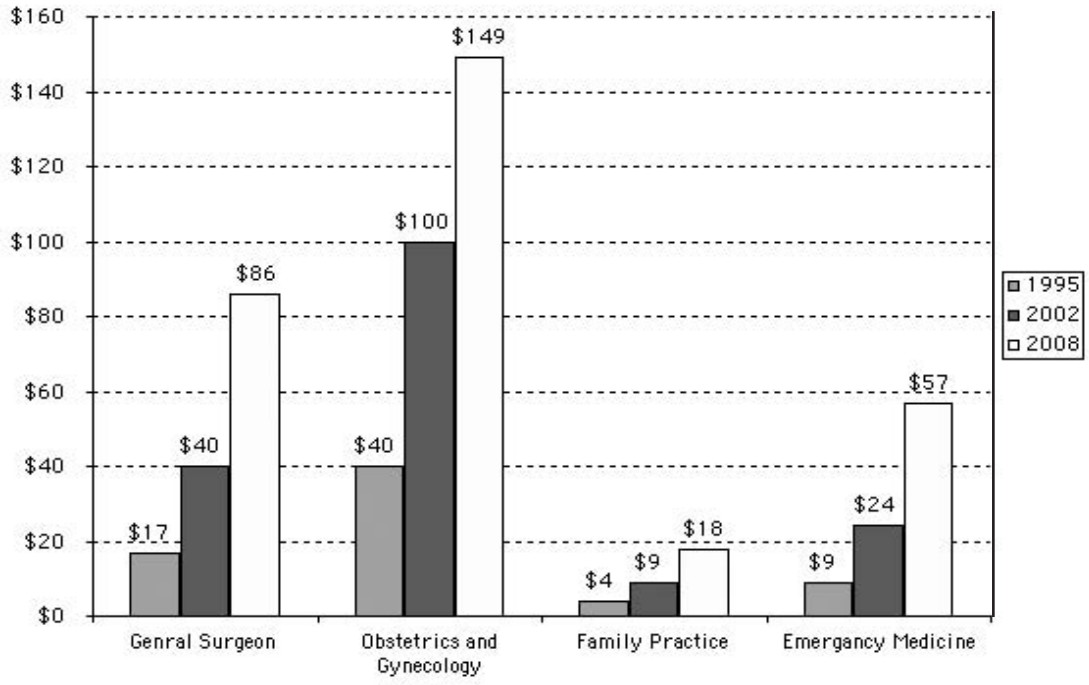
It would be astonishing if North Carolina were somehow immune from these tendencies.

According to the Dean of UNC's School of Medicine, it is not. Dr. Jeffrey Houpt testified in 2003 that his school had diverted considerable resources away from providing quality patient care, and toward perfecting and paying for its litigation team. Medical Mutual Insurance Company of North Carolina, the state's largest med-mal insurer, reports that from 1995-2003 the base premium rate has increased tremendously, as follows:

- *For General Surgeons:* a 127 percent increase, to $40,000 per year in basic liability premiums
- *For OB-GYN's:* a 137 percent increase, to $100,000 per year;
- *For family practitioners with no obstetric practice:* a 115 percent increase, to $9,000 per year;
- *For emergency room physicians:* a 153 percent increase, to $24,000 per year.[49]

These premium increases are not, political demagoguery notwithstanding, the result of "gouging" by insurers. Each year, nationwide, the Department of Justice concludes that the insurance industry is among the most competitive in the land—there is simply no chance to "gouge" when any pricing inefficiency will be competed away by another firm. Indeed, it is estimated that 80 percent of all practicing North Carolina physicians are either insured by a mutual insurance company (like Medical Mutual) *that they co-own* or are employees of an institution that is substantially self-insured. Nor is it true that "a few bad apples" among the

Base Premium Rate for North Carolina Medical Professional Liability Insurance: 1995, 2002, 2008 (Projected, in Thousands $)



Note: From 1995 to 2002, the actual increases were 127 percent for General Surgeons, 137 percent for Ob/Gyns, 115 percent for Family Practice physicians, and 153 percent for Emergency Medicine physicians.

doctors is causing the problem in North Carolina. Most Tarheel doctors are assuredly not incompetent, yet in several fields most are being sued. Mimicking nationwide trends, 55 percent of Medical Mutual's emergency physicians, 62 percent of its OB-GYN's, and 70 percent of its general surgeons have been sued for malpractice. A 1997 malpractice award of $23 million for a neurologically impaired baby easily eclipses the *Sabia* "horror story" from Connecticut, which I use in my Torts class as a case study for med-mal's problems. Just as in the *Sabia* case, however, the North Carolina plaintiff's lawyer seemed to concede that his case was not really about proving physician wrongdoing so much as it was about getting money from an insurer to take care of the upbringing of a handicapped child.[50]

It is not surprising, therefore, to learn that 79 percent of North Carolina physicians claim that they order more tests than they would have done based on their professional judgment of what is medically needed, simply as a "C.Y.A." measure to protect against med-mal claims. Seventy-four percent of Tarheel family practioners make what they themselves believe to be needless referrals to specialists for the same reason.[51]

Most Tarheel doctors are assuredly not incompetent, yet in several fields most are being sued. Mimicking nationwide trends, 55 percent of Medical Mutual's emergency physicians, 62 percent of its OB-GYN's, and 70 percent of its general surgeons have been sued.

This data tends to corroborate that North Carolina is caught up in the same torts outburst that afflicts much of the rest of the nation. But there are three countervailing arguments that we should examine as well:

Facts Indicating There Is No Crisis

1. The number of physicians registered in the state has not diminished.

Objective data indicate that the number of registered physicians *per capita* in North Carolina remained stable from 1999 to 2002. This is the case not only for the total number of physicians, but also for the number of physicians in the particular specialties most affected by med-mal. There has, in fact, been a very slow *increase* in the number of registered OB-GYN's in the state, and the actual number of registered North Carolina doctors has increased at a rate very slightly *higher* than the state's population increase.[52]

The problem with this data is that registration with the state medical association is simply not a good proxy for what one might call "vigor of practice." For instance, a physician who scales down her practice, who refuses to take new patients, who refuses to take high-risk patients, or who "unofficially" retires while maintaining her active status in case she changes her mind in the future, would still show up on the register. In other words, if registration decreases this is a good sign of a problem; but if registration does not decrease, this is an ambiguous sign at best.

