Where Have All the Baby-Doctors Gone? Women's Access to Healthcare in Jeopardy: Obstetrics and the Medical Malpractice Insurance Crisis

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COMMENTS

WHERE HAVE ALL THE BABY-DOCTORS GONE? 
WOMEN’S ACCESS TO HEALTHCARE IN 
JEOPARDY: OBSTETRICS AND THE MEDICAL 
MALPRACTICE INSURANCE CRISIS

Sarah Domin

Procreation—it is one of our country’s most fundamental rights, guaranteed by the Constitution and championed by the Supreme Court. Yet, despite its protected status, the right to make decisions concerning procreation is being threatened by an enemy that masks itself in the noble ideals of justice and fairness. This enemy is the rapidly rising medical malpractice insurance premiums, which in one year have increased as much as 60% for those providers with particularly risky services, such as obstetricians. Soaring malpractice insurance costs led

1. See U.S. CONST. amend. XIV, § 1; Skinner v. Oklahoma, 316 U.S. 535, 536-38, 541 (1942) (holding that forced sterilization of habitual criminals violates the equal protection clause of the Fourteenth Amendment and deeming the right to procreate a fundamental right essential to society).


3. Conversation with Doctor Wayne Domin, President of Lakes Region Ob-Gyn in Laconia, N.H. (Nov. 15, 2002); Joseph B. Treaster, Rise in Insurance Forces Hospitals to Shutter Wards, N.Y. TIMES, Aug. 25, 2002, at A1. According to The American College of Obstetricians and Gynecologists (ACOG), an obstetrician is a physician who practices obstetrics, which is defined as the medical specialty “that deals with the care of women during pregnancy, childbirth, and the recuperative period following delivery.” See AMERICAN HERITAGE DICTIONARY 1214 (4th ed. 2000). ACOG, an organization that represents over 45,000 obstetricians and gynecologists, reports that most obstetricians are also practicing gynecologists, and many family physicians are licensed to provide obstetric care as well. See Roger A. Rosenblatt et al., Why do Physicians Stop Practicing Obstetrics? The Impact of Malpractice Claims, 76 OBSTETRICS & GYNECOLOGY 245, 245 (1990). Therefore, unless otherwise specified, the term “obstetrician” and those statistics concerning the practice of obstetrics refer to those doctors that provide obstetric care, whether they are obstetricians, ob-gyns, or family physicians. According to a Medical
to the closings of trauma and maternity wards across the country during the summer of 2002,\(^4\) and have forced many obstetricians to give up obstetrics, restrict services, deny certain high-risk patients, become consultants, relocate, retire early, or abandon their practices all together.\(^5\)

\(^4\) Treaster, supra note 3. During the summer of 2002, at least six hospitals throughout the country closed their obstetric wards due to the increasing costs of medical malpractice insurance. \textit{Id.} Additionally, in July 2002, the only trauma center in Las Vegas closed for ten days when the doctors went on strike, protesting the rising medical malpractice insurance rates. \textit{See id.} Bethany Maher, a twenty-three-year-old woman from Gilford, New Hampshire, was nearly a casualty of this unprecedented closing when she was involved in a serious car accident outside of Las Vegas on the first day the trauma center reopened after the strike. Conversation with Bethany Maher (July 18, 2002). Had the trauma center remained closed any longer, this aspiring social worker would have been forced to travel an additional 300 miles to Los Angeles and risk facing debilitating complications from her vertebrate injury. \textit{Id.}

\(^5\) Treaster, supra note 3; Hearing, supra note 2; ACOG News Release, Statement of the American College of Obstetricians and Gynecologists on the Health Act of 2002 (April 25, 2002) [hereinafter News Release], at http://www.acog.org/from_home/publications/press_releases/nr04-25-02.cfm (last visited Oct. 22, 2003). According to ACOG, “When ob-gyns [cannot] find or afford liability insurance, they are forced to stop delivering babies, curtail surgical services, or close their doors.” \textit{Hearing, supra} note 2. Many older obstetricians are choosing to “play it safe” and retire early. Treaster, supra note 3; \textit{see also} Rosenblatt et al., supra note 3, at 245 (stating that in one study, obstetricians that chose to discontinue their practice because of rising liability insurance costs were generally “older”). Other obstetricians who have stopped delivering babies have become mere consultants, leaving the actual medical treatment to other physicians to avoid the need for medical malpractice insurance altogether. Treaster, supra note 3, at A20. For those obstetricians who choose not to stop delivering babies, another growing trend is to restrict surgical services to low-risk procedures. \textit{Id.} Other obstetricians have chosen to deny care to patients considered “high risk” or those lacking insurance coverage. \textit{See} Dianne Schleuning et al., \textit{Addressing Barriers to Perinatal Care: A Case Study of the Access to Maternity Care Committee in Washington State}, 106 PUB. HEALTH REP. 47, 47 (1991). This results in “inadequate prenatal and intrapartum care for that portion of the population with the greatest need.” \textit{Id.} Rather than restrict services, many obstetricians feel forced to move to states where the malpractice insurance prices have not escalated so drastically. Treaster, supra note 3, at A20. The trend is not a new one, as some researchers suggest that access to obstetrical services has been deteriorating since the late 1980s. Schleuning et al., supra. In a 1988 Washington State study, 25% of the subject obstetricians and family physicians ceased practicing obstetrics. Rosenblatt et al., supra note 3, at 245-46. Today, obstetricians are giving up obstetrics in record numbers, and unfortunately, once an obstetrician stops delivering babies, the decision is rarely reversed. \textit{See id.} at 245.
The problem is so far-reaching that it has affected over 1,300 healthcare institutions. The future of obstetrics looks particularly bleak considering the fact that in certain areas, obstetricians cannot obtain any insurance coverage because some insurance companies have terminated their obstetrics coverage. This situation is so volatile that the American College of Obstetricians and Gynecologists (ACOG) has identified twelve “red alert states,” where definite crises exist. Others disagree that a current “crisis” exists, but they warn that one is inevitable. However, when hospitals scale down services in droves and obstetricians face the impossibility of obtaining insurance coverage, calling the problem a “crisis” seems perfectly reasonable.

Mississippi, perhaps the hardest hit of ACOG’s “red alert states” has seen 324 of its physicians cease delivering babies in the last decade. In fact, most Mississippi cities with populations of less than 20,000 people no longer have obstetricians. Such startling statistics are a result of

6. Treaster, supra note 3. The American Hospital Association’s survey further illustrates the far-reaching nature of the problem: the survey reports that 20% of the 5,000 member hospitals and healthcare organizations have reduced services and 6% have eliminated some units, many of which are obstetrical wards, due to the rising insurance rates. Id.

7. See Hearing, supra note 2. In December 2001, the country’s second largest medical malpractice insurance carrier announced that it would not renew policies for 42,000 doctors nationwide; 60% of Las Vegas doctors are part of this group. Id.

8. Hearing, supra note 2. ACOG’s “Red Alert States” include: Florida, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, and Washington. Id. In April of 2003, ACOG added Georgia, Ohio, Oregon, and Virginia to this list of states experiencing acute malpractice insurance problems. News Release, AOCG, “Who Will Deliver My Baby?” Ob-gyns, Patients Push US Senate for Tort Reform, ACOG Names Latest “Red Alert” States Facing Liability Insurance Crisis, at http://www.acog.org/from_home/publications/press_releases/nr04-28-03-2.cfm [hereinafter Red Alert]. West Virginia, originally on ACOG’s list of “red alert states,” was moved to what ACOG calls a “to-be-watched” category because the West Virginia legislature recently enacted tort reform laws. Id.; Hearing, supra note 2. According to ACOG, “a crisis is brewing in” Alabama, Connecticut, Illinois, Kentucky, Missouri, and Utah. Red Alert, supra. In selecting these states, ACOG evaluated the following factors, all of which affect the medical malpractice insurance crisis facing obstetricians: lack of available professional liability coverage for ob-gyns; the number of insurance carriers currently providing coverage, as well as the number leaving the medical liability market; the cost of insurance premiums and their rate of annual increase based on industry monitor reports; a combination of geographical, economic, and other conditions affecting the already existing shortage of ob-gyns and other physicians; and the state’s tort reform history and the likelihood of future tort reforms being passed by the state’s legislature and upheld by the state’s highest court. Hearing, supra note 2.


10. See Hearing, supra note 2.

rapidly rising Mississippi insurance premiums.\textsuperscript{12} The Mississippi State Medical Association reports that medical malpractice insurance rates for obstetricians increased between 20% and 400% in the past year, depending on the insurance carrier, with annual rates ranging from $40,000 to $110,000.\textsuperscript{13} Such premiums can account for as much as 20% of obstetrics providers' gross revenue.\textsuperscript{14}

Obstetricians have struggled with increasing cost and availability of medical malpractice insurance since the 1970s.\textsuperscript{15} According to ACOG,

\begin{itemize}
    \item \textsuperscript{12} See Hearing, supra note 2.
    \item \textsuperscript{13} See Hearing, supra note 2. The situation would be different if these insurance hikes were affordable, but clearly, just the opposite is true. ACOG recently went so far as to label the most recent rise in liability premiums as "meteoric." The American College of Obstetricians and Gynecologists, \textit{How Caps Protect Women's Access to Health Care}, [hereinafter \textit{Caps}], at http://www.acog.org/from_home/departments/dept_notice.cfm?recono=11&bulletin=2078 (last visited Oct. 15, 2003). Unfortunately, such seemingly sensational language does not exist as the fruit of ACOG's obvious biases. Rather, the statistics show that the current cost of malpractice insurance really is astronomical. For instance, in 1960, overall medical malpractice insurance costs were $60 million, but by 1991, they had risen over a hundred-fold to $5.6 billion. Rebecca A. Cerny, \textit{Arbitration or Litigation: Efficacy and Fairness in Resolving Medical Malpractice Disputes Through Arbitration Proceedings}, 27 \textit{J. HEALTH & HosP. L.} 193, 194 (1994). More recently, annual professional liability insurance premiums have reached $10 billion nationwide. \textit{Id.}
    \item \textsuperscript{14} See Diane Levick, \textit{Insurers Squeeze State's Doctors; Malpractice Rates Increasing Dramatically}, \textit{HARTFORD COURANT}, Nov. 17, 2002, at A1 (reporting that Connecticut's rising medical malpractice insurance rates are consistent with the national trend).
    \item \textsuperscript{15} See News Release, supra note 5. Similarly, since the 1970s, patients have been experiencing a relatively high rate of medically related adverse events. See Michelle M. Mello & Troyen A. Brennan, \textit{Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform}, 80 \textit{TEX. L. REV.} 1595, 1599-1600 (2002). In the following studies, "adverse event" refers to an injury that either prolonged hospitalization or resulted in a disability at the time of discharge, and one that was caused by medical management rather than the natural disease process. \textit{Id.} at 1599 n.22. A mid-1970s California study conducted by the California Medical Association revealed that 4.65% of people hospitalized suffered an adverse event, and .79% suffered an adverse event for which the healthcare provider would likely be found liable. \textit{Id.} at 1599. Similarly, in the mid-1980s, after reviewing 30,000 medical records and 67,000 litigation records, researchers for the Harvard Medical Practice Study estimated that 3.7% of New York residents suffered adverse events and 1% suffered adverse events attributable to negligence. \textit{Id.} at 1599-1600. When these statistics were upweighed to reflect the entire state population, the study estimated that in 1984, nearly 7,000 New York residents died as a result of negligence. \textit{Id.} Even today, the occurrence of medical negligence or adverse events in our hospitals and healthcare facilities is not uncommon. According to a Kaiser National Survey conducted in 2000, 47% percent of Americans expressed concern that they would suffer an injury due to medical mistake in the course of hospital care. \textit{Id.} at 1630. If this process proves true, an increase in medical malpractice rates would not appear unfounded. However, the presence of negligence is not correlated with malpractice claims rates or even the outcome of individual trials. See Troyen A. Brennan et al., \textit{Relation Between...}
obstetricians and their patients now face a malpractice insurance crisis for the third time in three decades.16 These crises have been marked by rapidly increasing jury awards. Claims involving neurologically injured infants account for 30% of all cases against obstetricians and the average jury award in such a suit is nearly $1 million.17 Obstetrics also has experienced growing claims rates and now fields more malpractice claims than any other specialty.18 The frequency of claims has increased such

16. See Hearing, supra note 2. In fact, many researchers and experts agree that there have been at least two medical malpractice insurance crises since the 1970s. See, e.g., Mohr, supra note 9, at 1736-37. The insurance crises of the 1970s and 1980s were marked by spiraling medical malpractice costs, diminishing liability insurance availability, and increased liability insurance premiums. See Sandy Martin, M.D., Comment, NICA-Florida Birth-Related Neurological Injury Compensation Act: Four Reasons Why This Malpractice Reform Must Be Eliminated, 26 NOVA L. REV. 609, 610-11 (2002). According to Dr. Sandy Martin, “Patients and physicians were angry, and irrespective of where one wanted to place the blame, what had started as a malpractice epidemic had become a malpractice crisis.” Id. at 611.

