
MEDICAL MALPRACTICE MYTHS AND REALITIES: WHY AN INSURANCE CRISIS IS NOT A LAWSUIT CRISIS¹

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President Bush made legislative changes to the civil justice system a priority in his second term, arguing that federal displacement of traditional state common law will help solve the nation's healthcare crisis and bolster the economy.² Proposals for "tort reform" raise far-reaching and important issues. Certainly, careful analysis should precede any attempt to alter by legislative fiat several centuries of accumulated wisdom among judges, citizen-jurors, and litigants about how best to hold defendants accountable for wrongful conduct and to secure justice for injured victims. Unfortunately, the current debate over the civil justice system is characterized less by careful analysis than by unfounded claims, shrill rhetoric, and spurious anecdote.³

1. This Article is based in part on a white paper that the authors prepared for the Center for Progressive Reform.

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2. See George W. Bush, President of the U.S., Address Before a Joint Session of Congress on the State of the Union, 41 WEEKLY COMP. PRES. DOC. 126, 127 (Feb. 2, 2005)[hereinafter Bush, State of the Union Address] ("Justice is distorted and our economy is held back by irresponsible class actions and frivolous asbestos claims, and I urge Congress to pass legal reforms this year I ask Congress to move forward on . . . medical liability reform that will reduce health care costs and make sure patients have the doctors and care they need."); see also Jeffrey H. Birnbaum & John F. Harris, *President's Proposed Remedy to Curb Medical Malpractice Lawsuits Stalls*, WASH. POST, Apr. 3, 2005, at A5 (describing how the President's medical malpractice bill stalled in the Senate).

3. Marc Galanter has long provided the most skillful and engaging

The situation is particularly acute with respect to the debate over medical malpractice law, where a body of misinformation has proven so durable and influential that Tom Baker has dubbed it “the medical malpractice myth.”⁴ As he observes in his important recent book:

[b]uilt on a foundation of urban legend mixed with the occasional true story, supported by selective references to academic studies, and repeated so often that even the mythmakers forget the exaggeration, half truth, and outright misinformation employed in the service of their greater good, the medical malpractice myth has filled doctors, patients, legislators, and voters with the kind of fear that short circuits critical thinking.⁵

As detailed in this Article, the United States is unquestionably suffering from a healthcare crisis—one symptom of which is an unnecessarily high number of injuries caused by doctors and other healthcare providers—and also from a malpractice insurance crisis. However, contrary to the arguments of those who support restrictions on common law remedies, there is no medical malpractice *lawsuit* crisis.

Insurance companies, managed-care organizations, doctors’ associations, and other interest groups have heavily invested in media campaigns to convince policy-makers and the public that recent increases in malpractice insurance premiums have been caused by a civil justice system that too easily tolerates meritless malpractice claims.⁶ A growing number of empirical studies, however, conclude that the tort system in general—and malpractice

debunkings of popular misconceptions regarding the tort system. *E.g.*, Marc Galanter, *An Oil Strike in Hell: Contemporary Legends About the Civil Justice System*, 40 ARIZ. L. REV. 717 (1998); Marc Galanter, *Shadow Play: The Fabled Menace of Punitive Damages*, 1998 WIS. L. REV. 1; Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093 (1996); Marc Galanter, *Predators and Parasites: Lawyer-Bashing and Civil Justice*, 28 GA. L. REV. 633 (1994); Marc Galanter, *News from Nowhere: The Debated Debate on Civil Justice*, 71 DENV. U. L. REV. 77 (1993); Marc Galanter, *The Day After the Litigation Explosion*, 46 MD. L. REV. 3 (1986); Marc S. Galanter, *Reading the Landscape of Disputes: What We Know and Don’t Know (and Think We Know) About Our Allegedly Contentious and Litigious Society*, 31 UCLA L. REV. 4 (1983).

4. TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 1 (2005).

5. *Id.*

6. *See infra* Part IV.

liability in particular—have been quite stable for the past two decades.⁷ Furthermore, careful inquiries into insurance industry dynamics have identified insurers' business practices, rather than malpractice payouts, as the primary source of premium volatility.⁸ Indeed, as Baker observes, medical malpractice insurers are essentially locked in a boom-and-bust cycle that causes periodic premium spikes irrespective of caps on medical malpractice damages or other legislative restrictions.⁹

Advocates of malpractice-liability “reforms” have attempted to shift the blame for increased malpractice premiums onto the civil justice system, and the blame for the alarming lack of access to affordable, quality healthcare in the United States onto malpractice victims and their attorneys.¹⁰ These advocates claim that rampant lawsuit abuse drives physicians either to practice so-called “defensive medicine” or to leave the medical field entirely. They argue that these reactions increase healthcare costs and diminish healthcare availability.¹¹ However, given the overwhelming evidence of stability in the civil justice system, it would be surprising if either the defensive-medicine claim or the physician-flight claim fail to withstand empirical scrutiny. As it turns out, only a single study, which two non-partisan congressional research agencies have dismissed as unreliable, provides the primary support for the claim that the fear of lawsuits is driving doctors to order unnecessary tests and procedures.¹² Better designed follow-up studies have found little or no evidence that fear of liability causes unnecessary medical

7. *See infra* Part III.A.

8. BAKER, *supra* note 4, at 45.

9. *Id.* at 45 (2005) (observing that “the insurance industry goes through a boom-and-bust cycle that creates medical malpractice insurance crises” and that “[l]awyers, judges, and juries have little or nothing to do with it”).

10. *See, e.g.*, George W. Bush, President of the U.S., Speech at the Gateway Center in Collinsville, Illinois (Jan. 5, 2005), <http://www.whitehouse.gov/news/releases/2005/01/20050105-4.html> [hereinafter Bush, Collinsville Speech].

11. *Id.*

12. U.S. GEN. ACCOUNTING OFFICE, REP. NO. GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 29–30 (2003), *available at* <http://www.gao.gov/new.items/d03836.pdf>; CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 6 (2004).

expenditures.¹³ Similarly, with regard to the claim that the threat of malpractice awards has caused physician flight, a recent Government Accountability Office (GAO) report found that the physician supply in this country has outpaced the population growth for the past decade.¹⁴

In short, the “lawsuit” crisis appears to be nothing more than a well coordinated public-relations creation aimed at imposing radical restrictions on common law liability. The best available empirical evidence suggests that the civil justice system is not inundated with baseless claims, that insurance companies’ losses in malpractice lawsuits are not driving premium hikes, that doctors are not disappearing, and that there is no surge in “defensive medicine” contributing to increased healthcare costs. Thus, judicially or legislatively imposed restrictions on medical malpractice liability will serve to limit the liability of negligent healthcare providers and their insurance companies without significantly improving the quantity or quality of medical care. Worse still, such restrictions will deprive innocent victims of their right to redress for wrongful injury, and will greatly reduce the capacity of the civil justice system to hold negligent professionals accountable for their wrongful conduct.

I. THE POLITICAL SETTING FOR THE CURRENT MALPRACTICE DEBATE.

Shortly after winning the 2004 election, President Bush launched an aggressive campaign for a national overhaul of medical-malpractice liability,¹⁵ pressing Congress to enact legislation restricting liability not only for healthcare providers, but also for

13. Katherine Baicker & Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care 2*, 18 (Nat’l Bureau of Econ. Research, Working Paper No. 10,709, 2004) (finding “little evidence of change in treatment patterns in response to increases in premiums”).

14. See U.S. GEN. ACCOUNTING OFFICE, REP. NO. Gao-04-124, *Physician Workforce: Physician Supply Increased in Metropolitan and Nonmetropolitan Areas but Geographic Disparities Persisted 2* (2003), available at <http://www.gao.gov/new.items/d04124.pdf>.

15. See, e.g., Ron Hutcheson, *Bush Pushes Plan to Limit Medical Liability Suits*, KNIGHT RIDDER NEWSPAPERS, Jan. 5, 2005, <http://www.tilrc.org/docs/0105liability.htm>; Bush, Collinsville Speech, *supra* note 10 (emphasizing agenda to push medical malpractice liability limits before audience of healthcare professionals in southern Illinois).

manufacturers of drugs and other medical products.¹⁶ Several states have adopted similar legislation,¹⁷ and the U.S. House of Representatives has passed malpractice liability bills on a number of previous occasions.¹⁸ To date, however, opposition in the Senate has prevented malpractice legislation at the federal level.¹⁹ Nevertheless, President Bush and the various trade associations whose members would benefit from restrictions on medical malpractice liability apparently believed that under this administration, Congress would finally enact “real medical liability reform,” given that candidate Bush “often talked about malpractice litigation in [his] campaign” and therefore “now had a mandate.”²⁰

Although the war in Iraq and Hurricane Katrina soon moved malpractice-liability legislation off the political center stage, it remains a high priority for the Administration and many influential legislators.²¹ Bills currently in committee in both the House and the Senate²² would limit liability for healthcare providers and manufacturers of medical products by, inter alia, capping non-economic compensatory damages (known as “pain and suffering” damages) at two hundred and fifty thousand dollars,²³ restricting the

16. See Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2005, H.R. 534, 109th Cong. § 9(7) (2005). The Senate bill—S. 354—has the same title and language as the House bill; the bills differ only in their section numbering. Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2005, S. 354, 109th Cong. §3(7) (2005). The sections referenced throughout the remainder of this Article are in those in the House bill.