2. Recent hefty increases in liability insurance premiums may merely mean that physicians paid "too little" in premiums in the early 1990s.

There is some evidence to support the proposition that liability insurance premiums do not increase at a slow, steady rate, but in staccato-like fashion. In brief, this is because liability insurance premiums are calculated as a function of two factors: the amount the insurer expects to have to pay out in liability awards and legal fees on the one hand, and the amount the insurer expects to reap in investment income on the "float" (the premium retained before liability is incurred) on the other. If real interest rates and stock market returns are quite high, insurers can afford to lose some money on underwriting—they will more than make up that loss as a return on investment. It is indeed true that bond yields have declined, and equity values have come down from their highs of the 1990s. Most returns for liability companies like Medical Mutual must (under state regulation) derive from bond returns, and an interest rate assumption of (say) 5.5 percent rather than 6.5 percent leads to a rate increase of approximately 3 percent.[53] An increase in interest rate assumptions would lead to a corresponding decrease in premiums.

However, this data is at best ambiguous in its significance. First, it is a relatively minor factor in insurance premium calculation. Assume the projected payout costs (administrative plus claims-related costs) of a policy are $1,000. If the average payout time is three years (that is, if premiums collected in 2004 will on average be paid out to claimants in 2007), then the premiums can be invested for three years. At a 5.5 percent interest rate, a premium of $855 is required to cover this expected payout. At a 6.5 percent interest rate, the annual premium would have to be $830. Clearly, investment returns explain a part, but only a relatively small part, of the movement of liability insurance premiums. Without the distortion caused by the vagaries of investment returns, it is likely that we would have witnessed slightly more regular, steady increases in med-mal premiums over the past few decades. Instead, periods of no premium increase at all (or even premium decreases, as new entrants into the liability insurance industry tried to profit from high investment returns on the "float" of premiums) have alternated with periods of huge increases.

> *A physician who scales down her practice, who refuses to take new patients… would still show up on the register. In other words, if registration decreases this is a good sign of a problem; but if registration does not decrease, this is an ambiguous sign at best.*

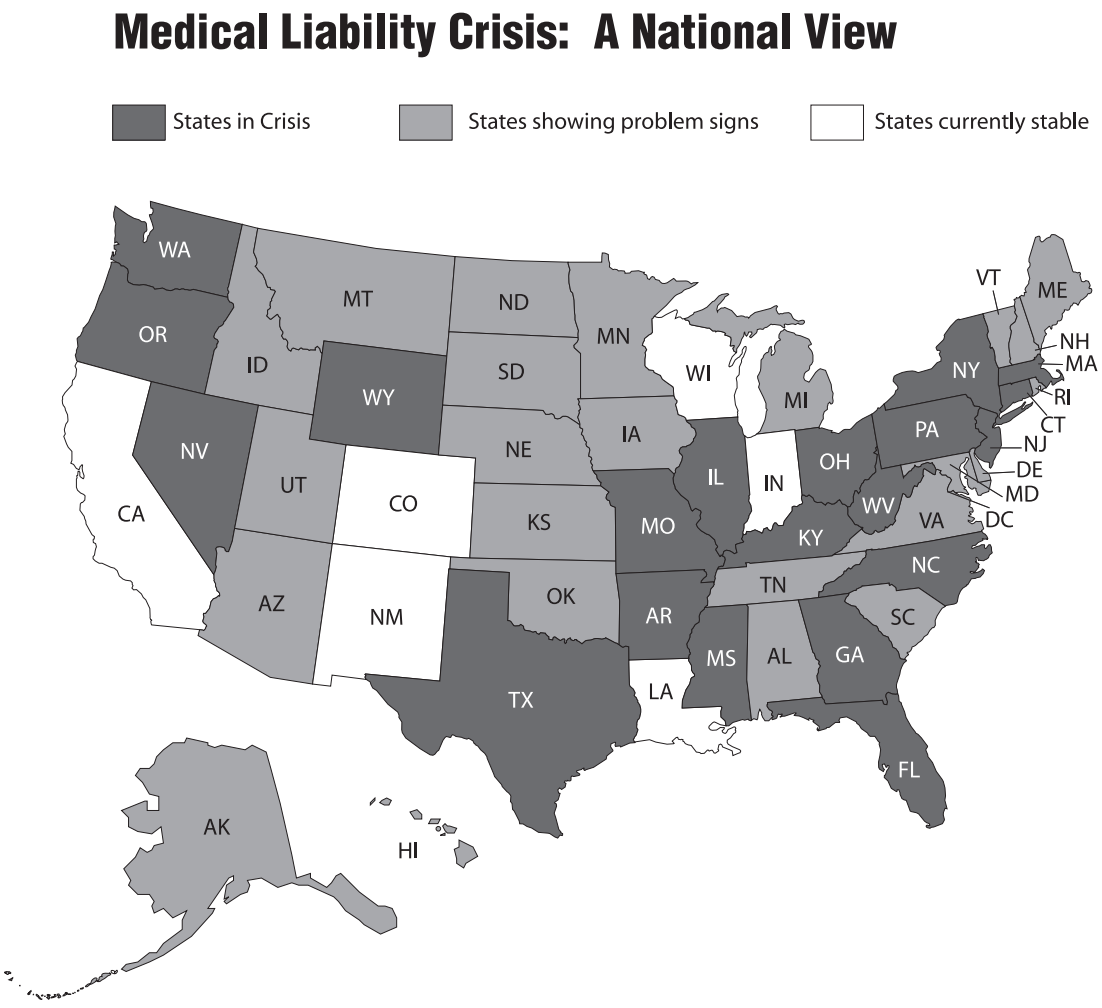
In other words, the argument about investment returns proves too much. Contrary to what populist demagogues may believe, insurance companies simply cannot charge high future premiums to make up for past investment losses. The market is simply too competitive to allow this to occur—even if regulators allowed the price increase, which most would not, new companies without prior losses would enter the market to undercut any proposed increase. Rather, and as a matter both of regulation and fundamental economic theory, companies must charge a premium that will allow them a competitive profit given *expected* investment gains or losses and *expected* liability payout.[54]

Incompetently managed companies, as St. Paul was (it charged premiums that were far too low, actuarially, and was obliged to exit the med-mal market), do occasionally crop up.[55] But the market exacts its own discipline against such companies. The fact remains that med-mal insurance premiums, fairly priced from a competitive actuarial standpoint, are much higher than they used to be, and are much higher than they are in other countries. [For example, our med-mal awards are approximately 1,000 percent of those of Canada, and our doctors are 500 percent more likely to be held liable than are Canadian doctors, yet I have read no claim that our doctors are five or 10 times less competent than Canadian doctors.[56]]

3. Payouts by medical liability insurers have approximately tracked the rate of medical inflation.

Interesting work by an anti-insurance lobby, *Americans for Insurance Reform*, concludes that since 1975 the amount paid out by med-mal insurers has increased by a percentage approximately comparable to the increase in what AIR calls the "medical inflation" rate.[57] Thus, concludes the lobby, there has been no *real* increase in med-mal in the state.