17. Hearing, supra note 2. In terms of general jury award trends, Jury Verdict Research in Horsham, Pennsylvannia, reports that from 1995 to 2000, the average medical malpractice jury award increased by more than 70% to $3.5 million, with a few claims being over $40 million. Treaster, supra note 3, at A20. A more recent report indicated that from 1999 to 2000, the median medical malpractice award increased from $700,000 to $1 million, which is a 43% increase, and has doubled since 1995. Hearing, supra note 2. Recently, a California jury delivered the highest individual tort verdict in United States history, awarding the plaintiff $28 billion in punitive damages. California Jury Awards Smoker $28 Billion: Decision Against Philip Morris is Largest Individual Award in a Tobacco Lawsuit, WASH. POST, Oct. 5, 2002, at A2. A sixty-nine-year-old woman, who had been smoking since she was seventeen years old and was dying of cancer, was successful in her lawsuit against tobacco giant Philip Morris U.S.A. Id.

18. Falk, supra note 3, at 2. The malpractice claims rate experienced by obstetricians has risen dramatically in the last four years. See id. at 1. From 1982 to 1986, the rate of obstetrics-related malpractice claims increased by as much as 113%. Id. Obstetric malpractice claims referred to by these statistics are “those relating to the care of [pregnant wom[e]n, including [prenatal, intrapartum, and postpartum [care], and the related care of the fetus and neonate.” Rosenblatt et al., supra note 3, at 246. A study of obstetricians practicing in Washington State defined a medical malpractice claim as any incident or occurrence that led the subject insurance company to open a formal claim file. See id. Studies show that obstetricians experience more medical malpractice lawsuits than physicians from all other specialties. Falk, supra note 3, at 2. One study revealed that from 1990 to 1991, 53.9% of all malpractice claims involved obstetrics. Bill Clements, Don't Get Sued, Dangerous Deliveries, Part IV, Avoiding Medical Malpractice, AM. MED. NEWS, Aug. 1, 1994, at 21. According to the Physicians Insurance Association of America, in 2000, ob-gyns had the highest number of claims filed against them out of twenty-eight specialty groups. Hearing, supra note 2. Interestingly, obstetricians are “three times more likely than family physicians to be the target of an obstetrically related malpractice claim.” Rosenblatt et al., supra note 3, at 249. The greater volume of deliveries performed by obstetricians, and the increased number of high-risk patients cared for by obstetricians, explains this difference when compared to the number of patients cared for by family physicians. Id.
that, in 1999, 76.5% of obstetrician-gynecologists (ob-gyns) surveyed by ACOG reported being sued at least once. However, this high claims rate does not indicate that obstetricians are more negligent than other physicians, as negligence does not indicate trial outcome. Rather, studies show that severity of patient injury, and not the presence of negligence, determines trial outcome. Is a system that so often allows for a finding of negligence when none exists really a justice system?

19. Hearing, supra note 2; see also Falker, supra note 3, at 1 (stating that 80% to 90% of obstetricians “can expect to be sued during their career”).

20. See, e.g., Brennan, supra note 15, at 1966; Stephen S. Entman et al., The Relationship Between Malpractice Claims History and Subsequent Obstetric Care, 272 JAMA 1588, 1590 (1994) (detailing a study that revealed that no relationship was found between prior medical malpractice claims experience and the technical quality of subsequent care rendered by Florida obstetricians). To say that obstetricians are sued most frequently due to the risky nature of the procedures they perform implies that these procedures involve negligence or adverse events more often than procedures performed by physicians of other specialties. However, such an assumption is not supported, due to the fact that the occurrence of an adverse event and/or negligence is not an indicator of trial outcome. See id. In fact, obstetrician-gynecologists (ob-gyns) are successful in defending most of the tort claims against them. Hearing, supra note 2. According to ACOG, roughly 54% of the claims filed against ob-gyns were dismissed, dropped, or settled without a payment, with ob-gyns winning 65% of the cases that ended with a verdict. Id.

21. See Brennan, supra note 15, at 1963-66. This article presents a follow-up of the Harvard Medical Practice Study, which indicated that the severity of patient injury, not the occurrence of an adverse event or an adverse event due to negligence, is a predictor of payment to the plaintiff. Id. A recent study conducted by ACOG and the American Academy of Pediatrics found that 70% of fetal and neonatal neurologic injuries, such as cerebral palsy, a major source of malpractice claims against obstetricians, were caused prior to labor and delivery. See Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology, The American College of Obstetricians and Gynecologists, American Academy of Pediatrics, at xvii- xviii (2003). This means that deprivation of oxygen during delivery, the commonly cited cause of such injuries, is not in fact the cause in the overwhelming majority of cases. Id. This ground-breaking study provides compelling proof that the many obstetricians held responsible for such injuries and ordered to pay damages have been blamed unjustly. See id.
Due in part to the disproportionate claims rate facing them, obstetricians are leaving their practices in record numbers, and thereby placing women's access to healthcare in jeopardy. Unfortunately, this reduced access to care disproportionately affects poor and rural women who already experience a disadvantage in their efforts to obtain adequate healthcare for themselves and their children. In fact, the medically indigent, many of whom come from the inner city, and rural inhabitants, are considered the most socially vulnerable groups in the fight to ensure access to obstetric care for all women.

To address this problem, its social origins must be identified. Obstetricians are leaving the practice of obstetrics because they are experiencing record high premiums. The premiums are high because

22. See Schleuning et al., supra note 5, at 47. The unavailability of obstetric services also results from the increasing cost and number of medical malpractice suits affecting obstetricians, which also lead to increases in insurance premiums. Id. Studies indicate that obstetricians involved in medical malpractice claims are more likely to stop practicing obstetrics. See, e.g., Rosenblatt et al., supra note 3, at 248. A study examining the reasons why physicians stop practicing obstetrics concluded that the personal involvement of obstetricians with medical malpractice claims has a direct relationship with the decision to discontinue obstetric practice. Id. at 249. According to the study, those who left obstetrics “had experienced over twice the average rate of obstetric claims and had a 25% higher rate of nonobstetric claims than their peers who continued to practice obstetrics.” Id. Hence, the experience of defending one malpractice claim does not lead the average obstetrician to give up obstetrics; rather, it is a combination of factors. Id. According to one study,

It is not the individual malpractice claim that persuades the physician to stop practicing obstetrics so much as the cumulative effect of many irritants and disincentives: the cost of purchasing malpractice insurance, the pervasive fear of being sued, and a general rise in the level of tension in the obstetric suite. Id. Other factors associated with the decision to stop delivering babies were the physician's age, and the type and location of his or her practice. Id. at 248. However, the age factor could relate to medical malpractice issues because older physicians, those between fifty to sixty years old, may worry about the potential of post-retirement claims if he or she continues practicing obstetrics. Id. at 249.

23. See Hearing, supra note 2; Falker, supra note 3, at 14; Schleuning et al., supra note 5, at 47; Treaster, supra note 3, at 1, 20.

24. Falker, supra note 3, at 14; Schleuning et al., supra note 5, at 47.

25. See Falker, supra note 3, at 14; Schleuning et al., supra note 5, at 47. Falker's article describes how by hindering access to obstetric care, rising medical malpractice and liability insurance rates most greatly hurt disadvantaged women, those living in rural areas, and those with high-risk pregnancies. Falker, supra note 3, at 14; see also Roger A. Rosenblatt, MD, MPH & Barbara Detering, BA, Changing Patterns of Obstetric Practice in Washington State: The Impact of Tort Reform, 20 FAMILY MEDICINE 101, 106 (1988) (detailing a study which found that rapidly increasing medical malpractice insurance premiums among obstetricians result in reduced access to obstetric care in rural areas and a severe curtailment of care to the medically indigent).

26. See Hearing, supra note 2; Treaster, supra note 3, at A1, A20. The fact that ob-gyns are dropping obstetrics is not the only effect of high medical malpractice insurance rates. See Hearing, supra note 2; Schleuning et al., supra note 5, at 47; Treaster, supra note
insurance companies assess obstetrics as a “high risk” specialty. This assessment results from the high obstetric claims rate, the delicate and essential nature of the practice, and the potential for costly catastrophic injury to the most vulnerable members of our society, infants. The corresponding damages for such injury are particularly lofty because they must account for an entire lifetime of injury. When faced with such financially devastating damages, parents often will seek the help of an attorney who aims to find negligence, even where none actually exists.

3, at A1, A20. Another effect of high medical malpractice premiums is the reduction of subsidies from the federal government and private insurers. Treaster, supra. According to Gavin Kerr, Chief Executive of Mercy Health System, “We had been subsidizing the program because we had the resources . . . [b]ut as the malpractice premiums increased, that dramatically shrunk the resources.” Id.

27. See Hearing, supra note 2.

28. See Martin, supra note 16, at 612 (“One might infer also that obstetrical injuries are worse, although not every obstetrical error is expected to be horrible.”). In researching possible remedies for the medical malpractice insurance crisis affecting Florida obstetricians, the Florida legislature characterized obstetrics as a specialty essential to our society. Id. According to Dr. Sandy Martin, “The Florida Legislature correctly realized that ob-gyns were a subset of physicians that had a disproportionate, if not unbearable insurance liability, but without whom our society would not function.” Id. at 611.


31. See Brennan, supra note 15, at 1966 (describing the results of a malpractice case study). The presence of negligence does not necessarily correspond to malpractice claims rates or even the outcome of individual trials. See id. Thus, the fact that only a small fraction of medical malpractice claims result in plaintiff compensation suggests that increased or high malpractice claims rates were not to blame for the insurance crises. A 1985 study suggested that only 4% of negligently injured patients are compensated for their injuries. Neville M. Bilimoria, New Medicine for Medical Malpractice: The Empirical Truth About Legislative Initiatives for Medical Malpractice Reform—Part I, 27 J. HEALTH & HOSP. L. 268, 271 (1994). This low frequency of claims indicates that the cost of injury due to negligence greatly outweighs the cost of actual claims. Id. Therefore, regardless of whether negligence was the cause of a particular adverse birth outcome, obstetricians were nonetheless sued. A July 2002 issue of USA Today quoted Carol Golin, editor of a newsletter that has followed medical malpractice issues for years, as saying, “There are neurologically impaired babies born that have nothing to do with what the physician did in the prenatal state or the delivery . . . . [b]ut when faced with the tremendous costs of caring for such a child, parents] have no option but to go and sue, even if they like their physician.” Rita Rubin, Fed-up Obstetricians Look For a Way Out; Insurance Rates Drive Some Off; Others Drive Away, USA TODAY, July 1, 2002, at D1.
The result is a high rate of claims and a history of expensive jury awards and settlements.\textsuperscript{32} These factors lead to the high insurance premiums that force obstetricians to stop delivering babies.\textsuperscript{33}

Therefore, obstetricians are caught in an ironic trap: they can practice only if they have insurance, but insurance is so expensive that the cost prohibits them from practicing.\textsuperscript{34} Something must be done before too many obstetricians stop delivering babies or leave their practices altogether. In order to ensure women’s access to healthcare, effective and comprehensive federal and state legislation is desperately needed.

This Comment examines how the medical malpractice insurance crisis has influenced obstetricians and the manner in which they practice, thereby affecting women’s healthcare. First, this Comment examines various malpractice reforms that could curb the rising premiums by highlighting specific cases and statutes that address these reform options. Next, this Comment analyzes these various approaches to reform, focusing on the advantages and disadvantages of each. Finally, this Comment argues that even in the face of these reforms something needs to be done and suggests a reform alternative that draws from the best aspects of the reforms previously discussed.

\textsuperscript{32} See Hearing, supra note 2; Treaster, supra note 3. Other factors, such as advances in technology and the quality of the doctor-patient relationship, also may influence a patient’s decision to sue. See Falker, supra note 3, at 11. Obstetricians utilize various forms of medical technology, including intravenous and fetal monitoring devices, not only to minimize complications during labor, but also to avoid malpractice litigation. Id. at 16. However, the use of this technology may actually lead to malpractice claims in certain situations. Id. at 5-6, 16. For example, the use of an external fetal monitor (EFM) during labor and delivery may lead to a false positive of fetal distress, which in turn, convinces the physician to perform a cesarean section, a very invasive surgery, when not actually necessary. Id. at 16. In 1978, doctors performed an estimated 96,500 cesarean sections for this reason. Id.