17. See J. ROBERT HUNTER & JOANNE DOROSHOW, CTR. FOR JUSTICE & DEMOCRACY, PREMIUM DECEIT: THE FAILURE OF “TORT REFORM” TO CUT INSURANCE PRICES app.A—Medical Malpractice “Tort Reforms” (2002) (listing the types of restriction on medical malpractice liability that have been enacted in each state).

18. See Steve Teske, *Frist Willing to Discuss Insurance Reforms to Move Malpractice Legislation This Year*, 14 HEALTH L. REP. 360 (Mar. 17, 2005).

19. *Id.*

20. See Robert Pear, *Bush Begins Drive to Limit Malpractice Suit Awards*, N.Y. TIMES, Jan. 6, 2005, at A18.

21. See *Medical Malpractice Legislation in Limbo Until Next Year*, WASH. SENTINEL, Oct. 31, 2005, at 1, available at http://www.aem.org/washingtonsentinel/washingtonsentinel_oct2005.pdf.

22. See S. 354, 109th Cong. (2005); H.R. 534, 109th Cong. (2005).

23. H.R. 534, 109th Cong., § 4(b), § 9(15) (2005).

availability and amount of punitive damages,²⁴ requiring plaintiffs to bring claims within three years of manifestation of their injury,²⁵ and restricting the amounts attorneys may collect on a contingency fee basis.²⁶ Although the bills pay lip service to federalism,²⁷ they will, if enacted, deeply encroach upon the longstanding ability of state courts and legislators to craft common law rules and to regulate the legal profession within their borders. According to President Bush, such legislation is necessary because a proliferation of “baseless suits” extending “all across this country” has resulted in high insurance premiums, in the practice of “defensive medicine” by doctors, and in a flight of doctors from the medical profession.²⁸

II. THE REALITY OF A MALPRACTICE CRISIS.

Like any business or profession, healthcare providers make mistakes; unlike many other businesses and professions, however, the consequences of errors are often much higher because healthcare providers are in the business of saving lives. According to the National Academy of Science’s Institute of Medicine (IOM), “medical errors are the leading cause of accidental death in the United States.”²⁹ IOM estimates that “[a]t least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented.”³⁰ Moreover, IOM cautions that these numbers are a “‘very modest estimate of the magnitude of the problem since hospital patients represent only a small proportion of the total population at risk’ from medical errors.”³¹

24. *See id.* § 7.

25. *Id.* § 3.

26. *Id.* § 5(a).

27. *See id.* § 11(b), (c) (discussing the effects of House Bill 534 on the states).

28. Bush Collinsville Speech, *supra* note 10.

29. Daniel P. Kessler & Daniel L. Rubinfeld, *Empirical Study of the Civil Justice System* 9 (Nat’l Bureau of Econ. Research, Working Paper No. 10,825, 2004) (citing INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (2000)).

30. INST. OF MED., REPORT BRIEF: TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM I (1999), available at <http://www.iom.edu/Object.File/Master/4/117/0.pdf>.

31. Robert S. Peck, *Tort Reform’s Threat to an Independent Judiciary*, 33 RUTGERS L.J. 835, 850 (2002) (quoting INST. OF MED., *supra* note 28, at 2).

At first glance, this sobering assessment would seem to explain the assertion—repeatedly made by proponents of increased federal control over the state civil justice system—that malpractice lawsuits flood state courts. The Congressional Budget Office (CBO) recently concluded, however, that very few medical injuries ever become the subject of a tort claim.³² For instance, data compiled in the landmark Harvard Medical Practice Study,³³ which remains to date the most important attempt to document the extent of medical negligence in the healthcare system, supports the conclusion that the tort system is vastly *underutilized*.³⁴ Using a conservative methodology for identifying negligent medical care,³⁵ the Harvard researchers found that of the 27,179 cases of medical negligence identified in New York State hospitals in 1984, only 1.5 percent of victims filed medical malpractice claims.³⁶ Several more recent studies support the conclusion that there is too *little* litigation brought against negligent care providers. As Baker observes, “[d]epending on how we count, there are between seven and twenty-five serious medical malpractice injuries for everyone one medical malpractice lawsuit.”³⁷

Although the evidence indicates that only a small proportion of malpractice victims seek redress in the civil justice system, tort liability remains a principal vehicle for holding healthcare providers accountable for medical errors.³⁸ There is no national system for

32. CONG. BUDGET OFFICE, *supra* note 12, at 7.

33. See A.R. Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence. Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245 (1991).

34. See *id.*

35. See BAKER, *supra* note 4, at 29.

36. CONG. BUDGET OFFICE, *supra* note 12. Further, as CBO points out, the 27,179 total cases of negligence “included 5,396 with strong evidence that the negligence contributed to patient disabilities of six months or more—and the estimated 415 claims actually filed correspond to just 7.7 percent of that smaller number of cases.” *Id.* at 7 n.19; see also PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 62 (1993) (suggesting that the “real tort crisis may consist in *too few* claims”).

37. BAKER, *supra* note 4, at 23. Baker supports his estimates through a careful and comprehensive review of medical error studies, some of which replicate the Harvard research team’s methodology and validate its results, and others of which reach the same general conclusion using different methodologies altogether. See *id.* at 30–36.

38. See, e.g., *id.* at 108–10 (describing the reaction of the American Society

disciplining careless medical practitioners. The limited oversight that does occur is undertaken by state medical boards composed primarily of physicians. The evidence suggests that these boards have not adequately provided the discipline necessary to reduce malpractice injuries to acceptable levels. For instance, although a very small number of negligent doctors appears to be responsible for most of the malpractice in this country,³⁹ physicians seem reluctant to revoke licenses or to take other disciplinary action against these few “bad actors.”⁴⁰ According to one report, state medical boards disciplined only 8% of the 35,000 doctors who made two or more payments on malpractice claims from 1990 to 2002, and only 17% of the 2,744 doctors who made five or more malpractice payments during that time period.⁴¹

Similarly, a recent *Washington Post* review of state medical board records found that “[s]cores of physicians in the [District of Columbia, Virginia, and Maryland] and across the country have been given repeated chances to practice, despite well-documented drug and alcohol problems.”⁴² According to the *Post*, records show that these doctors “have stayed in business with the permission of state medical boards and hospitals, even when many have relapsed multiple times and posed a danger to patients.”⁴³

Furthermore, because of weaknesses in the national system for reporting state disciplinary actions, even the relatively few physicians whose licenses are revoked by medical boards are often

of Anesthesiologists to the insurance crisis of the 1980s, in which the Society analyzed anesthesia-related medical malpractice claims and ultimately developed new equipment and practice guidelines that substantially lowered the rate of adverse anesthesia events and, consequently, also lowered insurance premium prices for anesthesiologists).

39. PUB. CITIZEN, STOPPING REPEAT OFFENDERS: THE KEY TO CUTTING MEDICAL MALPRACTICE COSTS (2002), <http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=8308> (describing how a mere five percent of practicing physicians accounted for over half of the medical malpractice that occurred in the United States from 1990 to 2002).

40. See Stephanie Mencimer, *Malpractice Makes Perfect: How the GOP Milks a Phony Doctors' Insurance Crisis*, WASH. MONTHLY, Oct. 2003, at 23–24.

41. See Sidney M. Wolfe, *Bad Doctors Get a Free Ride*, N.Y. TIMES, Mar. 4, 2003, at A25.

42. Cheryl W. Thompson, *Medical Boards Let Physicians Practice Despite Drug Abuse*, WASH. POST, Apr. 10, 2005, at A1.

43. *Id.*

able to obtain licenses in other states and thereby have an opportunity to commit malpractice once again.⁴⁴ To address this problem, Congress created a national reporting system, known as the National Practitioner Data Bank (NPDB), “to allow licensing boards and employers to check on doctors’ records before they are hired and to prevent problem doctors from state-hopping.”⁴⁵ The NPDB, however, is incomplete because many doctors subjected to disciplinary action are either never reported or are reported so late that they are able to move and set up practice elsewhere before detection.⁴⁶

In short, the limited evidence available on the performance of state medical boards is consistent with the folk wisdom that it is not wise to trust a fox to guard the henhouse. Physicians understandably regard the civil justice system with unease. Having devoted themselves to a life of study and practice in service of public health, physicians can easily be persuaded to view the civil justice system as society’s ungrateful and misinformed attempt to second-guess their work. Yet much medical-malpractice litigation is the inevitable result of the failure of their own professional associations to self-regulate.⁴⁷ Left to its own devices, the medical profession is not likely to police the activities of its own members with adequate enthusiasm, and it is not likely to levy stringent sanctions against those who are found to have violated professional norms.⁴⁸

The choice for doctors, then, is not between medical-malpractice law and self-regulation, but between medical-malpractice law and some more direct and intrusive form of government oversight. Understood from that vantage point, tort law would seem to represent an attractive vehicle for ensuring patient safety, even to those interest groups who currently seek its “reform.”⁴⁹

44. See Cheryl W. Thompson, *Poor Performance Records Are Easily Outdistanced*, WASH. POST, Apr. 12, 2005, at A1.

45. *Id.*

46. *See id.*

47. *See* Mencimer, *supra* note 40.