But even if it were true (liability insurance data is complex, easy to manipulate and subject to a variety of interpretations) that medical practitioner liability has increased at the same



(very high) rate as "medical inflation," it would not follow that there is no crisis. This is because, put simply, there is absolutely no reason why practitioner liability should increase proportionately with the cost of medical care. The latter cost has increased largely because of new machines, medical devices and pharmaceuticals that in fact increase human longevity and decrease medical failures. These developments reflect an increase in knowledge, which of course has been reflected in increased longevity. In brief, medical intervention succeeds as never before! This is precisely why we are willing to devote increasing percentages of our income to medicine!

Thus, if the standards of liability had been held constant over time, one would expect med-mal claim frequency to decrease, or at least to increase *far less* than "medical inflation." That this has not occurred is indirect evidence of exactly the existence of the torts outburst that the AIR lobby denies. There has surely been a real increase in both the *chance* a physician will be held liable, and the *extent* of damages if he/she is held liable.

The American Medical Association currently lists North Carolina as the most recent state added to the list of those in a full-blown med-mal liability crisis. The map on page 16 shows how the various states array in the AMA list.

I have undertaken substantial quantitative research into North Carolina med-mal situation. I see no reason to disagree with the AMA assessment. The annual number of settlements greater than $1 million for medical liability cases has more than tripled between 1993 and 2002 from 6 to 19. Hospitals in North Carolina have had insurance premiums go up 400 percent to 500 percent in the past three years. Liability insurance premiums for North Carolina neurosurgeons increased by 50 percent between 2000 and 2002. [57A]

What, then, to do about this new crisis?

IV. Medical Malpractice Reform: Is It Appropriate?

As mentioned above, almost all 50 states have enacted some kind of tort reform applicable to med-mal. [North Carolina is one of the only states not to have adopted any substantive tort reform over the last 20 years.] In some states, the tort reform enacted was general (i.e., it was applicable to all tort suits, including but not limited to med-mal), while in others the reform applied only to med-mal. In this section I will canvass the six principal kinds of reforms that have been adopted, pointing out whenever a proposal has been made to incorporate each kind of reform in North Carolina, and noting, where appropriate, the advantages and drawbacks of the proposed reform, as I see them.

1. Compulsory Use of Alternative Dispute Resolution.

Typically, this kind of reform prohibits the filing of a med-mal suit until the ADR system adopted by the plan (usually a non-binding arbitration of the claim by an expert panel of medical professionals) has been completed. The panel can recommend for or against compensation, but its sentence does not prevent the losing party from filing a tort suit *de novo.* The goal of this reform, presumably, is to nip in the bud the most frivolous law suits, by showing

the plaintiff's lawyer that he has no hope of success, at low cost to innocent physician defendants. If the result at arbitration is relatively certain and relatively cheap, it is felt that the defendant's insurer will be less likely to offer generous "nuisance settlements," which of course drive up premiums. Without a "nuisance settlement," the contingent fee attorney will drop a losing claim rather than invest hundreds of his own hours of labor in it.

Many states have incorporated a version of this reform, though North Carolina has not yet done so. "Bill 802," adopted by the State Senate in September 2003 but not yet dealt with by the State House, allows a judge to order mandatory non-binding arbitration at his or her discretion. The legislation requires that a panel of three expert "referees" be chosen (one by each side, a third jointly or by the judge). After reviewing the med-mal case, the panel would either recommend to the defendant that he settle (if the panel decides the plaintiff's case has merit) or to the defendant that he drop his suit (if the panel decides the case is without merit).[58]

The legislation requires that a panel of three expert "referees" be chosen. After reviewing the med-mal case, the panel would either recommend to the defendant that he settle or that he drop his suit.

In my opinion, most states' versions of this reform have proved ineffectual. Parties tend to consider the required ADR a delaying tactic, and plaintiffs who lose before the medical panel tend not to feel terribly disadvantaged when the panel's report is produced at trial so long as they are able to find an expert somewhere who agrees with their assessment of the defendant's behavior. Of course, the reform may not preclude a trial: *binding* or "final" arbitration through tort reform is not allowed, as 49 states (including North Carolina) guarantee to their citizens the right to a jury trial of all judiciable civil disputes. Plaintiffs often feel comfortable going forward with their (hired) expert before a jury increasingly inclined to see tort law as insurance.

North Carolina's reform, however, goes beyond the normal ADR provision. The North Carolina bill states that if a party (the plaintiff in most cases) loses before the arbitration panel *and again* before the jury, that party must pay the court costs (including lawyers' fees) of the winning side. This provision, if it is enacted and if it survives the expected constitutional challenge,[59] would arguably dissuade many a plaintiff's lawyer from pursuing a dubious suit after an adverse arbitral sentence.[60] Of course, settlements could not be easily subjected to the "loser-pays" rule, so I would expect lots of last-minute settlements of otherwise losing cases. On the other hand, insurers would be far less likely to advocate nuisance settlements when their bargaining position is increased by the fee-shifting threat.

This reform would, *if* it is applied forcefully by judges, and *if* it survives challenges, reduce the incentive to settle nuisance cases. But, perhaps as an aside, I note that an even more useful reform might be to allow freedom of contract in this domain. Most jurisdictions do not allow physicians to refuse to treat patients who decline binding arbitration.[61] The fear is that patients lack "equal bargaining power" with physicians, and therefore should not be allowed to renounce their right to a jury trial in return for receiving the physician's services at a given

price. But as the literature shows that juries have no particular accuracy when it comes to evaluating physicians' behavior,[62] it seems odd that the parties would not be allowed, in advance, to choose a more expert (and presumably accurate) forum.

