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Calling It a Leg Doesn’t Make It a Leg*: Doctors, Lawyers, and Tort Reform

Ellen Wertheimer**

It is at this point axiomatic that doctors hate lawyers. But why do doctors hate the legal profession so much?1 Many of my students have medical professionals in their families, and we reflect together in my Law and Medicine course on why these relatives hate attorneys so much. It is, of course, true that lawyers are the instrumentalities of lawsuits against doctors, and nothing can realistically be done about that. But the hatred seems to go beyond this. There are several possible explanations, all of them understandable and, if adequately confronted, tractable. The remedies may be painful for the legal profession, but failure to act will allow an untenable set of double standards to remain intact. This article explores some of the sources in the law and legal profession for this tension between the legal and

* Abraham Lincoln asked his audience: “If you call a tail a leg, how many legs has a dog? Four. Calling it a leg doesn’t make it a leg.” Brainy Quotes, Abraham Lincoln Quotes, http://www.brainyquote.com/quotes/authors/a/abraham_lincoln.html (last visited August 10, 2007). So also with tort reform: calling it tort reform doesn’t make it tort reform.

** Professor of Law, Villanova University School of Law. I want to thank Kim Yuhas, my research assistant, and Amy Spare, a wonderful librarian, for their help on this article. I also want to thank Sue Small, whose computer expertise was immeasurably helpful. Most of all, I want to thank Carl Bogus, the American Association for Justice, and the Roger Williams University School of Law for their support for this article.

1. See Stephanie Mencimer, Malpractice Makes Perfect: How the GOP Milks a Phony Doctors’ Insurance Crisis, WASH. MONTHLY, Oct. 2003, available at http://www.washingtonmonthly.com/features/2003/0310.mencimer.html ("All across the country, doctors . . . are telling reporters, legislators, and even their patients that frivolous lawsuits are driving up insurance costs and driving doctors out of practice. . . . [D]octors put the blame for their insurance woes on trial lawyers, malpractice suits, and juries.").
medical professions and reflects on their significance for true tort reform.

First, and most potentially painful for the legal profession, the legal system treats doctors and lawyers differently in the realm of professional malpractice. As this article will show, the legal system, populated by attorneys, evinces much greater tolerance for legal errors than for medical ones. The only cure for this is to adopt legal reforms that will hold attorneys to the same standards of care within their profession that doctors are required to meet in theirs.

Second, doctors believe that the tort system is responsible for the high legal costs of practicing medicine and for the high insurance premiums that they presume result from these costs. This has led to two problems. The first is the blame attached to the tort system by the medical profession, which is understandable in light of the false premise that lawyers, through the tort system, cause high insurance premiums. The second is likewise based on the inaccuracy of the premise. Efforts at tort reform, promulgated by law-dominated legislatures, inevitably fail to fix the problem of high premiums because the tort system is not wholly responsible for those high premiums. The fact that premiums stay high continues to be blamed on the tort system, and the failures of tort reform to remedy this simply allow the bitterness to remain. Of course, tort reform cannot fix the problem, but that is because it is not the tort system that caused it in the first place. Calling it tort reform does not make it serve as true reform, because the laws that are enacted are aimed at the wrong target. Indeed, calling it tort reform may itself be harmful, because it causes doctors to hope, a hope that is groundless and leads to further feelings of betrayal by a legal system that seems to doctors to cause them nothing but harm. If premiums do not go down when judgment awards decline (if they in fact do so after the reforms are enacted), it means that insurance companies are using premiums for purposes other than paying claims. The cure for this source of the problem is to enact genuine tort reform, which will require legislatures to regulate the insurance industry more effectively.

Lawyers, trained to objectivize their cases, fail to take into account the extent to which being sued is personal to the defendant in all cases, but perhaps most of all in medical
malpractice cases where the defendant's professional identity is under attack. Attorneys, whose exercise of professional judgment is much more rarely challenged, cannot share this traumatic experience with doctors.

This article contains two parts. In the first part, the article discusses and documents the contrasting treatment the tort system gives to doctors and lawyers, and the ways in which the tort system has developed to cause doctors the maximum in professional angst. The legal profession judges doctors; doctors get no opportunity to judge lawyers. Indeed, lawyers, through the legal system, judge themselves. This in itself could explain the particularly vituperative dislike doctors feel for lawyers. But there is more. In Part II, the article turns to the tort reforms that have been and are being enacted, allegedly to remedy the perceived problems in the tort system. None of these has proven successful, which in itself further fuels the fire of physician hatred, because lawyers are blamed both for the problems doctors confront and for the failure to fix them. The article concludes with several suggestions for the form that true tort reform, aimed both at the dissonance between the legal and medical professions and at tort judgments, might take.

I. DOCTORS V. LAWYERS

A. Doctors as Defendants

First, why do doctors hate the legal system—and lawyers—so much? I believe that there are many reasons besides the obvious one that doctors get sued. After all, lawyers get sued, too. They don't hate the system, although they may hate individual practitioners. Indeed, many businesses also get sued regularly, but they seem better able to take the challenge of litigation more or less in stride. In any event, the axiomatic hatred of doctors for lawyers does not appear in any other context. The generalized hatred felt by doctors for the legal profession seems to go beyond what one might normally expect. The following turns to some of the possible sources for this hatred.

1. Judges are Lawyers and Patients, Too

One source of hatred seems to be the view that those who file
and adjudicate cases are abysmally ignorant of the medical profession. This view may well be accurate, because the decision-makers in medical malpractice cases are lawyers and juries, and not doctors. This in itself would be enough to produce anger, but our society adds jealousy to the anger by also using lawyers to judge cases against lawyers. The differences in case results that this can produce can be both conspicuous and infuriating—if one happens to be a doctor. I believe that the primary reason for this is that the lawyer defendants have the immense advantage of a built-in sympathetic expert witness on the bench. This built-in empathy is reflected in the prevailing standards for attorney malpractice. The judge knows how complicated law is, how hard it is to predict what juries will do, and how pressured the life of an attorney is. Take, for example, the case of Lucas v. Hamm, a classic chestnut read by most first year law students. In that case, an attorney made a very serious mistake on a will, and the person who should have inherited, but did not, sued him. The judge decided that the plaintiff could sue the attorney for the deceased, despite the absence of a relationship between the would-be heir and the attorney, but that the plaintiff should lose as a matter of law, because the mistake was with respect to the rule against perpetuities, and no one understands the rule against perpetuities. The court reflected:

> Of the California law on perpetuities and restraints it has been said that few, if any, areas of the law have been fraught with more confusion or concealed more traps for the unwary draftsman. . . . [A]n attorney of ordinary skill acting under the same circumstances might well have 'fallen into the net which the rule spreads for the unwary' and failed to recognize the danger. . . . [A]n error of the type relied on by the plaintiffs does not show negligence or breach of contract on the part of the defendant.

The lawyer, therefore, was reasonable in making a colossal mistake that invalidated the intended inheritance. Can you

3. Id. at 686.
4. Id. at 690.
5. Id.
6. See also Gimbel v. Waldman, 84 N.Y.S.2d 888, 891 (Sup. Ct. 1948)
imagine a similar result or statement in a medical malpractice case? A judge saying, "yes, you made a mistake, you were even negligent, but no one really understands how the brain works so don’t worry about it?"

The professional empathy that is built in to the attorney malpractice standards is wholly absent from the field of medical malpractice. Research reveals that medical malpractice cases are vastly more common than legal malpractice cases. They are certainly more widely discussed in the media. Legal malpractice cases and issues maintain a much lower profile. While that may be because no one feels any urge to protect attorneys from being sued, it seems unlikely. It is far more likely that the answer lies in the fact that medical malpractice cases are vastly more frequent, demonstrated by their inarguably greater impact on daily life. It also seems clear that more mistakes are considered reasonable when lawyers commit them than when doctors do. I find it hard to imagine that the discrepancy between legal and medical malpractice cases has its source in any real differences between the quality of practice in the two professions. It must lie in the fact that judges have a greater understanding of and tolerance for legal mistakes than for medical ones. Indeed, the attorney’s duty to the client to investigate other avenues of pursuit, such as insurance, has been interpreted narrowly. Judges can imagine themselves in the attorney-defendant’s shoes and can sympathize with the challenges of practicing law. But in a medical malpractice case, their empathy is more likely to be personal than professional. They envision themselves not as doctors but as patients, and in the plaintiff’s position. They want everything from the medical profession that the plaintiff wants.

