A MORE BALANCED PRESCRIPTION: RECONCILING MEDICAL MALPRACTICE REFORM WITH FUNDAMENTAL PRINCIPLES OF TORT LAW

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ABSTRACT

For decades, the most common measure of tort reform deployed in medical malpractice cases has been caps on noneconomic damages. Healthcare providers, medical institutions, insurance lobbyists, and lawmakers who support these groups have advocated, and continue to advocate, for noneconomic damages caps as the solution to rising malpractice insurance premiums and healthcare costs. By limiting what an injured patient can recover for, inter alia, pain and suffering, these proponents prop up damages caps as the cure to what they label the medical malpractice crisis. Statutory limitations on damages in medical malpractice actions, however, are not the solution to any crisis that exists today. Caps on noneconomic damages are riddled with deficiencies—both in regard to constitutionality and efficacy. Indeed, noneconomic damages caps violate the Seventh Amendment's right to a civil jury trial, have proven ineffective at lowering malpractice premiums and healthcare costs, and harm injured patients seeking just compensation in the civil justice system.

This article explores each of these deficiencies and demonstrates that the reconciliation of medical malpractice reform with basic goals of tort law—compensation and deterrence—is long overdue. While reducing medical malpractice insurance premiums and healthcare costs are important government interests, lawmakers cannot turn a blind eye to the harm noneconomic damages caps have on victims of medical malpractice. This article argues that state legislatures should reshape medical malpractice laws to ensure injured patients are adequately compensated and to incentivize safer medical procedures while also placating physicians' concerns related to rising malpractice premiums. To that end, the article concludes by offering an alternative remedy to conventional noneconomic damages caps as a template for accomplishing these goals.

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INTRODUCTION

Imagine a young child is diagnosed with a simple virus and discharged from a hospital despite presenting symptoms of meningococcemia. The parents bring the child back to the hospital two days later because the child's conditioned has worsened. The treating physicians take no action for several days despite the differential diagnosis indicating bacterial meningitis. Rather than starting antibiotics or performing a lumbar puncture to rule out the bacterial meningitis, the physicians decide to wait and watch until it is too late. Due to the negligent care that the healthcare providers delivered, the child does not receive a timely diagnosis and treatment of bacterial meningitis. And as a result, she suffers a debilitating, permanent brain injury that could have been avoided if the healthcare provider followed proper medical protocol. The injuries the child has suffered will affect her for the rest of her life.

After a multi-year legal battle and four-week trial, the jury finds the healthcare providers liable and awards the child $3,000,000 in economic damages and $6,000,000 in noneconomic damages for, among other things, her pain and suffering. Following trial, however, the court reduces the jury's determination of the noneconomic damages award to $300,000 pursuant to a state statute enacted specifically to limit such recovery. This is the harsh reality for medical malpractice plaintiffs across the country whose damages award—determined by the jury—is automatically reduced pursuant to state law regardless of the circumstances surrounding the injury.[1]

Medical malpractice insurance is among the most expensive types of insurance coverage—ranging up to $100,000 annually depending on the practice area.[2] For the past several decades, legislators have turned to medical malpractice reform—the statutory modification of common law tort—in an attempt to steady escalating insurance premiums and assuage related concerns of the healthcare industry.[3] The most common tort reform measure employed by lawmakers in this area has been, and continues to be, damages caps—specifically, caps on

1. Statutory caps on damages are a constant obstacle for victims of medical malpractice. *See, e.g.*, Schmidt v. Ramsey, 860 F.3d 1038, 1042–43 (8th Cir. 2017) ("After a jury awarded $17 million to a child born with severe brain damage, the district court applied Nebraska's tort-reform act to reduce the verdict by almost 90 percent, to $1.75 million.").

2. *See* Manoj Jain, *Even with Malpractice Insurance, Doctors Opt for Expensive Defensive Medicine*, WASH. POST (Aug. 31, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/08/30/AR2010083003946.html.

3. Barry Furrow & David Hyman, *The Medical Malpractice Crisis: Federal Efforts, States' Roles and Private Responses Session 1: Federal Efforts and State Approaches to the Crisis*, 13 ANNALS HEALTH L. 521, 526, 530–31 (2004).

noneconomic damages.[4] It is thus not surprising that these statutory limitations on recovery have been an intensely debated topic for decades.[5]

Physicians, medical institutions, insurance lobbyists, and the lawmakers who support the industry—proponents of medical malpractice reform—point to an out-of-control judicial system that permits huge jury awards and consequently incentivizes frivolous claims.[6] This group asserts that runway jury verdicts, frivolous lawsuits, and the associated costs with defending against such claims are responsible for high malpractice insurance premiums and increased healthcare costs.[7] They contend that the spike in insurance rates are forcing medical professionals to either raise the cost of services or abandon their practices altogether.[8] There is a general consensus within the medical community that this phenomenon results in skyrocketing health insurance costs for patients and less qualified professionals entering high-risk specialties.[9] These proponents note that U.S. healthcare spending grew 3.9% in 2017, reaching $3.5 trillion or $10,739 per person, and accounted for 17.9% of the nation's GDP.[10] And while the U.S. spends significantly more than any other industrialized nation on

4. *Id.* at 524, 545.

5. *See* Theodore R. LeBlang, *The Medical Malpractice Crisis—Is There A Solution?*, 27 J. LEGAL MED. 1, 9 (2006) (noting "the controversy surrounding malpractice tort reform strategies and their effectiveness"); David Donovan, *Latest Data Show State's Tort Reform Act Delivered a Knock-Down Blow*, N.C. LAWS WKLY. (July 24, 2015), http://nclawyersweekly.com/2015/07/24/latest-data-show-that-states-tort-reform-act-delivered-a-knock-down-blow/ (quoting Charles Monnet, a North Carolina plaintiffs' attorney, "It's definitely not a level playing field. The truth is that they [doctors] have the advantage pretty much every step of the way. The crisis in medical malpractice litigation is that too many legitimate claims now go uncompensated.").

6. Kevin J. Gfell, *The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions,* 37 IND. L. REV. 773, 775,778–79 (2004).

7. *See* Eric S. Goodheart, *Two Tiers of Plaintiffs: How North Carolina's Tort Reform Efforts Discriminate Against Low-Income Plaintiffs,* 96 N.C. L. REV. 512, 513 (2018).

8. Eric Lindenfeld, *Moving Beyond the Quick Fix: Medical Malpractice Non-Economic Damage Caps are a Poor Solution to the Growing Healthcare Crisis*, 41 T. MARSHALL L. REV. 109, 112–113 (2015).

9. Emily Chow, *Health Courts: An Extreme Makeover of Medical Malpractice with Potentially Fatal Complications*, 7 YALE J. HEALTH POL'Y L. & ETHICS 387, 387–88 (2007) (explaining that the number of qualified professionals entering neurosurgery, obstetrics, and gynecology is decreasing).

10. *National Health Expenditure Data*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html (last visited Oct. 14, 2019).

healthcare, affordable healthcare remains unobtainable for many Americans.[11] Accordingly, this group believes tort reform—"passing laws to deter outrageous jury verdicts and windfall recoveries to undeserving parties"—is essential to remedying a crisis in the healthcare industry attributable to medical malpractice.[12]

On the other side of the debate, opponents of tort reform—injured patients, plaintiff's lawyers, and typically more liberal lawmakers—assert that the proponent's claims are not as drastic as they are portrayed.[13] These opponents point out that the combined costs from medical malpractice litigation only constitutes two percent of the nation's total healthcare expenditure.[14] Similarly, studies have indicated that reducing malpractice litigation costs cannot provide the redress that lawmakers hope to achieve.[15] Instead of arguing that the problem results from excessive litigation or frivolous malpractice claims, studies suggest the U.S. is suffering from an overabundance of substandard medical care—as demonstrated by statistics that medical negligence causes up to 98,000 deaths annually.[16] Critics of reform also argue that the empirical data, which is inconclusive at best,[17] fails to justify the arbitrary limitation such laws impose on a plaintiff's ability to bring a meritorious lawsuit.[18] Accordingly, injured patients and their lawyers have regularly challenged the constitutionality of such

11. David Morgan, *One in Four Americans Without Health Coverage: Study*, REUTERS, Apr. 19, 2012, http://www.reuters.com/ article/2012/04/19/us-usa-healthcare-insurance-idUSBRE83I17420120419; JESSICA C. SMITH & CARLA MEDALIA, U.S. CENSUS BUREAU, P60-250, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2013 (2014) (showing that nearly forty-two million Americans went uninsured in 2013, and around 15% of working-age Americans were uninsured at some point during that year).

12. *See* Roland Christensen, Comment*, Behind the Curtain of Tort Reform*, 2016 BYU L. REV. 261, 263–64 (2016) (labeling tort reform a "political agenda developed in response to perceived problems with the current tort system").

13. *See* Goodheart, *supra* note 7, at 513.

14. *See* Letter from Douglas W. Elmendorf, Director, Cong. Budget Off., to Orrin Hatch, Senator (Oct. 9, 2009), http:// www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf (including costs from awards, settlements, and related administrative expenses in the calculation).

15. *See* Darius N. Lakdawalla & Seth A. Seabury, *The Welfare Effects of Medical Malpractice Liability* 1, 4 (Nat'l Bureau of Econ. Research, Working Paper No. 15383, 2009), http:// www.nber.org/papers/w15383 (finding that a 10% reduction in malpractice costs would reduce total healthcare spending by 1.2%, at most).

16. *See* TOM BAKER, THE MEDICAL MALPRACTICE MYTH 22 (2005); INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al. eds. 2000) (estimating that 98,000 patients die every year from preventable medical errors).

17. *See* Lindenfeld, *supra* note 8, at 115 ("[T]he medical and financial data put forth by proponents is often inflated and misleading.").

18. *See* Goodheart, *supra* note 7, at 513.

laws on various grounds including equal protection, right to a jury trial, separation of powers, due process, and restricting access to the courts.[19]

The only undisputed fact in the debate over medical malpractice reform is that neither the healthcare industry nor injured patients are content with the current state of the law in this area. While noneconomic damages caps have reduced medical malpractice claims and payouts, physicians continue to pay inflated insurance premiums and healthcare costs continue to rise.[20] Indeed, medical malpractice insurance premiums and healthcare costs are rising annually with no sign of slowing down, despite mechanisms such as noneconomic damages caps allegedly enacted to prevent such escalation.[21] Noneconomic damages caps have neither reduced the price of medical malpractice insurance premiums, increased healthcare availability, nor decreased healthcare costs. In short, noneconomic damages caps have not accomplished the purported goals they were enacted to achieve.

Meanwhile, noneconomic damages caps deprive injured patients who lack significant economic damages the opportunity to assert meritorious claims and be made whole. Rather than acting as a deterrent against medical negligence, traditional noneconomic damages caps devalue certain groups of injured patients by preventing attorneys from taking cases where the potential for significant economic damages is lacking. Inflexible caps not only widen the social justice gap for injured patients generally but also disproportionality disadvantage certain groups—women, children, low-income patients, and the elderly. Indeed, these caps serve to harm injured patients who cannot change their unfortunate circumstances by preventing them from obtaining reprieve in the civil justice system.

Any solution to the crisis that shifts the burden to victims of medical malpractice seeking relief in the civil justice system should be recognized as fundamentally flawed. Reducing healthcare costs and controlling malpractice premiums are undeniably important goals, but lawmakers cannot turn a blind eye to the harm such laws have on victims of medical malpractice. Rather, legislators must consider the needs of all parties involved in the debate over medical malpractice reform, particularly those of injured patients who need to be "made whole." Injured patients, moreover, should not be forced into alternative forms of dispute resolution—where they might only recover a fraction of what they

19. Goodheart, *supra* note 7, at 539–40.

20. *See* Daniela Talmadge, *Keeping Medical Liability Costs Down: How Captive Insurance and Damage Caps Could Help Control Rising Healthcare Costs*, 43 J. CORP. L. 201, 201–02, 211 (2017).

21. *See id*. at 201; Constance A. Anastopoulo, *Taking No Prisoners: Captive Insurance as an Alternative to Traditional or Commercial Insurance*, 8 OHIO ST. ENTREP. BUS. L.J. 209, 212 (2013).

need to be made whole—as their sole avenue for relief. By adopting a more nuanced and contextual perspective, as discussed further below, lawmakers will be better equipped to implement reform that helps alleviate physicians' concerns about malpractice premiums and meritless claims without disproportionately impacting injured patients and widening the social justice gap.

Regardless of who is to blame for increased insurance costs, it is clear that previous attempts to remedy the problem through medical malpractice reform have fallen short. The rising costs of malpractice insurance and healthcare, combined with the inability of current measures to remedy the situation, beg for reform that will reduce the burden shouldered by both injured patients and physicians. The glaring economic, social, and constitutional issues associated with traditional noneconomic damages caps suggest that such measures are not the solution.[22] For this reason, it is imperative lawmakers recognize the inadequacy of noneconomic damages caps and instead seek to implement alternative measures of reform.

Reform is likely necessary to prevent further escalation of malpractice insurance premiums. But noneconomic damages caps are not the right type of reform. Neither the healthcare nor insurance industry, however, will accept a reform without some sort of limitation on noneconomic recovery. And why would they? Noneconomic damages caps limit the quantity of both medical malpractice claims and payouts—thereby reducing exposure to liability and increasing profitability. The Supreme Court, moreover, does not appear inclined to take up the question of whether noneconomic damages caps in medical malpractice actions violate the Seventh Amendment's guarantee of a civil jury trial.[23] Thus, the reality is that damages caps are likely not going anywhere anytime soon.

The fact that noneconomic damages caps are unlikely to disappear in the foreseeable future does not necessarily mean they are good policy. Current state legislation and federal attempts at reform have not been meticulously crafted to address the needs of both injured patients and the medical community.[24] This article advocates that the reconciliation of medical malpractice reform with the fundamental goals of tort law—compensation and deterrence—is long overdue. The main purpose of this article, however, is not to establish who the winner should be in the debate over medical malpractice reform. Rather, this article argues that through carefully balanced reform lawmakers can reshape medical malpractice laws to better compensate injured patients and incentivize safer

22. *See infra* Parts II & III.

23. *See* Schmidt v. Bellevue Med. Ctr. L.L.C., 138 S. Ct. 506 (2017) (denying petition for writ of certiorari from 8th Circuit case, effectively declining to review whether Nebraska's damages cap in medical malpractice cases violates the Seventh Amendment).

24. *See infra* Part III.A.

medical procedures, while also implementing insurance reform to placate physicians' concerns related to rising premiums. Although commentators may be correct in denouncing the current medical malpractice system as broken, this article posits that the system is not beyond repair.

The article proceeds as follows. Part I provides a brief summary of the history behind medical malpractice, analyzes the causes behind what is known as the medical malpractice "crisis," and discusses tort-reform measures legislatures enacted in response. Next, Part II argues that noneconomic damages caps—and damages caps generally—in medical malpractice actions insult a bedrock principle in the Constitution: the Seventh Amendment's guarantee of the right to trial by jury in civil cases. Under the Court's modern incorporation doctrine, the guarantee of the civil jury right in medical malpractice cases should apply with equal force to the states and mandate the invalidation of caps on noneconomic damages.

Part III analyzes the impact noneconomic damages caps have had on injured patients, healthcare quality, and malpractice insurance premiums. Empirical data and studies indicate that these caps are an arbitrary and ineffective solution for decreasing malpractice premiums and healthcare costs. Then, Part IV briefly discusses no-fault compensation schemes as a popular alternative to conventional tort reform tactic and considers the efficacy of this method. Part V offers an alternative remedy to conventional noneconomic damages caps as a template for reform that seeks to adequately compensate injured patients, incentivize safer medical procedures, and assuage concerns related to the high costs of malpractice insurance and healthcare. And finally, the article concludes.

I. MEDICAL MALPRACTICE REFORM

In general terms, medical malpractice is "a doctor's failure to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances."[25] A medical malpractice claim is a particular type of professional negligence claim.[26] "The distinction between an ordinary negligence claim and a medical negligence claim is that, in the latter, the duty is breached when a physician's treatment falls below the applicable standard of care."[27] A medical malpractice claim "arises when a physician acts in a manner that a reasonably careful physician would not, or fails to act as a reasonably careful physician would."[28] In contrast to general negligence, medical

25. *Medical Malpractice*, BLACK'S LAW DICTIONARY (10th ed. 2014).
26. Dotson v. Bernstein, 207 P.3d 911, 913 (Colo. App. 2009).
27. *Id.*
28. Hall v. Frankel, 190 P.3d 852, 864 (Colo. App. 2008).

negligence is defined according to professional standards of care applicable to individuals within a certain profession.[29]

To understand the ongoing debate over medical malpractice reform, it is important to recognize that medical malpractice lawsuits are not a novel concept. Medical malpractice has deep roots in both English and American common law.[30] Similarly, the idea that the U.S. is "facing a medical malpractice crisis is not new."[31] In fact, the U.S. Senate held hearings about medical malpractice as early as the late 1960s, and President Richard Nixon established a commission to analyze the issue.[32] This part provides a brief history of medical malpractice and summarizes the origin of the crisis, which led to the adoption of tort reform limiting recovery against physicians and hospitals.