\textsuperscript{33} See Treaster, supra note 3. The causes of the overall crisis, however, are not so clear. ACOG, for example, looks to the legal system and blames high jury awards and frivolous lawsuits for the insurance crisis. See Hearing, supra note 2. Studies show that higher rates of lawsuits directly lead to increases in medical malpractice insurance premiums. See Schleuning et al., supra note 5, at 47. Insurance companies, on the other hand, point the finger at both high awards in malpractice lawsuits and general economic factors. Treaster, supra note 3, at A20. For instance, some insurance companies admit that they have had to increase premium prices due to the slumping stock market, a problem that largely did not occur during the nineties because they were able to keep prices low by relying on profits from the then-growing equity and bond markets. Id. However, according to J. Robert Hunter, the insurance director of the Consumer Federation of America, another cause of soaring premiums may be the mismanagement of insurance companies. Id.

\textsuperscript{34} See supra note 33 and accompanying text.
I. GONE TO THE POLICY-MAKERS... EVERY ONE: EXISTING REFORM AND ITS CORRESPONDING CASE LAW

A. An Alternative to the Tort System: No-Fault Compensation

Fortunately, in response to some of the earlier medical malpractice crises, some states have already enacted malpractice legislation aimed at reducing malpractice insurance rates. Nevertheless, given the recurring nature of these crises, many of the statutes clearly are ineffective. In addition, most of the statutes have taken the form of general tort reform and, therefore, are not intended to remedy the insurance crisis of obstetricians in particular. For example, the two statutes specifically enacted to alleviate the problems faced by obstetricians and to ensure women's access to care have proven to be relatively unsuccessful.

Both Virginia and Florida enacted birth-related neurological injury compensation acts in an effort to combat the malpractice insurance crisis affecting obstetricians. Given that birth-related neurological injuries are not only a common source of malpractice claims, but also tend to result in the highest jury awards, it makes sense to remove the claims of neurologically injured infants from the tort system to decrease the cost of medical malpractice insurance premiums facing obstetricians. Such programs aim to lift from the backs of physicians the most frivolous and costly claims while at the same time compensating those patients with legitimate claims.


36. See Hearing, supra note 2; Mohr, supra note 9, at 1736-37 (describing factors affecting medical malpractice crises).

37. See, e.g., Arizona Medical Malpractice Reform Act, § 12-561 to 12-594; California Medical Injury Compensation Reform Act, ch. 2, § 12.5(b); 735 ILL. COMP. STAT. ANN. 5/2-1115; LA. REV. STAT. ANN. § 5628; N.Y. C.P.L.R. LAW § 214-a; VA. CODE ANN. § 8.01-581.15.

38. See Martin, supra note 16, at 621, 624.


40. King, 410 S.E.2d at 660.
Where Have All the Baby-Doctors Gone?

1. Virginia Birth-Related Neurological Injury Compensation Act

In 1987, Virginia enacted the Virginia Birth-Related Neurological Injury Compensation Act (the Act) in response to the obstetric malpractice crisis that was brewing in the state at that time. Because drastic measures currently taken by Virginia insurance companies would leave nearly one-fourth of all Virginia obstetricians without coverage, the Act was specifically tailored to drive down the insurance premiums of obstetricians. The ultimate purpose of the Act was to ensure that malpractice coverage was available to all obstetricians. The Act was designed to accomplish this goal by removing the most catastrophic injuries from the tort system, thereby limiting most of the risk associated with the coverage of obstetrics. These debilitating injuries, commonly referred to as "birth-related neurological injuries," are specifically described in the Act’s very narrow definition.

The Act is funded through the $5,000 annual fee required of participating obstetricians, a $250 annual fee from non-participating obstetricians, and a $50 per live birth fee from all hospitals. Despite the imposition of these fees, the Act negates the need to hire an "expert witness" for claim review because it provides for a three-doctor panel

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41. VA. CODE ANN. § 38.2-5000. Virginia was first in the nation to enact no-fault compensation legislation that focused exclusively on obstetrics-related malpractice claims. Falker, supra note 3, at 20 n.118.

42. Falker, supra note 3, at 20. ACOG currently has identified Virginia as a "crisis state." Red Alert, supra note 8.

43. Falker, supra note 3, at 20. In addition to record claim rates, high jury awards, and soaring insurance premiums, two of Virginia's major malpractice insurance carriers dropped obstetric coverage from their available policies and a third carrier threatened to curtail seriously its obstetric coverage. Id.

44. Id.

45. See King, 410 S.E.2d at 660.

46. Falker, supra note 3, at 20.


[I]njury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery, in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled.

48. Id. § 38.2-5020(A).

49. Id. § 38.2-5020(D).

50. Id. § 38.2-5020(C). Non-participating hospitals are protected by a $150,000 contribution cap for any twelve-month period. Id.
appointed by the deans of Virginia's medical schools. A State medical licensing board reviews each claim covered by the Act to evaluate physician competence and standards of care, thereby weeding out "bad apples" and improving doctor performance.

Compensation under the Act includes actual damages such as medical expenses, rehabilitation, and residential and custodial care. This also includes the purchase and use of special equipment and injury-related travel expenses. The Act includes a provision for loss of wages in the amount of 50% of the average state wage. However, the Act does not compensate plaintiffs for any pain and suffering, which means that patients seeking these damages likely will still sue in tort, where such damages are permitted.

In order to pass constitutional muster, the Act allows for a civil action where "clear and convincing" evidence demonstrates that the physician or hospital willfully caused or intended to cause a birth-related neurological injury. Although the Act does not require participating obstetricians and hospitals to notify their patients of their participation in the program, the Act has nonetheless withstood constitutional attacks.

In *King v. Virginia Birth-Related Neurological Injury Compensation*

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51. *Id.* § 38.2-5008(B); see also Falker, *supra* note 3, at 21.
52. VA. CODE ANN. § 38.2-5008(B).
53. *Id.* § 38.2-5008(A)(6); Falker, *supra* note 3, at 21.
54. VA. CODE ANN. § 38.2-5009(A)(1).
55. *Id.* The statute does not indicate what constitutes "injury-related travel" expenses. See *id.*
56. *Id.* § 38.2-5009(3).
57. Falker, *supra* note 3, at 21-22. The Act even provides for the medical care of low-income women by requiring participating physicians to help develop programs that serve the obstetrical needs of patients eligible for public health services and those who are indigent. VA. CODE ANN. § 38.2-5001.
58. *Id.* § 38.2-5002(C). According to the Act, Notwithstanding anything to the contrary in this section, a civil action shall not be foreclosed against a physician or a hospital where there is clear and convincing evidence that such physician or hospital intentionally or willfully caused or intended to cause a birth-related neurological injury, provided that such suit is filed prior to and in lieu of payment of an award under this chapter. Such suit shall be filed before the award of the Commission becomes conclusive and binding as provided for in § 38.2-5011.
59. Galen of Fla., Inc. v. Braniff, 696 So.2d 308, 310 (Fla. 1997) (determining that the Act's purpose "bears a reasonable relationship to the provision for assessments, and that the assessments are neither arbitrary nor discriminatory . . . ").
the highest court in Virginia upheld the Act against equal protection and due process challenges. The King court reasoned that no constitutional violations occurred because the Act's classifications and assessments were neither arbitrary nor discriminatory, and because they bore a reasonable relationship to the Act's purpose. By removing certain narrowly defined types of birth-related neurological injuries from the tort system, this legislation aims to reduce the number of damage awards that result from malpractice claims against obstetricians.

2. Florida's Birth-Related Neurological Injury Compensation Act

Like Virginia's Act, Florida's Birth-Related Neurological Injury Compensation Act (NICA) was adopted as a solution to the problems faced by Florida obstetricians. It was modeled after the strict liability worker's compensation plans, under which a claimant does not need to establish fault and the claim is handled administratively rather than legally. NICA focuses on birth-related neurological injury, which according to the statute's definition, only refers to a narrow class of injuries. Notably, this already narrow definition only applies to those

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61. 410 S.E.2d 656.
62. Id. at 661-62.
63. Id. at 659-61. The plaintiffs claimed that the statute violated equal protection and due process guarantees on both the state and federal level. Id. The court stated:
   It is reasonably conceivable that the General Assembly concluded that the removal of the claims of neurologically injured infants from the tort system would decrease the cost of medical malpractice insurance premiums for all physicians and, thus, make medical malpractice insurance available to all physicians practicing in Virginia, including the doctors in this proceeding. Accordingly, we hold that the classification is not arbitrary and that it bears a reasonable and substantial relation to a legitimate object sought to be accomplished by the legislation.

Id. at 660.
64. See Falker, supra note 3, at 20.
66. See Martin, supra note 16, at 609-10; see also Hearing, supra note 2. According to ACOG, Florida obstetricians have been hit very hard by medical malpractice insurance crises. Id. During the crisis of the 1980s, for example, the liability situation in Florida was so extreme that the state allowed its physicians to practice without liability coverage on the condition that they could post bond or prove their ability to pay a judgment of up to $250,000. See id.
68. Fla. Stat. Ann. § 766.302(2). According to NICA, a birth-related neurological injury only refers to the following:
   Injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate
infants born alive and those over a certain minimum birth weight, thereby further restricting the statute’s applicability and encouraging legal action only for serious injuries resulting in death.

NICA limits compensation for injuries to $100,000 plus actual expenses for certain medically reasonable bills related to the infant’s medical care, rehabilitative care, training, and custodial care. Considering that the average jury award in cases of neurologically injured infants is nearly $1 million, this limit is relatively low. However, if the claimant is not successful and the infant’s injuries are found to be noncompensable, he or she may pursue a remedy in tort.

To receive the benefits of NICA, the statute requires every licensed physician in the state to pay a $250 annual fee, with participating obstetricians paying $5,000 per year. Also, every hospital must pay an annual assessment of $50 per infant delivered in the hospital during the postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired.

Postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired.

Id.

69. Id.
70. § 766.31(1)(a)-(b)1. The statute states:
(a) Actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel. However, such expenses shall not include:
1. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by federal law.
2. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity.
3. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by federal law.
4. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

Expenses included under this paragraph shall be limited to reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person.

Id. § 766.31(1)(a)1.-4.
71. See Hearing, supra note 2.
72. FLA. STAT. ANN. § 766.304 (West Supp. 2003). According to the statute, “If it is determined that a claim filed under this act is not compensable, neither the doctrine of collateral estoppel nor res judicata shall prohibit the claimant from pursuing any and all civil remedies available under common law and statutory law.” Id.
73. Id. § 766.314(4)(b)(1); § 766.314(4)(c).
previous year. A group of Florida physicians soon challenged these statutorily mandated fees.

In *McGibony v. Florida Birth-Related Neurological Injury Compensation Plan*, the appellate court upheld NICA with respect to the assessment provision. The *McGibony* court held that the “tax” imposed on all physicians is constitutional even though the plan primarily affects only obstetricians. The court found that the tax actually benefits all Florida physicians because it will lead to a more efficient healthcare system overall. According to *McGibony*, equal protection guarantees did not violate the assessment provision because the physicians were not being singled out as a class, based on their profession, nor were they forced to pay a fee that does not benefit them.

NICA also requires that each participating physician, and their associated hospitals, give “clear and concise” notice of their participation in the plan to their patients. In *Galen of Florida, Inc. v. Braniff*, the Supreme Court of Florida held that in order to invoke NICA as the exclusive remedy, notice must be given prior to delivery. More
specifically, if the provider claims NICA as the exclusive remedy, notice must be given at a "reasonable" time before delivery; however, if pre-delivery notice is not practicable in a particular case, such notice will not be required. Looking to legislative intent, the court reasoned that without such notice, the claimant would be giving up his or her constitutional right to sue in tort without due process of law. The Braniff court further asserted that its holding would not hinder the statute's goal of stabilizing soaring medical malpractice insurance premiums because pre-delivery notice would not be required where it was "not practicable."

Both of these decisions, as well as those dealing with the Virginia Act, reflect how both NICA and Virginia's Act have withstood constitutional challenges thus far. Nevertheless, these cases also issue a warning of the possible constitutional challenges that similar statutes might face if enacted in other states or by the federal government. Other jurisdictions may not decide in favor of notice and fee provisions akin to those in NICA and Virginia's Act.