Another problem lies in the phenomenon of the lawsuit itself. Attorneys are taught to be disinterested, objectively pursuing their clients’ interests without emotion. It is all too easy to forget that being sued is personal to the doctors who are defendants. It is easy to convince an attorney representing one of the parties—and the insurance company covering the doctor—that a settlement

7. In fact, legal malpractice cases that are at all analogous to medical malpractice cases are extremely difficult to find.

makes economic sense, because it will be more expensive to litigate the case than to pay off the plaintiff. Most insurance companies, not the doctors, control this decision as a matter of contract.\(^9\) It is one thing to do a cost benefit analysis on litigating a case when one is not personally invested in the suit; it is quite another for the doctor to understand why his or her insurance company would settle without the doctor’s agreement and in the face of the doctor’s strong feeling that the settlement is tantamount to telling the doctor that he or she did something wrong. In this context all the lawyers, even the lawyers ostensibly representing the doctor’s interests, seem to side against the doctor. The doctor’s professional identity is under attack from all sides.

2. The Doctor as Victim in the Informed Consent Context

Another set of issues arises in the context of the contrast between the decision-making power given by the law to the patient and to the client. The rules applicable to legal practice allow clients to make fundamental decisions, such as whether to settle or how to plead. But the decisions on how to conduct the case are up to the attorney, and not the client.\(^10\) A client may wish for a case to take a certain form, or may be opposed to calling a particular witness, but the extent to which the client actually

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9. **Peter P. Budetti & Teresa M. Waters, Medical Malpractice Law in the United States** 9 (May 2005), http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf (“[P]hysicians feel that the high costs of defending lawsuits ha[ve] generated a likelihood that their own malpractice insurance company will 'reward' and indeed encourage non-meritorious lawsuits by settling them when the insurer thinks settlement would be less costly than defending the case.”).

10. See **Model Rules of Prof’l Conduct R. 1.2** (2007), available at http://www.abanet.org/cpr/mrpc/rule_1_2.html. The relevant text of the rule reads:

(a) [A] lawyer shall abide by a client's decisions concerning the objectives of representation and ... shall consult with the client as to the means by which they are to be pursued. A lawyer may take such action on behalf of the client as is impliedly authorized to carry out the representation. A lawyer shall abide by a client's decision whether to settle a matter. In a criminal case, the lawyer shall abide by the client's decision, after consultation with the lawyer, as to a plea to be entered, whether to waive jury trial, and whether the client will testify.
controls these decisions is limited. "Good faith tactical decisions or decisions made on a fairly debatable point of law are generally not actionable under the rule of judgmental immunity."\textsuperscript{11}

Attorneys cannot be placed in the position of having to accept direction from clients on intricate interpretations of the correct of current state of the law. The attorney, not the client, is the individual trained to interpret the law. This does not mean that an attorney should never be required to inform a client regarding a conflict in the law; however, when an interpretation has been made as to the state of the law in a given district and that interpretation has a proper basis of support, an attorney should not be required to compromise a reasoned judgment by having to factor into the judgment the client's reasoning on a fine point of law.\textsuperscript{12}

It is perhaps worth noting that the Model Rules of Professional Conduct require that the attorney "consult" with the client as to the means to be used to achieve the goals of the lawsuit, but conspicuously do not require that the attorney comply with the client. The list of areas of client control—whether to settle, plead, waive a jury trial, or testify—tends to be treated as exclusive, with the attorney in charge of all else.

In medicine, however, the doctrine of informed consent\textsuperscript{13} gives considerably more power to the patient than the law gives to clients. Clearly, the law, made by lawyers, recognizes that clients do not have the knowledge to make the kinds of decisions that the law is content to leave to attorneys. Patients are at least as ignorant of medicine as clients are of the law, however, so the refusal to impose analogous obligations on attorneys to those imposed on doctors can only proceed from a sense in the legal profession that law is different in some way. This is where the fact that those who create the obligations are themselves attorneys comes in. They have an appreciation for the

\textsuperscript{11} Crosby v. Jones, 705 So. 2d 1356, 1358 (Fla. 1998).
\textsuperscript{12} Id. at 1359.
\textsuperscript{13} See Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir. 1972) ("The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.").
complexities of their own profession, and not for the challenges of others, particularly because they are themselves in the patient role. Thus, attorneys, including judges, empathize with patients in the doctor/patient context, and with the lawyer in the attorney/client relationship. In a legal malpractice case, all the attorneys share a common language and a common fear that one day they too could be in the defendant's role. As one commentator observed, "the doctrine of informed consent has not received a warm welcome in legal malpractice cases." 14

In the medical malpractice field, widespread recognition of the doctrine of informed consent has increased the disclosure obligations of physicians. A medical professional, absent special circumstances, must disclose all material risks of, and alternatives to, a course of treatment, regardless of what is customary among professionals practicing in the community. The informed-consent doctrine has not yet found equally clear recognition in the legal malpractice field, although there is good authority that the same principles apply as readily in law as in medicine. 15

Doctors understandably feel that patients are at least as ignorant of medicine as clients are of law, but the law gives to patients a far greater say in their treatment than it gives to clients with respect to their cases. There is no reason why, in theory, informed consent doctrine should not apply equally to the legal and medical professions. The only explanation I can think of for this phenomenon is that the lawyers make the rules. At worst, they have no interest in giving clients more power than they already have; at best, they recognize the complexities of the law and genuinely believe that clients cannot be sufficiently educated to make reasonable decisions about their cases. Either way, the law of informed consent suffers because attorneys make it. The paternalistic approach that lawyers take to client decision-making is thoroughly rejected in the context of patient decision-making, in the glaring absence of any explanation as to why medicine is easier to explain to patients than law is to clients.

This is not to say that informed consent is a bad doctrine. In fact, informed consent is a vital doctrine, a testament to the view

14. Oddi, supra note 8, at 18.
that people are autonomous and that certain decisions should be left to the individual to make. It is only to point out that it is not applied evenhandedly to attorneys and doctors. Attorneys are given far more power over how a case is conducted than doctors, and are found liable far less frequently for violating the applicable standards. To win an informed consent case in the legal malpractice arena, the client must prove that the case would have turned out differently had the client's input been taken seriously.\(^\text{16}\) This is almost impossible to prove. This contrasts sharply with the standard for informed consent in medical malpractice cases, where the client must simply prove that he or she would have made a different decision had the physician provided the required information.\(^\text{17}\) While these cases are difficult to prove as well, the difference between proving that the case would have had a different result and that the patient would have made a different decision seems vast. Attorneys will only be liable for professional malpractice in the most egregious cases.

3. Doctors and Hindsight

The law is also much more willing to second-guess doctors than lawyers. Whether a decision was the right one to make at the time it was made is frequently the subject of malpractice suits. The comparable legal malpractice suit will be vastly more difficult to win, as the courts are more comfortable with lack of certainty in the legal profession than they are in the medical. Of course, judges are patients. It is impossible to keep this fact from spilling over into the decision-making process. I am sure that lawyers, as patients, would very much like medicine to be a more certain science than it is, and their view that it should be cannot help but have an impact upon their view of medical malpractice. Probably

\(^{\text{16}}\) John H. Bauman, *Damages for Legal Malpractice: An Appraisal of the Crumbling Dike and the Threatening Flood*, 61 TEMP. L. REV. 1127, 1130 (1988) ("The client must establish . . . that the lawyer's breach of duty was the cause in fact of the client's loss. . . . The loss of the claim should be sufficient to establish that the client suffered a legal wrong as a result of the attorney's negligence. The trial within a trial method, however, requires proof that the trial of the underlying claims would ultimately have resulted in a verdict for the client.").