A. *Origin of the "Crisis"*

Medical malpractice is not a new phenomenon. Injured patients have brought claims against physicians for centuries.[33] In fact, records of medical malpractice litigation occurring in England date back to as early as 1375.[34] While the term "malpractice" did not develop until the early nineteenth century,[35] medical malpractice claims were fairly common in England by the fifteenth century, and

29. *Compare* C.R.S. § 13-64-403(12)(b) (defining "professional negligence") *with Negligence*, BLACK'S LAW DICTIONARY (10th ed. 2014) (defining negligence as "[t]he failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation").

30. *See* Lindenfeld, *supra* note 8, at 111.

31. Alan G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice "Crisis"*, 23 STAN. L. & POL'Y REV. 477, 480, 480 n.14 (2012) (discussing how the federal government has been investigating the medical malpractice crisis since the 1960s).

32. *See* William J. Curran, *Public Health and the Law: A National Commission on Medical Malpractice*, 61 AM. J. PUB. HEALTH 2313 (1971); Rogan Kersh, *Medical Malpractice and the New Politics of Health Care, in Medical Malpractice and the U.S. Health Care System* 45 (William M. Sage & Rogan Kersh eds., 2006).

33. Lindenfeld, *supra* note 8, at 111–12.

34. Kaycee Hopwood, *"For It's One, Two, Three Strikes, You're Out . . ."*, 39 J. MARSHALL L. REV. 493, 496 (2006) (discussing the English case of *Stanton v. Cavendish*, where the plaintiff alleged a surgeon negligently performed a hand surgery); *see also* William J. Phelan, IV, *A Chronic Concern No More: How Federal Medical Malpractice Caps Will Survive Under the Equal Protection Clause of the United States Constitution*, 23 J. CONTEMP. HEALTH L. & POL'Y 168, 172 (2006) (recognizing medical malpractice has origins in American common law).

35. Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1195, 1196 n.11 (1992).

courts often subpoenaed physicians to testify in lawsuits.[36] Consequently, physicians acquired insurance policies specifically for high-risk procedures that could result in death.[37]

Medical malpractice lawsuits likewise exist "throughout the history of American common law."[38] In 1794, a plaintiff prevailed in a negligence case against a physician who killed the plaintiff's wife by ineptly amputating her breast.[39] Malpractice cases—especially those not resulting in death—remained relatively rare until the mid-nineteenth century, however.[40] Although there was an increase in orthopedic-related malpractice lawsuits in the late 1830s,[41] there are only twenty-seven recorded cases against doctors in the U.S. from 1794 until 1861.[42] Accordingly, the evolution of medical malpractice as a substantial and distinct body of law did not occur until the turn of the twentieth century.[43]

Advances in medical technology between 1935 and 1955—notably diagnostic imaging and antibiotics—resulted in an upsurge of medical malpractice lawsuits.[44] These advents increased the availability of objective data lawyers could use to prove that the physician breached the applicable standard of care.[45] According to a 1957 study by the American Medical Association (AMA), roughly one out of every seven doctors practicing then had been sued for malpractice.[46] The rise in medical malpractice suits, however, did not become a controversial public issue until the 1970s.[47] Professors from Harvard's School of Public Health and School of Medicine identified changes in litigation as responsible for the increase in malpractice cases:

> Judges discarded rules that had traditionally posed obstacles to litigation. For example, most jurisdictions rolled back charitable

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36. Robert J. Flemma, *Medical Malpractice: A Dilemma in the Search for Justice*, 68 MARQ. L. REV. 237, 239 (1985).

37. *Id.*

38. Phelan, *supra* note 34, at 172.

39. *See* Cross v. Guthery, 2 Root 90, 1794 WL 198, *90 (Conn. Super. Ct. 1794).

40. KENNETH ALLEN DE VILLE, MEDICAL MALPRACTICE IN THE NINETEENTH-CENTURY AMERICA 7 (1990).

41. Phelan, *supra* note 34, at 172.

42. Flemma, *supra* note 36, at 240.

43. *See id.* at 240–41.

44. *See id.* at 241.

45. *See id.*

46. American Medical Association, *Opinion Survey on Medical Malpractice*, 164 JAMA 1583, 1594 (1957).

47. *See* Michael J. Cetra, Comment, *Damage Control: Statutory Caps on Medical Malpractice Claims, State Constitutional Challenges, and Texas' Proposition* 12, 42 DUQ. L. REV. 537, 538 (2004).

> immunity for hospitals. Courts also moved toward national standards of care and abandoned strict interpretations of the "locality rule," which had required plaintiffs to find expert witnesses within the defendant's immediate practice community. At the same time, expansion of doctrines such as informed consent and *res ipsa loquitur* (the rule that certain events, such as the retention of instruments after surgery, carry an inference of negligence) paved new pathways to the courtroom. The more plaintiff-friendly environment fostered by these changes altered the cost-benefit calculus for plaintiffs' attorneys, leading to a steady growth in litigation.[48]

Studies indicate that between the 1950s and 1980s, the number of medical malpractice lawsuits filed rose by 1000%, and the number of "successful jury awards increased by more than 275%."[49]

In addition to more frequent lawsuits and higher jury awards, insurance premiums also significantly increased between World War II and 1968—rising three times faster than the inflation rate.[50] By 1975, malpractice insurance premiums had reached an annual cost of one billion dollars.[51] At this point, many insurance companies pulled out of the malpractice market, which left the remaining insurers free to continue increasing their rates.[52] Because of the "crisis of availability"[53] that developed, some physicians raised services prices, abandoned certain practice areas, or exited the field of medicine altogether.[54] Tom Baker, a prominent scholar on tort reform, notes:

> [T]he medical malpractice insurance crises of the mid-1980s and the early 2000s did not reflect a sudden or dramatic change in either litigation behavior or malpractice payments. What changed, instead, were insurance market conditions and the investment and loss predictions built into medical malpractice insurance premiums.[55]

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48. David Studdert et al., *Medical Malpractice*, NEW ENG. J. MED. 283, 284 (2004).

49. Alec Shelby Bayer, *Looking Beyond the Easy Fix and Delving into the Roots of the Real Medical Malpractice Crisis*, 5 HOUS. J. HEALTH L. & POL'Y 111, 115 (2005).

50. Phelan, *supra* note 34, at 172 n.24.

51. *See* TARKY LOMBARDI & GERALD N. HOFFMAN, MEDICAL MALPRACTICE INSURANCE: A LEGISLATORS View 1 (1978).

52. Phelan, *supra* note 34, at 173–74.

53. *See id.*

54. Lindenfeld, *supra* note 8, at 112–113; *cf.* Daniel J. Sheffner, *Fatal Medical Negligence and Missouri's Perverse Incentive*, 7 ST. LOUIS U. J. HEALTH L. & POL'Y 147, 152 (2013).

55. Baker, *supra* note 16, at 51.

Thus, the medical malpractice *insurance* crisis may be a more accurate label for what is known as the "medical malpractice crisis."

Regardless of what actually caused the spike in liability insurance costs, it was healthcare consumers—particularly those needing medical care the most—who ultimately suffered. In response to this chain of events and strong lobbying efforts by the medical industry, state legislatures acted by passing various laws aimed at curbing lawsuits against doctors.[56] And thus began the era of medical malpractice reform.

B. *Reshaping the Common Law*

Since the 1990s, the common trend in many states has been to enact laws aimed at curbing big jury awards in medical malpractice cases.[57] In general terms, "[t]ort reform . . . refers to legislative proposals or enactments that modify the common law rules of torts."[58] Tort reform in various states generally include procedural, evidentiary, and substantive changes designed to either limit a plaintiff's ability to bring a medical malpractice claim or recover a large sum. While procedural and evidentiary mechanisms play an influential role in how, or if, a plaintiff brings a claim, the most popular mechanism state legislatures deploy to limit damages against physicians and hospitals are damages caps—specifically, inflexible caps on noneconomic damages. Noneconomic damages caps thus continue to be the prime subject for criticism in the debate over medical malpractice reform. Accordingly, after briefly describing some of the mechanisms that states have enacted in response to the medical malpractice crisis, this section primarily discusses damages caps.

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56. Phelan, *supra* note 34, at 173.

57. *See Medical Malpractice Damage Caps*, MED. MALPRACTICE CTR., http://www.malpracticecenter.com/legal/damage-caps (last visited Oct. 14, 2019) (showing states that have employed statutory damages caps).

58. Julie Davies, *Reforming the Tort Reform Agenda*, 25 WASH. U. J.L. & POL'Y 119, 120 n.3 (2007) ("[T]ort reform can also occur through judicial decisions, as it did when courts created defenses such as contributory negligence or the fellow servant rule. The first wave of legislative tort reform occurred in the late 1800s in Germany and the United Kingdom and in 1910 in the United States, when workers' compensation legislation was enacted in New York. The second wave occurred in the 1970s, when automobile no-fault legislation was adopted in numerous states. The later waves of tort reform in the 1970s through 1990s have addressed medical malpractice and product liability and virtually all have had the effect of reducing plaintiffs' access to the courts.").

1. State Reform Generally

In an effort to reduce the number of medical malpractice lawsuits filed, state legislatures have enacted a variety of measures recognized as conventional tort reform.[59] While a discussion of the breadth of tort reform is beyond the scope of this article, this section briefly highlights a few of the more popular measures states have deployed. For example, state legislators have enacted laws that limit a plaintiff's access to the courts by shortening statutes of limitations and establishing mandatory screening panels.[60] Legislatures have also modified liability rules by imposing more difficult standards for proving that the physician failed to obtain informed consent, abolishing joint and several liability rules, and abrogating *res ipsa loquitur*.[61]

Another measure some states have taken is requiring more stringent expert review of the case before the plaintiff can file the action.[62] Expert witnesses generally are required for medical malpractice litigation because a plaintiff must use the expert testimony of a qualified member of the same profession to prove that the defendant deviated from the applicable standard of care and caused the plaintiff's injuries.[63] Because expert witnesses are nearly always necessary, requiring the plaintiff to have an expert review the case beforehand and submit an affidavit of merit to the court may not seem like much of a burden on plaintiffs. A plaintiff's failure to satisfy this requirement, however, constitutes grounds for dismissal.[64]

Commentators have opined that these procedural mechanisms "increase the costs of pre-trial preparation, as attorneys must spend more hours accumulating and reviewing all reasonably available medical records relevant to the case at

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59. *See* Williams, *supra* note 31, at 492–493.

60. *Id*. However, screening panels have been either repealed or overturned in several states. *See* MICHELLE M. MELLO & ALLEN KACHALIA, EVALUATION OF OPTIONS FOR MEDICAL MALPRACTICE SYSTEM REFORM: A REPORT TO THE MEDICARE PAYMENT ADVISORY COMMISSION 7 (2010), http://www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf.

61. *See* Studdert et al., *supra* note 48, at 288.

62. *See, e.g.*, N.C. GEN. STAT. § 1A-1, 9(j)(1) (West, Westlaw through S.L. 2018-145) ("The pleading specifically asserts that the medical care and all medical records pertaining to the alleged negligence that are available to the plaintiff after reasonable inquiry have been reviewed by a person who is reasonably expected to qualify as an expert witness under Rule 702 of the Rules of Evidence and who is willing to testify that the medical care did not comply with the applicable standard of care.").

63. *See* B. Sonny Bal, *The Expert Witness in Medical Malpractice Litigation*, 467 CLINICAL ORTHOPEDICS AND RELATED RES. 383, 383 (Feb. 2009), https://link.springer.com/content/pdf/10.1007%2Fsll999-008-0634-4.pdf.

64. *See* Goodheart, *supra* note 7, at 518.

hand."[65] Either the plaintiff or the plaintiff's attorneys must shoulder these costs at an early stage in the litigation.[66] In addition, states have also restricted attorney's fees, required collateral source offsets, and mandated periodic payments rather than permitting plaintiffs to recover lump sum payouts from liable defendants.[67]

2. Damages Caps

The most popular, and most controversial, tort-reform measure state legislatures have deployed are caps on noneconomic damages,[68] which limit what the plaintiff can recover for non-pecuniary loss such as pain and suffering.[69] There are three types of damages that a jury can award in medical malpractice cases: (1) economic damages, (2) noneconomic damages, and (3) punitive damages.[70] Economic damages include pecuniary losses such as past and future medical expenses, past and future lost income,[71] rehabilitation costs, and other financial expenses.[72] Noneconomic damages include pain and suffering, inconvenience, emotional distress, physical impairment or disfigurement, and loss of enjoyment of life that results from the medical negligence.[73] Punitive damages, which are

65. *Id.*

66. *Paying Experts*, AM. B. ASS'N (Winter 1997) ("While many law firms are willing to cover the costs of expert witnesses and hope for reimbursement out of the winnings, it is not uncommon for lawyers to ask clients to help pay the costs up front.").

67. Williams, *supra* note 31, at 493.

68. *See, e.g., The Medical Liability Crisis and Its Impact on Patient Care: Hearing Before the S. Comm. on the Judiciary*, 108th Cong. 8, 10 (2004) (statement of Dr. George Lee of the American Hospital Association); Christine Piette Durrance, *Non-Economic Damage Caps and Medical Malpractice Claims Frequency: A Policy Endogeneity Approach*, 26 J.L. ECON. & ORG. 569, 575 (2009) (noting that the American Tort Reform Association's "ideal package" caps noneconomic damages at $250,000); Eli Engel & Edward H. Livingston, *Solving the Medical Malpractice Crisis*, 145 ARCHIVES SURGERY 296, 299 (2010) ("[The approach] to tort reform . . . pursued most vigorously by physician groups has been the limitation of damage awards.").

69. *See, e.g.*, COLO. REV. STAT. § 13-64-302(1)(I)(b)–(c) (West, Westlaw through 2019 Sess.) (capping noneconomic damages at $300,000).

70. Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515, 516 (2005).

71. Future lost income is determined by "calculat[ing] the lost wages of the claimant by simply determining what wages were being earned at the time of the injury and using the appropriate multiplier to arrive at the [future] lost wages figure." JACOB A. STEIN ON PERSONAL INJURY DAMAGES § 9:5 (3d ed. 1997).

72. Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. REV. 391, 398 (2005).

73. *Id.*; *see, e.g.*, COLO. REV. STAT. § 13-64-302(1)(a)(II)(A); Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN.

"rarely awarded in medical malpractice cases"[74] and often not even permitted for fear of undue influence on the jury,[75] are designed to punish the alleged tortfeasor.[76]

Even if a plaintiff prevails in a medical malpractice case, what damages the plaintiff can recover is limited by statute in most states.[77] In Colorado, for example, damages—both economic and noneconomic—are capped at $1,000,000 in medical malpractice cases.[78] Noneconomic damages are capped at $300,000 for all defendants and are included in the $1,000,000 total damages limit.[79] The $300,000 amount includes both direct noneconomic loss to the injured patient and any derivative claims, such as loss of consortium.[80] If the plaintiff shows good cause, and the court determines application of the one million dollar limitation is unfair, "the court may award in excess of the limitation the present value of additional past and future *economic damages only*."[81] According to the plain language of the statute, this exception only applies to economic damages, and the statute does not permit such flexibility with noneconomic damages.[82] The Colorado General Assembly adopted caps on medical malpractice damages awards to contain "the significantly increasing costs of [medical] malpractice insurance for medical care institutions and licensed medical care professionals"—such cost increases making it necessary, in the legislature's judgment, "to enact this article limited to the area of medical malpractice . . . ."[83]

L. REV. 667, 694 (2006) (noting that noneconomic damages include the real expenses of "adapting the plaintiff to pursue whatever profession or avocation gave the plaintiff's life meaning before the injury").

74. Christine Piette Durrance, *Non-Economic Damage Caps and Medical Malpractice Claims Frequency: A Policy Endogeneity Approach*, 26 J.L. ECON. & ORG. 569, 576 (2009); Theodore Eisenberg et al., *The Predictability of Punitive Damages*, 26 J. LEGAL STUD. 623, 633–37 (1997) (concluding juries are reluctant to award punitive damages in malpractice cases); *see also* Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFF. 1569, 1571 (2010) (estimating punitive damages constitute only 3% of total medical malpractice damages awarded nationwide).

75. Williams, *supra* note 31, at 494.

76. Kelly & Mello, *supra* note 70, at 516.

77. *See Medical Malpractice Damages Caps*, *supra* note 57 (noting 33 states have enacted statutory damages caps that limit recovery in medical malpractice claims).

78. COLO. REV. STAT. § 13-64-302(1)(b).

79. *Id.* § 13-64-302(1)(b)–(c).

80. *See id.*

81. *Id.* § 13-64-302(1)(b) (emphasis added).

82. *See id.*

83. COLO. REV. STAT. § 13-64-102(1) (West, Westlaw through 2019 Sess.).

In addition to Colorado, other states have enacted similar statutes that impose either higher or lower caps on damages.[84] While the noneconomic damages cap is $500,000 in South Dakota and Mississippi, noneconomic damages are capped at $250,000 in Montana and Texas.[85] Some states, such as Tennessee, permit deviation from the limitation when the case involves extenuating circumstances—such as catastrophic injuries or wrongful death actions.[86] Though most states have only limited noneconomic damages, there a few states that have capped all damages recoverable—both economic and noneconomic—in medical malpractice cases.[87] In Nebraska, for instance, the "total amount recoverable . . . in any injury or death of a patient may not exceed . . . two million two hundred fifty thousand dollars for any occurrence after December 31, 2014."[88] The capped damages are allocated between two different sources. The first is the healthcare provider, whose liability is limited to $500,000 per occurrence.[89] The second is the "Excess Liability Fund" created by the Act, which pays the remainder of damages awarded up to the total cap amount.[90] In essence, the Nebraska statute creates a $500,000 cap on liability for negligent healthcare providers in the state.