48. *See* PUB. CITIZEN, *supra* note 38; Sidney M. Wolfe, Op-Ed., *Bad Doctors Get a Free Ride*, N.Y. TIMES, Mar. 4, 2003, at A25.

49. BAKER, *supra* note 4, at 114 (noting that unlike direct government regulation, “[l]awsuits represent a free-market, bottom-up approach to safety that fits well with our national character”).

Moreover, by joining forces with insurance companies and other healthcare industry giants, physicians' groups overlook a very real political opportunity to join with consumers, taxpayers, and citizens in an effort to resist ongoing business transformations that limit physicians' day-to-day exercise of medical discretion much more than the remote threat of lawsuits.⁵⁰ Ironically, at the same time that insurers, managed care companies, and other institutional players exert greater control over physicians' decisionmaking, they also obtain greater protection from government regulation and common law tort liability.⁵¹

Unless officials at both state and federal levels adopt serious changes in how they oversee the healthcare system—an unlikely possibility as long as physicians' groups provide political support and an appealing public face for the forces benefited by the status quo—the civil justice system will remain the primary regulatory vehicle for compensating wrongfully injured patients and deterring future medical error.⁵² Thus, in large part due to the political decisions of their own professional associations, physicians will find themselves in an increasingly uncomfortable straitjacket, as they remain the primary targets of the civil justice system even while their ability to influence patient outcomes is steadily eroded by structural changes in the management and delivery of healthcare.

III. THE REALITY OF AN INSURANCE CRISIS.

In addition to an epidemic of medical malpractice,⁵³ the nation suffers from recurring episodes in which insurance companies dramatically increase the cost of medical-malpractice insurance

50. See George Silver, *Health Care: Beyond Markets*, WASH. POST, Nov. 11, 2004, at A37.

51. *Id.* The late George Silver, an emeritus professor of public health at Yale University School of Medicine, observed that the modern healthcare system is dominated by “industrial giants, many of them publicly traded, [who] have been enticed to the table by the promise of large profits and guarantees of total federal immunity from efforts to regulate their practices and businesses.” *Id.*; see also *infra* note 59 (describing the preemptive effects of ERISA as applied to managed care providers).

52. See Stephanie Mencimer, *False Alarm: How the Media Helps the Insurance Industry and the GOP Promote the Myth of America's “Lawsuit Crisis,”* WASH. MONTHLY, Oct. 2004, at 18, 19–20; Silver, *supra* note 50.

53. BAKER, *supra* note 4, at 19.

coverage.⁵⁴ One such increase occurred from the late 1990s until around 2002, when insurance companies demanded escalating premiums for many of their policyholders seeking coverage for medical-malpractice liability.⁵⁵ For example, in Texas, one of the states that the American Medical Association (AMA) recently declared to be experiencing a “medical liability crisis,” malpractice premiums rose 135% from 1999 to 2002.⁵⁶ Such dramatic spikes create enormous financial hardship for physicians, who typically must obtain their own malpractice insurance, even when they practice within a hospital or managed care organization setting and tend to capture only a small portion of the revenues generated by the healthcare system.⁵⁷

Advocates of restricting access to civil justice for victims of medical injury point to these episodes of malpractice insurance volatility as evidence that their policy proposals are needed.⁵⁸ These advocates are inclined, however, to ignore some inconvenient realities. For instance, after the Texas legislature (at the urging of then-Governor George W. Bush) passed a law in 1995 limiting the amount of punitive damages that juries could assess for particularly egregious defendant behavior, insurance premiums continued to rise⁵⁹ despite the legislative changes. Rather than admit the

54. U.S. GEN. ACCOUNTING OFFICE, REP. NO. GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 3 (2003), available at <http://www.gao.gov/new.items/d03702.pdf>.

55. See, e.g., CONG. BUDGET OFFICE, *supra* note 12 at 1; U.S. GEN. ACCOUNTING OFFICE, *supra* note 54, at 3.

56. Ceci Connolly, *Malpractice Situation Not Dire, Study Finds*, WASH. POST, Mar. 10, 2005, at A8.

57. See BAKER, *supra* note 4, at 64–65, 174–78 (arguing that healthcare institutions, such as hospitals and managed care organizations, are better positioned to grapple with the year-to-year variance of liability insurance premiums and, more importantly, to negotiate with insurers for less volatile premium-setting practices).

58. MIMI MARCHEV, NAT’L ACAD. FOR STATE HEALTH POL’Y, THE MEDICAL MALPRACTICE INSURANCE CRISIS: OPPORTUNITY FOR STATE ACTION 1 (2002), available at http://www.nashp.org/Files/gn148_medical_malpractice.PDF.

59. TEX. CIV. PRAC. & REM. CODE ANN. § 41.008(b) (Vernon Supp. 2004). In contrast to the 1995 legislation restricting a Texas citizen’s right to seek judicial redress for wrongful injuries, the Texas legislature passed a law two years later that created a statutory cause of action for injuries caused by negligent healthcare treatment decisions against health insurance carriers,

possibility that the civil justice system was not responsible for the rising malpractice insurance rates, lobbyists for insurance companies and healthcare providers demanded even further cutbacks on the amount that malpractice victims could recover for non-economic compensatory damages.⁶⁰

The recent malpractice insurance crisis is not the first one that this country has experienced: Similar crises erupted in the mid-1970s and again in the mid-1980s.⁶¹ Like the current crisis, both of these previous episodes occurred during a time of relative stability in medical malpractice litigation and claim payments. They were seized upon by the insurance industry, the medical establishment, and various “think tanks” in an urgent call for limiting victims’ rights within the civil justice system.

In an attempt to address the first medical insurance crisis, California in 1975 passed the Medical Injury Compensation Reform Act (MICRA), which provides the model for federal legislation that President Bush is currently urging Congress to pass.⁶² In a major speech in which he advocated a two hundred and fifty thousand dollar federal cap on non-economic damages,⁶³ President Bush

health maintenance organizations, and other companies that manage healthcare plans. *Id.* § 88.002(a). However, the Supreme Court recently held that this Texas law was preempted by the federal Employee Retirement Income Security Act (ERISA). *AETNA Health Inc. v. Davila*, 542 U.S. 200, 221 (2004). As Justice Ginsburg pointed out in her concurring opinion, the Court’s expansive interpretation of the preemptive effect of ERISA in cases preceding *Davila* has resulted in a “regulatory vacuum,” given that adequate alternative rules or remedies are not provided by ERISA as interpreted by the Court. *Id.* at 222 (Ginsburg, J., concurring). The expansive preemptive effect of ERISA with respect to managed care companies underscores the necessity of considering the proposed federal medical malpractice liability restrictions in light of the lack of effective alternative means of protecting malpractice victims, as discussed *supra* Part II and *infra* Part V. See also Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1998–2002*, 2 J. EMPIRICAL LEGAL STUD. 207 (2005); Connolly, *supra* note 56 and accompanying text.

60. See, e.g., Bruce L. Ehni, Op-Ed, *Prescription: Lower Legal Awards*, CITIZENS AGAINST LAWSUIT ABUSE, Apr. 13, 2003, <http://www.tala.com/CIN/FWST4-13-03.htm>.

61. See Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 394 (2005).

62. See Bush Collinsville Speech, *supra* note 10.

63. Even the reasoning behind the \$250,000 amount for the non-economic damages cap in current proposed legislation is woefully inadequate. As

pointed to a similar cap in MICRA and noted that “since 1975, insurance premiums for California doctors have become much more affordable than anywhere else in the country—than in most states.”⁶⁴ The President did not mention that premiums in California continued to increase long after MICRA was enacted.⁶⁵ In fact, premium prices did not stabilize until 1988, after Californians voted in favor of “the nation’s most stringent reform of the insurance industry’s rates and practices.”⁶⁶ Now, unlike state insurance regulators who traditionally have lacked the power or the resources necessary to effectively oversee the business practices of liability insurers, California regulators benefit from reforms that have empowered them to bring much-needed stability to premium rate-setting practices.⁶⁷

Amanda Edwards has determined, the author of the original MICRA legislation in California settled on the \$250,000 amount out of a belief that it would provide a certain level of financial stability to seriously injured victims of medical negligence:

The theory was that you could never really and adequately compensate for pain and suffering, no matter how much money you provided. Money just doesn’t do it. But \$250,000 (in addition to meeting the medical and other needs of the patient), properly invested to the extent that it elevated the quality of life over and above the post-injury status, was thought to be enough to do that job.

Amanda K. Edwards, Note, *Medical Malpractice Non-Economic Damages Caps*, 43 HARV. J. LEGIS. 213, 226 (2006) (quoting former Assemblyman Barry Keene). The fact that proponents of medical malpractice law restrictions have failed to update this \$250,000 amount despite the erosive impact of inflation over the past three decades suggests just how far the medical malpractice debate has lost sight of the purposes and practices of tort law.