B. Tort Reform: Statute of Limitations

A statute of limitations aims to ensure finality and predictability in the justice system by establishing a limited time period during which a claim must be brought. With regard to medical malpractice lawsuits, a statute of limitations serves to discourage the filing of "long tail" claims, which are difficult to defend and unduly elongate the resolution process.

Compensation Plan as a condition precedent to the provider invoking NICA as the patients' exclusive remedy?" Id.

84. Id.

85. FLA. STAT. ANN. § 766.316 (West Supp. 2003); see also Braniff, 696 So.2d at 311. The statute states that notice need not be given to a patient when the patient has an emergency medical condition as defined in section 395.002(9)(b), or when notice is not practicable. Id.

86. In using the Virginia Birth-Related Neurological Injury Compensation Act as a model, the legislature was concerned that the Virginia Act lacked a notice provision. Braniff, 696 So.2d at 310.

87. Id.

88. Id. at 311.

89. BLACK'S LAW DICTIONARY 666-67 (2d pocket ed. 2001).

90. Long-tail claims are those that are filed many years after the injury in question. See Young v. Haines, 718 P.2d 909, 915 (Cal. 1986).

91. See id.
1. California

In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA), which includes a statute of limitations provision.\(^\text{92}\) The California legislature adopted MICRA in response to the major medical malpractice insurance crisis brewing in California at that time.\(^\text{93}\) The statute of limitations provision, codified in section 340.5 of the California Civil Procedure Code, requires the initiation of all medical malpractice actions within three years from the date of the injury, regardless of when the injury was discovered.\(^\text{94}\) The statute allows the time limit to be tolled only in cases of fraud, intentional concealment, or the presence of nontherapeutic and nondiagnostic foreign bodies.\(^\text{95}\) Minors are held to the same time period unless they are under six years old at the time of injury, in which case the tort action must be commenced within three years or before the minor turns eight years old, whichever is longer.\(^\text{96}\)

In *Kite v. Campbell*,\(^\text{97}\) a California appeals court found that section 340.5 was constitutional as it applied to minors.\(^\text{98}\) Despite the fact that the statute treats minor victims of medical malpractice tortfeasors differently from other minor victims of tortfeasors, the court found that the statute was rationally related to the state’s goal of ensuring quality access to healthcare, and therefore did not violate equal protection guarantees.\(^\text{99}\) Similarly, the court held that the statute did not violate the plaintiff’s right to due process of law because the enactment of a statute of limitations does not destroy fundamental rights, but rather represents a legislative prerogative.\(^\text{100}\) The court also found that the statute was not unconstitutionally vague,\(^\text{101}\) and proceeded to read a common law discovery rule into the statute.\(^\text{102}\)


\(^\text{93}\) *Haines*, 718 P.2d at 914. MICRA can be summarized by three main objectives: 1) to reduce incidence and severity of injuries resulting from medical malpractice; 2) to curtail excessive insurance premium increases; and 3) to reduce the cost and efficiency of medical malpractice litigation. MICRA, ch. 2, § 12.5.

\(^\text{94}\) *Id.*

\(^\text{95}\) *Id.*

\(^\text{96}\) *Id.*


\(^\text{98}\) *Id.* at 364.

\(^\text{99}\) *Id.* at 366-67.

\(^\text{100}\) *Id.* at 367.

\(^\text{101}\) *Id.*

\(^\text{102}\) *Id.* at 368-69. According to the discovery rule, the statute of limitations period does not begin to run until the plaintiff discovers or reasonably should have discovered the injury. *Id.*
However, three years later in *Young v. Haines*, the Supreme Court of California criticized the *King* holding, arguing that the appellate court erred when it applied the common law discovery provision to the statute. Rather, the *Young* court held that the three tolling provisions applicable to adults—namely the fraud, intentional concealment, and foreign body provisions—also applied to minors. By declining to interpret the statute in a fashion that would discriminate against minors, the court was satisfied that the statute was rationally related to the state’s goal, therefore negating any equal protection violation.

2. *Louisiana*

Louisiana has enacted a statute of limitations provision in response to the medical malpractice insurance crisis facing the state’s physicians. The statute was designed to stabilize skyrocketing malpractice insurance premiums by limiting the length of time in which plaintiffs could bring malpractice actions. Louisiana’s statute requires the filing of all malpractice claims within one year from the date of the actual injury or discovery of the injury.

103. 718 P.2d 909 (Cal. 1986).
104. *Id.* at 915-16.
105. *Id.* at 916, 919.
106. *Id.* at 919. In upholding the MICRA’s statute of limitations provision, Chief Justice Bird of the Supreme Court of California wrote,

> [T]he construction of section 340.5 which the court adopts today avoids [the] constitutional problem [of discrimination against minor medical malpractice plaintiffs]. Further, this construction follows previous decisions which recognized, as a matter of statutory interpretation, that the Legislature intended to achieve the goal of lowering malpractice insurance premiums in a rational manner.

*Id.*

108. *Id.*
109. LA. REV. STAT. ANN. § 5628 (West Supp. 2003). According to section 5628:

> [N]o action for damages for injury or death against any physician, chiropractor, nurse, licensed midwife practitioner, dentist, psychologist, optometrist, hospital or nursing home duly licensed under the laws of this state, or community blood center or tissue bank...whether based upon tort, or breach of contract, or otherwise, arising out of patient care shall be brought unless filed within one year from the date of the alleged act, omission, or neglect, or within one year from the date of discovery of the alleged act, omission, or neglect; however, even as to claims filed within one year from the date of such discovery, in all events such claims shall be filed at the latest within a period of three years from the date of the alleged act, omission, or neglect.

*Id.* Accordingly, even if brought within one year of the discovery of a particular injury, a claim will be permitted only if it is no more than three years from the date of the original injury. *Id.* However, if a plaintiff is to utilize this delayed discovery exception, the claim nonetheless must be filed within three years of the original date of injury. *Id.* Therefore,
The constitutionality of this statute was upheld in Crier v. Whitecloud, when the Supreme Court of Louisiana concluded that the statute did not violate the plaintiff's due process or equal protection rights. The court also found no infringement of the Louisiana constitution's "open courts clause." In reviewing the plaintiff's access to courts claim, the Louisiana Supreme Court relied on legislative intent to conclude that the clause did not bar the state from restricting causes of action or creating certain areas of statutory immunity from suit.

As to the plaintiff's due process claim, the court, citing Supreme Court cases, Boddie v. Connecticut and Martinez v. California, determined that the federal due process clause did not guarantee access to courts for all individuals at all times. The court held that the state government has the right to limit the causes of action, provided that it does so in order to promote a rationally-related purpose. Finally, applying the rational basis test, the court found no federal equal protection violations because the plaintiff failed to show that the statute did not further a legitimate state purpose.

3. New York

New York's statute proscribing special statute of limitation periods for medical malpractice cases requires that all medical malpractice actions commence within two years and six months of the date of the alleged act, omission, or failure. However, the statute provides a limited, delayed discovery exception where the malpractice involves a foreign object in the patient's body. In such a case, the action must commence within a year of when the object was discovered or when facts that would reasonably lead to such a discovery were ascertained.

this provision prevents claimants from bringing actions many years after a known injury under the guise that the claimant had not yet discovered it. See id.

10. 496 So.2d 305 (La. 1986).
11. Id. at 309, 311.
12. Id. at 309-10; LA. CONST. art. I, § 22. Article 1, Section 22 of the Louisiana Constitution of 1974 provides: "All courts shall be open, and every person shall have an adequate remedy by due process of law and justice, administered without denial, partiality, or unreasonable delay, for injury to him in his person, property, reputation, or other rights." Id.
13. Crier, 496 So.2d at 309-10.
16. Crier, 496 So.2d at 308.
17. Id. at 308-09.
18. Id. at 311.
20. Id.
21. Id.
As of 2003, two cases have addressed New York's section 214-a as applied to obstetrics related malpractice claims. In *Branigan v. DeBrovner*, the court held that prenatal care counts as "continuous treatment" and therefore extends to the time of birth. Thus, in cases alleging negligent infliction of injury to the mother in the course of prenatal care, the statute of limitations does not begin to run until the time of delivery.

In *LaBello v. Albany Medical Center Hospital*, the court concluded that the infant plaintiff's medical malpractice action, based on alleged negligence occurring prior to birth, began to toll at live birth rather than when the alleged negligence occurred. Under this interpretation, prenatal time will not count against plaintiffs, thereby providing injured neonates with reasonable time in which to sue.

**C. Tort Reform: Jury Award Caps and the Elimination of Putative Damages**

**I. Jury Award Caps**

The extreme nature of lawsuits against obstetricians has reached such proportions that suits cover not only alleged negligence, but also negligent infliction of emotional distress, which does not involve physical injury. Additionally, these lawsuits facing obstetricians call for high jury awards. For instance, 30% of claims against obstetricians involve neurological birth-related injuries that boast an average jury award of $1 million, with occasional awards reaching the $100 million mark. With the threat of such financially devastating lawsuits looming over so many obstetricians, it is no wonder that the purchase of malpractice insurance is not only suggested but imperative. The threat of such costly lawsuits

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123. 612 N.Y.S.2d 119.
124. *Id.* at 122.
125. *Id.*
127. *Id.* at 909, 911-12.
128. *See* *Burgess v. Superior Court*, 831 P.2d 1197, 1198 (Cal. 1992). In *Burgess*, the plaintiff's child suffered a prolapsed umbilical cord, which deprived the infant of oxygen for approximately forty-four minutes, therefore causing severe permanent brain and nervous system damage that resulted in the child's eventual death. *Id.* at 1198-99. The Supreme Court of California held that a mother whose child was injured during the course of labor could recover for negligent infliction of emotional distress against the attending obstetrician even where she suffered no physical injury. *Id.* at 1198. This case demonstrates the extent to which courts and juries have gone in finding negligence out of adverse outcomes.
129. *See* *Hearing, supra* note 2.
serves as a contributing factor in insurance companies' assessment of obstetricians as "risky." For this reason, ACOG advocates the adoption of statutory limitations on damages in medical malpractice cases as the most effective means of stabilizing the skyrocketing malpractice insurance premiums.

a. California

As part of California's 1975 MICRA, section 3333.2 mandates a $250,000 cap on noneconomic damages in cases where a verdict is returned against a physician or hospital for acts of malpractice. Noneconomic damages refer to those damages other than actual damages that include pain and suffering. Despite its revolutionary nature, this provision has withstood numerous constitutional challenges since its enactment.

In *Fein v. Permanente Medical Group* and *Hoffman v. United States*, courts held that MICRA's cap did not violate the Fourteenth Amendment. Specifically, in *Fein*, the Supreme Court of California held that the statute does not deny due process because section 3333.2 rationally relates to the state's legitimate interest in reducing the cost of medical malpractice insurance. Likewise, applying the same rational basis test, in *Hoffman*, the Ninth Circuit held that the statute did not violate equal protection.

More recently, the court addressed the scope of MICRA's jury award cap in *Western Steamship Lines v. San Pedro Peninsula Hospital*, finding that the cap applied even in an action for partial equitable indemnification by a concurrent tortfeasor. Citing public policy, the court reasoned that to exempt indemnity actions from the monetary recovery limit would threaten the statute's purpose of reducing the cost of malpractice insurance premiums. Therefore, the court concluded

130. See id.
132. CAL. CIV. CODE ANN. § 3333.2(b) (West 1997).
133. Id. § 3333.2(a).
135. Hoffman, 767 F.2d at 1437; Fein, 695 P.2d at 680-81.
137. Hoffman, 767 F.2d at 1437.
138. 876 P.2d 1062.
139. Id. at 1063.
140. Id. at 1068-69. Western Steamship Lines held that:
that MICRA's section 3333.2 necessarily furthered the government's goal. The outcome of this case reflects the California Supreme Court's devotion to MICRA, as well as the statute's parallel goals of stabilizing malpractice insurance premiums and ensuring access to healthcare for all citizens.

b. Virginia

In 1976, the Virginia legislature adopted a jury award cap in response to increasing malpractice insurance cost and unavailability. Virginia's jury award cap sets a limitation of $1.7 million on recovery for medical malpractice that occurred on or after August 1, 1999. In Etheridge v. Medical Center Hospitals, the Virginia Supreme Court upheld the statute against a constitutional attack based on both a federal and state right to a trial by jury. According to the court, the statute did not infringe on the right to a trial by jury because once the jury ascertained the facts and assessed the damages, the constitutional mandate was satisfied. The cap merely established the limits of a remedy as a matter of law, not a matter of fact, and therefore removed the issue from the jury's responsibilities. Applying a rational basis test, the court also found no federal or state due process violation because the state's goal of

MICRA ... reflects a strong public policy to contain the costs of malpractice insurance by controlling or redistributing liability for damages, thereby maximizing the availability of medical services to meet the state's health care need... The Legislature could reasonably have determined that an across-the-board limit would provide a more stable base on which to calculate insurance rates... Exempting indemnity actions from the $250,000 limit would threaten not only this goal, but the broader purpose of MICRA by resurrecting the pre-MICRA instability associated with unlimited noneconomic damages and increasing the overall cost of malpractice insurance to account for these larger recoveries.