For the last several decades, noneconomic damages caps have engendered substantial controversy.[91] Proponents of damages caps—primarily physicians and hospital groups—claim these statutory mechanisms reduce costs associated with medical malpractice litigation by avoiding overcompensation of meritorious claims, deterring frivolous claims, and incentivizing settlement.[92] Dissuading plaintiffs' lawyers from bringing meritless lawsuits allegedly decreases the amount insurers are forced to pay in defense costs, which presumably would result in lower premiums.[93] Most importantly, one scholar notes, is that proponents believe "non-economic damages caps would . . . shield insurance

84. Medical Malpractice Damages Caps, supra note 57.

85. S.D. CODIFIED LAWS § 21-3-11 (West, Westlaw through 2019 Sess. Laws, Exec. Order 19-1, & S. Ct. R. 19-18); MISS. CODE ANN. § 11-1-60 (West, Westlaw through 2019 Sess.); MONT. CODE. ANN. § 25-9-411 (West, Westlaw through 2019 Sess.); TEX. REV. CIV. STAT. ANN. § 74.301 (West, Westlaw through 2019 Sess.).

86. TENN. CODE ANN. § 29-39-102(c)–(d) (West, Westlaw through 2019 Sess.).

87. *See e.g.* NEB. REV. STAT. § 44-2825(1) (West, Westlaw through 2019 Sess.).

88. *Id.*

89. *Id.* § 44-2825(2).

90. *Id.* § 44-2825(3).

91. *See* Gfell, *supra* note 6, at 778–79.

92. *See id.*

93. Kyle Miller, *Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law*, 59 VAND. L. REV. 1457, 1478 (2006).

companies from large and unpredictable jury verdicts."[94] These proponents promote damages caps as the most effective reform measure to lower malpractice premiums, often pointing to statistics demonstrating a decrease in total damages plaintiffs have recovered and a marginal increase in physician supply in states with damages caps.[95] In contrast, opponents of damages caps—primarily injured patients and their lawyers—argue that such limitations on recovery, particularly those reducing noneconomic damages awards, are both ineffective[96] and unconstitutional.[97]

C. *Attempts at Federal Reform*

State legislatures are primarily responsible for the medical malpractice reform enacted across the nation. In past years the federal government has attempted—and failed—to enact nationwide tort-reform measures on several occasions. President George W. Bush, backed by a Republican Congress, attempted to pass federal reform in the early 2000s, claiming that frivolous medical malpractice lawsuits were exacerbating rising healthcare costs.[98] In addition to a $250,000 noneconomic damages cap, the federal reform included a more restrictive statute of limitations and permitted judges to evaluate contingency fee arrangements between plaintiffs and their lawyers.[99] This push for reform, not surprisingly, was in response to the escalation of malpractice insurance prices that started in 2001.[100] Studies indicate, however, that the spike in insurance premiums was caused by factors unrelated to the quantity of medical malpractice lawsuits filed or amount of damages awarded.[101] After a change in

94. Lindenfeld, *supra* note 8, at 115.

95. Williams, *supra* note 31, at 494; *see also* Daniel P. Kessler, et al., *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 J. AM. MED. ASS'N 2621 (2005) (indicating states with damages caps experienced a 2.4% increase in physician supply compared to states without caps).

96. *See* Mitchell S. Berger, *Following the Doctor's Orders — Caps on Non-Economic Damages in Medical Malpractice Cases*, 22 RUTGERS L.J. 173, 187–88 (1990).

97. Goodheart, *supra* note 7, at 539–540.

98. *See* Warren Vieth, *Bush Hammers Medical Malpractice Suits*, L.A. TIMES (Jan. 6, 2005), https://www.latimes.com/archives/la-xpm-2005-jan-06-na-bush6-story.html.

99. Andrea Stailey, *The Health Act's Same Old Story, Different Congress Dilemma: Overhauling the Health Act and Unifying Congress as a Remedy For Tort Reform*, 40 TULSA L. REV. 187, 189, 204, 206, 212 (2004).

100. Williams, *supra* note 31, at 483.

101. Bayer, *supra* note 49, at 118. Six factors contribute to higher malpractice insurance prices: increased medical costs, lost profit recovery, prior insufficient profit reserves and pressure from investors to show profit, investment income decrease, market security pressure to raise premiums, decline in the number of malpractice insurers. *Id.* (citation omitted).

White House and congressional composition in 2008, the drive for federal medical malpractice reform quelled for several years.[102]

In 2017, Representative Steve King, a Republican from Iowa's fourth congressional district, introduced the Protecting Access to Care Act of 2017—a bill designed to decrease healthcare costs by cutting down the number of medical malpractice lawsuits filed.[103] The bill is modeled on California's Medical Injury Compensation Reform Act (MICRA), which King claimed reduced defendant liability by an estimated 30% in California.[104] The proposed bill, among other things, mandated additional qualifications for expert witnesses, required plaintiffs to file an affidavit of merit, and imposed a $250,000 cap on non-economic damages.[105]

Opponents of the bill—predominately Democrats[106]—point to statistics showing that the cost of medical malpractice claims as a percentage of total healthcare expenditure decreased 61.9% between 2001 and 2013.[107] John Conyers, House Judiciary Committee lead Democrat Representative, stated "this bill would cause real harm by severely limiting the ability of victims to be made whole."[108] Conyers further explained the impact the Protecting Access to Care Act would have on certain groups of injured patients:

> The bill's $250,000 aggregate limit for noneconomic damages—an amount established more than 40 years ago pursuant to a California statute—would have a particularly adverse impact on women, children, the poor, and other vulnerable members of society. These groups are more likely to receive noneconomic damages in health care cases because they are less able to establish lost wages and other economic losses.[109]

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102. Williams, *supra* note 31, at 483.

103. Protecting Access to Care Act, H.R. 1215, 115th Cong. (1st Sess. 2017).

104. CAL. CIV. CODE § 3333.2; *see also H.R. 1215: Protecting Access to Care Act of 2017*, GOVTRACK (last visited May 3, 2018), https://www.govtrack.us/congress/bills/115/hr1215/summary.

105. H.R. 1215, 115th Cong. (2017).

106. *See H.R. 1215: Protecting Access to Care Act of 2017*, GOVTRACK, https://www.govtrack.us/congress/bills/115/hr1215/summary (last visited May 3, 2018) (Ted Poe, Republican Representative from Texas, is the only member of the House Judiciary Committee who crossed party lines and voted against the Protecting Access to Care Act).

107. *Id.* (citing Taylor Lincoln, *Medical Malpractice Payments Remained at Historic Low in 2013 Despite Slight Uptick,* PUBLIC CITIZEN (2014), https://www.citizen.org/wp-content/uploads/migration/medical-malpractice-2013.pdf).

108. *Id.*

109. *Id.*

While the bill passed the House by a razor-thin margin, the chance of enactment was always low.[110] And because the bill was never passed by the Senate, it died this past January (2019) in the 115th Congress.[111]

Attempts to pass federal legislation that would reform medical malpractice litigation have been largely ineffective. In addition to the political difficulties of enacting nationwide medical malpractice reform, federal legislation that preempts state medical malpractice laws would also trigger a variety of constitutional challenges. Although the Supreme Court has not definitively ruled on the constitutionality of noneconomic damages caps in medical malpractice cases, a substantial amount of scholarship indicates such caps implicate fundamental rights protected by the Constitution.[112] Accordingly, the next section discusses how these statutory limitations on noneconomic recovery violate the Seventh Amendment's guarantee of a jury trial in certain civil cases.

II. CONSTITUTIONAL DEFICIENCIES OF CAPPING NONECONOMIC DAMAGES

Since the early days of medical malpractice reform, plaintiffs have challenged caps on noneconomic damages on various constitutional grounds, including the right to a jury trial, due process, equal protection, and separation of powers.[113] With regard to whether these caps violate the right to a jury trial in certain civil cases, opponents of caps point out that Blackstone's Commentaries clearly support medical negligence as a common law cause of action.[114]

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110. *See H.R. 1215: Protecting Access to Care Act of 2017*, GOVTRACK, https://www.govtrack.us/congress/votes/115-2017/h337 (last visited Oct. 31, 2018).

111. *See H.R. 1215: Protecting Access to Care Act of 2017,* GOVTRACK, https://www.govtrack.us/congress/bills/115/hr1215 (last visited Jan. 12, 2019).

112. *See* Kelly & Mello, *supra* note 70, at 518, 520–21 (explaining that right to jury trial challenges have enjoyed varied success across the states); s*ee also, e.g.,* Kenneth Owen O'Connor, *Funeral for a Friend: Will the Seventh Amendment Succumb to a Federal Cap on Non-Economic Damages in Medical Malpractice Actions?*, 4 SETON HALL CONST. L.J. 97, 145–147, 156 (1993) (noting the right to trial by jury is a common challenge to caps and although many caps have been upheld, it has been on "shaky" grounds including the assumption that "the language of the Seventh Amendment was directed only to the court, thereby, expressing the intent of the framer's to permit legislative encroachment on the jury right").

113. Kelly & Mello, *supra* note 70, at 518.

114. *See, e.g.,* Bradley A. Bauer, *Don't Stop 'Til the Medical Malpractice Victim Gets Enough:* Watts v. Lester E. Cox Med. Ctrs., *376 S.W.3d 633 (Mo. 2012), and Why Caps on Noneconomic Damages Violate the Right to Trial by Jury in Medical Malpractice Case*, 38 S. ILL. U. L.J. 491, 507 (2014); *see also* 3 WILLIAM BLACKSTONE, COMMENTARIES 122–23 (William C. Jones ed. 1916); Klotz v. St. Anthony's Med. Ctr., 311 S.W.3d 752, 755 (Mo. 2010) (Wolff, J., concurring) ("Civil actions for damages resulting from personal wrongs have been tried by juries since 1820.").

Nonetheless, state courts have varied in deciding these challenges.[115] The Washington, Alabama, and Florida high courts have held that noneconomic damages caps violate the right to a jury trial.[116] Meanwhile, the state supreme courts that have validated noneconomic damages caps as constitutional include Nebraska, Idaho, Ohio, and Maryland.[117]

Despite some success in defending against these challenges, the constitutionality of noneconomic damages caps remains questionable and hotly contested.[118] Challenges brought under equal protection have also enjoyed limited success.[119] Analyzing each of the constitutional defects attendant with limiting an injured patient's noneconomic recovery—including equal protection, due process, and access to the courts—would turn this article into a longwinded piece more closely resembling a treatise. That is not the purpose of this article. Rather, this part focuses on how altering the jury's determination of damages by artificially limiting an injured patient's noneconomic recovery flies in the face of one particular bedrock principle in the Constitution—the Seventh Amendment's guarantee of the right to trial by jury in certain civil cases.

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115. Bauer, *supra* note 114, at 494.

116. *See* Sofie v. Fibreboard Corp., 771 P.2d 711, 712 (Wash. 1989); Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156, 164 (Ala. 1991); Smith v. Dep't of Ins., 507 So. 2d 1080, 1083, 1088–89 (Fla. 1987). *See also* Lakin v. Senco Prod., Inc., 987 P.2d 463 *overruled by* Horton v. Oregon Health & Sci. Univ., 376 P.3d 998, 1044, 1046 (Or. 2016) (Oregon previously held cap on noneconomic damages violated the right to trial by jury but recently reversed its position, holding caps constitutionally valid).

117. *See* Gourley *ex rel.* Gourley v. Nebraska Methodist Health Sys., Inc., 663 N.W.2d 43, 75, 78 (Neb. 2003); Kirkland v. Blaine Cty. Med. Ctr., 4 P.3d 1115, 1116, 1120 (Idaho 2000); Arbino v. Johnson & Johnson, 98 Ohio St. 3d 468, 469, 2007-Ohio-6948, 880 N.E.2d 420, 426, at ¶ 8; Murphy v. Edmonds, 601 A.2d 102, 118 (Md. 1992).

118. *See generally* Y. Peter Kang, *4 Tort Reform Challenges to Watch*, LAW360 (Jan. 29, 2018), https://www.law360.com/articles/1002005/4-tort-reform-challenges-to-watch.

119. *See* Kelly & Mello, *supra* note 70, at 522. Although not bound by the federal three-tier equal protection standard, state courts generally have used rational basis review to validate caps on noneconomic damages under their state constitutions. Goodheart, *supra* note 7, at 539. The Supreme Court of New Hampshire, however, deemed rational basis review inappropriate because of the important rights medical malpractice involved. Carson v. Maurer, 424 A.2d 825, 830 (N.H. 1980) *overruled by* Cmty. Res. for Justice, Inc. v. City of Manchester, 917 A.2d 707 (N.H. 2007). Rather, the court invalidated the cap under a form of intermediate scrutiny, requiring that the "challenged classifications are reasonable and have a fair and substantial relation to the object of the legislation." *Id.* at 831. *Carson*, however, was overruled to the extent that it deployed intermediate scrutiny. *See* Cmty. Res. for Justice, Inc. v. City of Manchester, 917 A.2d 707, 719 (N.H. 2007). Alabama, Florida, and New Hampshire are the only states where the respective high courts have invalidated noneconomic damages caps on equal protection grounds. Goodheart, *supra* note 7, at 539 n.170.

A. *Constitutional Right to a Jury Trial*

The right to a jury trial is of paramount importance to American government and constitutional law. It played a pivotal role both in the birth of our country and ratification of the Constitution. The Declaration of Independence accused the Crown of, *inter alia*, "depriving us in many cases, of the Benefits of trial by jury."[120] When "the jury right was threatened in the colonial era, citizen reaction was generally swift and hostile."[121] The nation's founders considered the right to a jury trial essential to democratic government—it was the only right universally protected in all thirteen original state constitutions.[122] Indeed, the "nascent American nation demonstrated at virtually every important step in its development that trial by jury was the form of trial in civil cases to which people and their politicians were strongly attached."[123] Without the guarantee of the Seventh Amendment's right to trial by jury, the Constitution most likely would never have been ratified: "One of the strongest objections originally taken against the [C]onstitution of the United States, was the want of an express provision securing the right of trial by jury in civil cases."[124]

In addition to securing ratification of the Constitution, the founders included the Seventh Amendment's right to a jury trial in the Bill of Rights to guarantee that lawmakers did not obstruct the jury's inherent prerogatives.[125] "Maintenance of the jury as a fact-finding body is of such importance and occupies so firm a place in our history and jurisprudence that any seeming curtailment of the right to a jury trial should be scrutinized with the utmost care."[126] The Seventh Amendment's right to trial by jury is a "fundamental and sacred [right]" which "should be jealously guarded by the courts."[127]

Despite the critical importance of the jury trial right in civil cases, it does not apply to every cause of action. In *Markman v. Westview Instruments, Inc.*, the

120. THE DECLARATION OF INDEPENDENCE para. 20 (U.S. 1776); *accord* Parklane Hosiery Co. v. Shore, 439 U.S. 322, 340 (1979) (Rehnquist, J., dissenting) (explaining the "extensive use of vice-admiralty courts by colonial administrators to eliminate the colonists' right of jury trial" led to complaints against England).

121. Stephan Landsman, *The Civil Jury in America: Scenes from an Unappreciated History*, 44 HASTINGS L.J. 579, 594 (1993).

122. *See Parklane Hosiery Co.*, 439 U.S. at 341 (Rehnquist, J., dissenting).

123. Charles W. Wolfram, *The Constitutional History of the Seventh Amendment*, 57 MINN. L. REV. 639, 656 (1973).

124. Parsons v. Bedford, 28 U.S. (3 Pet.) 433, 446 (1830).

125. Wolfram, *supra* note 123, at 664, 671–672; *see also* Alan Howard Scheiner, *Judicial Assessment of Punitive Damages, the Seventh Amendment, and the Politics of Jury Power*, 91 COLUM. L. REV. 142, 146–47 (1991).

126. Dimick v. Schiedt, 293 U.S. 474, 486 (1935).

127. Jacob v. City of New York, 315 U.S. 752, 752–53 (1942).

Supreme Court established a two-part test, grounded in historical analysis, for determining whether the Seventh Amendment right to trial by jury applies in a particular case: (1) "whether we are dealing with a cause of action that either was tried at law at the time of the founding or is at least analogous to one that was"; and (2) "whether the particular trial decision must fall to the jury in order to preserve the substance of the common-law right as it existed in 1791."[128] As to the first *Markman* question, the historical inquiry clearly supports application of the Seventh Amendment to medical malpractice cases. As noted above, medical malpractice has deep roots in both English and American common law.[129] Actions for medical malpractice were recognized at common law before the founding of our nation, and these cases were tried before juries.[130]

As for the second part of the *Markman* inquiry, the Seventh Amendment preserves the jury's indisputable prerogative to determine and award damages. The assessment of compensatory damages, which includes "damages for pain and suffering," concerns "only a question of fact."[131] And, as the Court recognized in *Feltner v. Columbia Pictures Television*, juries are the "judges of the damages."[132] Longstanding precedent establishes that a "court has no authority . . . in a case in which damages for a tort have been assessed by a jury at an entire sum, . . . to enter an absolute judgment for any other sum than that assessed by the jury [unless] the plaintiff elected to remit the rest of the damages."[133] The incontrovertible prerogative of the jury to determine damages has been established at least since the time of Sir Edward Coke—that is, at the turn of the sixteenth century.[134] According to Coke,[135] tort "Dammages" are "the

128. Markman v. Westview Instruments, Inc., 517 U.S. 370, 376 (1996).

129. *See supra* Section I.A.