No judicial discretion to order ADR would be needed if the parties could choose binding arbitration themselves. Physicians willing to subject themselves to juries would of course be free to do so, and patients would then presumably be free to pay the "tort premium" such physicians would require to practice their profession in this way.

2. Limitations on Contingent Fees.

Some jurisdictions have capped med-mal contingent fees at 33 percent, or at some lesser figure derived from a sliding scale of the amount eventually obtained. Typically, the maximum marginal "commission" for the plaintiff's attorney drops as the award or settlement amount increases. A limit on contingent fees was included in initial North Carolina tort reform debates in 2003 but did not survive the final Senate vote on Bill 802. These fee limitations have typically (but not invariably) been upheld by state courts applying their own constitutions—and the United States Supreme Court has not found fee caps to adversely affect any federal right to counsel.

There is some debate, however, whether fee caps merely lead attorneys to further inflate the *quantum* they demand, especially of non-economic damages (a.k.a. pain and suffering), in order to emerge with the same given fee. There is little solid empirical research on this point, though it does seem likely that attorneys will endeavor to equalize past income one way or another.

Presumably one real effect of such a reform, like all price controls, would be to induce unethical "side payments," or "gifts" made by a plaintiff to a particularly desirable or talented attorney, who is much in demand and who would otherwise equilibrate supply and demand by increasing his/her contingent fee. Money payments might be easy to trace, but barter arrangements (as where the plaintiff provides free or reduced-price services to the attorney) would be much harder to police.

An even more useful reform might be to allow freedom of contract in this domain. Most jurisdictions do not allow physicians to refuse to treat patients who decline binding arbitration.

Little known to tort reformers is that, even under current law, many and perhaps most contingent fees are already violations of states' ethics codes. Virtually every state's Rules of Professional Responsibility requires that a contingent fee be both "reasonable" (i.e., not too high, given the work invested by the lawyer and the true risk of non-recovery) and "subsidiary" (i.e., that the client prepared to pay an hourly or fixed fee be given that option). Most contingent fees fail one or both these tests, and can and should therefore be challenged as unethical and illegal.[63]

3. Modification of the Common Law "Collateral Source" Rule.

Say that a plaintiff is wrongfully injured by a defendant and suffers $10,000 in damages. Before the plaintiff can sue the defendant, a third party intervenes to reimburse the $10,000 lost. May the plaintiff nonetheless sue the defendant for this amount? The Common Law of many states, including North Carolina, does not allow a negligent defendant to deduct from what he owes his victim any sums given to the victim by third parties. Originally, this provision was meant to ensure that gratuities made to, or (non-subrogatory) insurance policies purchased by, the victim helped the victim and not the "bad guy."[64]

But the proliferation of third party payments has transformed this Common Law rule into what looks like a real boondoggle for some plaintiffs. To take but one example: in a case from my home state of Virginia, Kaiser Permanente (the victim's health provider and insurer) botched, through its employee-doctor, an operation. A second operation was required to repair the damage caused by the Kaiser employee's negligence. Kaiser Permanente offered this second operation free of charge to the victim. The victim accepted, had the second operation (it went without a hitch and was entirely successful), then turned around and sued Kaiser for the commercial value of that second operation (i.e., what the victim would have had to pay for it had he not been insured by Kaiser). Kaiser was ordered to pay, as it were, a second time![65] Similarly, if a doctor negligently causes a patient to miss a day's work, but the patient's employer pays the patient his salary for that day anyway, should the patient be able to recover that salary (a second time, as it were) by suing the physician? Yes, says the Common Law rule.[66]

North Carolina's current tort reform effort, Bill 802, does not purport to modify the Collateral Source rule.

It is clear that modification of the Collateral Source rule, to allow defendants to deduct from what they owe plaintiffs all sums received by plaintiffs from any source, will in the short run reduce payouts. On the other hand, in the long run many such receipts (whether gifts to the victim or insurance payments received by the victim) will be contractually modified to require reimbursement of the giver/insurer if a solvent tortfeasor becomes available. This is because neither the donor nor the purchaser of first party insurance wishes to benefit the tortfeasor in anyway. In this sense the Collateral Source rule reflects the situation that would likely prevail in its absence. This is a strong argument against its reform.

4. Periodic Payments.

Under this reform, a defendant may pay future economic damages (typically, medical payments) on a periodic basis, instead of paying an estimate in one lump sum as the Common Law provides. It is felt that this will reduce exaggerated damage claims by the plaintiff and overly generous lump-sum awards by the jury. A provision allowing periodic payments is part of Bill 802.

I confess that I am not a fan of periodic payment requirements. First, they must be accom-

panied (as Bill 802 is) by detailed bonding provisions—this is because the defendant must give some kind of guarantee that he or she will not dissipate his or her assets between this year's payment and next year's. In practice the guarantee is a bond or an annuity, which requires a lump sum payment by the defendant—but this payment goes to an insurance company, not to the plaintiff. This is cumbersome and costly administratively. Additionally, periodic payments encourage plaintiffs to malinger (so as to maximize next year's payment), and resemble in this way welfare payments. Malingering is discoverable, but it is costly to discover it. On the other hand, lump sum awards encourage the plaintiff to get well as soon as possible, and sooner than was predicted when the award was made, so as to maximize recovery. Surely it is in society's interest to have productive members back in the workforce sooner (the incentive under lump sum payments) rather than later (as is likely to happen with periodic payments)! Periodic payment provisions have not really caught on where they have been enacted—I suspect the reasons I have just enumerated explain why, to a great extent.

Periodic payments encourage plaintiffs to malinger (so as to maximize next year's payment), and resemble in this way welfare payments. Malingering is discoverable, but it is costly to discover it.

5. Caps on Damages.

This is the most typical type of tort reform. It comes in many different varieties, but it is useful here to outline two general species of caps:

a. Caps on non-economic damages ("pain and suffering").