64. *Id.*

65. *Id.*; see *Assessing the Need to Enact Medical Liability Reform: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 108th Cong. 3 (2003) (statement of Harvey Rosenfield, President, Foundation for Taxpayer and Consumer Rights), available at <http://energycommerce.house.gov/108/hearings/02272003Hearing796/rosenfield.pdf> [hereinafter *Rosenfield Testimony on Medical Liability Reform*].

66. *Id.*; see also Edwards, *supra* note 63, at 216-219. Like California’s MICRA statute, other states’ tort “reform” measures do not appear to have affected premium rates, as confirmed by a recent study of insurance rate activity in every state from 1985 to 1998. See J. ROBERT HUNTER & JOANNE DOROSHOW, CTR. FOR JUSTICE & DEMOCRACY, PREMIUM DECEIT: THE FAILURE OF “TORT REFORM” TO CUT INSURANCE PRICES 2 (2002).

67. See *Rosenfield Testimony on Medical Liability Reform*, *supra* note 65, at 9. Importantly, California’s insurance reform measure, Proposition 103, requires insurance companies to obtain the state insurance department’s approval before increasing or decreasing premium rates, a mechanism that

The failure of tort restrictions to stop the rise in premium rates is unsurprising. Insurance companies do not base premium rates solely—or even primarily—on claim payouts.⁶⁸ Because of the inevitable lag time between insurance companies' receipt of premiums and their obligation to pay claims,⁶⁹ companies invest paid-in premiums in bonds and other financial instruments.⁷⁰ Contrary to popular perceptions, it is the return from these investments, rather than present or past premium receipts that generates the bulk of insurance-company profits.⁷¹

Consequently, even when malpractice claim payouts remain stable, companies can incur significant losses if their earlier premium pricing practices were premised on unduly optimistic projections of either future investment returns or future payment obligations.⁷² Losses can be especially severe if, during these times of excess optimism, a company offers artificially low premium rates in an attempt to gain a larger market share.⁷³ And, of course, the presence of market competitors that are subject to these same financial and behavioral incentives can significantly amplify the pressure to engage in short-sighted pricing practices.⁷⁴ Ultimately, this industry behavior creates a boom-and-bust pattern—known as the “underwriting cycle”—that companies are largely powerless to escape.⁷⁵

This pattern occurred prior to each insurance premium “crisis” experienced in this country over the last two decades.⁷⁶ Thus,

enables state regulators to prevent companies from placing themselves (and their policyholders) in a precarious financial position by unduly lowering rates to increase market share. *Id.* at 8.

68. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 54, at 7, 15–17.

69. Baker, *supra* note 61, at 398; Baicker & Chandra, *supra* note 13, at 5.

70. Baker, *supra* note 61, at 406–08.

71. See AMS. FOR INS. REFORM, MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 2004, at 3 (2004), http://www.insurance_reform.org/StableLosses04.pdf.

72. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 54, at 35.

73. See Baker, *supra* note 61, at 400 (explaining the effect of relying on wrongly assumed rates at the start of a hard market).

74. U.S. GEN. ACCOUNTING OFFICE, *supra* note 54, at 7.

75. See Baker, *supra* note 61, at 396; BAKER, *supra* note 4, at 51.

76. Baker, *supra* note 61, at 394. Moreover, there is some reason to believe that the traditional causes of the underwriting cycle have been joined by an increasing willingness of at least some liability insurers to adopt more aggressive investing and accounting practices than they have in the past. See

although legislation severely limiting the amounts that victims of medical malpractice can recover from negligent healthcare providers may indeed decrease insurance companies' payouts, they will be the very sort of payouts that insurance companies are supposed to be in the business of insuring. Moreover, such legislation will fail to address the underlying business dynamics that lead to the problematic underwriting cycle.

To be sure, a successfully functioning healthcare industry requires a healthy medical insurance industry. But the rights and responsibilities created by the civil justice system respond to much more than simply a social desire for insurance companies to remain in the black. The primary goals of the civil justice system are to provide victims with compensation, to provide an incentive to healthcare professionals to adhere to minimum standards of care, and to provide society with a vehicle for condemning egregious misconduct.⁷⁷ Rather than treat the symptoms of an insurance market disease with another round of excisions and amputations of the civil justice system—this time through a gross intrusion of the federal government into areas of traditional state authority—Congress should stay its hand and allow the states to consider reforms similar to the successful California insurance market regulations.

U.S. GEN. ACCOUNTING OFFICE, *supra* note 54, at 35. Although the extent of such practices across the industry is unknown, anecdotal reports suggest that at least some insurers during the bull market of the 1990s began investing in growth companies such as Enron and WorldCom, as opposed the more conservative bond market investments that conventionally characterize insurance industry investment practices. *Id.*; *see, e.g.*, Press Release, Office of Senator Edward M. Kennedy, Statement in Opposition to the Medical Malpractice Amendment (July 26, 2002), <http://www.senate.gov/~kennedy/statements/02/07/2002730306.html> (describing how St. Paul, one of the largest of the financially-troubled medical malpractice insurers, sustained a \$108 million loss as a result of Enron's demise). The competitive drive to attract greater market share and inflows of capital also seems to have encouraged at least one prominent insurer to adopt misleading accounting practices. *See* Jenny Anderson, *Insurance Giant Calls Its Accounting Improper*, N.Y. TIMES, Mar. 31, 2005, at A1 (reporting that American International Group, one of the world's largest insurance companies and a leading malpractice insurer, admitted "that its accounting for a number of transactions . . . was improper").

77. *See, e.g.*, Steven B. Hantler, Mark A. Behrens & Leah Lorber, *Is the "Crisis" in the Civil Justice System Real or Imagined*, 38 LOY. L.A. L. REV. 1121, 1123 (2005).

III. THE MYTH OF A LAWSUIT CRISIS.

A broad assortment of politicians, healthcare providers, professional organizations, conservative think-tanks, and industry-funded “astroturf”⁷⁸ organizations have gone to great lengths to convince the public that meritless tort claims have loaded the civil justice system to the breaking point.⁷⁹ These groups support their case against supposed rampant “lawsuit abuse,” not by citing rigorous empirical studies, but by dint of constant repetition of isolated anecdotes⁸⁰ and by skillfully framing the debate with vague, but evocative terms like “flood,” “proliferation,” and “explosion.”⁸¹ These groups do not engage in careful empirical analysis of existing data on how litigants in fact use the civil justice system.⁸² Despite their crudeness, these perceptual machinations have been successful, even among sophisticated and engaged audiences: “When asked to list the two most important problems with healthcare and medicine today, nearly one-third of U.S. doctors listed medical malpractice lawsuits and insurance, while only 5 percent listed medical mistakes, injuries, or related topics.”⁸³

A. *The Alleged “Lawsuit Crisis.”*

The existing empirical data on how the civil justice system

78. An Astroturf organization is a corporate—or interest group—funded association that purports to represent a “grass roots” citizens movement. See Sharon Beder, *Public Relations’ Role in Manufacturing Artificial Grass Roots Coalitions*, 43 PUB. REL. Q. 21 (1998).

79. WILLIAM HALTOM & MICHAEL MCCANN, *DISTORTING THE LAW: POLITICS, MEDIA, AND THE LITIGATION CRISIS* 44 (2004).

80. *E.g.*, *id.* at 52 (noting that the tort-“reform” campaign has “shaped common sense less by rigorous arguments and systematic measurements than by skillful rhetoric, alluring narratives, and consistent convictions,” and that “remarkable encapsulizations of ideological and moral critiques of the modern tort regime persist in ‘tort tales,’ anecdotes and horror stories about civil litigation in the United States”).

81. See, *e.g.*, WALTER K. OLSON, *THE LITIGATION EXPLOSION: WHAT HAPPENED WHEN AMERICA UNLEASHED THE LAWSUIT* (1991); David E. Bernstein, *Procedural Tort Reform: Lessons from Other Nations*, REG.: CATO REV. OF BUS. & GOV’T, Winter 1996, at 71, available at <http://www.cato.org/pubs/regulation/reg19n1e.html>; Joseph Perkins, *We All Pay When Others File Frivolous Lawsuits*, CITIZENS AGAINST LAWSUIT ABUSE, <http://www.calahouston.org/perkins.html> (last visited Jan. 18, 2006).

82. See Mencimer, *supra* note 52, at 18, 19–20.

83. BAKER, *supra* note 4, at 95.

functions does not support the claim that the United States is experiencing a “lawsuit crisis.”⁸⁴ First, the vast majority of civil claims are not tort claims.⁸⁵ According to the most recent analysis by the Department of Justice’s Bureau of Statistics, tort claims accounted for only 10% of civil filings in state courts in 1993 and have remained stable since 1986.⁸⁶ Second, the kinds of tort claims that are targeted by those advocating restriction of the civil justice system (that is, medical malpractice and products liability claims) represent only a very small portion of the nation’s total tort filings.⁸⁷ The overwhelming majority of tort cases instead involve automobile accidents (60.1%), while the second largest category of tort filings concerns premises liability (17.3%).⁸⁸ Only 4.9% of the filings allege medical malpractice.⁸⁹

Third, if there is an “explosion” in civil litigation, it is not in malpractice lawsuits, but in claims for trademark infringement, breach of contract, and commercial torts.⁹⁰ The National Center for State Courts found that from 1998 to 2002, the number of tort cases has been “overtaken” by the “steadily” rising number of contract cases,⁹¹ which are more likely to involve businesses suing other businesses and which, unsurprisingly, are generally not a part of the civil justice system targeted for “reform.”⁹² Finally, the empirical evidence suggests that the number of tort filings has in fact been declining since the beginning of the 1990s.⁹³ The National Center for State Courts found that the number of tort claims filed in thirty-five states accounting for 77% of the United States population

84. Mencimer, *supra* note 52, at 18.

85. STEVEN K. SMITH ET AL., U.S. DEP’T OF JUSTICE, TORT CASES IN LARGE COUNTIES 2 (1995), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/tcile.pdf>.