\(^{\text{17}}\) See Canterbury, 464 F.2d at 790 ("A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it.").
because they understand their own profession, courts are more tolerant of unpredictability in the legal arena than in the medical one. When a case turns out badly, the court will refer to the truism that juries and/or the law itself are notoriously unpredictable, and it is not the attorney's fault.

As one commentator noted, "[a] legal malpractice action is unlikely to succeed when the attorney erred because an issue of law was unsettled or debatable. The perfect vision and wisdom of hindsight is an unreliable test for determining the past existence of legal malpractice." Because plaintiff (in the countersuit) acted in a manner that was reasonable and consistent with the law as it existed at the time of representation, it had no duty to inform defendants about possible "advertising liability" insurance coverage for their patent infringement litigation expenses.18

Some courts have gone further:

Under the venerable error-in-judgment rule, if an attorney acting in good faith exercises an honest and informed discretion in providing professional advice, the failure to anticipate correctly the resolution of an unsettled legal principle does not constitute culpable conduct. To require the attorney to further advise a client of the uncertainty in the law would render the exercise of such professional judgment meaningless.19

In other words, attorneys are not liable for failing to inform their clients about uncertainty in the legal issues confronting them. When did you last see an analogous analysis of a medical result? Courts have been willing to hold doctors liable for failing to inform patients that a proposed treatment is experimental or uncertain of success.20 Because judges are patients, they want from the medical system the same certainty that patients in general want. They do not demand it from the legal profession because they know it cannot be had.

18. Darby & Darby v. VSI Int'l, Inc., 739 N.E.2d 744, 748 (N.Y. 2000) (citations omitted); but see Williams v. Ely, 668 N.E.2d 799, 806 (Mass. 1996) ("The absence of a guarantee does not, however, foreclose liability for the adverse consequences of a negligent failure to advise a client of the uncertainty of the advice given.").
20. See Karp v. Cooley, 493 F.2d 408, 411 (5th Cir. 1974) (court did not dismiss case based on medical experimentation for failure to state a claim).
The case of In re AC provides a sad but powerful example of another aspect of this phenomenon. Courts are clearly unwilling to second-guess attorneys in the context of legal malpractice. They are far more willing to second-guess medical decisions made by doctors and those few medical decisions made by trial judges who are actually present on the scene of the crisis. In In re AC, the appellate court seemed sure about what AC wanted—in a situation where the doctors and the trial judge, who were there, were not. Usually, the judge is not in the same room as the patient, and is not exposed to the tragedy and uncertainty that presence brings. Surrounded by weeping people, dealing with an imminent death perhaps of AC and of her child, the judge does the best he or she can—and then gets shot down by the appellate court. This highlights the problem with adjudicating these cases in the quiet of the courtroom—a problem that applies equally to all judges, who do not see the turmoil that lies behind the decision. This has its positive attributes—it allows judges to set rules of decision at a time when they can think about what they are doing—but it is problematic if it leads to a lack of comprehension of the realities of medical practice. When the judges are in the hospital rooms, the results often look quite different from cases when they are not.

Unlike many of my fellow academics and attorneys, I have never joined the crowd ridiculing the famous or infamous Georgetown decision. It is all too easy to deride Judge Skelly Wright as an interfering do-gooder in ordering a blood transfusion for a young woman who, competently and coherently, refused to

21. In re AC, 573 A.2d 1235 (D.C. 1990). In this case, the pregnant woman, who desperately wanted her child, faced imminent death from cancer. Id. at 1238. The question was whether to perform an emergency caesarean section to deliver her child, which might accelerate her death but save the child, or wait to do so. Id. at 1238-39. The trial court, present in the hospital, ordered the caesarean based at least in part on the impossibility of ascertaining what her wishes were. Id. at 1240. Tragically, both the woman and her child died. Id. at 1241. The appellate court, apparently confident that the mother had rejected the surgery, reversed. Id. at 1253.

22. See Darby & Darby, 739 N.E.2d at 748.

23. See In re Estate of Brooks, 205 N.E.2d 435 (Ill. 1965) for an example of this phenomenon.

have one despite the risk that she would die.\textsuperscript{25} I picture the judge in the hospital room, with an order thrust in front of him, being told "If you sign it, she lives. If you don't sign it, she dies." We may all agree in the light of hindsight that he should not have signed the order, but we also need to think about the situation in which he found himself, the power of life and death in his hands. We need to forgive him for his act in coming up with what (again in hindsight) look like weak excuses for signing the order. To be honest, in the same situation, I am not sure I would have had the fortitude not to sign, especially in the dawn of the right to refuse life-saving treatment. What this case highlights for me is the difficulty of making decisions in life-and-death emergency contexts. Courts, especially appellate courts, see these decisions in the calm light after the emergency has passed and show no understanding for the conditions under which the decision was made.\textsuperscript{26} While this fact has its utility, in that the appellate courts can proclaim the standard of conduct for the future, it can seem uncomprehending as well. One of the lessons these cases can teach us is that it can be very difficult to reach a clearly mandated result. In other words, the medical facts are messier and the situations more intractable than the law would like them to be. While it is outside the scope of this article, it would be interesting to examine whether the medical malpractice opinions of judges who themselves have been in the emergency rooms forced to make a decision undergo any change as a result of that experience.

In later cases, courts have tended to allow the patient to refuse blood transfusions, even when doctors swore that death was imminent.\textsuperscript{27} These cases provide a look at the difference between the hindsight approach of the typical lawsuit and the uncertainty of the doctor's world. The opinions justifying the courts' refusals to authorize involuntary transfusions are, of course, written after the crisis has resolved itself and in the peace of the judicial chambers. Snide footnotes appear in many of them to the effect

\begin{itemize}
\item \textsuperscript{25} Id.
\item \textsuperscript{26} It is worth noting that the Court of Appeals for the District of Columbia Circuit, in denying rehearing, made it clear that its decision was "not necessarily to be taken as approving the action of... [the] judge in the matter sought to be reheard." \textit{Georgetown}, 331 F.2d at 1010.
\item \textsuperscript{27} \textit{See, e.g., In re Osborne}, 294 A.2d 372, 374 (D.C. 1972) (state not justified in ordering blood transfusion against patient's religious beliefs).
\end{itemize}
that the patient survived without the transfusion, impliedly ridiculing the medical profession when their sworn view that the patient was about to die proved incorrect.28 Were the doctors lying when they predicted certain death without a transfusion? No—they were just uncertain. But the legal system, which cannot deal with uncertainties of prediction in the medical world, itself probably forced them to sound more emphatic than they might have done had they been talking with another doctor, for example.

Yet another permutation of this problem appears in a case called In re Quackenbush.29 In that case, the judge held that Quackenbush was mentally competent to refuse life-saving medical treatment, stating that "I visited with Quackenbush for about ten minutes. . . . During that period . . . he seemed reasonably alert."30 Based on this ten minute conversation with the patient, the judge reached the conclusion that the patient was sufficiently coherent and competent to have his refusal of life-saving surgery upheld by the court.31 In this case, the judge reached a combined legal and medical conclusion in a situation that the doctors had been unable to resolve. While it is perfectly true that someone had to take a stand on the issue, and that the judge was, like Judge Wright, landed with this role, it might nonetheless be offensive to a lawyer if a doctor acted in a similar manner, assuming an expertise about the legal profession (after ten minutes’ study) that the doctor could not possibly possess.