130. *See* Weidrick v. Arnold, 835 S.W.2d 843, 846 (Ark. 1992); Wright v. Central DuPage Hosp. Ass'n, 347 N.E.2d 736, 742 (Ill. 1976); Allan McCoid, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549, 550 (1959).

131. St. Louis, Iron Mountain, & S.R. Co. v. Craft, 237 U.S. 648, 661 (1915), *cited with approval in* Cooper Indus., Inc. v. Leatherman Tool Group, Inc., 532 U.S. 424, 437 (2001).

132. Feltner v. Columbia Pictures Television, 523 U.S. 340, 353 (1998) (quoting Townsend v. Hughes (1677) 86 Eng. Rep. 994, 994–95; *see also* Dimick v. Schiedt, 293 U.S. 474, 486 (1935) (plaintiffs "remain entitled . . . to have a jury properly determine the question of liability and the extent of the injury by an assessment of damages. Both are questions of fact.").

133. Kennon v. Gilmer, 131 U.S. 22, 29–30 (1889).

134. *See* Austin Scott, *Trial by Jury and the Reform of Civil Procedure*, 31 HARV. L. REV. 669, 675 (1918).

135. Lord Coke was "widely recognized by the American colonists 'as the greatest authority of his time on the laws of England.'" Payton v. New York, 445 U.S. 573, 594 (1980) (quoting A.E. DICK HOWARD, THE ROAD FROM RUNNYMEDE: MAGNA CARTA AND CONSTITUTIONALISM IN AMERICA 119 (1968)); *see also* Pacific Mut. Life Ins. Co. v. Haslip, 499 U.S. 1, 29 (1991) (Scalia, J., concurring).

[recompense] that is given by the jury to the [plaintiff] . . . for the wrong the defendant hath done unto him."[136] Lord Coke's commentary on Magna Carta, from which the jury trial right is derived, "was widely accepted and imported by early American colonists where it was incorporated it into state constitutions."[137] Similarly, Sir William Blackstone[138] emphasized it is within the province of the jury to "assess the damages . . . sustained by the plaintiff in consequence of the injury."[139] Accordingly, if "damages are to be recovered, a jury must . . . assess them."[140]

The Court previously has—on repeated occasions—highlighted the historical foundation of the right to trial by jury in certain civil cases:

> "[B]y the law the jury are judges of the damages." *Lord Townshend v. Hughes*, 86 Eng. Rep. 994, 994-995 (C.P. 1677). Thus in *Dimick v. Schiedt*, 293 U.S. 474 (1935), the Court stated that "the common law rule as it existed at the time of the adoption of the Constitution" was that "in cases where the amount of damages was uncertain[,] their assessment was a matter so peculiarly within the province of the jury that the Court should not alter it." Id., at 480. And there is overwhelming evidence that the consistent practice at common law was for juries to award damages.[141]

The Court has further recognized that the amount of damages that may be due in actions cognizable at common law "has always been left to the discretion of the jury."[142] To be sure, "nothing is better settled than that, in . . . actions for torts where no precise rule of law fixes the recoverable damages, it is the peculiar function of the jury to determine the amount by their verdict."[143] As the *Feltner* Court made clear, the Seventh Amendment "includes the right to have a jury

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136. 2 EDWARD COKE, THE FIRST PART OF THE INST. OF THE LAWS OF ENGLAND § 257a (London, 19th ed. 1832) (1628).

137. 1 JENNIFER FRIESEN, STATE CONSTITUTIONAL LAW: LITIGATING INDIVIDUAL RIGHTS, CLAIMS, AND DEFENSES § 6.02[1] n.15 (4th ed. 2006).

138. If any English scholar can be compared with Coke for his impact on American understanding of the common law, it was Blackstone. Blackstone's Commentaries were considered "the most satisfactory exposition of the common law of England . . . undoubtedly the framers of the Constitution were familiar with it." Schick v. United States, 195 U.S. 65, 69 (1904).

139. 3 WILLIAM BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND 376 (1766).

140. *Id.*at 397.

141. Feltner v. Columbia Pictures Television, 523 U.S. 340, 353 (1998) (internal marks and citations omitted).

142. Day v. Woodworth, 54 U.S. 363, 371 (1851).

143. Barry v. Edmunds, 116 U.S. 550, 565 (1886); *see also* Pacific Mut. Life Ins. Co. v. Haslip, 499 U.S. 1, 16 (1991).

determine the amount of . . . damages" and "if a party so demands, a jury must determine the actual amount of . . . damages."[144] In sum, "from the beginning of trial by jury," damages and juries went hand-in-hand with the "amount of damages . . . a 'fact' to be found by the jurors."[145]

Despite the undisputed role of the jury in assessing liability and determining damages, the three federal circuit courts that have addressed whether damages caps violate the Seventh Amendment have responded in the negative.[146] The Eight Circuit and Sixth Circuit, relying almost exclusively on the Fourth Circuit's decision in *Boyd v. Bulala*, have held the jury's duty is complete when it renders its verdict, and the subsequent revision of damages pursuant to state law does not violate the Seventh Amendment.[147] In *Boyd*, the Fourth Circuit adopted the reasoning of the Virginia Supreme Court in applying the state's constitutional jury trial right to uphold a Virginia medical malpractice damages cap against a Seventh Amendment challenge.[148] The court—devoting a mere two paragraphs to the issue—found that while "it is the role of the jury as factfinder to determine the extent of a plaintiff's injuries . . . it is not the role of the jury to determine the legal consequences of its factual findings."[149] The Fourth Circuit further proffered that damages caps do not violate the Seventh Amendment because the legislature may permissibly limit damages for a cause of action it may permissibly abolish.[150]

By holding the jury's role is completed upon a verdict, and courts can then apply the law, *Boyd* and its progeny stand for the proposition that a state legislature may override the Seventh Amendment by amending the common law of damages. The Fourth Circuit's reasoning in *Boyd*—and consequently those of

144. *Feltner*, 523 U.S. at 353, 355.

145. Charles T. McCormick, HANDBOOK ON THE LAW OF DAMAGES 24 (1935).

146. *See e.g.,* Schmidt v. Ramsey, 860 F.3d 1038, 1046 (8th Cir. 2017) (upholding Nebraska's damages cap that reduced the plaintiff's $17 million jury verdict by almost 90% to $1.75 million); Smith v. Botsford Gen. Hosp., 419 F.3d 513, 519 (6th Cir. 2005) (upholding Michigan's cap that reduced the plaintiff's noneconomic damages from $5,000,000 to $359,000); Boyd v. Bulala, 877 F.2d 1191, 1196 (4th Cir. 1989) (upholding a Virginia statute that capped the plaintiff's multimillion-dollar verdict at $750,000).

147. *Schmidt*, 860 F.3d at 1046 ("We agree with *Boyd* and *Smith*."); *Smith*, 419 F.3d at 519 ("finding [*Boyd*'s] reasoning persuasive"); *Boyd*, 877 F.2d at 1196.

148. *Boyd*, 877 F.2d at 1196 (relying on Etheridge v. Med. Ctr. Hosp., 376 S.E.2d 525, 529 (1989)).

149. *Boyd*, 877 F.2d at 1196. Following suit, the Eighth Circuit recently held the Nebraska damages cap "does not determine damages in the first instance. The jury in this case performed its historical role by finding liability and assessing damages. The Nebraska cap imposed an upper legal limit on that jury determination . . . and the district court applied that limit as a matter of law." *Schmidt*, 860 F.3d at 1045.

150. *Boyd*, 877 F.2d at 1196.

its sister circuits, which have adopted that reasoning wholesale[151]—is shaky at best. First, as noted above, *Boyd* relied primarily on the Virginia Supreme Court's decision in *Etheridge v. Medical Center Hospitals*, which addressed the right of trial by jury under the Virginia Constitution.[152] The problem with the Fourth Circuit's reliance on *Etheridge* is that the civil jury trial provision in Virginia's Constitution is less mandatory than both the Federal Constitution and other state constitutions. Virginia's Constitution provides that "trial by jury is *preferable* to any other."[153] Due to this unique constitutional language, other state courts have criticized the Virginia Supreme Court's decision in *Etheridge* as "poorly reasoned."[154]

Second, *Boyd* found support for its holding in a misreading of the Supreme Court's decision in *Tull v. United States*.[155] The Fourth Circuit also erroneously relied on *Tull* for the proposition that "the right to a jury trial may not even extend to the 'remedy phrase of a civil trial.'"[156] The Court, however, unanimously rejected that reading of *Tull* in *Feltner*.[157] In *Feltner*, the respondent contended that the Seventh Amendment "does not provide a right to a jury determination of the amount of the award."[158] To support this argument, the respondent cited *Tull*, which held "that Congress could constitutionally authorize trial judges to assess the amount of the civil penalties" following the jury's determination of liability under the Clean Water Act.[159]

The *Feltner* Court disagreed, explaining that *Tull* dealt with the application of the Seventh Amendment to an action under a statutory right of action—the Clean Water Act—not a cause of action recognized at common law.[160] Because of the critical distinction between statutory causes of actions and those recognized at common law for purposes of the jury trial right, the Court labeled *Tull* "inapposite" to claims—such as medical malpractice—that satisfy the Seventh Amendment's historical test.[161] The Court also noted that *Tull* conflicts

151. *Schmidt*, 860 F.3d at 1046 ("We agree with *Boyd* and *Smith*."); *Smith*, 419 F.3d at 519 ("finding [*Boyd*'s] reasoning persuasive"); *Boyd*, 877 F.2d at 1196.

152. *Id.* n.4 ("The *Etheridge* court was addressing the right of trial by jury under the Virginia Constitution, *see* 376 S.E.2d at 528, but we think its reasoning applies here as well.").

153. VA. CONST. art. I, § 11 (emphasis added).

154. *See e.g.,* Sofie v. Fibreboard Corp., 771 P.2d 711, 724 (Wash. 1989); *see also e.g.,* Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156, 163 (Ala. 1991).

155. *See generally* Tull v. United States, 481 U.S. 412, 427 (1987).

156. Boyd v. Bulala, 877 F.2d 1191, 1196 n.5 (4th Cir. 1989) (quoting *Tull*, 481 U.S. at 426 n.9).

157. Feltner v. Colombia Pictures Television, Inc., 523 U.S. 340, 354–55 (1998).

158. *Id.* at 354.

159. *Id.*

160. *Id.* at 354–55.

161. *See id.* at 355.

with *Bank of Hamilton v. Lessee of Dudley*,[162] which held "in light of the Seventh Amendment that a jury must determine the amount of compensation for improvements to real estate," and with *Dimick v. Schiedt*,[163] which held "that the Seventh Amendment bars the use of additur."[164] Thus, under *Feltner*, "a jury must determine the actual amount of . . . damages" in order "to preserve the substance of the common-law right of trial by jury"[165] in medical malpractice cases.

B. *Incorporation of the Seventh Amendment*

Once a constitutional right has been incorporated, it must "be enforced against the States under the Fourteenth Amendment according to the same standards that protect those personal rights against federal encroachment."[166] The Supreme Court has not directly addressed whether the Seventh Amendment qualifies for application to the states since 1875, where it rejected incorporation by giving the Fourteenth Amendment an exceedingly narrow scope.[167] In *Palko v. Connecticut*, the Court, in dicta, adhered to its position against incorporation of the Seventh Amendment.[168] *Palko*, which held the Fourth Amendment was not applicable to the states, was subsequently overruled by *Wolf v. Colorado*[169] and *Mapp v. Ohio*.[170] To be sure, "*Palko* represented an approach to basic constitutional rights which this Court's recent decisions have rejected."[171] And since that time, the Court has found the majority of the Bill of Rights apply to the states through the Fourteenth Amendment.[172]

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162. *See generally* Bank of Hamilton v. Lessee of Dudley, 27 U.S. 492 (1829).

163. *See generally* Dimick v. Schiedt, 293 U.S. 474 (1935). *See also* Hetzel v. Prince William County, 523 U.S. 208, 211 (1998) ("[R]equiring the District Court to enter judgment for a lesser amount than that determined by the jury without allowing petitioner the option of a new trial, cannot be squared with the Seventh Amendment [jury-trial guarantee].").

164. Feltner v. Columbia Pictures Television, Inc., 523 U.S. 340, 355 n.9 (1998).

165. *Id.* at 355.

166. McDonald v. City of Chicago, 561 U.S. 742, 765 (2010) (quoting Malloy v. Hogan, 378 U.S. 1, 10 (1964)).

167. *See* Walker v. Sauvinet, 92 U.S. 90, 92 (1875). The Court's decision in *Walker* came on the heels of the *Slaughterhouse Cases*, 83 U.S. 36 (1873), which has often been criticized for unduly restricting constitutional liberties. *See* Richard L. Aynes, *Constricting the Law of Freedom: Justice Miller, the Fourteenth Amendment, and the Slaughter-House Cases*, 70 CHI.-KENT L. REV. 627, 644–51 (1994).

168. Palko v. Connecticut, 302 U.S. 319, 324–26 (1937).

169. *See* Wolf v. Colorado, 338 U.S. 25, 27–28 (1949).

170. *See* Mapp v. Ohio, 367 U.S. 643, 660 (1961).

171. Benton v. Maryland, 395 U.S. 784, 794 (1969).

172. *See* Duncan v. Louisiana, 391 U.S. 145, 148 (1968) ("[M]any of the rights guaranteed by the first eight Amendments to the Constitution have been held to be protected against state action by the Due Process Clause of the Fourteenth Amendment.").

The Court's decision in *Walker* analyzed incorporation of the Bill of Rights through an entirely distinct lens from the modern selective incorporation doctrine.[173] In *United States v. Cruikshank*, which was decided the same year as *Walker*, the Court held the Second Amendment only limited federal interference with the right to bear arms and did not restrict state action.[174] The Court in 1886, relying on *Cruikshank* and other case law, once again announced that the Second Amendment "has no other effect than to restrict the powers of the national government."[175] In *Heller v. District of Columbia*, the Court recognized the departure from its anachronistic doctrine of incorporation utilized at the time of *Cruikshank*.[176] "With respect to *Cruikshank's* continuing validity on incorporation, a question not presented by this case, we note that *Cruikshank* also said that the First Amendment did not apply against the States and did not engage in the sort of Fourteenth Amendment inquiry required by our later cases."[177] The *Heller* Court's dicta regarding Second Amendment incorporation put lower courts on notice that mere reliance on *Cruikshank*—and, by extension, the other incorporation cases of that time—was no longer appropriate. Indeed, following *Heller*, lower federal courts "can best perform their role in our hierarchical judicial system by treating the Supreme Court's modern incorporation jurisprudence as law."[178] As Professor Nelson Lund has noted, "[t]here is no legal requirement that lower courts 'wait' for the Supreme Court to apply the [selective incorporation] test to the right to keep and bear arms."[179]

Two years after *Heller*, the Court formally recognized incorporation of the Second Amendment in *McDonald v. City of Chicago*.[180] In holding the Second Amendment applies to the states, *McDonald* explicated the historical foundation of the right to bear arms and evolution of the incorporation doctrine. As *McDonald* explained, the Court repeatedly rejected incorporation of any particular provision of the Bill of Rights during the fifty-seven-year period—

173. *See generally* Walker v. Sauvinet, 92 U.S. 90 (1875).

174. *See* United States v. Cruikshank, 92 U.S. 542, 553 (1875).

175. *See* Presser v. Illinois, 116 U.S. 252, 265 (1886).

176. *See* Heller v. District of Columbia, 554 U.S. 570, 620 n.23 (2008).

177. *Id.* The *Heller* Court had no reason to inquire into the incorporation of the Second Amendment because the case concerned legislation in the District of Columbia, a federal jurisdiction.

178. Nelson Lund, *Anticipating Second Amendment Incorporation: The Role of the Inferior Courts*, 59 SYRACUSE L. REV. 185, 187 (2008).

179. *Id.* at 196.