Id. (internal citations omitted).

141. Id. at 1069.


144. VA. CODE ANN. § 8.01-581.15 (Michie 2000). The cap was originally set at $1.5 million when the law was enacted in 1976, but has increased by $50,000 per year beginning in 2000. Id.


146. Id. at 529.

147. Id.

148. Id.
maintaining adequate healthcare services was reasonably related to the legislative cap.  

2. Elimination of Punitive Damages

Unlike actual damages, punitive damages are not a form of compensation, but serve to punish the defendant and deter that party and others from committing similar acts in the future. Restriction or elimination of such damages arguably serves to contain medical malpractice jury awards, therefore reducing the risk that insurance companies will have to insure physicians against this costly form of damages. Embracing this theory, a few states, such as Illinois, have implemented medical malpractice reforms that include various punitive damage limitations.

As part of the 1985 Illinois Medical Malpractice Reform Act, the Illinois legislature eliminated punitive damages in order to help address the rising cost of malpractice insurance premiums. The statute prohibits the recovery of punitive damages in medical or legal malpractice cases. The statute also prohibits exemplary, vindictive, and aggravated damages; therefore, obstetricians in Illinois are not threatened by lawsuits where costly punitive damages are at stake. The

149. Id. at 531. The Etheridge decision was recently reaffirmed in Pulliam v. Coastal Emergency Services of Richmond, Inc., when the Virginia Supreme Court once again concluded that the cap did not violate any constitutional guarantees, specifically those of due process and equal protection. Pulliam v. Coastal Emergency Servs. of Richmond, Inc., 509 S.E.2d 307, 310 (Va. 1999).


151. See Bernier v. Burriss, 497 N.E.2d 763, 776 (Ill. 1986). ("The elimination of awards for punitive damages in actions for medical malpractice serves the legislative goals of reducing damages generally against the medical profession."); see also Tanya Albert, Bush Decrees "Junk Lawsuits," Calls for Federal Tort Reform, AM. MED. NEWS, Aug. 12, 2002. In an August 2002 speech in Greensboro, N.C., President Bush proposed a framework for federal legislation that included a limit on punitive damages in medical malpractice cases. Albert, supra. The President's proposal set the limit at $250,000 or twice the economic damages, whichever is less. Id. In his 2003 State of the Union Address, the President again called for tort reform. See Richard W. Stevenson, President Asks Congress for Measures Against Frivolous Suits, N.Y. TIMES, Jan. 17, 2003, at A20.

152. See, e.g., 735 ILL. COMP. STAT. ANN. 5/2-1115 (West 2003).

153. Id.

154. Bernier, 497 N.E.2d at 768.

155. 735 ILL. COMP. STAT. ANN. 5/2-1115 (West 2003). Illinois' prohibition of punitive damages provision provides that, "[i]n all cases, whether in tort, contract or otherwise, in which the plaintiff seeks damages by reason of legal, medical, hospital, or other healing art malpractice, no punitive, exemplary, vindictive or aggravated damages shall be allowed." Id.

156. Id.

157. See id.
elimination of this threat should decrease risks of obstetric coverage, thereby helping to lower premiums.\textsuperscript{158}

The constitutionality of the statute was addressed in \textit{Bernier v. Burris}.\textsuperscript{159} The Supreme Court of Illinois held that the statute did not violate equal protection or due process rights under either the federal or state constitutions.\textsuperscript{160} In doing so, the court found that the punitive damages provision was rationally related to a legitimate governmental interest.\textsuperscript{161} Therefore, in Illinois at least, statutes that mandate the elimination of punitive damages have been found constitutional.\textsuperscript{162}

\textbf{D. Tort Reform: Abolition of the Collateral Source Rule}

\textit{1. Arizona}

In an effort to control the rising medical malpractice insurance premiums burdening Arizona doctors, the legislature enacted the Arizona Medical Malpractice Act (AMMA)\textsuperscript{163} in 1976. The AMMA originally required submission of all medical liability cases to a medical liability review panel consisting of a judge, an attorney, and a doctor or licensed healthcare provider in the same specialty as the defendant.\textsuperscript{164} The panel would hold a hearing and file a decision in favor of one of the parties, which either of the parties could reject.\textsuperscript{165} If either party rejected the panel's decision, the plaintiff then could pursue a remedy in tort.\textsuperscript{166} Finally, the AMMA abolishes the collateral source rule,\textsuperscript{167} which requires

\begin{itemize}
  \item \textsuperscript{158} See \textit{Hearing}, supra note 2; \textit{Treaster}, supra note 3; \textit{supra} notes 27-33 and accompanying text.
  \item \textsuperscript{159} \textit{Bernier}, 497 N.E.2d at 779.
  \item \textsuperscript{160} \textit{Id.}; \textit{See also} U.S. CONST. amend. XIV; ILL. CONST. art. I, § 12.
  \item \textsuperscript{161} \textit{Bernier}, 497 N.E.2d at 776.
  \item \textsuperscript{162} \textit{See id.} at 766, 769.
  \item \textsuperscript{163} \textit{See Arizona Medical Malpractice Reform Act, ARIZ. REV. STAT. ANN. §§ 12-561 – 12-594 (West 2002); see also Eastin v. Broomfield, 570 P.2d 744, 751 (Ariz. 1977).}
  \item \textsuperscript{164} \textit{ARIZ. REV. STAT. ANN. §§ 12-561, 12-567(B) (West 2002) (repealed 1989).}
  \item \textsuperscript{165} \textit{Id. § 12-567(G) (repealed 1989).}
  \item \textsuperscript{166} \textit{Id. § 12-567(J) (repealed 1989).} The original act required the plaintiff to post a $2,000 bond if the decision was made to proceed with litigation, but the Supreme Court of Arizona held this provision unconstitutional in \textit{Eastin}. \textit{Eastin}, 570 P.2d at 754.
  \item \textsuperscript{167} \textit{ARIZ. REV. STAT. ANN. § 12-565(A).} According to Arizona's abolition of collateral source provision:
    \begin{itemize}
      \item In any medical malpractice action against a licensed health care provider, the defendant may introduce evidence of any amount or other benefit which is or will be payable as a benefit to the plaintiff as a result of the injury or death pursuant to the United States Social Security Act, any state or federal workers' compensation act, any disability, health, sickness, life, income-disability or accident insurance that provides health benefits or income-disability coverage and any other contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of income-disability or
    \end{itemize}
\end{itemize}
that any evidence of outside benefits received by the injured, such as insurance payoffs, be excluded from trial; as well, it prohibits any reductions of damages based on such benefits.\textsuperscript{166}

Arizona’s abolition of this rule was upheld by Arizona’s highest court in \textit{Eastin v. Bloomfield}.\textsuperscript{169} Specifically, the court held that the collateral source rule did not violate Arizona’s constitutional prohibition against “special laws.”\textsuperscript{170} Instead, the court found the AMMA to be an acceptable general law that “operates alike upon all of a given class,” namely healthcare providers and those suing them.\textsuperscript{171} The court also held that this provision was constitutional because it allows the jury to ignore the collateral benefits received by a given plaintiff, and as such, it does not constitute a limitation on damages and does not violate the Arizona Constitution.\textsuperscript{172}

\textbf{2. Kansas}

Section 60-471 of the Kansas Statute, enacted in response to the medical malpractice crisis in that state, modified the traditional collateral source rule as it applied to medical malpractice cases, and aimed to reduce medical malpractice insurance premiums by lowering judgments in malpractice lawsuits.\textsuperscript{173} Differing slightly from the Arizona provision, the Kansas statute did not abolish the rule completely, but rather, admitted evidence of any reimbursement or indemnification received by the injured party, other than payments from such party’s insurance company.\textsuperscript{174} Under the statute, a jury was not allowed to hear evidence that some services actually were paid for by insurance, but could hear evidence that a service was provided for free.\textsuperscript{175}

However, this distinction was challenged and ultimately found unconstitutional in \textit{Doran v. Priddy}.\textsuperscript{176} The Kansas District Court found that the distinction between insurance and gratuitous sources violated the Fourteenth Amendment’s Equal Protection Clause because it

\begin{itemize}
\item medical, hospital, dental or other health care services to establish that any cost, expense, or loss claimed by the plaintiff as a result of the injury or death is subject to reimbursement or indemnification from such collateral sources.
\end{itemize}

\textit{Id.}

\textsuperscript{168} \textit{Eastin}, 570 P.2d at 751.
\textsuperscript{169} \textit{Id.} at 754-55.
\textsuperscript{170} \textit{Id.} at 752, 755.
\textsuperscript{171} \textit{Id.} at 752; see also ARIZ. CONST., art IV, pt. 2, § 19.
\textsuperscript{172} \textit{Eastin}, 570 P.2d at 752-53; ARIZ. CONST., art XVIII, § 6.
\textsuperscript{174} \textit{KAN. STAT. ANN.} § 60-471(a) (repealed 1985).
\textsuperscript{175} \textit{Doran}, 534 F. Supp. at 35.
\textsuperscript{176} \textit{Id.} at 37.
discriminated against injured plaintiffs who relied on charity for their care versus those who had insurance. The Kansas Legislature repealed the statute in response to the court’s decision. Therefore, in light of the varying constitutional paths of the Kansas and Arizona statutes, clearly courts are not in agreement on the issue of collateral source rule reform.

E. Tort Reform: Monetary Limitations on Plaintiff’s Attorney Fees

According to ACOG, less than half of the money awarded in medical liability settlements ever reaches the plaintiff. This is partly because a rather large percentage of the jury award goes to the plaintiff’s attorney. For the medical malpractice attorney working on a contingency fee basis, the high jury awards associated with obstetrical claims may serve as an incentive to file actions against obstetricians. Some states have instituted limitations on the contingent fees charged by attorneys involved in malpractice suits.

1. New York

New York, for example, enacted section 474-a in an effort to reduce the monetary incentive for attorneys to seek excessive jury awards and to ensure that more of the award goes to the plaintiff. The provision only targets contingent fees and has the greatest impact on the fees associated with larger jury awards. Specifically, the statute outlines a graduated

177. Id. Four years after the federal court’s decision in Doran, the Supreme Court of Kansas affirmed the Doran decision and struck down the statute on equal protection grounds. Wentling v. Med. Anesthesia Servs., 701 P.2d 939, 950-51 (Kan. 1985). The legislature consequently repealed the statute and enacted a new one in its place. Coburn v. Agustin, 627 F. Supp. 983, 985 (D. Kan. 1985). The new law provides for the admissibility of insurance and any benefit plan or program provided by law. Id. However, in Coburn v. Agustin, the federal court once again found § 60-471 unconstitutional on equal protection grounds despite the legislature’s modifications. Id. at 996-97. The court, applying heightened scrutiny, found that the benefits conferred on health care providers, but denied to other tortfeasors, and the detriments imposed on plaintiffs injured via medical malpractice but not to other plaintiffs, were not sufficiently related to the legislative goal of improved health care. Id.

178. KAN. STAT. ANN. § 60-471 (repealed 1985).


180. See Hearing, supra note 2.

181. See Hearing, supra note 2; Martin, supra note 16, at 621; Will, supra note 11.

182. Falkner, supra note 3, at 12.


185. Id. § 474-a(2).
fee schedule that reduces the contingent fee as the award increases.\textsuperscript{186} Therefore, according to the statute, if a jury awards $2 million in damages, the attorney would receive $300,000, which is half of what the attorney would receive if the standard contingency of 30\% were applied.\textsuperscript{187} This is significant because it decreases the incentive for attorneys to take malpractice cases on a contingency basis.