86. *Id.* (indicating that most civil filings in 1993—41%—were for cases involving domestic relations, such as divorce and child custody).

87. *Id.* at 2 tbl.1.

88. *Id.*

89. *Id.*

90. See PUB. CITIZEN, FREQUENT FILERS: CORPORATE HYPOCRISY IN ACCESSING THE COURTS 6–7 (2004), available at http://www.citizen.org/documents/Frequent_Filers_FINAL.pdf.

91. NAT’L CTR. FOR STATE COURTS, EXAMINING THE WORK OF STATE COURTS, 2003, at 23 (2004), available at http://www.ncsconline.org/D_Research/csp/2003_Files/2003_SubCivil-TORTCON.pdf.

92. PUB. CITIZEN, *supra* note 89, at 3.

93. NAT’L CTR. FOR STATE COURTS, *supra* note 90, at 23.

dropped by four percent during the period from 1993 to 2002.⁹⁴ When adjusted for population, the decline in tort filings over the same time period is even steeper: For the 31 states reporting adjusted data to the Center, the average change in the rate of tort filings per 100,000 people decreased by approximately 13.6%.⁹⁵

When the focus is narrowed to malpractice litigation, the empirical basis for claims of a “lawsuit crisis” still appears weak. Nationally, the population-adjusted number of medical malpractice claims filed in states reporting to the National Center for State Courts actually dropped by 1 percent from 1992 to 2001.⁹⁶ A more detailed study of Texas medical malpractice claims, undertaken by Professors Black, Silver, Hyman and Sage, severely undermines the claim that the recent medical malpractice insurance crisis originated in the civil justice system.⁹⁷ The study examined a database of all closed claims maintained by the Texas Department of Insurance between 1988 and 2002.⁹⁸ When adjusted for population, the number of paid claims of more than \$25,000 remained roughly constant, and the number of smaller claims actually declined.⁹⁹ Moreover, the amount paid out per large claim increased only 0.1% to 0.5% per year when controlled for inflation.¹⁰⁰ Having found no “evidence in claim outcomes of the medical malpractice insurance crisis that produced headlines over the last several years and led to legal reform in Texas and other states,”¹⁰¹ the authors instead concluded that “much of the rise in premiums reflects insurance market dynamics, not litigation dynamics.”¹⁰²

This story is not unique to Texas. Florida’s legislature severely curtailed malpractice victims’ rights to recovery in 1986 to combat an alleged insurance crisis brought on by the tort system.¹⁰³ Despite

94. *Id.*

95. *See id.* at 24 (discussing growth rates of tort filings in unified and general jurisdiction trial courts in thirty-one states between 1993 and 2002).

96. *See id.* at 28.

97. *See* Black et al., *supra* note 59 at 252; *see also* Bernard Black et al., *False Diagnosis*, N.Y. TIMES, Mar. 10, 2005, at A27.

98. Black, et al., *supra* note 58, at 207.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.* at 210.

103. *See Rosenfield Testimony on Medical Liability Reform*, *supra* note 66, at 14.

this legislation, insurance companies have increased medical malpractice premiums in the state by “an average of 30 percent to 50 percent since 2000.”¹⁰⁴ Indeed, even after convincing Florida lawmakers to further limit medical malpractice victims’ rights in 2003, insurance companies successfully sought permission from the state insurance agency to increase rates by as much as forty-five percent.¹⁰⁵ The explanation for these developments is not to be found in some explosion of medical malpractice suits: A study of Florida claims similar to the Texas study found that the medical malpractice liability system in Florida remained essentially stable during the fourteen-year period from 1990 to 2003.¹⁰⁶

In particular, the Florida researchers found that insurance companies in the state paid approximately the same average number of malpractice claims per capita from 1999 to 2003 as they did from 1990 to 1994.¹⁰⁷ Although the number of claims over the time period was quite stable, the researchers did observe an upward trend in mean and median recovery.¹⁰⁸ The researchers attributed this trend in large part to a change in the mix of cases reported toward more severe injuries and death, as well as possibly to increases in medical care costs that have outpaced inflation.¹⁰⁹

A particularly revealing finding was that almost ninety-three percent of awards for one million dollars or more came from private

104. Stephanie Horvath, *Study Finds Tort Reform Not the Answer for Medical Malpractice Crisis*, PALM BEACH POST, Mar. 22, 2005, at 1D.

105. See Chris Grier, *Despite Malpractice Reforms, Florida Clears Huge Rate Hike*, BestWire Serv., (Jan. 5, 2004), available at http://www.williamgammon.com/Personal_Injury_Law.html; Chris Grier, *Florida Weighs Giving Consumer Agency Oversight of Medical Malpractice Rates*, BestWire Serv., (Feb. 9, 2004).

106. See Neil Vidmar et al., *Uncovering the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315, 353 (2005); cf M. Alexander Otto, *Numbers Deny Malpractice Crisis*, NEWS TRIB. (Tacoma, Wash.), Oct. 5, 2005, <http://www.thenewstribune.com/news/local/story/5230867p-4751465c.html> (announcing the release of a report by the Washington insurance commissioner’s office that “Washington state hasn’t seen a sudden spike in closed malpractice cases in the last 10 years”).

107. See Vidmar et al., *supra* note 105, at 334 n.103. There was a small increase in the average number of paid claims per capita from 1995 to 1998 (specifically, about two more claims per 100,000 persons). See *id.* at 334 tbl.4.

108. *Id.* at 337.

109. See *id.* at 343 fig.3, 344 & n.121.

settlements rather than from jury verdicts.¹¹⁰ In some respects, this percentage is not surprising, given that the overwhelming share of civil claims more generally are settled rather than tried.¹¹¹ On the other hand, the underlying picture of coherence and predictability of jury practices that are implied by the finding is starkly out of line with the depiction of “runaway juries”¹¹² that fuels much of the medical malpractice and tort law “reform” movement.¹¹³ Contrary to the “tort lottery” conception of chaos and extremism in jury decision-making,¹¹⁴ these settlement practices instead suggest that defense attorneys and other sophisticated players are quite capable of estimating trial outcomes.¹¹⁵ Hence, the Florida researchers stated that, at a minimum, their findings suggest that “debate about the role of juries in so-called ‘mega awards’ is misplaced insofar as Florida is concerned.”¹¹⁶

A recent study of medical-malpractice litigation in Illinois¹¹⁷ further undermines the assertion that the civil justice system has been spawning “out-of-control” jury verdicts.¹¹⁸ The study’s findings are especially revealing because two of the Illinois counties analyzed—Madison and St. Clair Counties—were dramatically designated as the country’s number-one and number-two “judicial hellholes” in 2004 by the American Tort Reform Association (ATRA),¹¹⁹ an

110. *See id.* at 349–50. The researchers also reported that,

[o]ver the fourteen years examined in . . . [the article], thirty-four of the 801 million-dollar cases resulted in payments over five million dollars. Only two were settled following a jury trial. Five of the 801 cases exceeded ten million dollars but only one was the result of a jury trial. Of the remaining four cases over ten million dollars, one was settled in prelitigation negotiations, and three settled before a trial had commenced.

Id. at 349.

111. *See* Marc Galanter, *The Vanishing Trial: An Examination of Trials and Related Matters in Federal and State Courts*, 1 J. EMPIRICAL LEGAL STUD. 459, 514–15 (2004).

112. *See* Vidmar et al., *supra* note 105, at 349–50.

113. *See id.* at 355.

114. *Id.* at 316.

115. *See id.* at 355.

116. *Id.*

117. *See* NEIL VIDMAR, MEDICAL MALPRACTICE AND THE TORT SYSTEM IN ILLINOIS: A REPORT TO THE ILLINOIS STATE BAR ASSOCIATION (2005), available at <http://www.isba.org/downloadnow/medicalmalpracticestudy.pdf>.

118. *Id.* at 83.