Over half of all tort awards these days pay for non-economic damages, also known as "general damages" or "pain and suffering." Both pain and suffering are quite real phenomena, and a wrongdoer has no *carte blanche* to inflict them on innocent victims. On the other hand, pain and suffering are intrinsically tough to quantify—is the pain caused by the amputation of my hand "worth" $5,000, or $500,000, or $5,000,000, or $50,000,000 or some other sum? Is the suffering occasioned by my knowledge that I am disfigured for life, and less attractive because I have only one hand, "worth" $10,000 or $100,000, or $1 million or some other sum? Despite ingenious attempts by economists to quantify pain and suffering, the facts remain that juries are not instructed on economic theory, and that jury awards on these counts vary tremendously. For economic damages, on the other hand, empirical evidence is "harder," and, therefore, it is easier for a judge to strike down a jury award that is beyond the pale of good objective analysis. Negligently cause me to miss one week's work, and the judge won't allow the jury to give me two weeks' pay.

Only a cap, either judicial (as has been done by Canada's Supreme Court) or legislative, as has been done in many states, can chop the tail off of the snake of non-economic damages. Since high variance awards have a very significant affect on expected liability and therefore on willingness to settle,[67] caps on non-economic damages are meaningful in the extreme. My own view is that a cap of $250,000, initially proposed for North Carolina, is clearly insuffi-

cient these days—if only because the lower the cap, the greater the likelihood that a state court will find that the tort plaintiff has been denied her constitutional right to seek redress for the harm caused her.

But a cap of two times that amount (as exists in Maryland, for example) would preclude jury awards of "$1 billion in pain and suffering," as sometimes happens when juries are precluded (as they are in North Carolina) from granting huge punitive awards. A cap on non-economic damages, in other words, prevents "pain and suffering" from becoming an end run around caps on punitive damages, such as North Carolina's. Such a cap is thus sorely needed in the Tarheel State.

North Carolina's initial 2003 tort reform proposal contained a cap on non-economic damages, but Senate Bill 802 has eliminated this measure. This is a shame.

In the many states with such caps, plaintiffs' lawyers have challenged them on state constitutional grounds. In a few states (like Ohio) these challenges have been broadly sustained and the entire cap quashed. But in most states this kind of tort reform has survived state constitutional scrutiny.

Only a cap can chop the tail off of the snake of non-economic damages. Since high variance awards have a very significant affect on expected liability and therefore on willingness to settle, caps on non-economic damages are meaningful in the extreme.

b. Caps on med-mal recovery.

A few states, such as Virginia, have no cap on global "pain and suffering." But they do have a cap on *total* med-mal damages, *whatever their source*. Thus, if a total med-mal cap were $1 million, no judgment could be obtained for more than that amount, even if, say, a negligent physician caused a patient to require 10 remedial operations, at a cost of $3 million. Under Virginia's cap, the patient, and not the negligent physician, is on the hook for the amount in excess of the cap.

This type of reform, not contemplated in North Carolina, is very difficult to defend. It surely reduces maximum awards, but only by making the victim of the tort bear part, or most, of the damage caused to her by the tortfeasor. This is simply not compatible with the nature of tort law, as discussed above. Why should a barely injured victim of med-mal be compensated for 100 percent of her injuries, while a dreadfully injured person gets only, say, 33 percent of his damages from the negligent doctor? This kind of inequality has resulted in the quashing of this kind of reform in most states where it has been enacted. [In Virginia, though, the reform has been upheld.]

Both because it denies basic tort principles, and because it risks "equal protection" attacks as just mentioned, I do not advocate a Virginia-type cap.

6. Replacement of Med-Mal by No-Fault Compensation.

One effort to stem the abuse of tort law in the OB-GYN field consists of removing recovery from tort law, and treating the issue as one of insurance, having nothing to do with fault.

Virginia implemented this solution in 1987, with its Birth-Related Neurological Injury Compensation Act.[68] That act created the Birth-Related Neurological Injury Compensation Fund (Fund). Participation in the Program is not mandatory for either physicians or hospitals. Obstetricians who want to participate in the Program pay $5,000 into the Fund each year, while all other physicians licensed in the state, including those who do not practice any obstetrics at all and who do not participate in the fund, are nonetheless assessed $250 per year. Participating hospitals pay a sum equal to $50 multiplied by the number of deliveries made during the prior year, with a cap of $150,000 per hospital per year. If these assets are inadequate to maintain the Fund on an actuarially sound basis, a premium tax of up to one-quarter of one percent of net direct premiums written in the state can be assessed on all liability insurance carriers in the state. All these payments will go directly into the Fund, which is designed to be self-sufficient—none of the money for the Program is to come from the state's general revenues.

If a participating hospital or physician is sued for a neurological birth related injury (which includes, notably, injury "occurring in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery") that hospital or physician may refer the case to the Fund. Upon a determination by Virginia's Workers' Compensation Commission that an infant comes within the terms of the Act, the Commission awards a remedy limited to net economic loss less any amount received from collateral sources. The award is paid out as it accrues, rather than in a lump sum as a civil remedy typically would be. In addition to reasonable medical expenses, the award compensates for reasonable expenses, including attorney's fees and loss of earnings from the age of 18. No non-economic (pain and suffering) damages are allowed, no recovery is allowed for amounts obtained collaterally, and no recourse to a tort tribunal is allowed. If a newborn baby dies soon after birth, the Commission may award up to $100,000 even if there were no economic damages. On the other hand, if economic damages are substantial, Virginia's med-mal cap (currently at $1.75 million), described above, does not apply to amounts awarded under the act.

Surprisingly, perhaps, the Fund has not proven to be universally popular among OB-GYN's in Virginia. Many have opted not to pay $5,000 per year for the protection the Fund affords, perhaps because any med-mal award would be limited while Fund awards are not. Many also may believe the hospital where they have privileges has Fund protection. Much litigation has centered on whether a given baby's injury qualifies as a "birth related neurological injury"[69]—a skillful plaintiff's attorney intent on obtaining tort relief can characterize a child's injury in ways which maximize the chance the Commission (always intent on minimizing payoffs to ensure solvency of the Fund…) will turn down the physician's referral. Finally, since a mother may sue her OB-GYN in tort for the mother's own alleged injuries (even if the physician is a participant in the Fund), the statute has not been fully successful in

thwarting access to Common Law courts. As a result, only a half-dozen claims per year, on average, have been resolved through the Fund.[70]

In brief, in a climate conducive to tort recovery and dominated by an aggressive Plaintiffs' Bar, Virginia has attempted to import notions of Workers' Compensation insurance. Such imports should be expected to be partial and very gradual in their effects.