2. Arizona

Unlike New York, Arizona’s version of an attorney fee limitation statute does not outline specific fee percentages, but instead legislates the right of any party in a medical malpractice action to review attorneys’ fees.\textsuperscript{188} Upon such a request, the court shall determine the reasonableness of both parties’ attorneys’ fees, taking into consideration a variety of factors including the case’s degree of difficulty, community standards for fees, and other work lost by the attorney as a result of the case.\textsuperscript{189} This plan allows for the limitation of attorneys’ fees while still maintaining a certain degree of flexibility.\textsuperscript{190}

\textbf{F. Tort Reform: Periodic Payments of Damages}

In response to medical malpractice insurance crises, many states have enacted laws that include periodic payment provisions that permit periodic installment payments of large awards for future damages.\textsuperscript{191} These statutes aim to ease the burden of paying one lump sum for costly jury awards.\textsuperscript{192} This is significant because insurance companies likewise

\begin{itemize}
\item \textsuperscript{186} \textit{Id.} The statute mandates that attorneys will collect 30\% of the first $250,000 recovered, 25\% of the next $250,000 recovered, 20\% of the next $500,000 recovered, 15\% of the next $250,000 recovered, and only 10\% of any amount that is over $1,250,000 of the total sum recovered. \textit{Id.}

\item \textsuperscript{187} \textit{See id.} The attorney would receive $300,000 because: 30\% of 250,000 + 25\% of 250,000 + 20\% of 500,000 + 15\% of 250,000 + 10\% of (2,000,000 - 1,250,000) = $300,000.

\item \textsuperscript{188} ARIZ. REV. STAT. ANN. \S 12-568 (McKinney 2003).

\item \textsuperscript{189} \textit{Id.} \S 12-568(A)1-8. Upon the request of one or both the parties, the court shall determine the reasonableness of both parties’ attorneys’ fees, taking into consideration the following factors: 1) time, labor, and difficulty involved and skill necessary; 2) likelihood that participation in the lawsuit will preclude the attorney from accepting other employment; 3) the customary fee charged; 4) the amount involved and the result obtained; 5) the time limitations imposed; 6) the nature and length of the attorney-plaintiff relationship; 7) the experience, reputation, and ability of the attorney; 8) and whether the fee is fixed or contingent. \textit{Id.}

\item \textsuperscript{190} \textit{Id.} \S 12-568.

\item \textsuperscript{191} Bernier v. Burris, 497 N.E.2d 763, 772 (Ill. 1986) (listing examples of numerous state statutes).

\item \textsuperscript{192} \textit{See id.} at 772, 773. The states that have enacted periodic payment provisions for cases of medical malpractice include: Alabama, Alaska, Arkansas, California, Delaware, Florida, Kansas, New Mexico, Oregon, South Carolina, Washington, and Wisconsin. \textit{Id.} at 772.
\end{itemize}
will not be required to pay an expensive jury award all at once, thereby rendering obstetricians less burdensome clients to cover. 193

1. California

In California, for example, MICRA allows judges to order periodic payments of damages at the request of either party, but only if the award is equal to or greater than $50,000. 194 In American Bank & Trust Co. v. Community Hospital of Los Gatos-Saratoga, Inc., 195 the court upheld the constitutionality of California’s periodic payments provision despite the claim that it infringed upon equal protection and due process guarantees. 196 The Supreme Court of California found there was no violation of plaintiff’s substantive due process rights because the provision was rationally related to the legitimate state interest in limiting defendant’s immediate obligation to pay for future damages in medical malpractice cases. 197 The court also concluded that section 667.7 of the California Code did not infringe on the plaintiff’s equal protection rights even though the provision denies medical malpractice plaintiffs the benefits of a lump-sum award. 198 In reaching this conclusion, the court held that stare decisis mandates that a state can implement reform measures on a piecemeal basis. 199

2. Illinois

The Illinois version of a statutory periodic payments provision is similar to that of California, but Illinois law makes it slightly more difficult for a defendant successfully to elect periodic payments of damages. 200 The Illinois statute only allows periodic payments when future damages exceed $250,000, and requires a defendant to show: 1) that he or she can provide security for the amount of the total claim (past and future damages), or that he or she can provide $500,000, whichever is less; and 2) that future damages are likely to accrue for a period longer than one year. 201

In Bernier v. Burris, 202 this provision withstood equal protection and due process challenges. 203 The Supreme Court of Illinois held that the

193. See Hearing, supra note 2.
194. CAL. CIV. PROC. CODE ANN. § 667.7(a) (Deering 1998).
196. Id. at 672.
197. Id. at 676.
198. Id. at 677.
199. Id.; See also Williamson v. Lee Optical, 348 U.S. 483, 489 (1955).
200. See 735 ILL. COMP. STAT. ANN. § 5/2-1705 (West 1992).
201. Id. § 5/2-1705(c)(3)(ii).
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provision was rationally related to the state's goal of ensuring the availability and affordability of professional liability insurance. The Bernier court found no due process violation because not only were the plaintiff's objections merely speculative, but also because the "provisions . . . contain certain safeguards designed to reduce the risk of insolvency."

G. Insurance Reform

1. Experience-Rated Insurance

Researchers have found that while most acts of negligence never give rise to a lawsuit, many lawsuits are brought and even won without evidence of negligence. Statistics show that most physicians rarely are or never sued, with only a few "bad apples" experiencing frequent suits. For instance, according to one study, 55% of physicians experienced zero malpractice claims in a seven-year period, while 79% had fewer than two claims, and less than 3% had five or more claims.

These statistics have led to the development of insurance based on the insured's individual experience of being sued. This insurance system, referred to as "experience rating," makes premiums directly dependent on the number of claims that have been brought against the insured. When applied to malpractice insurance, premiums increase according to the number of times a doctor is sued. Unfortunately, experience rating only has been experimented with statutorily in a few states and has not yet been the subject of a major case.

203. Id. at 773.
204. Id.
205. Id. at 774.
207. Id. at 1616-17.
209. See Mello & Brennan, supra note 15, at 1626.
210. See id.
211. See id.
212. See N.Y. INS. LAW, §§ 201, 203, 2343(d) (McKinney 2000); MASS. GEN. LAWS ANN. ch. 175A § 5C (West 1998 & Supp. 2003); see also FRANK A. SLOAN, ET AL., INSURING MEDICAL MALPRACTICE 171-73 (describing the features of New York's and Massachusetts' experience rating statutes).
2. Hospitals or Physicians Creating Non-Profit Insurance Companies

Another area of insurance reform involves the creation of non-profit insurance companies by hospitals or physicians. In New York City, for example, many of the largest hospitals have instituted their own non-profit insurance companies. In 1982, to remedy the high costs and limited availability of medical malpractice insurance, the Washington State Medical Association established a physician-owned and operated professional liability company, the Washington State Physician’s Insurance Exchange and Association.

II. GONE TO COURTROOM … EVERY ONE: THE CURRENT REFORMS ARE NOT ENOUGH

A. No-Fault Plans Directed at Obstetrics

No-fault systems, such as Virginia’s and Florida’s birth-related neurological injury acts, do not require the claimant to prove that their injury resulted from negligence in order to receive compensation. This system is based on the argument that the presence of negligence is not strongly related to the incidence of adverse outcomes. Studies show that the presence of negligence was not the most significant predictor of the outcome of a lawsuit. Rather, the most important factor in determining whether or not a patient would recover in a legal action was the severity of the patient’s injury, regardless of whether any negligence actually caused the injury.

One argument is that the mere threat of malpractice claims more strongly may influence the way physicians practice than their actual experience with past claims. Indeed, the threat of a lawsuit, alone, is enough to make some doctors practice defensive medicine. Doctors

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213. Treaster, supra note 3, at A20.
214. Rosenblatt et al., supra note 3, at 245.
216. See Mello & Brennan, supra note 15, at 1619 (“[T]he presence of negligence was not a statistically significant predictor of the [lawsuit’s] outcome.”).
217. Id. Similarly, a 1984 study indicated that a negligent physician had only a 4% chance of having to compensate the patient. Id. at 1618; See also Brennan et al., supra note 15, at 1966 (citing a study that revealed little relation between the plaintiff’s decision to file a claim and the presence of negligence).
218. See Mello & Brennan, supra note 15, at 1608.
219. See id. Another effect of high obstetric claims rates is an increase in the practice of defensive medicine. See Bilimoria, supra note 31, at 270. Defensive medicine is the phenomenon of proscribing procedures and ordering tests purely in an effort to reduce the risk of lawsuits. See id. Physicians and insurance companies cite defensive medicine as a
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major reason why tort reform is needed. Mello & Brennan, supra note 15, at 1606. Some doctors consider the practice medically inappropriate, but feel that they have no choice but to do it. See id. According to one study, in 1994, an estimated $9.9 billion was spent annually on defensive medicine and an additional $15 billion can be attributed to the liability system for superfluous procedures conducted solely to satisfy patient expectations. Cerny, supra note 13, at 194. Another source also estimates that 15 to 30% of total healthcare costs can be attributed to the practice of defensive medicine. Id. The U.S. Chamber of Commerce estimates that American consumers pay between $60-100 billion in these defensive medicine costs annually. Will, supra note 11. Defensive medicine, which is viewed as being widely practiced by obstetricians, drives up the overall cost of healthcare. See Falker, supra note 3, at 17-18; Mello & Brennan, supra note 15, at 1607. Some studies indicate that fear of a lawsuit may contribute to a greater incidence of cesarean sections. Falker, supra note 3, at 15-16. For instance, a Pennsylvania State University study revealed that the odds of performing a cesarean section were 15% more likely where the hospital’s obstetricians, as a group, had experienced a certain amount of litigation in the previous four years. Id. at 16. Similarly, a Journal of American Medical Association study of cesarean section rates in New York indicated that the regions where medical malpractice insurance premiums were three times greater than other regions also had a cesarean section rate that was three times greater than those regions with low premiums. Id. at 15. See generally A. Russell Localio et al., Relationship Between Malpractice Claims and Cesarean Delivery, 269 JAMA 366 (1993) (detailing a study that reveals that a positive relationship exists between medical malpractice claims and the rate of cesarean delivery). But see Mello & Brennan, supra note 15, at 1607 (suggesting that other researchers have found that where the obstetrician is at a greater risk of being sued, the less likely the doctor is to perform a cesarean section). See generally A. Dale Tussing, PhD & Martha A. Wojtowycz, MA, The Cesarean Decision in New York State, 1986: Economic and Noneconomic Aspects, 30 MED. CARE 529, 539 (1992) (detailing a study that indicates that there is a negative relationship between fear of malpractice and cesarean section use); Lisa Dubay et al., The Impact of Malpractice Fears on Cesarean Section Rates, 18 J. HEALTH ECON. 491 (1999) (discussing a study that suggests that increased cesarean sections resulting from medical malpractice fear have only a small impact on total obstetric care costs). Some researchers argue that the increased costs associated with defensive medicine also are evident in the widespread use of electronic fetal monitors (EFM) and increased time spent with patients. See Falker, supra note 3, at 17-18. Despite the negativity surrounding the practice of defensive medicine, some critics assert that, as with defensive driving, defensive medicine actually is beneficial because it forces doctors to deliver better care to patients. Bilimoria, supra note 31, at 272. According to an editorial in a 1993 issue of the American Bar Association Journal, “If we were to find that the tort system was producing more defensive driving, and we asked the public if they supported such an incentive, my guess is that the vast majority, including most physicians, would say it was a good thing.” Kenneth Jost, Still Warring Over Medical Malpractice, A.B.A. J., May 1993, at 68. The fear of litigation and liability is so pervasive that academic centers incorporate defensive medicine practices into the education that medical students receive. See Falker, supra note 3, at 14. According to the New England Journal of Medicine, as medical malpractice rates increase, medical schools have tailored their curriculums and practices to address the changing face of medicine in such a litigious society. Id. at 14 & n.5. For example, the fear of lawsuits has spurred many medical schools to spend a significant amount of time on teaching students how to avoid lawsuits and how to be prepared to answer if one arises. Time spent on teaching defensive medicine cuts into the amount of hands-on experience these future physicians receive, and ironically, causes them to be less prepared for actual practice and therefore more likely to experience a lawsuit, the very thing defensive medicine aims to avoid. See id. at 14.
especially want to do what is necessary to avoid claims, because such claims would push their already costly insurance premiums even higher.\textsuperscript{220} Fear of litigation pressures providers to avoid both negligent injury and non-negligent adverse events.\textsuperscript{221}

Some of the expected advantages of a no-fault system include reduced legal costs, less delay in monetary recovery, shorter time involvement on the part of the doctors, and decreased incidence of defensive medicine due to the strict liability nature of no-fault.\textsuperscript{222} Patients, hospitals, and physicians most likely will find a no-fault system appealing where avoidable adverse events are identified and patients are compensated appropriately.\textsuperscript{223} Proponents of no-fault, for instance, suggest that this system gives physicians the freedom to practice in an environment without worrying about the economic and psychological effects of litigation.\textsuperscript{224} They argue that a focus on avoidable adverse events may help to eliminate the idea that negligence is morally wrong and therefore should be hidden.\textsuperscript{225} Under this theory, a no-fault system would foster the view that mistakes should undergo open evaluation and compensation, existing not as immoral blemishes but as errors to be studied in an effort to avoid future mistakes.\textsuperscript{226}