180. *See* McDonald v. City of Chicago, 561 U.S. 742, 767 (2010) ("Our decision in *Heller* points unmistakably to the answer.").

from 1868 until 1925—following the adoption of the Fourteenth Amendment.[181] It was during this period the Court held the Seventh Amendment's guarantee of a civil jury trial did not qualify for application to the states. But since that time (i.e., after 1925), the Court has steadily increased the number of protections under the Bill of Rights which apply to the states through the Fourteenth Amendment's Due Process Clause.[182] Indeed, after *McDonald*, the only Bill of Rights protections "not fully incorporated are (1) the Third Amendment's protection against quartering of soldiers; (2) the Fifth Amendment's grand jury indictment requirement; [3] [the Sixth Amendment right to a unanimous jury verdict;] [4] the Seventh Amendment right to a jury trial in civil cases; and [5] the Eighth Amendment's prohibition on excessive fines."[183] Regarding the Seventh Amendment's civil jury requirement, the Court has specifically recognized that its previous decisions "long predate the era of selective incorporation."[184]

The current test for incorporation articulated in *McDonald* makes clear that the protections of the Seventh Amendment—like the protections of the Second Amendment—should apply against the states. Under the modern incorporation doctrine, "the governing standard is not whether any 'civilized system [can] be imagined that would not accord the particular protection.' . . . Instead, the Court inquire[s] whether a particular Bill of Rights guarantee is fundamental to our scheme of ordered liberty and system of justice"[185] or "whether this right is 'deeply rooted in this Nation's history and tradition.'"[186] The Supreme Court has frequently described the Seventh Amendment right of trial by jury in civil cases as "fundamental."[187] To be sure, the protection of the Seventh Amendment is essential to the guarantee of a fair trial.[188]

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181. *See id.* at 806, 865 (Thomas, J., concurring) (noting the adoption of the Fourteenth Amendment in 1868 and the "path-marking case of *Gitlow v. New York*" in 1925 where the First Amendment was first incorporated under the Fourteenth Amendment).

182. *See id.* at 764–65 n.12.

183. *Id.* at 765, 765 n.13.

184. *Id.* at 765 n.13.

185. McDonald v. City of Chicago, 561 U.S. 742, 764 (2010) (quoting Duncan v. Louisiana, 391 U.S. 145, 149 n.14) (1968)) (emphasis omitted).

186. *Id.* at 767 (quoting Washington v. Glucksberg, 521 U.S. 702, 721 (1997)).

187. *See, e.g.*, Jacob v. New York City, 315 U.S. 752, 752–53 (1942) (explaining that the "right of jury trial in civil cases" is a "right so fundamental and sacred to the citizen [that it] should be jealously guarded by the courts"); Hodges v. Easton, 106 U.S. 408, 412 (1882) (holding that "trial by jury is a fundamental guaranty of the rights and liberties of the people"); *see also* Parklane Hosiery Co., Inc. v. Shore, 439 U.S. 322, 338 (1979) (Rehnquist, J., dissenting) ("The right of trial by jury in civil cases at common law is fundamental to our history and jurisprudence.").

188. *See* Simler v. Conner, 372 U.S. 221, 222 (1963); Byrd v. Blue Ridge Rural Elec. Coop., Inc., 356 U.S. 525, 537–39 (1958).

Central to the *McDonald* Court's determination that the Second Amendment applies against the states through the Fourteenth Amendment is the historical significance and ubiquity of the right.[189] Under that same criteria, the historical context of the civil jury trial demonstrates an even stronger prerogative for incorporation. The guarantee of trial by jury in civil cases is "of ancient origin,"[190] and the right was preserved in Magna Carta:

> No Freeman shall be taken, imprisoned, disseised, outlawed, banished, or in any way destroyed, nor will We proceed against or prosecute him, except by the lawful judgment of his peers and by the law of the land.[191]

McDonald emphasized that "Blackstone was able to assert that the right to keep and bear arms was 'one of the fundamental rights of Englishmen.'"[192] In similar fashion, Blackstone proclaimed that the right to trial by jury is the "principal bulwark of our liberties," "the glory of the English law," and "the most transcendent privilege which any subject can enjoy."[193] There is no doubt the civil jury right was a fundamental guarantee of British common law.

As discussed above, preservation of the right to trial by jury in civil cases also was a hallmark guarantee in the American colonies. As Justice Story aptly noted: "The trial by jury in all cases, civil and criminal, was as firmly, and as universally established in the colonies, as in the mother country."[194] Indeed, "the right of trial by jury was held in such esteem by the colonists that its deprivation at the hands of the English was one of the important grievances leading to the break with England."[195] Inclusion of the Seventh Amendment in the Bill of Rights played a critical role in the ratification of the Constitution.[196] Eighty years later, Congress ratified the Fourteenth Amendment. At this time, the state constitutions of "[t]hirty-six states out of thirty-seven . . . guaranteed the right to

189. *See McDonald*, 561 U.S. at 767 ("Self-defense is a basic right, recognized by many legal systems from ancient times.").

190. Dimick v. Schiedt, 293 U.S. 474, 485 (1935).

191. *Magna Carta of King John*, Chap. 39 (1215).

192. *McDonald*, 561 U.S. at 768.

193. 3 WILLIAM BLACKSTONE, COMMENTARIES ON THE COMMON LAW OF ENGLAND 350, 379 (1765).

194. 1 JOSEPH STORY, COMMENTARIES ON THE CONSTITUTION OF THE UNITED STATES § 165 (Ronald D. Rotunda & John E. Nowak, ed. 1987) (1833).

195. Parklane Hosiery Co., Inc. v. Shore, 439 U.S. 322, 340 (1979) (Rehnquist, J., dissenting).

196. *See supra* notes 115–19 and accompanying text; *cf. McDonald*, 561 U.S. at 768 ("[T]hose who were fearful that the new Federal Government would infringe traditional rights such as the right to keep and bear arms insisted on the adoption of the Bill of Rights as a condition for ratification of the Constitution. . . . This is surely powerful evidence that the right was regarded as fundamental in the sense relevant here.").

jury trials in all civil or common law cases."[197] That is, "98% of all Americans in 1868 lived in jurisdictions where they had a fundamental state constitutional right to jury trial in all civil or common law cases."[198] By comparison, only "22 of the 37 States in the Union had state constitutional provisions explicitly protecting the right to keep and bear arms."[199] The Supreme Court, nonetheless, held that the right to keep and bear arms was one of the "foundational rights necessary to our system of Government" and "among those fundamental rights necessary to our system of ordered liberty."[200]

Whether the Seventh Amendment's right to trial by jury is applicable to the states has not been briefed or argued under the Court's current incorporation jurisprudence. The Court's recent decisions, however, demonstrate that *Walker*—which was decided under a completely different incorporation doctrine the Court has since backed away from—does not foreclose application of the Seventh Amendment's guarantee of civil jury trial to the states. Rather, under the doctrine of selective incorporation, as illustrated by the Court's decisions in *Heller* and *McDonald*, the Seventh Amendment undoubtedly qualifies for incorporation through the Fourteenth Amendment. Any argument against incorporation of the Seventh Amendment right to trial by jury in civil cases "is nothing less than a plea to disregard 50 years of incorporation precedent and return . . . to a bygone era."[201]

Several comments and questions during the recent oral argument in *Timbs v. Indiana*, which concerns whether the Eighth Amendment's excessive fines clause is incorporated against the states under the Fourteenth Amendment, may best reflect the Court's general feelings on incorporation.[202] Justice Gorsuch (rhetorically) asked: "Well, whatever the Excessive Fine Clause guarantees, we can argue, again, about its scope and in rem and in personam, but whatever it, in fact, is, it applies against the states, right?"[203] After observing that most of the cases holding that the Bill of Rights are incorporated "took place in like the 1940s," Justice Gorsuch implored: "And here we are in 2018 . . . still litigating incorporation of the Bill of Rights. Really? Come on . . . . "[204]

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197. Steven G. Calabresi & Sarah E. Agudo, *Individual Rights Under State Constitutions When the Fourteenth Amendment Was Ratified in 1868: What Rights Are Deeply Rooted in American History and Tradition?*, 87 TEXAS L. REV., 2008, at 7, 77.

198. *Id.*

199. McDonald v. City of Chicago, 561 U.S. 742, 777 (2010).

200. *Id.* at 777–78.

201. *Id.* at 780.

202. *See* Transcript of Oral Argument at 33, Timbs v. Indiana, No. 17-1091 (Nov. 28, 2018).

203. *See id.* at 32.

204. *Id.* at 32.

In similar fashion, Justice Kavanaugh continued: "Isn't it just too late in the day to argue that any of the Bill of Rights is not incorporated?"[205] Thomas Fisher, the Indiana solicitor general arguing on behalf of the state, responded that the "Court has never incorporated a right against the states where it could not conclude that there was a relationship that was fundamental or—and deeply rooted in our history and tradition."[206] But, Justice Kavanaugh replied, "aren't all—all the Bill of Rights at this point in our conception of what they stand for, the history of each of them, incorporated?"[207] Not surprisingly the *Timbs* Court—in an opinion that regarded the question presented as an easy one—unanimously held that the Eighth Amendment's excessive fines clause is an incorporated protection applicable to the states under the Fourteenth Amendment.[208] Under the Court's modern incorporation doctrine, the guarantee of the civil jury right in medical malpractice cases should likewise apply with equal force to the states and mandate the invalidation of caps on noneconomic damages. I mean, Really? Come on.

III. IMPACT OF REFORM

In addition to the constitutional deficiencies of noneconomic damages caps, the controversy surrounding these caps also involves: (1) whether they actually decrease medical malpractice insurance premiums, (2) whether they reduce healthcare costs, and (3) the negative impact these limitations have on injured patients. The healthcare industry continues to support noneconomic damages caps as the solution to rising malpractice premiums and healthcare costs despite empirical evidence indicating otherwise.[209] While the stated purpose of medical malpractice reform is to control malpractice insurance rates and, consequently, healthcare costs by "prevent[ing] frivolous malpractice claims"[210] and averting huge jury awards,[211] such reform more often only hinders an injured patient's ability to bring a meritorious claim. While noneconomic damages caps undoubtedly decrease the number of medical malpractice claims filed, they also widen the social justice gap by preventing certain groups of individuals—namely women, children, the elderly, and the poor—from having their day in court.

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205. *Id.* at 33.

206. *See id.*

207. *Id.*

208. *See* Timbs v. Indiana, 139 S. Ct. 682, 698 (2019).

209. *See, e.g.*, Berger, *supra* note 96, at 187–88 (explaining National Association of Insurance Commissioners report that damages "caps are not likely to affect malpractice insurance premiums greatly").

210. *See, e.g.*, Moore v. Proper, 726 S.E.2d 812, 817 (N.C. 2012).

211. *See* Lindenfeld, *supra* note 8, at 115.

A. *Insurance Premiums and Healthcare Costs*

Proponents of noneconomic damages caps claim that medical malpractice claims are the driving force behind high healthcare costs[212] and unavailability of quality care.[213] While these supporters believe statutory limitations that restrict the amount plaintiffs can recover for pain and suffering are the solution, the empirical data behind such assertions is inconclusive at best. In fact, non-economic damages caps (along with other conventional tort-reform measures) have had little, if any, effect on either the cost of medical malpractice premiums or healthcare.[214]

Studies indicate that medical malpractice reforms passed in the 1970s and 1980s neither decreased the number of claims filed nor reduced the cost of malpractice insurance premiums.[215] A report conducted by the National Association of Attorneys General (NAAG) found that the "present 'crisis' of unavailability and unaffordability is not caused by the civil justice system but by the unrestrained price cutting recently undertaken by the [insurance] industry when it attempted to obtain as much new business as possible to invest premiums received at the then high interest rates."[216] The NAAG report concluded "[t]here is little evidence that making the changes in the tort system proposed by the federal government and the insurance industry will prevent a similar 'crisis' in the future given the cyclical nature of the insurance industry."[217]

Indeed, one study conducted over a twelve-year period demonstrates that medical malpractice premiums actually rose following the first major wave of reform.[218] States with "damages caps experienced a 48.2% increase in the median

212. *GOP Pushing Malpractice Reform*, ROLL CALL (July 2, 2009, 12:05 PM) http://www.rollcall.com/issues/55_1/-36429-1.html ("Republicans have long argued that the system is weighted against doctors" and "say that limitless damage awards lead to crushing insurance costs for doctors, who pass them along to patients, and that physicians are practicing defensive medicine, which drives up health care costs through unnecessary treatments.").

213. *See* John Wagner, *Malpractice Pinch Has Md. Doctors Mulling Whether to Wait-or Leave*, WASH. POST (Nov. 30, 2004) https://www.washingtonpost.com/archive/local/2004/11/30/malpractice-pinch-has-md-doctors-mulling-whether-to-wait-or-leave/5d3776da-4cf1-42f4-9a0c-16c5cc268137/ (indicating physicians are transferring states in search of lower insurance premiums).

214. *See* Berger, *supra* note 96, at 187.

215. *See* Baker, *supra* note 16, at 54–55.

216. Nat'l Ass'n of Attorneys Gen., AN ANALYSIS OF THE CAUSE OF THE CURRENT CRISIS OF UNAVAILABILITY AND AFFORDABILITY OF LIABILITY INSURANCE 2 (May 1986).

217. *Id.*

218. *See Weiss Ratings: Caps Fail to Contain Malpractice Cost Increases*, S. FLA. BUS. J. (June 2, 2003, 9:43AM), http:// www.bizjournals.com/southflorida/stories/2003/06/02/daily3.html?page=all (finding that only 10.5% of states with damages caps experienced declining

[cost of] premiums," while median premium rates only increased 35.9% in states without caps.[219] Further, in 2003, congressional testimony before the Health of the House Committee on Energy and Commerce revealed that the states with five most expensive malpractice premiums deployed damages caps, whereas the states without damages caps enjoyed the lowest insurance rates.[220] Some scholars claim this phenomenon results from insurance companies "pocketing profits generated by the damages cap" rather than passing the savings along in the form of reduced malpractice premiums.[221]

While it is entirely possible that insurance companies have been the only winners in the debate over medical malpractice reform, the unintended consequences may also be attributed to several other factors. Studies by the U.S. Government Accountability Office (GAO) demonstrate that multiple factors—including rapidly rising reinsurance rates, competition among insurers, and decreased interest rates for investment income—contribute to the cost of medical malpractice insurance.[222] Accordingly, the GAO report indicates that there is not a direct correlation between noneconomic damages caps and lower premiums.[223] This could explain why malpractice insurers continue to raise the price of premiums in states that have enacted a damages cap.[224]

Many courts have corroborated the findings of these studies. As the Supreme Court of Utah observed, "after assessing the factual basis for the so-called malpractice crisis and the legislative findings supporting tort reform legislation, a number of courts held that the crisis did not warrant restricting the rights of individuals injured by malpractice."[225] One justice of that court even described

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or stable malpractice rates, while 18.7% of states without damages caps enjoyed declining or stable insurance premium rates).

219. Lindenfeld, *supra* note 8, at 116; *see also* Patrick A. Salvi, *Why Medical Malpractice Caps Are Wrong*, 26 N. ILL. U. L. REV. 553, 555 (2006).

220. *Assessing the Need to Enact Medical Liability Reform: Hearing on H.R. 5 Before the Subcomm. on Health of the House Comm. on Energy and Commerce*, 108th Cong. 13–14 (2003), http://www.gpo.gov/fdsys/pkg/CHRG-108hhrg86049/pdf/CHRG-108hhrg86049.pdf.

221. Nicholas T. Timm, *From Damages Caps to Health Courts: Continuing Progress in Medical Malpractice Reform*, 2010 MICH. ST. L. REV. 1209, 1216–17 (2010).

222. U.S. Gen. Accounting Office, GAO–03–702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 4–5 (June 2003), http:// www.gao.gov/assets/240/238724.pdf.

223. *See id.* at 41–43.

224. *See* Press Release, Consumer Watchdog, Nation's Largest Medical Malpractice Insurer Declares Caps on Damages Don't Work, https://consumerwatchdog.org/newsrelease/nations-largest-medical-malpractice-insurer-declares-caps-damages-dont-work-raises-docs- (last visited Sept. 28, 2019) (explaining that one Texas insurer increased premiums 19% despite the damages cap).

225. Lee v. Gaufin, 867 P.2d 572, 584 (Utah 1993).

the "assertion of an insurance crisis in Utah . . . [as] a pure sham."[226] Other courts have likewise determined the crisis is nonexistent.[227] The Wyoming Supreme Court aptly described the lack of correlation between medical malpractice and the crisis:

> [T]he absence in the record of any evidence demonstrating the existence of such a crisis in Wyoming or elsewhere. More importantly, we note the absence in the record of any evidence that the "crisis," if in fact it exists, is in any way connected with medical malpractice claims. The statement of purpose contained in the act offers no explanation as to why the legislature's sole response to the insurance "crisis" was to attempt to change commonly recognized procedures and principles related to causes of action in tort. The act is silent as to other conceivable causes of the "crisis" such as poor management, bad underwriting, and bad investments by the insurance industry. Likewise, the act is silent as to other conceivable approaches to solving the alleged crisis such as regulation of the insurance industry. Apparently, tort reform was the only avenue explored by the legislature in its efforts to solve the "crisis."[228]

Deterring frivolous lawsuits filed in hopes of lottery awards is one of the central themes behind the push for tort reform. In the medical malpractice context, however, empirical evidence demonstrates traditional noneconomic damages caps have failed to accomplish this goal.[229] Statistics also indicate that conventional medical malpractice reform has not increased physician availability.[230] For example, the state of Texas has deployed a $250,000

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226. Craftsman Builder's Supply, Inc. v. Butler Mfg. Co., 974 P.2d 1194, 1217 (Utah 1999) (Stewart, J., concurring).