North Carolina has not proposed the creation of a Workers' Compensation type mechanism funded by health care providers (who then, presumably, factor this cost into their fees). Instead, the proposed bill takes a more socialist route, holding that "excess liability" will be paid by the government. The insurance fund would initially be created with $20 million in taxpayer money. Doctors, hospitals, and other health care providers would then pay annual assessments to keep the fund at a level to meet claims. The fund would provide insurance above primary coverage, typically $500,000 in liability for obstetricians or emergency room doctors. Tort recovery, in other words, would remain the rule under this proposal.

The North Carolina approach is a curious one in several ways. If the problem is "excess verdicts," an answer might be caps, or a collateral source rule. If the problem is that certain compassionate losses deserve payment irrespective of fault, then leaving the realm of torts and entering the realm of insurance (as Virginia has done for birth-related injuries) might be the way to go. But North Carolina has retained torts and has essentially constituted itself as *uber*-insurer. This seems to imply that private insurance companies are not doing their jobs adequately – but I have found utterly no evidence that this is so. So I must conclude that the North Carolina excess liability fund and program is an incoherent answer to whatever problem the legislators were addressing.

Conclusion

This report has attempted to provide the reader several insights that usually escape political debates about tort reform. First, it attempted to describe the nature and function of tort law. Only through knowledge of tort's appropriate role is it possible to understand how tort has been abused—and a sketch of this abuse has also been provided. Notably, misunderstandings about the role and function of insurance have led many to erroneous conclusions. Hopefully, readers of this report will be less vulnerable to this peril.

Some reforms (such as caps on non-economic damages) seem fully compatible with the nature of tort law, while other reforms do not. North Carolina's past reforms (limiting punitive damages,[71] specifying that wrongdoing is necessary for product liability,[72] and facilitating appeals of exorbitant awards[73]) have no real impact on med-mal cases. Bill 802, if adopted without modification, may do some good, and will certainly do some bad. My hope is that this report will contribute to intelligent discussion and decision-making.

Notes

1. Michael Krauss, *Fire and Smoke: Government Lawsuits and the Rule of Law*, Independent Institute, June 2000.

2. Martin F. Connor, "Taming the Mass Tort Monster," National Legal Center for the Public Interest, October 2000, p. 4.

3. See Tresa Baldas, "Verdicts Swelling from Big to Bigger," *National Law Journal*, November 25, 2002, pp. A1, A6.

4. Center for Legal Policy, "Trial Lawyers Inc.," Manhattan Institute, 2003, p. 2.

5. David Hechler, "Study Sees Rise in Cost of Tort System. Is It Right?" *National Law Journal*, December 22, 2003, p. 12.

6. Hechler, "Study Sees Rise in Cost of Tort System," p. 12.

7. $12 in 1950 dollars is the equivalent of $87.15 in 2002 dollars. See www.westegg.com/inflation/.

8. Center for Legal Policy, p. 5.

9. Weiler, *Medical Malpractice On Trial*, 1991, at 14 See also, e.g., David M. Studdert et al., "Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?" *Law and Contemporary Problems* 60 (1997): 33–34; Paul C. Weiler, "Fixing the Tail: The Place of Malpractice in Health Care Reform," *Rutgers Law Review* 47 (1995): 1165; Richard L. Abel, "The Real Tort Crisis — Too Few Claims," *Ohio State Law Journal* 48 (1987): 448; Paul C. Weiler et al., *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (Cambridge, MA: Harvard University Press, 1993): pp. 61–76; and Philip Slayton and Michael J. Trebilcock, eds., *The Professions and Public Policy* (Toronto: University of Toronto Press, 1978).

10. See "Nonprofits Battle Each Other for Bucks," July 17, 1995 *Legal Times* 8; Claudia MacLachlan, "Doing Well vs. Doing Good: Students are Increasingly Tempted to Forgo Public Service for Law Firm Salaries," September 4, 2000 *Legal Times* 50.

11. But see, e.g., Randy Barnett, *The Structure of Liberty: Justice and the Rule of Law* (1998).

12. *See, e.g.*, Friedrich A. Hayek, *The Constitution of Liberty*, (1960); Bruno Leoni, *Freedom and the Law* (1961).

13. *See* Michael I. Krauss, *Tort Law and Private Ordering*, 53 St. Louis Univ. L. J. 423 (1992); , Ernest Weinrib, *The Idea of Private Law.*

14. Peter A. Bell, "Analyzing Tort Law: The Flawed Promise of Neocontract," 74 *Minn. L. Rev.* 1177 (1990); Jane Stapleton, "Tort, Insurance and Ideology," 58 *Mod. L. Rev.*: 820-845 (1995).

15. Of course the victim may not recover from the tortfeasor if the victim has already been paid by and transferred her tort entitlement to this first-party insurer. Unless this transfer has taken place, the victim has a suit against the person who has wrongfully harmed her. *See, e.g.*, *Harding v. Town of Townshend,* 43 Vt. 536 (1871) (defendant is not entitled to have deducted the amount received by the plaintiff from an insurance company on account of the injuries for which he claims to recover against the town); *Clark v. Wilson*, 103 Mass. 219 (Mass.,1869) (payment of a loss by insurers does not defeat a right of action by the assured against a third person whose fault caused the loss); *Perrott v. Shearer*, 17 Mich. 48 (Mich. 1868) (tresspass sustained after plaintiff had recovered from insurance company full value of goods destroyed by fire); *Illinois Cent. R. Co. v. Hicklin*, 115 S.W. 752 (Ky. 1909) (applying collateral source rule); *Johnson v. Kellam*, 175 S.E. 634 (Va. 1934) (tort damages not reducible when plaintiff compensated for loss by insurance for which

he has paid); *Helfend v. Southern California Rapid Transit Dist*., 465 P.2d 61 (Cal. 1970) (applying collateral source rule in a motorcycle accident case); *Brown v. American Transfer and Storage Co*., 601 S.W.2d 931 (Tex. 1980) (applying collateral source rule in action under Deceptive Trade Practices Act); but see *Haynes v. Yale-New Haven Hosp*., 699 A.2d 964 (Conn. 1997) (underinsured motorist benefits governed by rule precluding double recovery, rather than by collateral source rule, despite contractual aspect of benefits).