Hindsight can be a positive force, but it can also be a negative one. I have never seen a comparable reference in a legal malpractice opinion that would call attention to the fact that the attorney had been wrong in his or her predictions about future events. While it is of course an excellent result if the patient survives without the transfusion that the doctors believed was necessary, it does not mean that the doctors were wrong at the time of their prediction or that they exaggerated the dire nature of the patient's situation. Their ability to predict the future course of events is limited. Courts often seem unable, however, to tell

28. See id. at 376 n.6 ("We are also advised that the patient has recovered though his chances were very slim and that he has been discharged from the hospital.").
31. Id. at 788, 790.
hindsight from foresight.

4. Medicine as a Science: Sometimes There Is a Right or Wrong Answer

From the start of my teaching career, I have had fascinating conversations with doctors who happen to have entered law school. They often express frustration with the medical malpractice cases that we study, but the frustration often comes from a surprising direction. The doctors, quite simply, point out that what were found as "facts" by the court could not have happened. Sometimes the "findings" favor plaintiffs, sometimes they favor defendants. But in either case, what triggers the frustration is not so much the outcome of the case as the distance between the judicially determined "facts" of the record and what my doctor students know to be scientific reality. In other words, someone has made a mistake along the line somewhere, leading to a result that makes no scientific sense.

In one of the cases, for example, Feldman v. Lederle Laboratories, the defendant drug company (and, a fortiori, the dentist who prescribed the drug) won on the ground that the risks of the drug were not known, and thus could not have been included in a warning or taken into account by the dentist in prescribing the drug. One of my medically-trained students demonstrated that this result is indefensible, given what was known about doxycycline at the time that the drug was prescribed. It turns out that the risk that the drug would cause tooth problems if it was ingested by someone whose permanent teeth were as yet unformed was widely known. Given that the defendant won that case on the ground that the risk was unknown, someone made a mistake along the way somewhere and generated a decision that is individually wrong on the true facts as opposed to the record and legally indefensible.

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33. The dentist, who was also the father of the plaintiff, was not sued in this case. If he had been, he would have prevailed on the same ground as the manufacturer: that the risk was not known. See id. at 376-77.
34. Id. at 376, 387 (no liability for failing to warn of unknowable dangers).
35. In Feldman, the Supreme Court of New Jersey abandoned the Beshada rule that knowability of a danger was not relevant in strict products
Of course, one can try to defend this result as one of the inevitable mistakes made by the adversary system, or by the attorneys who practice it, but that seems to miss the point. We could have a system that made such mistakes less likely and finds facts more reliably. Of course, that may lead to more decisions against doctors, but it would at least be more scientifically defensible.

5. Doctor as Professionals

As health maintenance organizations (HMOs) have become common, cases analyzing them make it clear, at least by implication, that the law has a low opinion of doctors' ethics. HMO policies are upheld as providing a necessary check on doctors' perceived tendency to recommend unnecessary and excessive treatment, a product of the conflict of interest inherent in the idea that no treatment means that doctors do not get paid. In *Pegram v. Herdrich*[^36^], for example, the Supreme Court of the United States referred to the need for HMOs as a cost cutting mechanism to discourage treatment and to counteract the conflict of interest inherent in the medical decision-making process.

HMOs became popular because fee-for-service physicians were thought to be providing unnecessary or useless services; today, many doctors and other observers argue that HMOs often ignore the individual needs of a patient in order to improve the HMOs' bottom lines. Although it is true that the relationship between sparing medical treatment and physician reward is not a subtle one . . . no HMO organization could survive without some incentive connecting physician reward with treatment rationing.[^37^]

If a doctor does not treat, he or she does not get paid. Thus, an incentive system whereby doctors will get paid more if they do not treat is necessary. I have not succeeded in finding a case that says anything similar about attorneys who suffer from the identical conflict: no lawsuit, no payment, or less, anyway.

[^37^]: *Id.* at 220.
Moreover, if a doctor needed not to treat in order to get paid, it would seem that the identical conflict of interest would exist, in this case leading to profit-motivated decisions to forego treatment, based on the assumption that doctors are too unprofessional to put their patients' interests ahead of their own. The implication that doctors need a system to curb their greed, which would otherwise cause them to recommend treatments that their patients do not need, is insulting. Like lawyers, doctors are professionals obligated to put their patients' interests above their own. The accusation that doctors are incapable of fulfilling this obligation, and thus need HMOs to govern them, amounts to hypocrisy.\textsuperscript{38} It is perhaps worth pointing out that it is lawyers, in the form of judges, who are making these implicit accusations.

Thus, doctors see lawyers as blind to their profession's ethical issues. As the court pointed out in \textit{Wickline v. State}\textsuperscript{39} and \textit{Pegram}\textsuperscript{40}, doctors are viewed as having a built in conflict of interest. If the surgeon doesn't operate, he or she doesn't get paid. In the \textit{Wickline} case, the court used this conflict as a justification for a health care insurance/delivery system that encouraged less medical care and provided an incentive for doctors to provide less care.\textsuperscript{41} The entire phenomenon of the HMO was built around the idea that doctors needed a financial disincentive to providing treatment. This legal construct is downright insulting, implying as it does that doctors cannot be trusted to put patients' interests ahead of their own. The HMO rests on the premise that doctors will fall victim to their own greed and recommend treatments that patients don't need in order to make money. The HMO provides a financial disincentive to force doctors not to fall victim to this conflict. Have you ever heard of an attorney accepting a scheme that provides a disincentive to providing legal advice and action? I was fascinated when, in the early days of medical malpractice reform, the defense bar opposed compulsory arbitration laws.\textsuperscript{42}

\textsuperscript{38} The one situation in which at least some lawyers are willing to consider the possibility of attorneys being motivated by profits is the contingent fee context. But even in this situation, the attitude of the legal profession towards its own motivations is not comparable to its willingness to condemn doctors wholesale.

\textsuperscript{40} \textit{See Pegram}, 530 U.S. at 229.
\textsuperscript{41} \textit{Wickline}, 239 Cal. Rptr. at 819.
\textsuperscript{42} \textit{See Lauren R. Reskin, Lawyers Oppose Medical Malpractice Bill}, 71
The plaintiff's bar understandably did, but the defense bar? Their clients favored such legislation, but the defense bar did not. The only reason I can think of for this opposition is that the defense bar gets paid by the hour.

In any event, the legal profession buys into the idea that doctors require anti-treatment incentives to counterbalance their inevitable conflict of interest, but there is no shortage of attorneys willing to take on frivolous lawsuits. Clearly the legal profession does not buy into the idea that it has a beam in its own eye.43

With respect to payment for medical services, courts are perfectly content to hold that doctors must provide treatment even if they are not going to get paid for it. While the opinions may not explicitly say this, by a process of elimination it must be true. It is malpractice to discharge a patient from the hospital before the doctor feels it is appropriate to do so, whether the HMO has agreed to pay for the treatment or not44. Even if the HMO refuses to pay for the treatment, the doctor cannot discharge the patient. The costs of the hospitalization and the physician's treatment must fall somewhere. If the patient has no resources and the HMO refuses to pay, the hospital may well end up covering the cost of the hospitalization, and the doctor may go unpaid.45 Moreover, if the doctor discharges the patient, he or she is guilty of malpractice and potentially liable for damages, even if the HMO has refused to pay for additional treatment. While "cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."46 This is all very well and good, but if there is no way to sue the HMO for failure to pay for needed treatment, a gap in responsibility that has been created

A.B.A.J. 40 (1985) (only one-third of defense attorneys support bill allowing doctors and hospitals to make settlement offers within 180 days of a medical malpractice claim).

43. Matthew 7:3 (King James) ("And why beholdest thou the mote that is in thy brother's eye, but considerest not the beam that is in thine own eye?")

44. See Wickline, 239 Cal. Rptr. at 819 (noting that a "physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care.").


46. Wickline, 239 Cal. Rptr. at 820.
by the Supreme Court's interpretations of ERISA,\textsuperscript{47} then there is no way for the hospital and doctor to be paid for their services. I have been unable to find a decision requiring that lawyers provide free service in similar circumstances, where the relationship began with the expectation that the lawyer would be paid for his or her services. Of course attorneys supply legal services to the indigent, but through publicly or privately funded defender or other organizations, where lawyers usually do get paid, and there is no expectation from the start that the attorney will be paid by the client. It is also true that an attorney may not withdraw from representation without giving the client a chance to find a replacement, a rule which applies to doctors as well, but that is a far cry from the situation in which the professional must supply services whether he or she is going to get paid or not.