Nevertheless, some opponents of no-fault liability systems argue that such systems are inherently flawed.\textsuperscript{227} This argument is based on the assumption that courts will hold some doctors liable for failure to prevent a bad outcome, even after they did everything in their power to treat a patient.\textsuperscript{228} For many, this would offend the ideals of both justice and individual accountability.\textsuperscript{229} Conversely, for those cases that involve avoidable instances of negligence, a no-fault system by its very name removes any degree of personal physician responsibility.\textsuperscript{230} Therefore, opponents suggest that no-fault systems do not deter negligence as effectively as does tort liability.\textsuperscript{231} This is because deterrence among doctors is based largely on fear of the embarrassment of a courtroom

\begin{itemize}
\item \textsuperscript{220} See Treaster, \textit{supra} note 3.
\item \textsuperscript{221} See Mello & Brennan, \textit{supra} note 15, at 1608.
\item \textsuperscript{222} See \textit{id.} at 1628-29.
\item \textsuperscript{223} See \textit{id.} at 1629.
\item \textsuperscript{224} See \textit{id.}
\item \textsuperscript{225} See \textit{id.} at 1628. According to the Mello & Brennan article, "Regrettably, in medicine such events are hidden under the cloaks of peer review and attorney-client privilege." \textit{Id.}
\item \textsuperscript{226} See \textit{id.}
\item \textsuperscript{227} See, \textit{e.g.}, Martin, \textit{supra} note 16, at 623-24.
\item \textsuperscript{228} See \textit{id.}
\item \textsuperscript{229} See \textit{id.}
\item \textsuperscript{230} See \textit{id.} at 624.
\item \textsuperscript{231} See \textit{id.}
\end{itemize}
trial where one's mistakes meticulously receive experience detailing. Opponents further argue that "no-fault" really means "no-deterrence," because people generally are not motivated to avoid certain behavior if they are not held personally responsible for the outcomes of that behavior.

However, hard empirical evidence supporting deterrence theory remains scarce, especially in relation to the practice of obstetrics. For example, studies have not indicated that the quality of care depends on the obstetrician's history of malpractice claims. Indeed, a study published in The Journal of the American Medical Association that examined the effect of malpractice threat on various birth outcomes found no conclusive relationship between positive outcomes and a meager prior claims record.

Such studies undoubtedly have influenced the creation of no-fault plans, such as those established in Virginia and Florida, which are tailored to address the needs of obstetricians and their patients. Given the fact that claims stemming from birth-related injuries are among the most expensive and most common, the Virginia and Florida legislatures were justified in focusing on such injuries. Unfortunately, the implementation of these statutes has not proven as successful as one might hope. In Florida, for example, the costly tort claims of the type NICA was designed to eliminate are still common, suggesting that NICA is not really working. Despite the fact that NICA has been in effect for almost ten years, Florida obstetricians nevertheless face the highest premiums in the country. However, some researchers argue that the true benefits of Florida and Virginia's no-fault plans are found in their

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232. See id.
233. See id.
235. See id. at 1607. According to a study conducted by the Journal of the American Medical Association, "A review of obstetric-care medical records for sentinel markers of errors and other indicators of substandard care found no relationship between the provider having been punished by the malpractice system and having fewer future deviations from the standard of care." Id. at 1607-08.
236. Id. at 1608.
238. See Hearing, supra note 2.
239. See Martin, supra note 16, at 620-21 (indicating "that high cost tort claims, of the type that the no-fault [Florida statute] was designed to eliminate, persist").
240. Id.
241. See Hearing, supra note 2. For instance, in 2001, the annual premiums in South Florida were as high as $210,576, which, according to the Medical Liability Monitor, were the highest in the United States. Id.
efficiency—namely their speed of resolution and lower administrative costs.\textsuperscript{242} Such a benefit is significant, given that one of the strongest criticisms of the current medical malpractice tort system is its inefficiency.\textsuperscript{243} According to a 1992 United States General Accounting Office Study of Medical Malpractice Alternatives, resolving a medical malpractice claim in the tort system took an average of thirty-three months.\textsuperscript{244}

Another benefit of the Virginia and Florida Acts may be found in the nature of their compensation.\textsuperscript{245} For instance, according to a study of compensation outcomes for birth-related injury, NICA recipients broke even while families who received tort settlements were overcompensated.\textsuperscript{246} The study also concluded that medical expenses of NICA recipients were adequately compensated for, but that income loss was not.\textsuperscript{247} Despite this fact, the study found that overall, NICA recipients were satisfied with their compensation.\textsuperscript{248}

However, there are some significant structural problems with NICA and Virginia's similar plan.\textsuperscript{249} Most notable is that the narrow definition of birth-related injury covered by these statutes threatens the very victims they were intended to protect.\textsuperscript{250} The definition in the Virginia statute, for example, is so narrow that only a small handful of injuries fall under the statute each year, resulting in a negligible number of claims being filed.\textsuperscript{251} Without broader definitions, such statutes shut out certain catastrophic birth-related injuries, or at the very least, require families to endure litigation, which is exactly what these no-fault systems were designed to avoid.\textsuperscript{252} Similarly, the small incidence of claims filed under these statutes indicates that obstetricians still need comprehensive malpractice insurance coverage to cover the many claims that do not fall

\textsuperscript{242} See, e.g., Studdert, supra note 237, at 229. \textit{But see} Martin, supra note 16, at 621 (stating that the Florida statute “has not met its expectations” of, among other things, reduced costs).

\textsuperscript{243} See Cerny, supra note 13, at 193.

\textsuperscript{244} Id.

\textsuperscript{245} See FLA. STAT. ANN. § 766.31 (West Supp. 2003); VA. CODE ANN. § 38.2-5009 (Michie 2002); Frank A. Sloan, et al., \textit{The Road From Medical Injury to Claims Resolution: How No-Fault and Tort Differ}, 60 LAW & CONTEMP. PROBS. 35, 65 (1997).

\textsuperscript{246} Sloan et al., supra note 245, at 61.

\textsuperscript{247} See id. at 61, 65-66.

\textsuperscript{248} Id. at 66.

\textsuperscript{249} Falker, supra note 3, at 20-22 (discussing the Virginia statute); Martin, supra note 16, at 644 (discussing the Florida statute).

\textsuperscript{250} Martin, supra note 16, at 644; see also FLA. STAT. ANN. § 766.302(2); VA. CODE ANN. § 38.2-5001.

\textsuperscript{251} Falker, supra note 3, at 22; see also VA. CODE ANN. § 38.2-5001.

\textsuperscript{252} Martin, supra note 16, at 643.
under the statute. Therefore, most insurance companies still perceive Virginia and Florida obstetricians as high risk clients and consequently maintain high premiums. For this reason, the Virginia and Florida statutes that focus on certain neurological birth-related injuries are ineffective in combating the malpractice. Although these attempts to resolve the malpractice insurance crisis have been relatively unsuccessful, a more effective no-fault system could be developed, and legislatures should continue to explore additional remedies.

B. Statute of Limitations

Statutes that impose reduced time periods in which plaintiffs may file medical malpractice claims are designed to promote greater certainty among insurance carriers in terms of their risk of liability for a given period of coverage. This increased certainty lends itself to premiums that more accurately reflect the liability facing insurance companies when they provide coverage to obstetricians. For example, California’s MICRA includes a statute of limitations provision intended to foster such certainty and thereby reduce medical malpractice insurance premiums. In fact, all of MICRA’s provisions are designed “to reduce the cost of malpractice insurance by limiting the amount and timing of recovery in cases of [medical malpractice].” It seems that MICRA has been effective in producing its desired results. As a testament to MICRA’s efficacy, ACOG endorses MICRA as the most comprehensive and successful medical tort reform in the United States. MICRA has been tremendously successful in reducing the cost of medical liability insurance, as California premiums, once the highest in the country in 1975, were well below the national average in 1991, and in 2001, premiums for California obstetricians were less than half of what

253. See Hearing, supra note 2.
254. See id.; Martin, supra note 16, at 643-44.
256. See id.
obstetricians in the rest of the country were paying. In fact, medical malpractice premiums for most of California’s hospitals decreased by 25% in the years immediately following MICRA’s enactment. Thus, statutes modeled after MICRA, containing a three-year statute of limitations provision, likely will be effective in combating the rising malpractice insurance premiums that are forcing obstetricians to stop delivering babies.

C. Jury Award Caps and the Elimination of Putative Damages

Limitations on the amount of money juries can award plaintiffs for non-economic damages arguably are the most important and necessary form of tort reform. Those in favor of such caps point to the escalation of medical malpractice jury awards throughout the country. For instance, from 1997 to 1998, the average number of awards higher than $1 million rose by 39%, increasing by 45% from 1998 to 1999. Similarly, in 1993, the average medical liability award was $500,000, but by 1999 it had increased to $800,000, while the median medical liability settlement climbed 63%, from $400,000 to over $650,000. ACOG faults litigation in those states with no jury award limitations as the culprit for these increases.

For those states with no award caps, learning from California’s success and enacting cap statutes similar to the one in MICRA may prove wise. ACOG cites MICRA’s jury award cap as having played an integral role in helping to ensure that California women have access to healthcare by encouraging many obstetricians to continue delivering babies. MICRA’s $250,000 cap on non-economic damages such as pain and suffering likely has played a role in the stabilization of California’s external_i
medical malpractice insurance rates.\textsuperscript{271} According to ACOG, "[w]ithout a cap on non-economic damages women's access to healthcare will suffer. Every dollar an obstetrician spends on liability insurance translates into one less dollar available for women's health care."\textsuperscript{272} Accordingly, those in favor of jury award caps cite them as the key to resolving the current medical malpractice insurance crisis.

Unfortunately, one result of these caps may be that some legitimate victims of negligence suffer because some lawyers refuse to represent malpractice victims when a cap is in place.\textsuperscript{273} Those opposed to jury award ceilings also say that the threat of costly settlements encourages doctors and hospitals to exercise the utmost caution, which in turn, improves overall quality of care.\textsuperscript{274} Accordingly, some exholt high jury awards in the name of just compensation, retribution, or deterrence.\textsuperscript{275} However, while high jury awards may deter some negligence, if they encourage attorneys to file more claims than they would otherwise, then such awards cannot be said to deter malpractice litigation overall.\textsuperscript{276} Regardless of their impacts on deterrence, if the goal is to reduce malpractice insurance premiums, the evidence certainly suggests that jury award caps are effective in achieving this goal.\textsuperscript{277}

The logic behind statutes that impose jury award caps is very similar to the logic behind statutes that eliminate punitive damages. Punitive damages, although rare, historically have accounted for some of the highest jury awards in medical malpractice cases.\textsuperscript{278} According to Justice Powell, "[i]n most jurisdictions jury discretion over the amounts awarded is limited only by the gentle rule that they not be excessive. Consequently, juries assess punitive damages in wholly unpredictable amounts bearing no necessary relation to the actual harm caused."\textsuperscript{279} By eliminating punitive damages in malpractice lawsuits, juries will be prevented from utilizing this often unbridled form of punishment, therefore helping to reduce the risk that malpractice cases will result in astronomical jury awards. This reduced risk should help curb rising

\begin{thebibliography}{9}
\bibitem{271} Treaster, \textit{supra} note 3.
\bibitem{272} See \textit{Caps, supra} note 13.
\bibitem{273} Treaster, \textit{supra} note 3.
\bibitem{274} See \textit{id}.
\bibitem{275} See \textit{id}.
\bibitem{276} Falker, \textit{supra} note 3, at 12-13.
\bibitem{277} See Albert, \textit{supra} note 260; Treaster, \textit{supra} note 3; \textit{Caps, supra} note 13.
\bibitem{278} See Bernier v. Burris, 497 N.E.2d 763, 776 (Ill. 1986); Valerie Hans & Stephanie Albertson, \textit{Empirical Research and Civil Jury Reform}, 78 NOTRE DAME L. REV. 1497, 1515-16 (2003); see also Hearing, \textit{supra} note 2 (citing $100 million awarded by a Philadelphia jury in an obstetric-related medical malpractice case).
\end{thebibliography}
insurance premiums, thereby discouraging obstetricians from giving up the practice of obstetrics.