227. *See e.g., In re* Certification of Questions of Law from the United States Ct. of App. for Eighth Cir., Pursuant to Provisions of SDCL 15–24A–1, 544 N.W.2d 183, 190 (S.D. 1996); Sorrell v. Thevenir, 69 Ohio St. 3d 415, 423, 1994-Ohio-38, 633 N.E.2d 504, 515; Crowe v. Wigglesworth, 623 F. Supp. 699, 706 (D. Kan. 1985); Kenyon v. Hammer, 688 P.2d 961, 975–76 (Ariz. 1984); Boucher v. Sayeed, 459 A.2d 87, 92–93 (R.I. 1983); Arneson v. Olson, 270 N.W.2d 125, 136 (N.D. 1978).

228. Hoem v. State, 756 P.2d 780, 783 (Wyo. 1988).

229. *See* Michelle M. Mello, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reform*, 10 THE SYNTHESIS PROJECT 1, 15 (May 1, 2006), http://www.rwjf.org/files/research/15168.medmalpracticeimpact.report.pdf [hereinafter Mello, *Impact of the Crisis*].

230. *See, e.g.*, Steve Jacob, *Studies: Texas Tort Reform Has Had No Effect on Physician Supply, Lowering Costs*, D CEO HEALTHCARE (Aug. 28, 2012), http://healthcare.dmagazine.com/2012/08/28/studies-texas-tort-reform-had-no-effect-on-physician-supply-lowering-costs/.

noneconomic damages cap since 2003.[231] While Texas enjoyed an estimated 70% decrease in medical malpractice claims between 2003 and 2012, the decrease in claims has neither resulted in decreased healthcare costs nor led to increased physician availability.[232]

After a year-long study, the West Virginia Legislative Committee concluded damages caps do not have a meaningful impact on the price of malpractice premiums.[233] A similar study in Illinois conducted before the state legislature enacted a damages cap in medical malpractice cases revealed that the number of licensed physicians in the state was not decreasing.[234] Rather, the study found an upward trend, even in certain specialty fields considered high-risk.[235] Other commentators have conducted physician surveys and concluded that "many policies aimed at controlling malpractice costs may have a limited effect on physicians' malpractice concerns."[236]

Because a direct correlation is lacking between noneconomic damages caps and malpractice insurance premiums, it is unlikely this conventional tort-reform measure will ever have a demonstrable effect on healthcare costs. A study conducted by the Harvard School of Public Health found that "medical liability costs totaled about 2.4% of annual healthcare spending in the United States, or $55.6 billion per year in 2008."[237] While the press release recognized the $55.6 billion as a large price tag, it also made clear that the cost was not a significant driver behind total healthcare spending.[238] Indeed, a Congressional Budget Office (CBO) report suggested that "caps on damages would reduce national

231. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.301(a) (West 2018); *see also* Charles Silver, David A. Hyman, & Bernard S. Black, *The Impact of the 2003 Texas Medical Malpractice Damages Cap on Physician Supply and Insurer Payouts: Separating Facts from Rhetoric*, ADVOCATE, at 25 (Fall 2008).

232. Jacob, *supra* note 230.

233. *See* Gfell, *supra* note 6, at 803.

234. *See* Michael S. Kenitz, *Wisconsin's Caps on Noneconomic Damages in Medical Malpractice Cases: Where Wisconsin Stands (and Should Stand) on "Tort Reform"*, 89 MARQ. L. REV. 601, 622 (2006).

235. *Id.*

236. *See, e.g.*, Emily R. Carrier et al., *Physicians' Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 HEALTH AFF. 1585, 1585 (2010).

237. Press Release, Harvard School of Public Health, Medical Liability Costs in U.S. Pegged at 2.4 Percent of Annual Health Care Spending (Sept. 7, 2010), https://www.hsph.harvard.edu/news/press-releases/medical-liability-costs-us/ (finding $45.6 billion of this total amount was associated with the practice of defensive medicine costs, and only $5.7 billion was spent on malpractice claims payments).

238. *See id.*

health care spending by 0.5%."[239] Another study concurred with the CBO estimate and concluded that damages caps did not significantly impact national healthcare costs.[240]

These numbers likely derive from the fact that the vast majority of injured patients never file a claim for medical negligence.[241] And only a small fraction of the claims filed result in a damages award above the standard statutory cap amount.[242] Thus, there are very few cases where capping noneconomic damages actually saves money after a case is filed.[243] Rather than decreasing medical malpractice premiums and reducing healthcare costs, these limitations shield healthcare providers from lawsuits where a patient lacks potential for obtaining a significant economic damages award.

Assuming, *arguendo*, that noneconomic damages caps could have been considered a rational response when they were first enacted years ago, a "past crisis does not forever render a law valid."[244] And "[w]here validity of legislation depends on factual justification, if the pertinent facts are of such nature that they may change with the times, a statute or regulation which is valid at one time may become invalid at a later time, and vice versa."[245] It is a "well settled" principle that "[o]ver a period of time social, political and economic changes may render a statute obsolete" and "that the continued existence of facts upon which the

239. MJH Life Sciences, *Who Benefits from Tort Reform*?, MED. ECON., (Aug. 9, 2013), https://www.medicaleconomics.com/medical-economics/news/who-benefits-tort-reform.

240. *See* Frank A. Sloan & John H. Shadle, *Is There Empirical Evidence for "Defensive Medicine"? A Reassessment*, 28 J. HEALTH ECON. 481, 488 (2009) (explaining that the study based its conclusion on over twenty-five years of Medicare data).

241. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 8 (2002) ("Most victims of medical error do not file a claim . . . only 1.53 percent of those who were injured by medical negligence even filed a claim."); *see also* JOINT ECON. COMM., THE PERVERSE NATURE OF THE MEDICAL LIABILITY SYSTEM, Res. Rep. 109-2 (2005) (concluding that only three percent of injured patients actually file suit against their healthcare provider).

242. Bauer, *supra* note 114, at 493; *see also* U.S. GEN. ACCOUNTING OFF., GAO/HRD-87-55, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 50 (1987) (concluding that only 2.1% of noneconomic damages awards were over $200,000).

243. Noneconomic damages caps more often "disproportionately burden the most severely injured patients" instead of "discouraging 'frivolous' litigation." *See* Mello, *Impact of Crisis*, *supra* note 229, at 15.

244. Ferdon ex rel Petrucelli v. Wisconsin Patients Compensation Fund, 2005 WI 125, 284 Wis. 2d 573, ¶ 114, 701 N.W.2d 440, 468, *overruled by* Mayo v. Wisconsin Injured Patients and Families Compensation Fund, 2018 WI 78, 383 Wis. 2d 1, 914 N.W.2d 678.

245. NORMAN J. SINGER, 1 SUTHERLAND STATUTORY CONSTRUCTION § 2:6 (Rev. 2001) (6th ed. 2000) (citing Chastleton Corp. v. Sinclair, 264 U.S. 543 (1924)).

constitutionality of legislation depends remains at all times open to judicial inquiry."[246]

Conventional noneconomic damages caps have neither reduced the price of malpractice insurance premiums, decreased healthcare costs, nor advanced the availability of healthcare providers. In short, they have not accomplished the purported objective that legislators sought to achieve. Meanwhile, injured patients who lack significant economic damages are deprived the opportunity to assert meritorious claims and be made whole. The next section discusses the impact noneconomic damages caps—the favorite tort reform tool of most legislatures—has on the ability of injured patients to bring a lawsuit against physicians and medical institutions.

B. *Injured Patients' Access to Justice*

Prevailing in a medical malpractice action against physicians and medical institutions is exceptionally difficult. First, plaintiffs must meet the burden of proof—proving by a preponderance of the evidence that the healthcare provider breached the standard of care and caused the injury—to win the case.[247] In addition, procedural mechanisms including, but not limited to, certificates of merit,[248] restricted statutes of limitations,[249] and statutes of repose[250] contribute to the uphill battle plaintiffs face in bringing a medical malpractice action.[251] If a plaintiff fails to "clear one of these hurdles," the action is dismissed—the defendant only needs to make the plaintiff fail once to succeed.[252]

Medical defendants generally have the upper hand financially in medical malpractice actions because it is cheaper for them to defend claims than for

246. *Id.* at § 34:5 (citing cases).

247. *See* Wischmeyer v. Schanz, 536 N.W.2d 760, 767 (Mich. 1995); *see also* Gideon Parchomovsky & Alex Stein, *Empowering Individual Plaintiffs*, 102 CORNELL L. REV. 1319, 1340 (2017).

248. A certificate of merit is an affidavit provided by a medical expert that attests to the legitimacy of the plaintiff's medical malpractice claim. Lindenfeld, *supra* note 8, at 123. If a plaintiff fails to submit a certificate or if the certificate does not comply with the statutory requirements, the case is dismissed—sometimes with prejudice. *Id.*

249. Parchomovsky & Stein, *supra* note 247, at 1341 ("Under a typical limitations statute, a plaintiff must file her suit within two years from the accrual of the cause of action against the physician. The limitation period starts running from the point in time at which the plaintiff knew or had reason to believe that her physician may have mistreated her and thereby worsened her condition.").

250. *See id.* (Statutes of repose bar plaintiffs from bringing claims against doctors after three years have passed following the alleged malpractice even if the patient is latent during this period).

251. *See id.* at 1340–43.

252. *Id.* at 1343.

individual plaintiffs to prove their case.[253] Conversely, tort-reform measures that limit the amount of recoverable damages make it less likely an attorney will take a medical malpractice case unless the potential award is significant.[254] Studies indicate medical malpractice lawyers "routinely 'reject 80 percent or more of the requests for representation they receive.'"[255] Consequently, noneconomic damages caps make it more difficult for certain groups of plaintiffs to assert a meritorious claim.

Although there are those who would argue these disadvantages are mitigated by the contingency fee,[256] the effect on a lawyer's willingness to take up a particular case renders such an argument inapposite.[257] In a contingency fee arrangement, plaintiffs' attorneys only get paid if they win at trial or settle the case.[258] The defendants' advantages in a medical malpractice action "reduces the expected recovery amounts for plaintiffs' attorneys and requires them to expend more efforts on the litigation."[259] An attorney in Texas estimated that a typical medical malpractice case "involves hiring half dozen expert witnesses and costs about $100,000."[260] Medical malpractice cases are not only costly for plaintiffs but also risky for attorneys because of the contingency fee arrangement.[261] Consequently, medical malpractice attorneys working on a contingency fee tend to take easy cases that will likely settle while steering clear of more difficult, complex cases that lack potential for a substantial award.[262]

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253. *Id.* at 1324 (explaining that "[d]octors, hospitals, and their insurers have accumulated nearly all information pertaining to the medical standards and experts").

254. *Id.*

255. Carol J. Miller & Joseph Weidhaas, *Medical Malpractice Noneconomic Caps Unconstitutional*, 69 J. MO. B. 344, 349 (2013).

256. *See Contingency Fee*, BLACK'S LAW DICTIONARY (8th ed. 2004) ("A fee charged for a lawyer's services only if the lawsuit is successful or is favorably settled out of court. Contingent fees are usu[ally] calculated as a percentage of the client's net recovery . . . ").

257. *See* Parchomovsky & Stein, *supra* note 247, at 1324.

258. *See* Romulado P. Eclavea, Annotation, Validity, Construction, and Effect of Contract Providing for Contingent Fee to Defendant's Attorney, 9 A.L.R. 4th 191, 193 n.1 (1981).

259. Parchomovsky & Stein, *supra* note 247, at 1324.

260. Rachel Zimmerman & Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J. (Oct. 8, 2004, 12:01 AM), http://www.wsj.com/articles/SB109717758841639476; *see also* Richie Kemp, *When Attorneys Come Back for Seconds: Increased Attorney Fees for Extraordinary Work in Medical Malpractice Cases*, 25 J. LEGAL MED. 79, 89 (2004) (Attorneys "ordinarily risk between $50,000 and $100,000 preparing and litigating the average medical malpractice action.").

261. Kemp, *supra* note 260, at 89 ("A typical medical malpractice case is undertaken by a plaintiff's attorney under a contingent fee agreement.").

262. Lindenfeld, *supra* note 8, at 118.

Damages caps further discourage plaintiffs' attorneys—regardless of merit—from filing claims on behalf of injured patients. Even the American Medical Association (AMA), a long-time proponent of tort reform, recognizes that plaintiffs who lack economic damages have a difficult time finding an attorney.[263] Dr. Donald J. Palmisano, former president of the AMA, explained, "If their claim is not of high monetary value, then it's hard for them to find an attorney."[264] Accordingly, noneconomic damages caps "have led to a seemingly permanent decrease in the number of medical malpractice claims filed, as the likelihood of attorneys taking on malpractice cases is similarly diminishing."[265] Indeed, "some cases that previously might have brought in big verdicts are now difficult for lawyers to justify taking on given the high cost of litigating medical malpractice claims and the uncertainty of prevailing on them."[266]

Noneconomic damages caps—in addition to other traditional tort reform—have the effect of denying many medical malpractice victims their only avenue for recourse and, consequently, access to justice.[267] Because fewer attorneys are willing to take on injured patients as clients, fewer cases are being filed and there are less insurance payouts—creating the statistical impression that noneconomic damages caps are working. Yet, as discussed below, noneconomic damages caps devalue certain groups of plaintiffs irrespective of whether the claims have merit. The next section addresses this disparate effect.

C. *Disparate Impact on Certain Groups*

This part has already discussed why the nature of medical malpractice litigation generally incentivizes attorneys to only accept cases from plaintiffs who are expected to receive large awards and how caps on noneconomic damages exacerbates that effect. In the aftermath of medical malpractice reform across the nation, plaintiffs in most states need both a strong factual case and potential for large economic damages for a medical malpractice attorney to take on a case.[268] Consequently, plaintiffs who have potential to receive significant economic damages are more valuable to medical malpractice attorneys that are paid on contingency.[269] Caps on noneconomic damages, the most popular tort reform

263. Zimmerman & Hallinan, *supra* note 260.

264. *Id.*

265. Goodheart, *supra* note 7, at 528.

266. Donovan, *supra* note 5.

267. *See* Parchomovsky & Stein, *supra* note 247, at 1363 ("[I]n the case of individual plaintiffs, we deal with people whose rights under the law have been violated, breached, or compromised.").

268. *See* Donovan, *supra* note 5.

269. *See* Goodheart, *supra* note 7, at 530.

mechanism deployed by state legislatures, thus have an even more significant effect on groups that aren't expected to receive a large economic damages award—such as low-income plaintiffs, women, children, and the elderly. This section discusses the adverse impact noneconomic damages caps have on these particular victims of medical malpractice.

1. Low-Income Plaintiffs

Application of California's Medical Injury Compensation Reform Act (MICRA) illustrates the disproportional effect rigid caps on noneconomic damages impose on low-income plaintiffs.[270] In 1975, California passed MICRA, which limits noneconomic damages to $250,000 in medical malpractice cases.[271] The cap applies regardless of how much the jury awards in non-economic damages or how little the plaintiff receives in economic damages.[272] A California attorney handled two factually identical cases for two virtually indistinguishable breast cancer patients—both plaintiffs were mothers with two children, and ultimately died.[273] The attorney explained that "[o]ne plaintiff was a housewife and her case was settled for $300,000. The other was a Silicon Valley executive whose family won a $2 million settlement."[274] In another set of similar cases involving the death of two young mothers, the jury awarded each $3 million in noneconomic damages.[275] Both verdicts were subsequently reduced to $250,000 pursuant to the MICRA.[276] While one plaintiff who worked as a school administrator and held a master's degree received $1.6 million in economic damages, the other plaintiff, an unmarried woman on welfare, was awarded $200,000 in economic damages.[277]

Noneconomic damages often constitute the largest part of the compensatory award for most middle and working-class plaintiffs because their income is relatively low.[278] When a statute limits noneconomic damages, a plaintiff's opportunity for a large award is dependent on how much the plaintiff can recover in economic damages. Such reforms systematically devalue low-income plaintiffs because "lawyers are forced to consider the likelihood of recovering

270. *See* Zimmerman & Hallinan, *supra* note 260.

271. *See* CAL. CIV. CODE § 3333.2(b) (West, Westlaw through 2019 Reg. Sess. Ch. 860).

272. *See id.*; Zimmerman & Hallinan, *supra* note 260.

273. *See* Zimmerman & Hallinan, *supra* note 260.

274. *Id.*

275. *See id.*

276. *Id.*

277. *Id.*

278. Parchomovsky & Stein, *supra* note 247, at 1343.

significant economic damages as the barometer for a successful claim."[279] Because many low-income plaintiffs lack significant economic damages, they are unable to secure adequate representation and deprived the opportunity to bring their claims. This has led legal scholars to proclaim that noneconomic damages caps create "two tiers of plaintiffs"[280] based on income and "have a distinctly regressive effect on the dispensation of justice in our society."[281]

2. Women

"When you put a cap on noneconomic damages . . . quite literally women's lives are valued lower."[282] Although cases implicating caps on noneconomic damages are not separated based on gender, this assertion carries weight because women are paid less than men on average.[283] According to the U.S. Census Bureau, women earned 80% of what their male counterparts earned in 2017.[284] Because women typically are paid less than men for the same work or position, limitations on noneconomic recovery have potential to prevent women from recovering as much as men for the same injury.[285]

Women that elect a domestic role at home rather than work outside of the home are affected in an even more significant fashion. Through surveying thousands of working and stay-at-home moms, selecting a handful of jobs that reflect a day in the life of a mom, and using market compensation data for those roles, Salary.com estimated the median annual salary of a stay-at-home mom in 2018 is $162,581.[286] This estimate, regardless of the accuracy of the methodology used in creating it, does not reflect what a stay-at-home mom would receive for

279. Goodheart, *supra* note 7, at 514.

280. *See generally id.*

281. Parchomovsky & Stein, *supra* note 247, at 1343.

282. Zimmerman & Hallinan, *supra* note 260 (quoting National Organization for Women President Kim Gandy).

283. *See* Jeanne Sahadi, *6 Things to Know About the Gender Pay Gap*, CNN MONEY (Apr. 12, 2016, 10:46 AM), http://money.cnn.com/2016/04/12/pf/gender-pay-gap-equal-pay-day/ (showing that for every dollar men earn, women generally earn seventy-nine cents).