B. Doctors as Scientists

1. The Standard of Care

Yet another issue crops up in the context of the standard of care. In \textit{Helling v. Carey}\textsuperscript{48}, the court concluded that the defendant ophthalmologists had been negligent in failing to test the patient for glaucoma as a matter of law, despite a jury verdict that they had met the standard of care of a reasonable physician in the circumstances. The court stated:

\begin{quote}
 [T]he standard of the profession of ophthalmology . . . does not require the giving of a routine pressure test to persons under 40 years of age. . . . [H]owever, [t]he precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.\textsuperscript{49}
\end{quote}

The court in \textit{Helling} thus decided that the standard of care of

\textsuperscript{47} Aetna Health Inc. v. Davila, 542 U.S. 200, 221 (2004) (claim that denial of benefits from an employee benefit health plan is pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA)).

\textsuperscript{48} Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974).

\textsuperscript{49} Helling, 519 P.2d at 982-83.
the profession before it was fatally flawed, and replaced the medical evidence with its own conclusion about what constituted the appropriate practice. I can find no comparable legal malpractice case in which the court ruled that the lawyer had been negligent as a matter of law after the jury had decided that the standard of care—evidenced by peer testimony—had been met. The *jury* in *Helling* concluded that the defendants had not been negligent in failing to administer a glaucoma test to the plaintiff; *a fortiori* the defendants had not been negligent in failing to recognize symptoms that would have indicated the need for such a test.50 The Supreme Court of Washington, in its reversal of this jury verdict, left ophthalmologists in Washington no choice but to give such tests to any patient who walks in the door. While the court tried to pretend that this was not the result, it clearly was. The jury found as facts that the doctors had not been negligent in failing to recognize glaucoma and in failing to administer a glaucoma test. Thus, the ruling that they had been negligent in failing to give the test as a matter of law meant that they were not entitled to the reasonable use of their medical judgment in deciding whether to administer the test.

After *Helling* was decided, the Washington legislature enacted a statute that codified the standard of care for medical professionals as follows: “the plaintiff in order to prevail shall be required to prove . . . that the defendant or defendants failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession . . . .”51 This statute clearly intended to establish a rule that, contrary to *Helling*, would permit liability for malpractice if, and only if, the defendant had failed to act as a reasonable medical professional in the circumstances. The Supreme Court of Washington, in *Gates v. Jensen*,52 however, stood by its decision in *Helling*, holding that “[t]he doctrine of Helling v. Carey, that reasonable prudence may require a higher standard of care [than the applicable professional standard of care] applies.”53 The court discounted the statutory language that apparently forbade this result on the ground that

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50. So much for the idea, beloved of tort reformers, that juries always decide in favor of the plaintiff.
53. Id. at 924.
the statute used the word "possessed," a broader term (in the court's view) than the concept of the reasonable professional standard of care.

The statute as passed requires physicians to exercise the skill, care and learning possessed by others in the same profession. This standard . . . allows ample scope for the application of the limited *Helling* rule. It is not argued that respondent and other ophthalmologists did not possess the skill, care and learning required to choose and administer the two [glaucoma] tests.\(^{54}\)

Not surprisingly, a vigorous dissent argued that the statute was enacted with the intent of replacing *Helling* with a professional standard of care.

This case reflects judicial willingness to reject the reasonable doctor standard in the face of the judges' own assessments that the doctors were negligent. In other words, under *Helling* and *Gates* a doctor who complied with the standard of care of a reasonable doctor in the circumstances could be found negligent if the court viewed the conduct as having been negligent under some judge-made (and scientifically unsupported) standard. It is impossible to imagine an equivalent decision in the context of legal malpractice, in which the court would find the defendant attorney liable after the jury had decided he or she had acted reasonably. The very impossibility of this result is underlined by the ineffective assistance of counsel lines of cases. In criminal cases, attorneys can sleep through trials,\(^{55}\) do no investigation,\(^{56}\) call no witnesses\(^{57}\)—all without the courts being willing to label them as incompetent. Doctors are permitted no such leeway when they practice their profession.\(^{58}\)

\(^{54}\) *Id.*

\(^{55}\) See, e.g., Tippins v. Walker, 77 F.3d 682, 686 (2d Cir. 1996) (holding that defense counsel sleeping through a criminal trial is not a deprivation of effective assistance of counsel).

\(^{56}\) See, e.g., Schriro v. Landrigan, 550 U.S. ___, 127 S.Ct. 1933 (2007) (holding that defense counsel's failure to investigate mitigating evidence for the sentencing phase of a criminal trial, in which the defendant was given the death penalty, is not a deprivation of effective assistance of counsel).

\(^{57}\) *Id.*

\(^{58}\) While it is true that the *Helling* decision is atypical, the fact that it existed, and led to the *Gates* decision, is itself significant.
2. The Problem of Prediction in Medicine

What may appear to be a semantic difference in language between law and medicine takes on a much greater and more intractable guise when it is examined closely. A college friend of mine reflected on this, many years ago. A psychologist, she was often called as an expert witness in child custody cases. The attorney—or sometimes the judge—would ask her if the parent at issue would be a "good parent." The court needs an answer to this as part of the decision-making process on custody. However, no psychologist can possibly answer that question in the form that the court wants it answered because there are too many variables—income, other support, school system, etc. This problem recurs in medical malpractice cases all the time. The courts want an ANSWER, not an equivocal maybe. But scientists do not think that way, and cannot reliably answer a question that way—"[u]ncertainty permeates modern medicine." The concept of definite and percentage-based predictions is not one that a medical person can effectively handle. This goes well beyond vocabulary and into the essential attributes of the two professions. An expert witness who is forced to answer the question in a way that the courts can process is being required to betray the values and thought-processes of the medical profession. It is up to the law to change: we cannot change science, so the law must develop to make medical malpractice work.

Another set of recurring problems centers around vocabulary: the legal understandings of the scientific use of the terms "experiment," "innovation," and "mistake." To begin with the last in the series, doctors often make mistakes. It does not follow from this that the doctor was negligent: there are mistakes that a reasonable doctor would make, even acting reasonably. This

60. There may well be more than one treatment of choice in a particular situation, in which case it is not negligent to prefer one over the other, unless a reasonable doctor could not have selected the particular option. This is the concept behind the differing schools of thought doctrine. See Parris v. Sands, 25 Cal. Rptr. 2d 800, 803-04 (Ct. App. 1993) (holding that proper jury instruction for medical malpractice cases includes: "Where there is more than one recognized method of diagnosis or treatment, and no one of them is used exclusively and uniformly by all practitioners of good standing, a physician is not negligent if, in exercising his or her best judgment, he or she selects one
ineluctable fact has produced the so-called honest error in judgment doctrine, pursuant to which the courts attempt to deal with the fact that not all medical mistakes are produced by negligence. This doctrine would be unnecessary if courts would insist on evidence of negligence and would differentiate between negligent and non-negligent mistakes.

Similarly, something that a doctor might say was experimental within the meaning given to the word in the medical arena might or not be experimental within the meaning of the word in the legal context. Therapeutic innovation—the use of an off-label drug or a treatment altered to fit the circumstances—is not an experiment in the Frankensteinian sense of the term. The doctor is trying to treat the patient, not to generate information. The law, in its inability to tell the two kinds of situation apart, has caused tremendous difficulties for the medical profession. As one court pointed out: "[t]oo often courts have confused judgmental decisions and experimentation. Therapeutic innovation has long been recognized as permissible to avoid serious consequences." The medical profession might consider a treatment decision to be a therapeutic one, but nonetheless call it an experiment. Courts and juries cannot understand this use of the term, tending to associate experiments with guinea pigs and not patients.