119. *See* AM. TORT REFORM ASS’N, JUDICIAL HELLHOLES 2005 at 4, 20–28

industry organization specifically created to advocate legislative restrictions on the tort system.¹²⁰ ATRA coined the term “judicial hellholes” to refer to areas in the country where alleged bias on the part of judges and juries in favor of tort plaintiffs result in unjustifiable verdicts and exorbitant damage awards.¹²¹ However, the Illinois study shows that plaintiffs prevailed in only eleven of the forty trials involving medical malpractice claims in Madison and St. Clair Counties over the fourteen-year period from 1992 to 2005.¹²² Of these cases, only two awards exceeded one million dollars.¹²³ As the study’s author, Duke University Law School Professor Neil Vidmar, concluded, “[t]here is no evidence to support the perception that medical malpractice jury trials in these counties are frequent or that jury verdicts for plaintiffs are outrageous.” He further noted that, “[i]nsofar as medical malpractice litigation is concerned, the reputation of Madison and St. Clair counties as ‘judicial hellholes’ is not justified.”¹²⁴

Finally, Baker’s recent nationwide study of the amounts that insurance companies pay for malpractice claims casts even further doubt on the assertion that an “out of control” malpractice liability system necessitates premium hikes.¹²⁵ In fact, according to data from the Department of Health and Human Services, payments for medical malpractice claims actually decreased by 8.9% last year.¹²⁶ Alluding to the confluence of his findings with those of the Texas and Florida studies, Baker observed that “[w]hen we’re getting the same answer using completely different research methods, you can

(2005), available at <http://www.atra.org/reports/hellholes/report.pdf>.

120. See Carl Deal & Joanne Doroshow, *Corporate Astroturf and Civil Justice: The Corporations Behind “Citizens Against Lawsuit Abuse,”* MULTINATIONAL MONITOR, Mar. 2003, at 21.

121. See AM. TORT REFORM ASS’N, *supra* note 118, at 6, 8.

122. See VIDMAR, *supra* note 116, at 52 tbl.4.1, 58 tbl.4.2, 64.

123. *Id.* at 64.

124. *Id.* at ii.

125. Baker, *supra* note 61, at 394, 402–07; see also THOMAS H. COHEN, DEP’T OF JUSTICE, MEDICAL MALPRACTICE TRIAL AND VERDICTS IN LARGE COUNTIES, 2001 at 2 (2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mmtvlc01.pdf> (reporting that, in the seventy-five most populous counties in the United States, “[t]he number of medical malpractice jury trials since 1992 has remained stable”).

126. Joseph B. Treaster & Joel Brinkley, *Behind Those Medical Malpractice Rates*, N.Y. TIMES, Feb. 22, 2005, at C1.

be pretty sure we're right."¹²⁷ Consequently, he noted that "[i]f what you want to do is protect doctors from the next malpractice insurance crisis, tort reform is not going to do it."¹²⁸

B. Existing Constraints on Lawsuit Abuse.

Proponents of additional restrictions on the rights of malpractice victims argue that greedy trial lawyers bring too many "frivolous" lawsuits against innocent healthcare providers.¹²⁹ Although isolated horror stories undoubtedly exist, the more general claim has little empirical support. A survey of one hundred cases in which federal judges throughout the country imposed sanctions pursuant to Rule 11 of the Federal Rules of Civil Procedure revealed that businesses were 69% more likely than individual tort plaintiffs and their attorneys to be sanctioned for engaging in frivolous litigation.¹³⁰ This result is not surprising given that the contingency fee system provides an implicit check on frivolous litigation by trial attorneys representing individual plaintiffs.¹³¹ While corporate attorneys are typically paid by the hour regardless of outcome, trial attorneys working on a contingency-fee basis are paid for their work only if their clients prevail. Furthermore, unlike corporate attorneys, trial attorneys must pay the costs of preparing and trying cases—often hundreds of thousands of dollars for medical malpractice cases—and are not reimbursed unless the case succeeds.¹³² As one trial attorney specializing in medical malpractice succinctly observed, "We do everything we can to weed out cases that are without merit. We have

127. Horvath, *supra* note 103.

128. *Id.* An analysis of data from the National Practitioner Data Bank and the *Medical Liability Monitor* conducted by the public interest group Public Citizen found that the median payout and total amount of damages paid by obstetricians/gynecologists have either declined or risen only at the same rate as the cost of medical care services since 1991. PUB. CITIZEN, DATA SHOWS RISING OB/GYN LIABILITY PREMIUMS NOT CAUSED BY MEDICAL MALPRACTICE LAWSUITS 2 (2004), available at <http://www.citizen.org/documents/ACF42D4.pdf>.

129. Bob Herbert, Op-Ed., *Not so Frivolous*, N.Y. TIMES, June 18, 2004, at A31.

130. PUB. CITIZEN, *supra* note 89, at 11.

131. *See id.*

132. *See id.* (observing that medical malpractice trial attorneys take all of the risk and only recover the occasional substantial claim).

to. Our own money is at risk.”¹³³

While there is currently little empirical evidence that overly aggressive plaintiffs’ attorneys are bringing “frivolous” lawsuits,¹³⁴ courts are well-equipped to discourage and punish such abuse if it should become a significant problem in the future. Rule 11 of the Federal Rules of Civil Procedure and its state analogues give judges discretion to impose a variety of sanctions—including reprimands, fines, dismissals of claims, and injunctions—to punish litigation abuse, deter future misconduct, and compensate parties that incur unnecessary expenses.¹³⁵ Furthermore, as the U.S. Supreme Court has recognized, courts may employ various sanctions to address “a full range of litigation abuses” pursuant to their inherent judicial power, which predates and continues to co-exist with Rule 11.¹³⁶ Thus, “if in the informed discretion of the court,” existing rules “are [not] up to the task, the court may safely rely on its inherent power” to impose sanctions for bad-faith conduct in litigation.¹³⁷ Importantly, unlike remote federal legislators yielding blunt instruments such as caps on contingency fees, judges can ensure that they use these case-by-case devices only when necessary and only in a specifically tailored fashion.

C. “*Defensive Medicine*” and “*Doctor Flight*.”

The absence of an empirical basis for a lawsuit crisis casts serious doubt on claims that doctors are practicing defensive medicine or are leaving the medical profession out of fear of being sued. These two impressions underlie the broader argument that the civil justice system makes healthcare more expensive and less accessible to ordinary citizens, because malpractice insurance premiums alone have only a nominal effect on overall healthcare spending.¹³⁸ As the Congressional Budget Office (CBO) noted in a recent report analyzing proposed federal medical malpractice

133. *Id.*

134. *See, e.g.*, BAKER, *supra* note 4, at 83–87.

135. *See* 5A CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE & PROCEDURE § 1336.3 (3d ed. 2004).

136. *Chambers v. NASCO, Inc.*, 501 U.S. 32, 46 (1991).

137. *Id.* at 50.

138. CONG. BUDGET OFFICE, *supra* note 12, at 1.

legislation, “even large savings in premiums can have only a small direct impact on health care spending—private or governmental—because malpractice costs account for less than 2 percent of that spending.”¹³⁹ Thus, unless tort-change proponents have strong evidence to support the conclusions that the threat of malpractice liability causes doctors to employ unnecessary medical procedures or to leave the practice of medicine altogether, the effort to link the healthcare crisis to an alleged “lawsuit crisis” is highly implausible.

Those who claim that defensive medicine is driving up healthcare costs frequently rely on a 1996 study published in the *Quarterly Journal of Economics* in which two economists compared the costs of care for elderly Medicare patients hospitalized for two types of heart disease in states with and without certain legislatively-imposed tort restrictions.¹⁴⁰ The researchers concluded that the tort restrictions yielded a hospital costs savings of 5 to 9 percent, a figure that they then speculated “could lead to expenditure reductions of over \$50 billion per year without serious adverse consequences for health outcomes” if the results “are generalizable to medical expenditures outside the hospital, to other illnesses, and to younger patients.”¹⁴¹ The Bush administration appeared to rely solely on this 1996 study and its highly speculative extrapolation in order to estimate the total national costs of “defensive medicine.”¹⁴² However, the U.S. Government Accountability Office (GAO) pointed out in a 2003 report that there is little empirical or analytical basis for generalizing the study’s limited findings to all patients throughout the entire nation in the manner that the researchers and

139. *Id.*

140. Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. ECON. 353, 372–78 (1996).

141. *Id.* at 387–88.

142. U.S. DEP’T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM (2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>. The Bush administration laid out the basis for its claim that the medical liability system is the primary cause of rising healthcare costs in this 2002 Department of Health and Human Services report. *Id.* at 7 & n.28. The report calls Kessler and McClellan’s 1996 piece “[t]he leading study” on the costs of defensive medicine and uses their estimate of the costs of defensive medicine as support for medical liability restrictions. *Id.*

the Bush administration did.¹⁴³

Subsequent studies with a broader scope refute the proposition that fear of liability results in unnecessary medical expenditures.¹⁴⁴ When CBO applied the same methods that the 1996 study developed to “a broader set of ailments,” the agency found “no evidence that restrictions on tort liability reduce medical spending.”¹⁴⁵ CBO confirmed this result in another analysis that used “a different set of data,” finding “no statistically significant difference in per capita health care spending between states with and without limits on malpractice torts.”¹⁴⁶ Observing that the 1996 study relied “on indirect evidence from tort reform, rather than direct evidence on malpractice costs themselves,” two scholars from the National Bureau of Economic Research (NBER) examined the defensive-medicine claim with more empirical precision by comparing physicians’ treatment patterns in light of states’ actual malpractice premium rates rather than states’ tort restrictions.¹⁴⁷ Using this improved methodology and a wider array of information than used in the 1996 study, the NBER scholars found “little evidence of change in treatment patterns in response to increases in premiums.”¹⁴⁸

In the rhetoric of proponents of malpractice liability cutbacks, the term “defensive medicine” signifies treatments that do not improve the quality of healthcare.¹⁴⁹ When evaluating these studies, however, it is important to bear in mind that, even if a change in physician use of a medical procedure was observed in response to changes in the threat of malpractice, it would still be extremely difficult to determine whether the change constituted “defensive medicine” thus defined.¹⁵⁰ After all, the social desirability of

143. U.S. GEN. ACCOUNTING OFFICE, *supra* note 12, at 29–30.

144. *See infra* notes 145–148 and accompanying text.