16. See, e.g., Kurt Vonnegut, *Harrison Bergeron*.

17. See Ernest Weinrib, *The Special Morality of Tort Law*, 34 McGILL L. REV. 341 (1990).

18. See *Wright v. Tate*, 156 S.E.2d 562, 566 (Va. 1967).

19. Jules Coleman, *Risks and Wrongs*.

20. H.L.A. Hart, *Immorality and Treason*, in R. Wasserstrom, ed., *Morality and the Law*, 1971

21 . P. Devlin, *The Enforcement of Morals*, 1965, ch. 1.

22. See, e.g., *Bowers v. Hardwick*, 478 U.S. 186 (1986).

23. It is true that modern day products liability suits are often characterized by huge *punitive* damages. But punitive damages are extremely rare in tort adjudication in general. Only about 3 percent of victorious tort suits adjudge punitive damages, and most of them are cases involving intentional tort. See the *Bureau of Justice Statistics Study*, Civil Justice Survey of State Courts, 1996 *Tort Trials and Verdicts in Large Counties* [released in August 2000]. My own view is that such damages are incompatible with the nature and history of common law tort. That issue is not germane to this essay. For a discussion, *see* Krauss, *supra* note 9.

24. See, e.g., Michael J. Graetz, *To Praise the Estate Tax, Not to Bury It*, 93 YALE L.J. 259, 274-79 (1983).

25. Some may object that *strict liability* does not require wrongdoing for tort liability. But when the term *strict liability* is invoked in products cases, the court is in fact assigning liability for negligence (in defective design cases), or for breach of contract (in defective manufacturing and "failure to warn" cases). *See* Krauss, *supra* note 9; James A. Henderson, Jr., and Aaron D. Twerski, *The Products Liability Restatement in the Courts: An Initial Assessment*, 27 *Wm. Mitchell L. Rev*. 7 (2000).

26. "Owners" would in fact become "tenants" of government in such a system — the only party that would truly absorb a loss would be government. A new risk would of course exist in such a system – the risk that government would decide that one's holdings more properly belonged to someone else. This political risk of publicly ordered societies has of course proven to be one of the downfalls of Marxist collectivism.

27. Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong., 1st sess. (March 13, 2003).

28. Juliet Eilperin, "House Struggles to Find Its Place on Hill; Feeling Ignored, Members Say Most High-Profile Issues Are Decided in Senate," *Washington Post*, April 4, 2003, p. A4.

29. White House, "President Proposes Major Reforms to Address Medical Liability Crisis," news release, July 25, 2002, www.whitehouse.gov/news/releases/2002/07/20020725-1.html.

30. Allison H. Eid, "Tort Reform and Federalism: The Supreme Court Talks, Bush Listens," *Human Rights* 29 (Fall 2002): 10, 11.

31. Technically, there is no "spending power" in the Constitution. Some authorities believe that the spending

power is implicit in the power to tax; see U.S. Const. Art. I, § 8, cl. 1. Other authorities, ourselves included, believe that spending is authorized only if it is necessary and proper; see U.S. Const. Art. I, § 8, cl. 18, for executing powers enumerated elsewhere in the Constitution. We need not resolve that controversy here; the constitutionality of federal spending for medical care in the context of malpractice reform has not been challenged. The dispute here is not whether federal spending is itself legitimate but whether malpractice reform can be and has been legitimately imposed as a condition on state recipients of the spending.

32. White House.

33. See, e.g., *South Dakota v. Dole*, 483 U.S. 203 (1987).

34. Eid, p. 11.

35. White House.

36. See Laura-Mae Baldwin et al., "Defensive Medicine and Obstetrics," *Journal of the American Medical Association* 274 (1995): 1606–10; and Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics* 111 (1996): 359.

37. See Lisa Dubay et al., "The Impact of Malpractice Fears on Caesarean Section Rates," *Journal of Health Economics* 18 (1999): 491–522.

38. See Gary M. Fournier and Melayne Morgan McInnes, "The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation," *Journal of Risk and Insurance* 68 (2001): 274 (physicians, especially rural obstetricians, are choosing to limit practice or self-insure rather than pay soaring premiums unrelated to their own claims experience); "Echo Malpractice Mess," editorial, *Charleston Gazette and Daily Mail*, January 3, 2002, p. 4A (physicians are leaving West Virginia because lawsuits are increasing the cost of insurance coverage); Ovetta Wiggins, "Doctors to Protest Premium Increases," *Philadelphia Inquirer*, April 23, 2001, p. B1 (Pennsylvania Medical Society asserts that 11 percent of Pennsylvania physicians "have either moved out of state, retired [prematurely], or scaled back their practices [due to] 'skyrocketing' malpractice insurance rates."); and Patricia Poist-Reilly, "Malpractice Maelstrom: Skyrocketing Malpractice Insurance Premiums Have Doctors and Healthcare Professionals Here—and Around the State—Clamoring for Reform," *Lancaster New Era/Intelligencer Journal/Sunday News*, December 17, 2001, p. 1 (high jury awards pushing up insurance rates and forcing physicians to retire early, move to more rate-friendly states, or limit patient access to medical care).

39. See, e.g., David M. Studdert et al., "Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?" *Law and Contemporary Problems* 60 (1997): 33–34; Paul C. Weiler, "Fixing the Tail: The Place of Malpractice in Health Care Reform," *Rutgers Law Review* 47 (1995): 1165; Richard L. Abel, "The Real Tort Crisis — Too Few Claims," *Ohio State Law Journal* 48 (1987): 448; Paul C. Weiler et al., *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (Cambridge, MA: Harvard University Press, 1993): pp. 61–76; and Philip Slayton and Michael J. Trebilcock, eds., *The Professions and Public Policy* (Toronto: University of Toronto Press, 1978).

40. If there were insufficient liability, there would be wrongfully injured parties dependant on the public dole — and this would be likely to create an outcry against the local physician, who would in essence be a leech on the fisc.

41. See generally, Nancy K. Bannon, *AMA Tort Reform Compendium* (Chicago: American Medical Association, 1989) (detailing tort reforms then in effect); and American Tort Reform Association, "Tort Reform Record," June 30, 2002, www.atra.org/wrap/files.cgi/7469_record602.htm.

42. See American Tort Reform Association, "Tort Reform Record," December 2003, www.atra.org/files.cgi/

7668_Record12-03.pdf, for a summary of state reforms enacted since 1986.

43. *U.S. Tort Costs – 2003 Update*, Tillinghast Towers Perrin, at 16, also Appendix 5.