284. Kayla Fontenot et al., *Income and Poverty in the United States: 2017*, U.S. CENSUS BUREAU (Sept. 12, 2018), https://www.census.gov/library/publications/2018/demo/p60-263.html.

285. Rebecca Korzec, *Maryland Tort Damages: A Form of Sex-Based Discrimination*, 37 U. BALT. L.F. 97, 98–99 (2007).

286. *Moms: We know you're worth it. But how much is "it" really worth?*, SALARY.COM (May 9, 2018), https://www.salary.com/articles/stay-at-home-mom/; *Salary.com Reveals Stay-at-Home Moms are Worth $162,581 a Year*, HR DRIVE (May 13, 2018), https://www.hrdive.com/press-release/20180514-salarycom-reveals-stay-at-home-moms-are-worth-162581-a-year/.

economic damages in a medical malpractice case. Plaintiffs' attorneys and their experts have attempted to quantify activities such as cooking, cleaning, and chauffeuring children for purposes of proving economic loss.[287] Most attempts, however, generally have failed because such activities are difficult to quantify under traditional damages rules.[288] Many attorneys often decide not to pursue these cases because they typically do not result in a significant jury award.[289] Thus, noneconomic damages caps arguably have an even more crippling effect on what this particular group of women can recover in a medical malpractice case.

In addition to the adverse effect resulting from earning power inequality, noneconomic damages caps also place women at a disadvantage because certain injuries that women almost exclusively endure are impossible to quantify as economic loss. Reproductive harm such as pregnancy loss, for example, generally is not categorized as an economic aspect of a woman's life for damages purposes.[290] "Rather, the impact is more in terms of emotional suffering and self-esteem—an impaired sense of self and ability to function as a whole person, or damaged relationships."[291]

While these types of emotional harm were at one time not considered worthy of compensation,[292] courts have recognized that not all aspects of a woman's life correspond with traditional economic terms.[293] In the last twenty-five years, judges and juries have been more willing to award noneconomic damages for reproductive harm.[294] Noneconomic damages caps that place strict limitations on what a woman may recover for such harm negate this advancement and devalue women. In states where noneconomic damages are capped, women also face the obstacle of finding an attorney who is willing to take on this type of case. Indeed, "[l]imiting non-economic damages for medical malpractice suits [has] the effect of setting back significant progress made in gender . . . equality."[295]

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287. *See* Zimmerman & Hallinan, *supra* note 260.

288. *See id.*

289. *See id.*

290. Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1281 (2004).

291. *Id.* at 1266.

292. *See e.g.,* Lisa M. Ruda, *Caps on Noneconomic Damages and the Female Plaintiff: Heeding the Warning Signs*, 44 CASE W. RES. L. REV. 197, 214 (1993); *see also* Leonard J. Nelson, III et. al., *Medical Malpractice Reform in Three Southern States*, 4 J. HEALTH & BIOMEDICAL L. 69, 97 (2008).

293. *See* Lindenfeld, *supra* note 8, at 115; *see also* Lucinda M. Finley, *Female Trouble: The Implications of Tort Reform for Women*, 64 TENN. L. REV. 847, 860–61 (1997) (discussing large noneconomic damage awards in cases concerning reproductive health).

294. *See* Lindenfeld, *supra* note 8, at 115.

295. *Id.* at 120.

3. The Elderly and Children

Elderly victims of medical malpractice are also disadvantaged by the operation of damages caps that restrict noneconomic recovery. They often are neither employed at the time of the injury nor plan to work in the years following the injury, which precludes them from asserting damages claims for lost past and future wages.[296] Noneconomic damages often are the primary form of compensation for these plaintiffs. Under these circumstances, caps on noneconomic damages leave elderly patients without an alternative form of recovery that would make them whole.[297] In addition, "[c]apping noneconomic damages is in effect a death penalty for many elder abuse and mistreatment claims because the victims are unable to find attorneys to represent them when noneconomic damages are downsized."[298]

The effect of noneconomic damages cap on children and their families presents different considerations. Because children have a greater likelihood of recovering a larger amount in future economic damages than elderly plaintiffs,[299] the impact on children who survive medical malpractice generally is less severe. While injured children, similar to elderly patients, typically are not employed at the time of the injury and are precluded from being awarded lost wages, they do have the ability to recover damages for lost earning capacity.[300] Proving lost earning capacity with a degree of certainty, however, is very difficult.[301] Because of the speculative nature that goes into determining what a child would have earned in the future had the injury not occurred, children often are left with insignificant economic damage awards.[302] As one scholar notes, "It is not uncommon for a jury to award earning losses as little as $5,000 a year for children under the age of seven."[303]

Noneconomic damages caps place children who die as a result of medical negligence and the families who bring claims on their behalf at an even more significant disadvantage. While a claim for an injured child who dies includes

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296. *See* Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 ELDER L.J. 331, 335 (2007).

297. Lindenfeld, *supra* note 8, at 119.

298. Rustad, *supra* note 296, at 335.

299. *See* Goodheart, *supra* note 7, at 536.

300. *Id.* (defining lost earning capacity as "the amount of money the child would have been able to earn in the future but for the injury").

301. *See* John Zevalking, *Cast Adrift: The Patently Unjust Shift of Healthcare Costs to Those Who Can Least Afford Them Is Constitutionally Intolerable*, 24 T.M. COOLEY L. REV. 347, 407 (2007).

302. *See id.* at 404–05.

303. Lindenfeld, *supra* note 8, at 114–15.

past medical expenses, the plaintiff bringing the claim is precluded from recovering any future economic damages. A noneconomic damages cap under these circumstances "has the effect of making an infant who is severely injured more valuable than those who don't make it since families of children who die are limited to the cap."[304] This effect can also result in plaintiffs' attorneys losing incentive to pursue a claim and dropping the lawsuit following the death of a child injured at birth—leaving the family members with nothing for their loss.[305]

While supporters of noneconomic damages caps argue such limitations are facially neutral and reasonable, certain groups of plaintiffs are disproportionately impacted. Women, children, elderly, and economically disenfranchised plaintiffs who receive a larger jury award than the statutory cap permits are undercompensated for their injuries based on a legislative decision to reduce healthcare-defendants' liability. The problem is further exacerbated by the fact that these caps dissuade attorneys from taking on a plaintiff's otherwise meritorious case because the potential for economic damages is lacking.

In addition to widening the social justice gap and precluding injured patients from receiving compensation, noneconomic damages caps decrease the deterrent value of the medical malpractice system, which leads to even more injuries.[306] But "the most profound loss of all," legal scholar Lucinda Finley explains, "will be to the fairness and equality of our civil justice system, as the effects of cap laws send the message that women, the elderly, and the parents of dead children should not bother to apply."[307]

Regardless of what actually triggers a crisis or who is to blame for increased medical malpractice insurance costs, it is clear that past attempts to remedy the problem have fallen short. Inflexible caps on noneconomic damages not only widen the social justice gap for injured patients generally but also disproportionality disadvantage certain groups of plaintiffs: women, children, low-income individuals, and the elderly. For these reasons, both scholars and lawmakers in certain states have recognized the inadequacy of noneconomic damages caps and sought to implement alternative solutions to lower malpractice premiums and healthcare costs. The next section briefly discusses a popular alternative to traditional medical malpractice reform that has been implemented in some states and heavily debated by scholars.

304. Daniel Costello, *Malpractice Law May Deny Justice*, L.A. TIMES (Dec. 29, 2007, 12:00 AM), http://articles.latimes.com/2007/dec/29/business/fi-malpractice29.

305. *See e.g.,* Zimmerman & Hallinan, *supra* note 260.

306. *See, e.g.,* Finley, *supra* note 290, at 1313.

307. *Id.*

IV. AN ALTERNATIVE SOLUTION: NO-FAULT COMPENSATION SCHEMES

Numerous policymakers and scholars have weighed in on both the efficacy and negative implications of conventional tort reform—particularly noneconomic damages caps. Indeed, there is no shortage of proposed remedies. While this article primarily focuses on why traditional, inflexible noneconomic damages caps are not the panacea, it is imperative to briefly highlight a different type of reform offered as a solution. Accordingly, this section explores no-fault compensation schemes—a popular alternative to conventional medical malpractice reform that has been debated in both the academic community and healthcare industry.

An alternative to traditional tort reform is the implementation of a no-fault compensation scheme in the place of medical malpractice litigation. As suggested by its name, a no-fault compensation scheme does not use legal fault—whether a physician acted negligently—as the basis for determining liability.[308] Because the injured patient is not required to prove breach of the applicable standard of care, the dispositive issue usually turns on whether the doctor caused the injury.[309] Thus, no-fault compensation schemes examine (1) whether a duty existed between the injured patient and the medical actors, (2) whether an injury occurred during treatment, (3) whether the physician's actions caused the injury, and (4) whether the injury falls within the scope of compensable damages, as defined by statute.[310]

Under a no-fault compensation regime, medical negligence cases are removed from the civil justice system and placed in an administrative setting.[311] While these systems remain largely experimental in the U.S., both Florida and Virginia have instituted limited no-fault compensation schemes for birth-related neurological injury cases.[312] In Florida, for example, an administrative law judge presides over the case, makes determinations based on the evidence presented

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308. *See* David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect of Error Prevention*, 286 J. OF THE AM. MED. ASS'N 217, 219 (2001).

309. *See id.*

310. *See* Jill Horwitz & Troyen A. Brennan, *No-Fault Compensation for Medical Injury: A Case Study*, 14 HEALTH AFF. 164, 167 (1995).

311. Goodheart, *supra* note 7, at 542.

312. *See* FLA. STAT. ANN. § 766.303 (West, Westlaw through 2019 Sess.); VA. CODE ANN. § 38.2-5002 (West, Westlaw through Acts 1987). Both Florida's and Virginia's no-fault compensation schemes are based in part on—albeit they are more limited than—New Zealand's no-fault liability system. *See* Marie Bismark & Ron Paterson, *No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, And Patient Safety*, 25 HEALTH AFF. 278 (2006) (discussing how New Zealand replaced its tort system with a no-fault compensation system "essentially barr[ing] medical malpractice litigation").

and, if appropriate, awards compensation.[313] How much compensation a successful claimant receives is largely determined by statute.[314]

Like many alternatives to traditional tort reform, a no-fault compensation scheme has both advantages and disadvantages. Proponents of a no-fault system contend that such a scheme reduces litigation expense, increases efficiency, resolves matters with expedience, and assuages some of the psychological impact traditional litigation has on both plaintiffs and defendants.[315] Because an injured patient may recover without showing fault on the part of the physician, a no-fault system increases the likelihood that an injured patient will recover something for their injuries.[316] Moreover, such a model eliminates the need to target a specific physician or healthcare professional to discover who committed what wrong.[317] By removing blame from the equation, supporters argue that no-fault systems foster an environment more conducive to the discussion and reduction of medical error.[318]

While the benefits of a no-fault compensation scheme are appealing, such a system has numerous drawbacks that cannot be overlooked. In addition to funding issues,[319] critics argue that no-fault systems provide insufficient damages and fail to make injured patients whole.[320] As one commentator noted, the no-fault model "seems to value providing recovery to as many parties as possible, while the American tort system seems to value maximizing recovery for plaintiffs who are able to bring successful claims."[321] The removal of fault, commentators explain, deprives negligent medical professionals "of meaningful

313. FLA. STAT. ANN. § 766.309(1)(c)–(d) (West, Westlaw through 2019 Sess.).

314. FLA. STAT. ANN. § 766.331(1) (West, Westlaw through 2019 Sess.).

315. Joseph Bernstein et al., *Topics in Medical Economics: Medical Malpractice*, 90 J. BONE & JOINT SURGERY 1777, 1778–79 (2008).

316. *See* Horwitz & Brennan, *supra* note 310, at 165.

317. *See* Duncan MacCourt & Joseph Bernstein, *Medical Error Reduction and Tort Reform Through Private, Contractually-Based Quality Medicine Societies*, 35 AM. J. L. & MED. 505, 529–30 (2009).

318. *See id.*

319. *See, e.g.,* Sandy Martin, *NICA—Florida Birth-Related Neurological Injury Compensation Act: Four Reasons Why This Malpractice Reform Must Be Eliminated*, 26 NOVA L. REV. 609, 624–30 (2002) (describing the problems with funding Florida's Birth-Related Neurological Injury Compensation Act); *see e.g.,* Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice*, 54 DEPAUL L. REV. 503, 519–20 (2005) (noting the financial problems identified with Virginia's Birth-Related Injury Compensation Program).

320. *See* Bismark & Paterson, *supra* note 312, at 282.

321. Goodheart, *supra* note 7, at 543; *see also* Bismark & Paterson, *supra* note 312, at 281 ("No-fault systems have the potential to compensate many more patients than malpractice litigation can.").

feedback on faulty practices and [arguably] mitigates any deterrence."[322] No-fault systems, similar to inflexible damages caps that severely limit noneconomic recovery, don't punish tortfeasors and may offer less incentive for physicians to avoid negligent conduct in the future.[323] Because no-fault compensation schemes fail to adequately compensate victims of medical malpractice and do not operate to deter negligent behavior, such an alternative, at least alone, is a poor substitute for accomplishing the fundamental goals of tort law. While this can be an option for injured patients—and could be a good one for those who do not wish to file a civil action—it should not be the only route to a remedy.

This article does not aim to disregard the value alternative systems of dispute resolution can bring to the table. Indeed, lawmakers and regulators should do everything within their power to implement reforms designed to reduce malpractice premiums, lower healthcare costs, and improve the quality of care. Many alternative systems, however, fail to adequately compensate victims of medical malpractice and lack the necessary deterrent effect. Such reform often does not provide sufficient reprieve to patients following an adverse medical incident. While alternative types of dispute resolution solutions—such as a no-fault compensation schemes—have potential to provide adequate relief depending on the particular situation in a particular state, the primary remedy for making a victim of medical malpractice whole should exist in the civil justice system. The next section proposes three nontraditional types of reform lawmakers should seek to implement in an effort to reconcile medical malpractice reform with fundamental principles of tort.

V. A MORE BALANCED PRESCRIPTION

While commentators may be correct in asserting that the current medical malpractice system is broken, the system is not beyond repair. Yet the glaring economic, social, and constitutional issues of noneconomic damages caps suggests that such measures are not the solution to reducing insurance premiums and healthcare costs. The rising costs of malpractice premiums and healthcare costs combined with the inability of current measures to remedy these issues beg for reform that will reduce the burden shouldered by both injured patients and physicians. This section first discusses the fundamental goals of tort law—compensation and deterrence—which should be kept in center focus when considering any type of tort reform. The article then offers suggestions for medical malpractice reform that offers reprieve to both sides of the debate without disparately impacting certain groups of individuals.

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322. MacCourt & Bernstein, *supra* note 317, at 530.

323. Todres, *supra* note 73, at 701 (explaining that a no-fault compensation scheme "would not provide any deterrence of negligent acts by physicians").

A. *Fundamental Goals of Tort Law*

As a leading authority on tort law provides, "[t]he most commonly mentioned aims of tort law are (1) compensation of injured persons and (2) deterrence of undesirable behavior."[324] Tort law is not solely adopted to obtain compensation to a particular plaintiff. Rather, the law of torts protects society as a whole by serving as a basis for deterrence of conduct that falls below accepted standards of care. This deterrent function is inherent in the reasonable care analysis and is one of the central considerations balanced against the foreseeable risk created by the actor's conduct.[325] Indeed, "[t]he law of torts is concerned not solely with individually questionable conduct but as well with acts which are unreasonable, or socially harmful, from the point of view of the community as a whole."[326]

Juries play a crucial role in accomplishing these fundamental goals of tort. Over 145 years ago, the Supreme Court recognized that the jury is in the best position to determine what actions pose a risk to the community.[327] It has been said that "jurors collectively represent a cross-section of the conscience of the community."[328] Moreover, juries "are the bulwark or our system of justice," comprising "the voice of the defendant's peers and the conscience of the community."[329] If juries were not intended to speak for their respective communities, there would be no reason for juries instead of judges, venue rules that require trials to be held where the alleged wrongdoing occurred, or the

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324. DAN B. DOBBS, THE LAW OF TORTS § 8 (2000).

325. *See* RESTATEMENT (THIRD) OF TORTS § 3, cmt. d (AM. LAW. INST. 2010) (stating "the primary factors are most relevant in cases in which the actor is generally aware of some risk entailed by conduct yet because of the burden of risk prevention is willing to tolerate that risk"); *see also* Kandt v. Evans, 645 P.2d 1300, 1305 (Colo. 1982) (discussing an employee's liability for torts occurring in the workplace and stating "[d]ecisions which have adopted the minority view point out that immunity would allow a worker who commits an intentional tort to use the compensation law as a shield against liability, and would eliminate the beneficial deterrent effect of the threat of such liability for intentional torts").