II. WHY TORT REFORM DOES NOT WORK

Periodically, those in favor of reducing the perceived burden of malpractice litigation on doctors have attempted, through statutes, to change medical malpractice law. Back in the 1980s, "tort reform" took on a specific meaning: tort curtailment. Anyone of the approved methods, which later turns out to be a wrong selection . . . ."

The phrasing of the court's opinion is itself interesting here, as it should of course be the patient that makes the choice.

61. Slides can be misread, for example. This is not medical malpractice nor negligence unless a reasonable doctor could not have made such an error. See Hanks v. Drs. Ransom, Swan & Burch, Ltd., 359 So. 2d 1089 (La. 1978) (upholding jury verdict of no negligence when frozen section slide of breast tissue misdiagnosed as malignant, leading to unnecessary mastectomy). See also Lauro v. Travelers Ins. Co., 261 So. 2d 261, 266 (La. App. 1972) ("not unreasonable" to misdiagnose frozen section tissue sample as cancerous).

who sought tort reform was seeking to limit the number or size of tort suits. These efforts were based on the unproven presumptions that there were too many lawsuits, that plaintiffs won too many of them, and that the amounts awarded by juries were too large. It is perhaps worth pointing out that these presumptions only represent problems if there are too many frivolous or unjustified lawsuits, if plaintiffs are winning lawsuits that they should lose, and if juries are consistently awarding plaintiffs damages in excess of their injuries. Whatever tort reform does, it should not be taking away from plaintiffs the opportunity to file and win justified lawsuits and recover damages produced by medical negligence.

The fact that the first major medical malpractice crisis occurred in the 1980s is far from coincidental. As is the case today, the crisis in the 1980s took the form of wildly escalating malpractice premiums. If medical malpractice premiums had gone into their exponential rise in the 1980s because of any alteration in tort law, it would have had to be a cataclysmic one to have led to so sudden an increase. No such development in tort law took place. There was, however, an event in the 1980s that can be identified as the culprit: economic recession.

During the 1970s, when interest rates were high and property values were escalating, insurers . . . enjoyed high returns on their investments. . . . But in the early 1980s, when the industry was hit by what was then the sharpest recession since World War II . . . insurers . . . used their monopolistic pricing, and their ability to manipulate rate-setting procedures, to orchestrate sharp increases in liability premiums in order to offset their disappointing investment results.63

If actual experience in paying claims is not the primary basis on which premiums are based, then changing the number of claims filed and the amounts actually paid on them will not have a discernible impact on malpractice premiums. As was the case in the 1980s, there is today no recent change in tort law on which to pin increased premiums. Expecting changes in tort law to eliminate the crisis in insurance premiums thus makes little

sense. If the premiums are set based on factors other than actual experience paying judgments or defending cases, and there is a lot of evidence that they are, then changing how the tort system works can have no impact upon them. As one author pointed out with respect to today's alleged crisis:

Because of the overall surge in malpractice premiums with no corresponding surge in claims payments during the last five years, the leading malpractice insurers have increased their surplus by more than a third in only three years, and they are now charging more for malpractice insurance than either their actual payments in malpractice cases or their estimated future payments in malpractice cases would justify.

Not surprisingly, then, the tort reforms of the 1980s have not served to cure the problems, as the current alleged medical malpractice crisis shows, and changes in the tort system in the 2000s will not help either. Indeed, the very fact that we are in a crisis situation itself proves that the tort reforms enacted to date must have been misguided, for if they had not been misguided they would have helped alleviate the current situation.

Current tort reforms target the perceived problem of excessive judgments. The syllogism goes like this:

1. Malpractice premiums are based on the claims that insurance companies pay.

2. Malpractice premiums are too high.

64. See id. See also U.S. Gen. Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates 44 (2003), available at http://www.gao.gov new.items/d03702.pdf. This GAO study points out a list of factors that contribute to higher premiums and more inaccessible insurance. See generally id. While the study maintains that increased payouts play a role in higher premiums, id. at 15-16, it fails to harmonize this conclusion with the fact that malpractice insurance crises occur primarily during recessions. If higher payouts played a major role, it would seem to follow that insurance crises would be more consistent over time. The fact that insurance crises follow recessions lends weight to the argument that their primary cause is not tort law, but rather the economy generally.

3. Therefore, we must reduce the claims that insurance companies pay.

The flaw here is, of course, the assumption that the premiums are based on experience. There is considerable evidence, discussed above and below, that they are not. The world of tort reform seems to operate backwards: the reformers want certain aspects of the tort system to be changed for whatever reasons, and because they want these they postulate that the system is broken. There is no evidence that the tort system, even if broken, is causing the problems which the reformers purport to target.

A. The Reforms So Far

This article now turns to some of the reforms that tort reformers have succeeded in persuading legislatures to adopt. No one questions the presumption that the system is broken in the first place, nor that these reforms will help with the perceived crisis. Not surprisingly, because the tort system is not the sole cause of high medical malpractice insurance premiums, these reforms inevitably fail to cause their reduction. If the tort system is not responsible for the insurance premiums that have caused this latest crisis (and indeed all medical malpractice crises in the past), then changing the tort system will not protect doctors from these premiums. Moreover, efforts at reform through the courts or legislatures by their very failures increase the hatred of doctors for lawyers. Doctors pin their hopes on hard-won reforms; when they fail, disappointment and frustration both enter what is already a shaky relationship between the professions.

Some of the types of reforms that have been tried as vehicles for alleviating legal pressure on the medical profession are discussed below. As the current situation of the medical profession demonstrates, they have almost uniformly failed.

1. Caps on Damages

Caps on damages set a ceiling beyond which the award of damages, sometimes all damages and sometimes non-economic damages only, cannot go. Such caps will only solve the apparent medical malpractice crisis if the crisis is attributable to the large awards at which this reform is aimed.

Numerous states recognize the increasing costs of medical
malpractice insurance and the burdens that these rising insurance costs place on health care providers.\textsuperscript{66} In an effort to alleviate these medical malpractice cost pressures, many jurisdictions have responded by setting caps on damages awards.\textsuperscript{67} In fact, a majority of states have some type of statutory limit on medical malpractice damages.\textsuperscript{68} These caps come in different forms. Some states set a ceiling on non-economic damages only, some limit punitive damages, while other states set caps on all damage awards.\textsuperscript{69} These caps have proven successful in reducing the amount of payouts by insurers.\textsuperscript{70} However, they have been ultimately unsuccessful in lowering malpractice costs because, while the cost to insurers has gone down, states with caps still continue to experience rising insurance premiums. Indeed, insurance premiums in states with caps increased at a rate of 48.2\%, while states without caps saw premium increases at a rate of 35.9\%.\textsuperscript{71} The experience of Texas, which amended its

\textsuperscript{66} See, e.g., 2004 N.J. Sess. Law Serv. ch. 17 (West) ("The [New Jersey] Legislature finds . . . the state’s health care system and its residents’ access to health care providers are threatened by a dramatic escalation in medical malpractice liability insurance premiums . . . .").

\textsuperscript{67} See, e.g., 2005 Ill. Legis. Serv. 94-677 (West) ("The increasing cost of medical liability insurance results in increased financial burdens on physicians and hospitals . . . . This health care crisis . . . . requires significant reforms . . . . Limiting non-economic damages is one of these significant reforms designed to benefit the people of the State of Illinois.").


\textsuperscript{69} Id.