44. Hurley, "A New Crisis for the Med Mal Market?" 2002/4, *Emphasis* at 2 (Tillinghast Towers Perrin quarterly magazine). Medical Mutual of North Carolina, today the largest single med-mal insurer in the state, was formed by North Carolina physicians with their own money as a result of St. Paul's actions.

45. Summary of testimony from Jeffrey L. Houpt, MD, University of North Carolina School of Medicine, NC. Senate Select Committee on Insurance and Civil Justice Reform, May 6, 2003, found on the web site of the "NC Access to Quality Heathcare Coalition."

46. National Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care*, Victoria Rostow, director, 1990.

47. The case was the object of Barry Werth's detailed book, *Damages* [2003]. This book makes use of *Sabia v. Norwalk General Hospital*, the most significant medical malpractice case in the history of the state of Connecticut when the book was written. I recommend its reading to all those interested in the "inside story" of med-mal today.

48. Medical Mutual of North Carolina charged approximately $9,000 for $1 million worth of liability coverage for a family practitioner in 2003. For OB-GYN's the liability premium soared to near $100,000. Clearly this prices the G.P. out of the obstetrics business, thereby reducing supply and further increasing prices. *See* N.C. House Committee, Blue Ribbon Task Force on Medical Malpractice, Physician Professional Liability Insurance Data, December 2, 2003.

49. D. Sousa, "NC Medical Malpractice Insurance Data," *NC Medical Journal*, July/August 2003, v. 64, #4, p. 182.

50. "Jury award sets record," Raleigh *News & Observer,* Sept. 6, 1997, viewable at www.news-observer.com/edwards/candidate/story/2097907p-1998142c.html. The plaintiffs' attorney was the now-Senator John Edwards. The Griffins "were very excited that their child is going to be taken care of," Mr. Edwards said. "That's what this was all about."

51. See N.C. House Committee, Blue Ribbon Task Force on Medical Malpractice, Physician Professional Liability Insurance Data, December 2, 2003 at 67.

52. The North Carolina Health Professions Data System, operated by the Sheps Center for Health Services Research at UNC Chapel Hill, maintains excellent data on this subject. The data may be viewed at www.shepscenter.unc.edu/data/nchpds/download/downall.htm.

53. In 2002, the interest assumption was in fact lowered from 6.5 percent to 5.5 percent. *See* N.C. House Committee, Blue Ribbon Task Force on Medical Malpractice, Physician Professional Liability Insurance Data , December 2, 2003 at 17.

54. This point was made quite lucidly by James Hurley, Chairman of the Medical Malpractice Subcommittee of the American Academy of Actuaries, in a Hearing ["Harming Patient Access to Care: The Impact of Excessive Litigation"] by the Subcommittee on Health of the U.S. House Committee on Energy and Commerce, July 17, 2002. The document can be accessed at www.actuary.org

55. Rachel Zimmerman and Christopher Oster, "Assigning Liability: Insurers' Missteps Helped Provoke Malpractice 'Crisis' — Lawsuits Alone Didn't Cause Premiums to Skyrocket; Earlier Price War a Factor— Delivering Ms. Kline's Baby," *The Wall Street Journal* 6/24/02 A1.

56. Dewees and Trebilcock, "The Efficacy of the Tort System and Its Alternatives: A Review of the Empirican Evidence," 30 *Osgoode Hall L.J.* 57 (1992).

57. Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates in North Carolina," April 2003, available at www.insurance-reform.org.

57A. Winston-Salem *Journal*, March 9, 2004.

58. Senate Bill 802, "Medical Providers/Civil Justice Reform Act", Adopted Sept. 15, 2003. www.ncga.state.nc.us/html2003/bills/CurrentVersion/Senate/Sbil0802.full.html.

59. I predict a litigant will claim that the fee-shifting provision "chills" the exercise of the right to a jury trial. Some states have upheld analogous challenges to tort reform, others have not.

60. I assume that contingent fee attorneys will bear this cost — i.e., they will agree to "hold harmless" their clients against any claim of attorneys' fees by the defendant physician.

61. See, e.g., *Obstetrics and Gynecologists v Pepper*, 693 P.2d 1259 (Nev., 1985)

62. See, e.g., Paul Weiler, *Medical Malpractice on Trial*, 1991, p. 14 (jury verdicts in med-mal cases have no accuracy when compared to expert evaluation of the event).

63. See, e.g., Peter Passell, "Windfall Fees in Injury Cases Under Assault," *New York Times*, February 11, 1994, p. A1; L. Brickman *et al*., *Rethinking Contingent Fees: A Proposal to Align the Contingency Fee System With Its Policy Roots and Ethical Mandates*, 1991.

64. As indicated earlier, if the victim's first party insurance policy has a subrogation clause (i.e., a clause allowing the insurance company to recover its payment from any available tortfeasor), then that clause will be enforced and the insured will not be "paid twice." The collateral source rule applies, therefore, to third party payments that are not made subject to subrogation clauses.

65. *Karsten v. Kaiser Foundation Health Plan*, 808 F. Supp. 1253 (1992).

66. *Bullard v. Alfonso*, 595 S.E.2d 284 (Va., 2004).

67. The higher the variance of awards, the greater the risk for the defendant and his/her insurer, and therefore the greater the likelihood of high nuisance settlements, for instance.

68. Va. Code § 38.2-5001 et seq. Florida has similar legislation.

69. The statute requires that : (1) the infant was born alive; (2) an injury occurred to the spinal cord or brain; (3) the cause of injury was deprivation or mechanical injury during labor, delivery, or resuscitation; (4) the infant is permanently disabled as a result and is "in need of assistance in all activities of daily living"; (5) the injury was not caused by "congenital or genetic abnormality, degenerative neurological disease, or maternal substance abuse"; and (6) the injury was either caused by a physician participating in the program or occurred in a participating hospital. As the *Sabia* case described by Werth in *Damages* shows (see note 48), however, the cause of the child's damage is precisely what is disputed in virtually all these cases.

70. Bovbjerg, Sloan & Rankin, "Administrative Performance Of "No-Fault" Compensation For Medical Injury," [1997] *Law and Contemporary Problems* 71.

71. North Carolina General Statutes, Ch. 1-D.

72. North Carolina Generral Statutes, Ch. 99B.

73. North Carolina General Statutes, § 1-289.

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