145. CONG. BUDGET OFFICE, *supra* note 12, at 6.

146. *Id.* at 6–7. It is also not feasible to design a study examining rates of procedure usage that controls for motivating factors other than fear of liability. As CBO pointed out, “some so-called defensive-medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients.” *Id.* at 6.

147. *See* Baicker & Chandra, *supra* note 13, at 8–9.

148. *Id.* at 18.

149. *See, e.g.*, Bush Collinsville Speech, *supra* note 10 (alleging that doctors are “writing prescriptions or ordering tests that really aren’t necessary, just to reduce the potential of a future lawsuit”).

150. The authors of the 1996 study attempted to make this assessment by

treatment changes in response to malpractice costs depends on whether the status quo practices sufficiently protected patient welfare before the influence of tort incentives. Thus, the fact that the NBER scholars found a correlation between increases in malpractice costs and increased use of mammography in Medicare patients¹⁵¹ does not by itself suggest that the treatment was unjustified. Instead, it could represent precisely the kind of effort to improve care and lower overall accident costs that tort law should encourage.¹⁵²

Legitimate concerns do exist, of course, about the accumulated costs of countless screening tests, each of which individually may appear desirable and necessary from the perspective of malpractice law. But such concerns are best addressed as part of a broader policy debate over how to design an equitable and sustainable healthcare system that serves the needs of all Americans, wealthy or poor, young or old, healthy or ill. Such a broader debate would begin, not by fixating on a malpractice liability issue that represents at most 2% of the country's annual healthcare expenditures, but by acknowledging the gross disparities in insurance coverage, treatment options, and quality of care that characterize the American healthcare system. Most notably, approximately one in six Americans, including 11.4% of American children, currently lacks any form of healthcare insurance.¹⁵³

As with the "defensive medicine" claim, the "doctor flight" assertion has more basis in rhetoric than reality. As an empirical matter, there simply has not been a mass exodus of doctors from the medical profession.¹⁵⁴ In fact, as GAO recently reported, not only has the number of physicians in this country been *increasing* for the

comparing overall longevity rates between states with and without tort restrictions. See Kessler & McClellan, *supra* note 139 at 361–62. Finding no significant difference between the two categories of states, the researchers concluded that the higher level of Medicare expenditures in non-restricted states was not improving patient welfare. See *id.* at 388.

151. Baicker & Chandra, *supra* note 13, at 19.

152. See generally GUIDO CALABRESI, THE COST OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS (1970) (offering a pioneering vision of tort law from this instrumentalist perspective).

153. See Press Release, Ctr. on Budget & Policy Priorities, Census Data Show Poverty Increased, Income Stagnated, and the Number of Uninsured Rose to a Record Level in 2003 (Aug. 27, 2004), <http://www.cbpp.org/8-26-04pov.htm>.

154. U.S. GEN. ACCOUNTING OFFICE, *supra* note 14.

past decade, but the physician increase has outpaced the U.S. population increase.¹⁵⁵ According to GAO, “[t]he number of physicians in the United States increased about 26% from 1991 to 2001, [approximately] twice as much as the nation’s population.”¹⁵⁶ Consequently, the number of physicians adjusted for population (per 100,000 people) rose 12% from 1991 to 2001.¹⁵⁷ Furthermore, from 1996 to 2001, the period in which the most recent malpractice premium spike occurred—the population-adjusted increase in the number of physicians was 2% higher than the population-adjusted physician increase from 1991 to 1996—the period during which insurance companies offered exceedingly low premiums as they vied for larger market shares.¹⁵⁸

It is difficult to reconcile the fact that the physician population is growing faster than the total U.S. population with claims of doctor flight and resulting medical access problems.¹⁵⁹ When GAO attempted to confirm such claims by conducting investigations in five states that the AMA had deemed “crisis” states, the agency found that “many of the reported provider actions taken in response to malpractice pressures [could] not [be] substantiated or did not widely affect access to health care.”¹⁶⁰ In particular, GAO noted that, although there was “extensive media coverage” of reports by provider organizations that “some physicians in each of the five states are moving, retiring, or closing practices in response to malpractice pressures,” those reports were either “inaccurate or

155. *Id.* at 7.

156. *Id.* at 2.

157. *Id.* at 7. GAO also found that, even though the physician supply has significantly increased over the past decade in both metropolitan and non-metropolitan areas, “[t]he disparity in the supply of physicians per 100,000 people between [the two] areas persisted because physicians continued to disproportionately locate in metropolitan areas.” *Id.* at 12–13. As GAO pointed out, however, the geographic disparity in physician supply is a long-standing problem that the U.S. government has been trying to address through various programs for decades. *See id.* at 5–6; *see also* Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind “Tort Reform,”* 5 YALE J. HEALTH POL’Y L. & ETHICS 357, 361 (2005).

158. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 14, at 7 n.15.

159. *See, e.g.,* AM. MED. ASS’N, MEDICAL LIABILITY CRISIS MAP (2005), <http://www.ama-assn.org/ama/noindex/category/11871.html>.

160. U.S. GEN. ACCOUNTING OFFICE, *supra* note 12, at 5. More specifically, “[t]he five states with reported problems are Florida, Mississippi, Nevada, Pennsylvania, and West Virginia” *Id.* at 3 n.3.

involved relatively few physicians” and thus “did not widely affect access to health care.”¹⁶¹ In fact, the only access problems that GAO could “confirm[] were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”¹⁶²

Among the “doctor flight” anecdotes that GAO found to be untrue were some involving obstetricians. Advocates of reduced access to the civil justice system frequently recite such anecdotes, undoubtedly because the anecdotes strongly appeal to the public’s understandable concern about the availability of high quality healthcare to pregnant women.¹⁶³ Despite the fact that obstetrics-gynecology practitioners have often faced particularly high premium spikes,¹⁶⁴ there remains no convincing evidence that the spikes have resulted in widespread access problems due to provider flight.¹⁶⁵

161. *Id.* at 16–17.

162. *Id.* at 13. Before issuing its report finding the medical establishment’s claims of “crisis” states to be unfounded, GAO solicited comments “from three independent health policy researchers and from AMA.” *Id.* at 38. Although all three independent experts “generally concurred with [GAO’s] findings,” the “AMA questioned [the] finding that rising malpractice premiums have not contributed to widespread health care access problems, expressing concern that the scope of [GAO’s] work limited [its] ability to fully identify the extent to which malpractice-related pressures are affecting consumers’ access to health care.” *Id.* The AMA’s complaints included that “the small number of states studied [by GAO] doesn’t give an adequate picture of overall trends.” Tanya Albert, *GAO Report Calls Liability Crisis Localized*, AM. MED. NEWS, Sept. 22–29, 2003, <http://www.ama-assn.org/amednews/2003/09/22/gvsb0922.htm>; see also U.S. GEN. ACCOUNTING OFFICE, *supra* note 12, at 38. However, as GAO pointed out in response to the AMA’s complaint, “because they are among the most visible and often-cited examples of ‘crisis’ states . . . the experiences of these five states provide important insight into the overall problem.” *Id.* at 7. The AMA also questioned other aspects of GAO’s methodology and the reliability of the data underlying the agency’s findings, but GAO disagreed with these criticisms as well. See *id.* at 38.

163. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 12, at 18.

164. See Rita Rubin, *Fed-up Obstetricians Look for a Way Out*, USA TODAY, July 1, 2002, at 1D.

165. It bears emphasizing again that healthcare is improved when actual malpractice suits—rather than premium increases—lead a physician who has repeatedly committed malpractice to leave the practice of medicine. For example, Compton Girdharry, an obstetrician-gynecologist from Ohio whom Bush invited to share the stage with him at an anti-lawsuit speech, told the crowd that he quit medicine because of high malpractice premiums. See Bob Herbert, Op-Ed., *Not So Frivolous*, N.Y. TIMES, June 18, 2004, at A31. It appears, however, that “[s]ince the early 1990s, [Girdharry] has settled

One recent study, for instance, found no empirical support for claims of an exodus of obstetrician-gynecologists and other physicians from Illinois in general or from the state's two ATRA-designated "judicial hellhole" counties of Madison and St. Clair.¹⁶⁶ Rather, based on the AMA's own statistics, the study found that the number of obstetrician-gynecologists, neurological surgeons, and other physicians in Illinois had "increased steadily" in both absolute and population-adjusted terms from 1993 to 2003.¹⁶⁷

The NBER scholars also addressed the claim that the medical liability system has led to a decrease in the physician supply. Their conclusion that "[o]n average, the size of the physician workforce in each state does not seem to respond to increases in premiums"¹⁶⁸ reinforces the findings of GAO and other researchers. The NBER study did find "weak evidence that some physicians on the margins of their careers make entry and exit decisions in part based on the size and number of malpractice payments" and that malpractice costs increases "may [decrease] the size of the rural physician workforce."¹⁶⁹ Nevertheless, even if some rural physicians quit or relocate because of malpractice insurance considerations, the number of physicians in both rural and urban areas continues to increase.¹⁷⁰ Indeed, the number of rural physicians has increased at a higher rate than the number of urban physicians.¹⁷¹ In light of evidence such as this, the CBO concluded that the cases for defensive medicine and doctor flight as significant social problems are both currently "weak and inconclusive."¹⁷²

IV. THE ONGOING PUBLIC RELATIONS CAMPAIGN.

Rather than born of reality, the much-publicized "lawsuit crisis" has been the result of a carefully orchestrated public relations campaign sponsored by trade associations and other entities with an

lawsuits and agreed to the payment of damages in a number of malpractice cases in which patients suffered horrible injuries." *Id.*

166. See VIDMAR, *supra* note 116, at 74–82.

167. *Id.* at ii, 82–84.