\textsuperscript{71} WEISS ET AL., supra note 70, at 7-8 (stating that although the states with caps had lower median payout rates, their insurance premiums continued to increase at a rapid pace of 48.2\%, while those states without caps actually experienced slower premium increases at a rate of 35.9\%).
constitution to allow caps on medical malpractice awards,\textsuperscript{72} is illuminating. Proponents of the cap claim success in luring more doctors to Texas.\textsuperscript{73} Those who are more skeptical of the actual role of caps in this process point out that there was "little increase in Texas insurance awards from 1990 to 2002, [the twelve years preceding the enactment of the cap]," and that there is no evidence supporting the conclusion that the malpractice cap has had the major impact that its advocates claim for it.\textsuperscript{74} The fact that insurance awards did not change between 1990 and 2002 in itself demonstrates the lack of relevance of caps in the process of easing the crisis, and the extent to which the crisis was never one of liability in the first place. As Pennsylvania Governor Edward Rendell pointed out in a recent statement, the number of doctors in Pennsylvania has stayed the same in recent years.\textsuperscript{75} Governor Rendell rejected the idea that an unfavorable malpractice climate had caused doctors to leave the state, arguing that the allegations of an exodus had been "perpetrated . . . for political purposes."\textsuperscript{76} Of course, to the extent that the malpractice crisis is political and not factual, the perception of a cure can gain significance in itself, a phenomenon with which all doctors are familiar in the form of the placebo effect. The facts do not bear out either that the insurance premium problem was caused by tort law in the first place, or that changes in tort law can fix it.

Caps on damages do not affect the smaller nuisance claims that insurance companies pay because it remains less expensive to pay them than to litigate them. They do not affect the vast majority of claims that fall under the cap. They only have an impact on claims made by those who are the most profoundly injured in the most tragic situations—in other words, those who need the recovery the most.

2. Shortening the Statute of Limitations

Shortening the statute of limitations or abolishing the

\textsuperscript{72} TEX. CONST. art. III, § 66(b).
\textsuperscript{73} Ralph Blumenthal, After Texas Caps Malpractice Awards, Doctors Rush To Practice There, N.Y. TIMES, Oct. 5, 2007, at A21.
\textsuperscript{74} Id.
\textsuperscript{76} Id.
discovery rule,\textsuperscript{77} sometimes precluding suits before the plaintiffs even know they have been injured, will only help with the crisis if the longer statutes of limitations or the discovery rule is the source of the problem. The discovery rule was developed to help plaintiffs in situations where the negligence of the doctor has been clear, for example when equipment has been left behind in the patient after the completion of surgery. Foreclosing suit in such a situation simply allows a clear act of negligence to go undeterred and unrecognized, and does not help anyone.

Statutes of limitation are another form of tort curtailment initiated by the states in order to address rising medical costs. In fact, every state within the United States has some form of statute of limitation regarding medical malpractice claims.\textsuperscript{78} Some jurisdictions start the tolling of the statute on the actual date of the injury, in others, statutes start tolling when the injury is actually discovered, while still other jurisdictions impose a time limit whether the injury can be reasonably discovered or not.\textsuperscript{79} Although all insurance industries have estimated underwriting cycles, the medical malpractice industry has an especially long lag time between the time of the actual event and when the claim is filed.\textsuperscript{80} Because these prolonged periods equal greater costs for insurance companies, causing them greater uncertainty about the scope of their obligations and requiring them to retain reserves for longer periods, states impose statutes of limitation to shorten the amount of time for injured parties to file lawsuits.\textsuperscript{81} These statutes are an attempt to lessen the costs that delayed periods of uncertainty can have on insurers.\textsuperscript{82} Statutes of limitation have proven unsuccessful in cutting malpractice costs.\textsuperscript{83} Whether insurers are saving money due to shorter underwriting cycles or

\textsuperscript{77} Under the discovery rule, the statute of limitations does not begin to run until the plaintiff knew or should have known of the injury. See Mastro v. Brodie, 682 P.2d 1162, 1168 (Colo. 1984) (citing COLO. REV. STAT. § 13-80-105(1) (1983 Supp.) (codifying discovery rule)).

\textsuperscript{78} See State Medical Liability Laws, supra note 68.

\textsuperscript{79} Id.


\textsuperscript{81} BUDETTI & WATERS, supra note 9, at 12-13.

\textsuperscript{82} Id. at 13.

\textsuperscript{83} See ANGOFF, supra note 65, at 20.
not, they are not passing savings onto doctors, as insurance premiums continue to rise.84

3. Requiring an Affidavit

Several states require plaintiffs to provide affidavits signed by medical professionals, certifying the merit of their medical malpractice claim, before the case goes to trial.85 These signed affidavits are designed to weed out frivolous lawsuits, thus decreasing the overall frequency of unmeritorious malpractice claims.86 This reform might seem particularly attractive, providing a direct disincentive to the filing of non-meritorious lawsuits. It has not, however, caused a decrease in the number of claims filed. Although the number of medical malpractice claims has been rising steadily, so has the number of physicians entering the medical profession.87 When these numbers are taken into account, the number of malpractice claims has remained relatively flat over the last several years.88 Even though the number of malpractice claims has remained relatively constant, insurance premiums have not gone down.89 Actually, medical malpractice insurers have collected more than double in insurance premiums while the amount and frequency of their claims has remained relatively flat.90

4. Regulating Attorneys’ Fees

Numerous states have enacted statutes limiting the amount that attorneys can recover in fees from medical malpractice

84. Id.
85. See, e.g., N.J. STAT. ANN. § 2A:53A-27 (West 2004) (“[A] plaintiff shall . . . provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational standards or treatment practices.”).
86. Scaffidi v. Horvitz, 779 A.2d 439 (N.J. 2001) (“The essential purpose of the Affidavit of Merit Statute is ‘to weed out frivolous lawsuits at an early stage’ by requiring ‘a plaintiff in a malpractice case to make a threshold showing that the claims asserted are meritorious.’” (citing Galik v. Clara Maass Med. Ctr., 771 A.2d 1141, 1147 (N.J. 2001)).
87. See BUDETTI & WATERS, supra note 9, at 19-20, 24.
88. See Thorpe, supra note 80.
89. See ANGOFF, supra note 65, at 4.
90. Id.
awards.91 Some jurisdictions limit the attorney’s compensation to a percentage of the entire judgment, while others impose limits based on a sliding scale with the percentage to the attorney decreasing as the size of the award increases.92 Jurisdictions with these statutory limits in place have done so in response to rising medical malpractice insurance costs.93 Because attorneys receive a contingency fee (a percentage of the award only if their client wins), by limiting the percentage that the attorney can claim, states hope to deter attorneys from filing non-meritorious lawsuits simply because they promise significant payouts.94 However, limiting attorneys’ medical malpractice fees has not lowered health care costs for medical providers.95 Even if attorneys are now being more selective in the lawsuits they bring, the statutory limits have not affected insurance prices as premiums continue to rise.96

5. Panels and Pre-Complaint Screening

One group of reforms has a chance at some success. These are reforms that require review by an independent and neutral expert in medicine at some point in the process before the case gets to discovery and trial.97 These programs endeavor to filter out

91. See State Medical Liability Laws, supra note 68.

92. Id.

93. See BUDETTI & WATERS, supra note 9, at 9 ("The way that lawyers representing injured parties are paid in most medical malpractice cases has also generated a great deal of controversy. . . . In medical malpractice . . . lawyers representing patients usually receive a fee only if their client wins the case. . . . [P]hysicians feel that more often it means that lawyers will bring cases without merit but involving a seriously injured person simply because a highly sympathetic victim can lead to an award regardless of the quality of medical care involved."); see also CAL. BUS. & PROF. CODE § 6146 (West 2003).

94. See BUDETTI & WATERS, supra note 9, at 9; see also CAL. BUS. & PROF. CODE § 6146 (West 2003).

95. See ANGOFF, supra note 65, at 20.

96. Id.

97. See, e.g., MASS. GEN. LAWS ch. 231, § 60B (2006) ("Every action for malpractice, error or mistake against a provider of health care shall be heard by a tribunal consisting of a single justice of the superior court, a physician licensed to practice medicine in the commonwealth . . . and an attorney authorized to practice law in the commonwealth. . . . Each such action for malpractice shall be heard by said tribunal within fifteen days after the defendant’s answer has been filed.").
unmeritorious claims, thus reducing litigation costs and the risks involved for defendants in taking cases to trial. In Massachusetts, for example, in order to bring an action for medical malpractice, the claim must first be presented to a tribunal consisting of a superior court justice, physician, and attorney. The plaintiff bears the burden of proof in front of the tribunal, and must show that there is sufficient evidence for the claim to go to court. If the Massachusetts tribunal finds that the evidence is insufficient to sustain an adequate legal claim, then the plaintiff must file a six thousand dollar bond in order to pursue the case. While it is too early to predict possible success, these reforms bring medical professionals into the case at an earlier point in time than the others, and perhaps for that reason might succeed in reducing the number of nonmeritorious cases that are filed.