**D. Abolition of the Collateral Source Rule**

The collateral source rule is another mechanism by which jury awards reach outlandish proportions. According to the *Eastin* court, this rule has allowed plaintiffs to double and even triple their recovery.\(^{280}\) By abolishing this rule, and admitting evidence of collateral benefits received by plaintiffs, juries more accurately can assess the amount of money that is truly needed to compensate the plaintiffs for their injuries. *Doran* and *Eastin* suggest that if a law that abolishes the collateral source rule is found constitutional, it must involve a complete abolition, as was done in Arizona, and not a partial abolition, as was done in Kansas.\(^{281}\) A law calling for total abolition must allow the admissibility of all benefits received by the injured party, whether gratuitous or from insurance.\(^{282}\)

**E. Monetary Limitations on Plaintiff Attorney Fees**

The President's Council of Economic Advisors estimates that fifty-eight cents of every dollar from tort settlements goes to administrative and defense costs, and especially to attorney fees, which constitute the highest overhead.\(^{283}\) In light of such a startling statistic, statutes that place limits on attorney contingency fees in malpractice cases, such as New York's statute,\(^{284}\) aim to lower malpractice insurance rates by discouraging the likelihood of filing suits with costly damages at stake. By reducing the contingency percentage as the damages go higher, New York's statute ensures that more money goes to the plaintiff and reduces the incentive for attorneys to ask for damages greater than $1.25 million, because any amount above this will result only in a 10% contingency fee for the attorney.\(^{285}\)

**F. Periodic Payments**

Statutes that allow for the payment of damages by periodic installments aim to reduce the burden of requiring a physician's insurance company to pay the damages in one lump sum. Given the fact that lawsuits involving obstetricians often result in high jury awards, such statutes are effective tools in the effort to make obstetricians more

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285. *See id.* § 474-a(2).
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attractive clients for insurance companies. These statutes also help ensure that plaintiffs do not spend the awards for future damages before the damages are actually incurred. 286

III. GONE TO DELIVER BABIES . . . EVERY ONE: HOW TO KEEP OUR OBSTETRICIANS WHERE THEY BELONG – IN THE DELIVERY ROOM

Regardless of the various levels of efficacy of the aforementioned statutory reform options, some action is necessary before pregnant women across the country are left without obstetricians. As a result of the medical malpractice insurance crisis, women’s access to healthcare is clearly in jeopardy. 287 ACOG outlines the following problems as part of the larger maternal healthcare access crisis: fewer obstetric providers, a rural crisis, community clinic cutbacks, less prenatal care, less preventative healthcare, and more uninsured patients. 288 Access to prenatal care, already considered a problem by many physicians and public health scholars, is diminished further as a result of the rising insurance rates that force obstetricians to leave their practices. 289


287. See The American College of Obstetricians and Gynecologists, ACOG’s Action Agenda for the 107th Congress, at http://www.acog.org/from_home/departments_govtrel/action02.doc (last visited Oct. 22, 2003). According to ACOG, “[t]oday, litigation is driving premiums up, recreating a shortage of obstetric care. Skyrocketing premiums have forced ob-gyns to retire early, discontinue the obstetric side of their practice, or relocate—leaving mothers around the country without access to care.” Id.

288. See Caps, supra note 13. According to ACOG, rising insurance premiums lead to an increase in overall healthcare costs, which in turn, discourage employers from offering insurance benefits. Id. Many women then lose their insurance coverage, and those whose incomes are above the poverty guidelines are ineligible for Medicaid. Id. The end result is an overall increase in the number of uninsured women of childbearing age, which, at 11.7 million in 2001, cannot afford to go any higher. Id.; see also infra notes 7-20 and accompanying text (discussing how rising medical malpractice insurance premiums have led to a shortage of obstetrical providers). Excessive litigation and the staggering premiums that result not only threaten women’s access to obstetric care, but threaten their access to gynecologic care as well. See Hearing, supra note 2. As staggering premiums continue to burden women’s healthcare professionals, women may not have adequate access to all the gynecological services they need. Id. These imperative services consist of: “regular screenings for gynecologic cancers [including breast cancer], hypertension, high cholesterol, diabetes, osteoporosis, sexually transmitted diseases, and other serious health problems.” Id.

289. See Caps, supra note 13. This occurs because the rates not only tax the overall maternal healthcare system, but also increase the distances that women have to travel for prenatal care, thereby discouraging some women from obtaining all the prenatal care they need. See id. Notwithstanding the malpractice crisis in obstetrics, ensuring adequate prenatal care for low-income inner-city women always has been difficult; it is a challenge already hindered by poverty, drug use, and lack of social support. See Schleuning et al., supra note 5, at 47.
Unfortunately, the obstetric shortage hurts poor and disadvantaged women the most. Many of these women rely on community care clinics, which are being forced to limit the number of patients they help due to the fact that they cannot shift some of the cost of higher insurance premiums onto their patients, who are largely uninsured. The result is that many of these women are left without access to obstetric care. The situation is worst in rural areas where the problem undoubtedly has reached crisis status. As opposed to urban communities, rural communities tend to depend on a relatively small number of physicians and a single hospital, which means that when rural physicians leave obstetrics, local access to obstetrical services rapidly deteriorates. Clearly, women's access to obstetric care, particularly that of poor and rural women, hangs in the balance as obstetricians stop delivering babies in record numbers due to rapidly increasing malpractice insurance premiums.

290. See Hearing, supra note 2; Schleuning et al., supra note 5, at 47.
291. Caps, supra note 13. Certain groups of vulnerable women, such as rural residents and medically indigent women, tend to be more dependent on family physicians than obstetricians for obstetric services. See Rosenblatt et al., supra note 3, at 248. Therefore, the fact that family physicians are giving up obstetrics more rapidly than obstetricians will have a particularly harmful impact on these women's access to healthcare. See id.
292. See Caps, supra note 13.
293. See id. See generally Rena J. Gordon et al., The Effect of Malpractice Liability on the Delivery of Rural Obstetric Care, 3 J. RURAL HEALTH POLICY 7 (1987) (detailing the rates at which rural providers have been leaving obstetrics and the pregnancy outcomes in light of the decreased availability of obstetric care); Roger A. Rosenblatt & Barbara Detering, Changing Patterns of Obstetric Practice in Washington State: The Impact of Tort Reform, 20 FAMILY MED. 101 (1988) (detailing a study that found that rapidly increasing medical malpractice insurance premiums among obstetricians result in reduced access to obstetric care in rural areas and a severe curtailment of care to the medically indigent).
294. See Schleuning et al., supra note 5, at 47-51. Changes affecting the practice of obstetrics, such as increasing malpractice insurance premiums, are most disrupting to the lives of rural physicians. Id. at 51. However, rural physicians are less likely to have a voice in any of the reform efforts because they tend to live far from the urban centers where policy is made and implemented. Id. Even if they are able to get involved, their heavy workload and geographic isolation make it difficult to have a meaningful impact in committee work and lobbying. Id. Being hit with astonishingly high medical malpractice insurance rates, the economic security of these rural obstetricians was already shaky due to "sparse population, low insurance reimbursement for pregnancy services, and growing managed care constraints." Caps, supra note 13.
295. See Hearing, supra note 2. On June 30, 2002, the Methodist Hospital in South Philadelphia closed its maternity ward for the first time since its founding in 1892, thereby leaving the women of that area of the city, many of whom are economically disadvantaged, without easily accessible obstetrical care. Id. in the summer of 2002, at least six hospitals throughout the country closed their obstetric wards due to the soaring costs of malpractice insurance. Treaster, supra note 3. Currently, no obstetricians are practicing in Yazoo City, Mississippi, a city of 14,550 people. Hearing, supra note 2. In December 2001, a survey of ob-gyns in Las Vegas, Nevada, revealed that 60% were planning to drop obstetrics after
Given the current state of women's access to obstetric care, the overall goal of any solution must be to lower the insurance premiums that are forcing obstetricians out of business. However, an effective solution should do so without losing sight of the tort system's overall goals, which include deterrence, fairness for both obstetrician and patient, compensation for those who deserve it, and efficiency.

With this in mind, the solution proposed by this Comment is multifaceted and comprised of both tort and insurance reform with short and long-term remedies, made possible through federal initiative. Specifically, the federal government immediately should enact legislation that establishes a uniform medical malpractice insurance reform plan modeled after MICRA. This plan should include provisions for a statute of limitations, elimination of the collateral source rule, periodic payments, and most importantly, jury award caps.296

the nation's second largest liability insurance carrier announced it would no longer renew the physicians' policies. Id.

In terms of insurance reform, the federal plan should encourage the formation of physician-owned insurance companies by providing grants to state medical associations for the purposes of establishing such companies. The plan also should require, or at the very least provide incentives for, insurers of physicians and hospitals to base their premiums on an experience rating system that takes into account physicians' history of claims and acknowledges the fact that only a few "bad apple" doctors are responsible for the majority of malpractice claims.

The federal plan should call for the establishment of a National Medical Malpractice Review Board. This review board would be comprised of physicians, lawyers, public health officials, legislators, and insurance company representatives. The Board would oversee the implementation of the plan and also would serve as a consultant to the legislature on any matters relating to medical malpractice. In light of research on the effects of a poor doctor-patient relationship, the Board also would establish a committee devoted to promoting healthier doctor-patient relationships. This committee would be responsible for sponsoring clinics and conferences that focus on this issue with an emphasis on improving certain physician skills such as effective communication, empathetic listening, and patience.

Finally, in light of the disturbing statistics suggesting that trial outcome does not depend on physician negligence, the legislation should establish a committee to investigate the possibility of removing medical malpractice claims from the tort system altogether. Based on the beginning of a specialty-specific approach to tort reform. Id. The Healthy Mothers and Healthy Babies Access to Care Act focuses on the liability problems facing obstetricians and is modeled after California's MICRA. Id.; see also ACOG News Release, Senators Did Not Rise Above Politics to Protect Prenatal and Delivery Care (Feb. 25, 2004), at http://www.acog.org/from_home/publications/press_releases/nr02-25-04.cfm. The Act includes, among other things, a $250,000 cap on non-economic damages, a collateral source provision, a statute of limitations provision, guidelines for the award of punitive damages, a safeguard against unreasonable attorneys' fees, and a periodic payments provision. S. 2061. The Act also imposes the clear and convincing evidence standard as the required burden of proof in cases where the plaintiff seeks punitive damages. Id. Unfortunately, the bill succumbed to partisan politics and was defeated by a Senate vote of 48-45. See ACOG News Release, supra.

297. Research suggests that tension in the doctor-patient relationship also may play a role in the frequency of medical malpractice claims. See Falker, supra note 3, at 8-11. According to a study conducted by the American Medical Association (AMA), a patient's degree of dissatisfaction with her obstetrician was "highly correlated" with her tendency to sue. Id. at 9-10. Other studies cited ineffective doctor-patient communication and the patient's perception that the doctor did not have time for her as major sources of dissatisfaction. See id. at 8-9. Such a relationship is ripe for the existence of misunderstanding, mistrust, and anger, therefore making it more likely that a patient will sue her doctor if an adverse outcome in medical care arises. See id. Consequently, it appears that a negative doctor-patient relationship contributes to the disproportionately high rate of claims burdening obstetricians. Id. at 2, 8-9.
principles behind no-fault compensation, the committee would determine the feasibility and constitutionality of a system where claims were addressed and resolved by a panel of medical and legal experts, thereby effectuating what the tort system is supposed to do: ensure justice. This would eliminate the injustice of non-negligent doctors being held responsible and ordered to pay for injuries and disabilities they did not cause, yet at the same time provide financial assistance to those who need it. Given the complexity and technicality of medical malpractice claims, the committee also would explore the possibility of creating special medical courts, which would be run by expert judges. Similar to our system of separate tax, patent, and workers’ compensation courts, these medical courts would reduce the likelihood of trial outcomes determined on the basis of severity of plaintiff injury (and corresponding juror sympathy), rather than negligence. In short, this committee would work to find a long-term solution that would ensure justice for all and possibly replace the legislation’s above-described short-term remedies.

The overall goal of the federal legislation would be to reduce and stabilize the medical malpractice insurance premiums that are rising so rapidly. Because obstetricians face disproportionately higher insurance rates, the reform provisions encompassed in this plan undoubtedly will benefit obstetrics and other “high risk specialties” the most. Therefore, this plan, or something very similar, would help ensure access to healthcare for women in America.

IV. CONCLUSION

The medical malpractice crises of the past three decades mostly were marked by rapidly increasing malpractice insurance premiums and high jury awards—a trend that hit the practice of obstetrics the hardest. Currently, obstetricians across the country are giving up the very thing that defines their specialty: the delivery of babies. Clearly something needs to be done. If no action is taken, this country soon will be on the brink of a serious shortage of the doctors that help effectuate the most basic of human functions, leaving women to face an unprecedented barrier to their access to healthcare.