168. Baicker & Chandra, *supra* note 13, at 17.

169. *Id.* at 17, 20.

170. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 14, at 15.

171. *Id.* at 12.

172. CONG. BUDGET OFFICE, *supra* note 12, at 1.

interest in reducing access to the civil justice system.¹⁷³ After an early direct-advertising campaign decrying the purported irrationality of the civil justice system failed to change public attitudes in the 1950s,¹⁷⁴ these entities shifted strategies in an effort to disseminate similar messages through seemingly independent sources. Especially beginning in the mid-1980s, proponents of tort restrictions began to finance the generation of material by nominally independent think tanks for use by journalists, thereby transforming the message of the earlier failed advertising campaign into “news.”¹⁷⁵

The principal think tank employed in this capacity over the intervening twenty years has been the Manhattan Institute for Policy Research,¹⁷⁶ which in 1986 launched its Project on Civil Justice Reform with the support of the insurance industry.¹⁷⁷ As William Hammett, the Manhattan Institute’s president, explained in a 1992 memorandum describing the project’s mission:

Journalists need copy, and it’s an established fact that over time they’ll “bend” in the direction in which it flows. For that reason, it is imperative that a steady stream of understandable research, analysis, and commentary supporting the need for liability reform be produced. If sometime during the present decade, a consensus emerges in favor of serious judicial reform, it will be because millions of minds have been changed, and only one institution is powerful enough to bring that about: the combined force of the nation’s print and broadcast media, the most potent instrument for public education—or miseducation—in existence.¹⁷⁸

Constant repetition of misleading or even outright false anecdotes concerning ridiculous suits brought by opportunistic plaintiffs and lawyers also promotes a public perception of a “lawsuit crisis”. For instance, one frequently repeated anecdote mischaracterizes the medical malpractice case brought by Judith Richardson Haines for

173. See Mencimer, *supra* note 52, at 18–19.

174. See *id.*

175. See *id.* at 21.

176. See HALTOM & MCCANN, *supra* note 78, at 40; Mencimer, *supra* note 52, at 21.

177. Mencimer, *supra* note 52, at 21.

178. *Id.*

injuries she allegedly suffered as a result of her severe allergic reaction to radioactive dye administered in preparation for a CAT scan.¹⁷⁹ In think tank documents, newspaper articles, and political speeches, the case is described as one in which a jury awarded Ms. Haimes almost one million dollars for her claim that she lost her psychic powers because of a CAT scan.¹⁸⁰

In reality, Haimes presented the jury with evidence that the defendant radiologist pressured Haimes to consent to a test-run of a small dose of an iodine-based dye, despite her warning that she had been advised to avoid such dyes due to a previous allergic reaction.¹⁸¹ The injection of the dye allegedly sent Ms. Haimes into anaphylactic shock before she could begin the CAT scan, and she spent the next several days with severe nausea, vomiting, and debilitating headaches.¹⁸² She testified that she continued to suffer from the severe headaches whenever she engaged in deep mental concentration, forcing her to quit practicing as a professional psychic.¹⁸³ Haimes asked for relief for the immediate pain and suffering she experienced as well as for lost income.¹⁸⁴ The judge, however, did not allow the jury to consider the lost-income claim because she did not offer expert testimony showing that the dye caused her continuing headaches.¹⁸⁵ The judge later vacated the jury's award as excessive and ordered a new trial, which was eventually dismissed after a different judge determined that Haimes's medical expert lacked the proper qualifications.¹⁸⁶

Anecdotes like the popularized version of the Haimes case, which present simplistic versions of the facts and selectively omit key information, are readily reduced to eye-catching headlines, but do little to promote public understanding and appreciation of the civil justice system. Few public benefits are apparent in anecdotes that

179. See HALTOM & MCCANN, *supra* note 78, at 1–4.

180. See *id.* at 2–4.

181. *Id.* at 1.

182. *Id.*

183. *Id.* at 2. Haltom and McCann note that “[n]ational and local law enforcement officials affirmed that [Haimes] in the past had aided them in solving crimes through use of her unusual gifts, a legacy well documented for some time by Philadelphia media.” *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

invariably portray plaintiffs, jurors, and trial attorneys as abusing the civil justice system, rather than as deploying it to combat and prevent malfeasance. The fact that tort legislation has become such a starkly partisan political issue¹⁸⁷ only increases the chance that rhetoric, anecdote, and obfuscation will impede genuine public understanding of the issues. The full details of the Haimes case present a much different picture of the civil justice system than the rendition of anti-tort campaigners: one of a seriously injured plaintiff, a sincere effort to understand the cause of her suffering, and a judicial process well-equipped to cut off that search for answers and accountability when it was no longer justified.

V. CONCLUSION

America does indeed face a healthcare crisis, both in the form of skyrocketing medical costs and decreasing availability of healthcare insurance, and in the form of widespread medical error that often goes unrecognized and uncorrected. The country also faces a medical-malpractice insurance crisis, as insurance companies and allied interest groups have succeeded in distracting legislative and public attention away from the kind of insurance reform that has proven effective at dampening the business dynamics that give rise to the underwriting cycle which, in turn, gives rise to episodic insurance premium crises. What America does not face, however, is a malpractice lawsuit crisis.

In a prescient 1994 report, the Congressional Office of Technology Assessment warned that, “given new incentives to do

187. Campaign contributions to Republicans from healthcare professionals and the insurance industry during the past two years have been about double those to Democrats. See Dana Milbank, *The Political Mind Behind Tort Reform*, WASH. POST, Feb. 25, 2003, at A21 (citing the Center for Responsive Politics’ reports on political contributions during the first half of Bush’s first term as president, noting that “health care professionals and insurers have given two-thirds of their \$71 million in contributions to Republicans”). Conversely, the plaintiff’s lawyers who would be harmed financially by most legislative proposals to restrict tort law constitute “the Democratic Party’s second-largest funding base.” Mencimer, *supra* note 40, at 24. Compare Center for Responsive Politics, Top Industries: Republican Party (2004 Election Cycle), <http://www.crp.org/parties/indus.asp?Cmte=RPC&Cycle=2004>, with Center for Responsive Politics, Top Industries: Democratic Party (2004 Election Cycle), <http://www.crp.org/parties/indus.asp?Cmte=DPC&cycle=2004>.

less rather than more” in a healthcare system increasingly controlled by profit-driven HMOs and insurance companies, restrictions on malpractice liability “that reduce or remove incentives to practice defensively could reduce or remove a deterrent to providing too little care at the very time that such mechanisms are most needed.”¹⁸⁸ If the current political push for nationwide malpractice liability restrictions ultimately succeeds, and if powerful external regulatory controls are not enacted to replace the lost incentives provided by the civil justice system, the economic forces driving the healthcare industry will encounter little resistance in the constant press to minimize costs and maximize income. The results are predictable: the social costs of injury and suffering from medical negligence—costs that are typically invisible in policy debates but that are all too real in our lives—will rise.

A year after it issued the 1994 report, the Office of Technology Assessment became a victim of the “regulatory reform” movement that was led by a Congress determined to implement its self-proclaimed “Contract with America.”¹⁸⁹ During the ensuing ten years, the same forces that killed the messenger have effectively stifled the message on medical malpractice, and they are on the verge of removing the last effective protection for victims of an increasingly depersonalized system of medical care. Congress should carefully count the social costs before yielding to pressures from the healthcare industry to remove the modest remaining restraints that the civil justice system places on that industry’s power to affect the lives of those in need of medical services.

188. U.S. CONG. OFFICE OF TECH. ASSESSMENT, PUB. NO. OTA-H-602, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE 16 (1994), available at <http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1994/9405/9405.pdf>.

189. See Robert L. Glicksman & Stephen B. Chapman, *Regulatory Reform and (Breach of) the Contract With America: Improving Environmental Policy or Destroying Environmental Protection?*, 5 KAN. J.L. & PUB. POL’Y 9, 16, 19 (1996) (criticizing elimination of the Office of Technology Assessment).