6. The Problem of Legislative Involvement

Most of the reforms discussed above were enacted into law by state legislatures. Not surprisingly, most of the legislators lack medical training. Equally unsurprisingly, legislatures are heavily lobbied, and by none more thoroughly than the insurance industry. Legislatures love to get involved in the tort system, though—particularly medical torts. They can look like they are doing something to solve what has been sold to them as a problem with tort judgments that are excessive in both number and amount. But do the legislatures help?

First and foremost, is the tort system broken? There is a lot of evidence that it is not, and that tort judgments have little to do with malpractice insurance crises. The idea that they do itself causes harm, because it further inflames doctors against lawyers. Doctors and their lobbying groups can be manipulated into the

98. Id.
99. Id.
100. Id.
belief that the tort system is the source of the problems they confront with malpractice insurance. Then, when the requested reforms of the tort system fail to produce any relief, they become even more outraged at the system, and hate lawyers even more. The reason why the so-called reforms do not solve any problems is that the reforms are not directed at the real source of physician discomfort: insurance.

B. The Reforms the System Needs

The above section discusses some of the common reforms that legislatures have so far enacted. It is perhaps worth pointing out that many of them have already been enacted in many jurisdictions, but they were completely unable to abate the current crisis. The reason is that they were not aimed at the correct target. If they had been, they would have worked and future crises, like the one now, would have been avoided.

While it is beyond the scope of this article to detail the reforms that might truly serve to reduce inappropriate tort liability (if there is any), there are several kinds of reforms that might be worth pursuing. The reforms that might help would be directed at the real problems created by the intersection of medicine and the law. These include reforms directed at the inequality of standards for professional malpractice between the professions and reforms that would make the legal approach to medicine more scientifically rational.

Reforms directed at the double standard for malpractice between the legal and medical professions would require that the law be willing to be judged by the same criteria that doctors now face. Informed consent, for example, would look the same, whether involving a patient or a client. There is no analytical reason why informed consent should not apply equally to both professions. This particular reform might produce the unintended dividend of improving attorney/client relationships in general, as well as improving medicine's view of the law. It might also, of course, lead legislatures, with their lawyer-heavy memberships, to curtail all malpractice liability, be it legal or medical. This could not happen without compelling legislatures at the least to confront the malpractice system as a whole, and potentially even improve its operation and fairness to all parties, not just defendants.

A second source of reform lies in changing the insurance
industry. The insurance industry must be regulated in such a way that any reduction in judgments is passed through to those who buy premiums. Medical malpractice premiums should not be used to make up for investments that produce less in times of recession, but should rather depend on experience. If medical malpractice crises are caused not by judgments nor by increased negligence, but rather by premium-setting practices, these reforms should be the most effective of all. These reforms will be hard to attain in the face of the insurance agency’s massive lobbying expenditures, but they have possibly the greatest chance of success.

Finally, another source of reforms would be those that would make the intersection between the legal and medical professions more scientifically viable. The lost chance doctrine is an example of a modern legal doctrine that, if expanded, has the potential to make the juncture between law and medicine both more scientifically and legally defensible. Under the usual rule in tort cases, a plaintiff must prove by a preponderance of the evidence that the defendant was responsible for his or her injury. A plaintiff who meets this standard will win 100% of his or her damages, even if the evidence shows that the defendant was barely over 50% responsible for the injury. It follows from this that a plaintiff who shows that the defendant was 50% responsible, minus a fraction, recovers nothing.

The preponderance of the evidence standard makes little sense in the medical context with respect to cases where the doctor was less than 50% responsible for the injury. With respect to situations when the plaintiff cannot meet the preponderance of the evidence standard, but can show that the defendant cost the plaintiff some statistically provable chance at recovery, courts sometimes use the lost chance doctrine. Under this doctrine, the doctor may be sued for costing the patient an increased chance of survival. In Herskovitz v. Group Health Coop. of Puget Sound, for example, the patient had a 25% chance of survival after the doctor’s negligence, but would have had a 39% chance of survival had the doctor not been negligent. The doctor’s negligence cost

102. Id.
the plaintiff a significant percentage of his chance of survival, but considerably less than 50%. The court noted that ruling in the defendant's favor because the plaintiff could not meet the preponderance of the evidence burden of proof "would be a blanket release from liability for doctor and hospitals any time there was less than a 50% chance of survival."\(^{105}\)

How does this expansion of medical liability beyond the preponderance of the evidence standard help the medical profession? Under a preponderance of the evidence system, the plaintiff would have lost the case and collected nothing, while under the lost chance doctrine the plaintiff collects damages. But if one turns the analysis around, something it has apparently not occurred to the courts to do, the result could end up being far more equitable and scientifically sensible to doctors than first appears. If the doctor was negligent and the plaintiff can meet the preponderance of the evidence standard by showing that there is a greater than 50% chance that the doctor's negligence caused the injury, why shouldn't the same rule operate to reduce the damages the doctor pays? Under the preponderance of the evidence system, the plaintiff will collect 100% of his or her damages, even if the evidence shows that there was a 49% chance that the damages would not have occurred in the absence of negligence. There should be a tradeoff: in exchange for the doctor being liable for less than 50% of the damages in some cases, the doctor should also be liable for less than 100% of the damages in cases where the doctor caused less than 100% of the damages. This would probably be most medical malpractice cases, and might lead not only to a reduction in verdicts across the board but also to a system that more reliably reflects scientific reality than the one we have now.

Extending the lost chance doctrine to all cases of medical harm represents a true reform in tort law, one that could make the concept of causation in tort law match scientific causation to a greater extent than the all-or-nothing approach to causation is capable of doing. It could lead to substantial reductions in judgments, as the amounts of any judgments would match the percentage of responsibility for the injury caused by any medical

105. *Id.* at 477; see also Falcon, 462 N.W.2d at 56-57 (loss of 37.5% chance of survival).
negligence that occurred. This percentage would rarely be 100%, as numerous other factors are likely to have contributed to the end result.

There are other types of reforms of the legal system in addition to the lost chance doctrine that provide at least a start in bringing science and the law together. The law needs more fully to recognize scientific exigency, and, in order to be fair to those it judges, adjust its system to reflect medicine more accurately. Jury instructions could be drafted with the assistance of scientific experts that would more reliably convey the realities of medical practice to the jury, providing a basis for decision that would draw closer to reality. Changing the standard through jury instructions would allow the direct and cross examinations of expert witness to follow the needs of science, not of certainty.

CONCLUSION

It is beyond argument that doctors feel unfairly burdened by the legal profession. They are to a large extent justified. The absence of success to date in alleviating the burden on doctors proves that the reforms beloved by those who would curtail tort liability and doctrine are aimed at the wrong target. Thus, they cannot succeed. But this lack of success is not only problematic for that reason: the lack of success itself causes harm. Doctors, persuaded that lawyers are the source of their problems, see the lack of success in the so-called reforms, and blame the legal profession even more. Promises of relief go unfulfilled, leading to the decline of the false hopes generated by the reforms as an initial matter. True reform involves looking more deeply into the sources of friction between the legal and medical professions. This article has attempted to take such an approach. The reforms it has suggested are fundamental and involve the legal profession taking a good hard look at itself. The tort system is not broken, and true change must go far beyond the band-aid approach that has thus far failed to alleviate the tensions between our two great professions.