326. W. PAGE KEETON, ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 2, at 6–7 (5th ed. 1984); *see also* Kandt v. Evans, 645 P.2d 1300, 1305 (Colo. 1982) (explaining the deterrent function of tort liability).

327. *See* Sioux City & P.R. Co. v. Stout, 84 U.S. (17 Wall.) 657, 663– 64 (1873) ("Twelve men of the average of the community, comprising men of education and men of little education, men of learning and men whose learning consists only in what they have themselves seen and heard, the merchant, the mechanic, the farmer, the laborer; these sit together, consult, apply their separate experience of the affairs of life to the facts proven, and draw a unanimous conclusion.").

328. Simpson v. Anderson*,* 517 P.2d 416, 418 (Colo. App. 1973), *rev'd on other grounds,* 517 P.2d 416 (Colo. 1973).

329. Garcia v. People, 997 P.2d 1, 12 (Colo. 2000).

requirement that jurors be peers selected from the same community as the defendant.

"Juries—comprised as they are of a fair cross-section of the community—are more representative institutions than is the judiciary."[330] They more accurately reflect the "composition and experiences of the community as a whole, and inevitably make decisions based on community values more reliably, than can that segment of the community that is selected for service on the bench."[331] Indeed, "a jury . . . can do little more—and must do nothing less—than express the conscience of the community."[332]

Community values drive justice. The whole point of our system of trial by jury is to invite jurors to apply community standards, rules, and norms to determine their verdict.[333] In fact, legal duties are recognized based on public safety concerns. Standards of care in medical malpractice are adopted and developed both for the injured patient in the particular case and other patients who are similarly situated. Duties and standards of care thus not only protect specific patients from harm but also prevent other individuals in society from suffering similar harm through deterring future tortfeasors. Thus, even foregoing a claim for punitive damages, a damages award for a violation of these standards of care should both compensate injured victims and deter healthcare providers from injuring other patients in the future.

B. *An Egalitarian Solution*

This section offers a remedy to the medical malpractice insurance crisis that seeks to accomplish what lawmakers purported to achieve through traditional caps on noneconomic damages. Even with the empirical data demonstrating the inefficacy of noneconomic damages caps to lower malpractice premiums or healthcare costs, the use of statutory limitations on recovery in medical malpractice cases is unlikely to subside. Both the healthcare industry and medical malpractice insurers will fiercely oppose the abrogation of noneconomic damages caps. Similarly, the Supreme Court will not likely take up the issue of whether these caps violate the Seventh Amendment's guarantee of a civil jury trial in the near future. Crafting an effective solution thus requires acceptance of this reality while also considering the concerns that exist for those on the other side of the debate. It is essential that any proposed reform both offers an olive

330. Schriro v. Summerlin, 542 U.S. 348, 360 (2004) (Breyer, J. dissenting) (citation omitted) (quotations omitted).

331. *Id.*

332. Witherspoon v. Illinois, 391 U.S. 510, 519 (1968).

333. *See* Keeton, *supra* note 326, at § 37, 237–38 (explaining that "our legal system has entrusted negligence questions to jurors, inviting them to apply community standards").

branch to the medical industry and does not neglect those most in need—victims of medical malpractice.

Much like an efficient mediator, the goal of lawmakers in this arena should be to find middle ground, which, if done right, would leave neither side happy but both sides placated. This means keeping a version of a noneconomic damages cap that operates as a reasonable limitation and effective deterrent, rather than an arbitrary restriction on recovery that effectively disenfranchises certain groups of injured patients. In addition to a flexible noneconomic damages cap, the remedy also includes adopting a full medical apology law. Medical apology laws promote open dialogue between injured patients and physicians following an incident by alleviating the fear such conversations will be used against the healthcare providers at trial. To decrease the cost of malpractice premiums—which is the purported goal of most damages caps—insurance reform is included as part of the solution because of its potential to alleviate the financial burden insurers impose on physicians.

The remedy consists of three components, which lawmakers could implement either collectively (which is ideal) or independently depending on the particular legal and economic landscape in their respective state. The first part of the remedy concerns damages caps. Though the remedy does not include a cap on economic damages, it does offer a flexible noneconomic damages cap designed to better compensate injured patients and deter negligent healthcare providers.

Second, the remedy proposes the adoption of a medical apology law. This evidentiary rule would prohibit a plaintiff from using a healthcare-provider defendant's apology as an admission of liability. Finally, the third component of the remedy is insurance reform, which has proven more effective at controlling malpractice premiums than noneconomic damages caps or other methods of conventional tort reform. In sum, the remedy seeks to ensure injured patients are adequately compensated, deter medical negligence, encourage a physician to apologize or give an explanation to an injured patient following an incident, and decrease the cost of malpractice premiums through insurance reform.

1. Flexible Noneconomic Damages Caps

While the first component of the solution establishes substantive limitations on recovery, it does not include any restriction on economic damages. Economic damages compensate plaintiffs for verifiable, objective monetary losses such as past and future medical expenses and lost wages.[334] The jury awards economic

334. *Ending the Confusion: Economic, Non-Economic, and Punitive Damages*, AM. COLL. OF SURGEONS, https://www.facs.org/advocacy/federal/liability/guide-to-liability-reform/ending-the-confusion (last visited Oct. 20, 2019).

damages to compensate the plaintiff for medical expenses and other pecuniary loss that "can be estimated and monetarily compensated."[335] A statutory limitation on economic damages is contrary to a cornerstone principle of tort—compensating the plaintiff in a manner that attempts to make the plaintiff whole. Accordingly, this article does not suggest imposing any limitation on a plaintiff's economic recovery.

Next, we move to the elephant in the room—a noneconomic damages cap. Noneconomic damages caps, as explained above, contravene the Seventh Amendment's right to a civil jury trial.[336] They are also riddled with deficiencies concerning efficacy and their disparate impact on certain groups.[337] The purpose of this article, however, is not to take an all-or-nothing stance over medical malpractice reform and argue for the total abrogation of noneconomic damages caps.

Much to the chagrin of injured patients and their attorneys, without a decision from the Supreme Court holding otherwise, noneconomic damages caps are unlikely to disappear anytime soon. And proponents of damages caps will do everything within their power to shoot down any legislation in their respective state that does not deploy some sort of limitation on noneconomic recovery in medical malpractice cases. Accordingly, this article seeks to offer a template for reform that physicians, medical institutions, injured patients, and plaintiffs' lawyers could agree to, or at least stomach, and does not deprive victims of medical malpractice the opportunity to be made whole.

The results of several studies regarding the composition of medical malpractice defendants demonstrates that very few doctors are responsible for most medical malpractice claims. A study published in the New England Journal of Medicine, for example, found that around 1% of all doctors accounted for 32% of paid malpractice claims.[338] Another study also concluded that approximately 1.8% of physicians were responsible for half of all medical malpractice payments reported to the National Practitioner Data Bank.[339] Accordingly, the cap accounts for this phenomenon.

The flexible noneconomic damages cap would limit noneconomic recovery to $1.5 million, which would include both direct noneconomic loss to the injured patient and any derivative claims asserted by the patient's loved ones, such as

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335. *Pecuniary Damages*, BLACK'S LAW DICTIONARY (11th ed. 2019).

336. *See* discussion *supra* Part II.

337. *See* discussion *supra* Part III.

338. David M. Studdert, et al., *Prevalence and Characteristics of Physicians Prone to Malpractice Claims,* 374 N. ENGL. J. MED. 354, 356 (Jan. 28, 2016).

339. Robert E. Oshel & Philip Levitt, *The Detection, Analysis, and Significance of Physician Clustering in Medical Malpractice Lawsuit Payouts*, J. OF PATIENT SAFETY 1, 2 (Dec. 2016).

loss of consortium. The cap, however, would either apply with less force or not apply at all upon two conditions: (1) the plaintiff establishes good cause that the application of the one-million-dollar limitation is unfair; and (2) the defendant (i.e., the physician and/or medical institution) has a poor medical malpractice payout record. If a plaintiff shows good cause that the application of the one-million-dollar limitation is inequitable, the court may award in excess of the limitation additional noneconomic damages up to the amount of the adjusted cap based on the defendant's malpractice payout record. While the judge's discretion in determining "good cause" would need to be limited by statute, the contours of such a provision will have to come in future work.

Assuming the plaintiff establishes good cause to exceed the cap, the next step is to evaluate the defendant's medical malpractice payout history. If the physician-defendant has incurred one significant medical malpractice payout in the past five years, the cap amount triples. If the physician has two significant malpractice payouts in the previous five years, the cap increases nine-fold. And if the physician has incurred more than two significant malpractice claim payouts in the past five years, the cap does not apply at all.[340] Rather than deploying an across-the-board limitation on noneconomic damages, the cap recognizes the concentration of medical malpractice is clustered around a small number of bad physicians. In addition, the flexible cap rewards physicians who have not recently incurred a significant medical malpractice payout, thereby providing an incentive to practice with more care.

For a medical institution (e.g., a hospital), the cap would operate in a similar, albeit slightly different, fashion. If the hospital credentialed and privileged the physician following an adverse incident that resulted in a significant medical malpractice payout, the cap triples. Likewise, if the physician retained privileges after two significant malpractice payouts while working at the hospital, the cap increases nine times. And if the hospital privileged the physician after three or more significant malpractice payouts, the cap does not apply. Because application of the cap is based on malpractice history, hospitals and clinics would have a greater incentive to diligently review and assess the ability of their physicians to provide the highest level of quality care to patients. In short, the cap would deter medical institutions from engaging in negligent credentialing and privileging.

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340. The three-times multiplier is based on the multiplier typically used for treble damages, which award a plaintiff up to, but no more than, three times their actual injury. *See* Parchomovsky & Stein, *supra* note 247, at 1362. While the author is well aware that treble damages are punitive in nature and noneconomic damages are compensatory, the three-times multiplier is simply a point of reference for adjusting the cap based on a physician's malpractice payout record.

Because this is not the first proposed cap that uses medical malpractice payouts as a benchmark, guidance as to what constitutes a "significant payout" can be gleaned from the literature. For example, one scholar has suggested that only cases where the payout by either a physician or medical institution is greater than $100,000 should qualify as a predicate for a cap exemption.[341] Although this metric may be appropriate for some physicians, whether it is suitable for all medical malpractice cases is questionable. Some specialties, such as neurosurgery and emergency medicine, involve greater risk for medical error and are more vulnerable to malpractice claims. Whereas other specialties, such as chiropractic and pathology, involve less risk and are less likely to commit malpractice. What is a "significant payout" for one physician should not necessarily be the same as a physician in a different specialty. Thus, tailored rules may be necessary for determining whether a physician's previous payout qualifies as a predicate for cap exemption.

The same scholar has also suggested that there should be a ceiling on a plaintiff's noneconomic recovery based on economic damages.[342] Such a limitation, however, leaves certain groups of injured patients—those that lack the potential for substantial economic damages—vulnerable to the disparate impact of traditional, rigid caps. Accordingly, the flexible cap proposed in this section does not endorse using economic recovery as a standard for placing an upper limit on the amount of noneconomic damages a plaintiff may recover in a medical malpractice case.

While any cap on noneconomic damages concededly has the potential to disparately impact certain groups of injured patients who cannot prove significant economic loss, the political reality (at least for now) is that there must be a cap. But noneconomic damages caps that apply the same way regardless of a physician's malpractice claim and payout history only serve the interests of those physicians most responsible for medical error. A flexible cap that increases based on a physician's or medical institution's malpractice history has potential to provide social benefits by deterring negligent behavior.[343] The civil justice system remains an effective deterrent that lawmakers can rely on in an effort to decrease negligent medical care. Increasing noneconomic damages caps and allowing for flexibility provides patients lacking economic loss a better opportunity to be made whole or, at the very least, bring their claims and have their day in court.

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341. Williams *supra* note 31, at 515, n.227.

342. *See generally, e.g.*, *id.* at 515–18 (proffering a cap that limits noneconomic damages to nine-times the economic recovery).

343. *But see* Sharkey, *supra* note 72, at 404 (arguing that noneconomic damage awards operate as an over-deterrence and perpetuate the practice of defensive medicine).

2. Full Medical Apology Law

In addition to and as a counterweight for a higher and more flexible cap on noneconomic damages, the remedy includes the enactment of a medical apology law. Apology laws are evidentiary rules that prohibit a defendant's apology and related statements made to the plaintiff from being used as evidence of liability.[344] Healthcare providers instinctually refrain from apologizing to a patient or even discussing what happened during a procedure following an adverse incident. This instinct has been built into the culture of the medical community—and continues to be fed—by fears that disclosure will provide an injured patient with an incentive to file a medical malpractice claim and serve as evidence of an admission of liability at trial. These fears, however, are not only misguided but come at a significant cost to both patients and physicians. Increasing transparent communication generally speaking and especially following an adverse incident would provide crucial benefits to both physicians and patients. Thus, the remedy includes an evidentiary rule that prohibits the use of apologies and admissions of fault as evidence of liability in medical malpractice cases.

Concerns that an apology or admission of fault made during discussion with a patient following an adverse incident will later be used as evidence against the physician gave birth to the "deny and defend" strategy perpetuated by the healthcare industry and their attorneys.[345] This lack of dialogue is largely due to a myriad of fears, including "a natural aversion to confronting angry people; concerns that disclosure might invite a claim that otherwise would not be asserted; anxiety that the discussion will compromise courtroom defenses later; and fear that the conversation may lead to loss of malpractice insurance or higher premiums."[346] These fears are compounded by defense attorneys sermonizing "deny and defend" as the safest route for medical providers following recognized or suspected medical error.[347] Many malpractice defense attorneys habitually advise healthcare providers to neither apologize nor show remorse to the patient following an adverse incident.[348] Thus, "medical providers [often] fail to address and apologize [to patients] for medical errors" following an adverse incident.[349]

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344. *See, e.g.*, COLO. REV. STAT. § 13-25-135 (West, Westlaw through Sept. 1, 2019 Sess.).

345. Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125, 129 (2009).

346. *Id.* at 128.

347. *See* Jennifer K. Robbennolt, *Attorneys, Apologies, and Settlement Negotiation*, 13 HARV. NEGOT. L. REV. 349, 353 (2008).

348. *See id.*

349. Talmadge, *supra* note 20, at 211.

A physician's decision to apologize or discuss an adverse incident can influence whether an injured patient decides to file a lawsuit for medical malpractice. How it may impact the patient's decision, however, demonstrates that medical providers' fears are largely unfounded and the decision to deny and defend comes at a significant cost. To be sure, the "deny and defend" tactic "is an incredibly inefficient and costly (financially, emotionally, and otherwise) response to patient complaints."[350] Studies have indicated that patients would respond positively to their physician apologizing or explaining a medical error, and the absence of such communication drives the patient to hold the physician accountable for an unfortunate outcome.[351] One study, which surveyed 227 patients and family members planning to bring claims for medical malpractice, found that 90% of the individuals surveyed intended to take legal action to receive an explanation from the physician or to prevent the medical error from occurring to others in the future.[352] The same study further determined roughly 40% of the patients said they would not have filed a lawsuit if their medical provider had either apologized or gave them an explanation.[353]

Other studies have concluded that after a patient has received information through the litigation discovery process that revealed answers to questions they sought before filing suit and showed the physician's conduct was not negligent, the patient tended to dismiss the action.[354] The research indicates prompt disclosure, explanation, and an apology—what the injured patient is often seeking following an adverse incident—from a medical provider to the patient can reduce the potential for malpractice liability.[355] In addition to the opportunity

350. Boothman et. al., *supra* note 345, at 129.

351. Eleanor D. Kinney, *The Potential of Captive Medical Liability Insurance Carriers and Damage Caps for Real Malpractice Reform*, 46 NEW ENG. L. REV. 489, 492–93 (2012); *see also* Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 463 (2003); Wendy Levinson, *Physician-Patient Communication: A Key to Malpractice Prevention*, 272 J. AM. MED. ASS'N 1619, 1619–20 (1994).

352. Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1611–12 (1994).

353. *See id.* at 1611.

354. Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 NEW ENG. J. MED. 370, 373–74 (1991) (discussing two studies—one by Harvard researchers and the other by the University of Michigan and Massachusetts Institute of Technology).

355. *See* Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANN. INTERN. MED. 213, 213, 215, 219 (2010); *see also* Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 39 J. HEALTH L. 107, 121–22 (2006); *see also* Kathleen M. Mazor et al., *Health Plan Members' Views About Disclosure of Medical Errors,* 140 ANN. INTERN. MED. 409, 415–16 (2004) ("Our findings confirmed that patients want to be told of medical errors, even if there is nothing that can be done about them.").

cost related to litigation, deny and defend also carries substantial costs for the physician-patient relationship and quality of care. "[B]y defaulting to deny and defend," rather than providing an apology or explanation following an adverse incident, "true quality improvement is inhibited and patient safety suffers."[356]

While some commentators have opposed the adoption of medical apology laws on grounds that an apology loses sincerity and its rehabilitative effect when inadmissible,[357] others have argued for federal protection of full apologies in civil cases.[358] In a jurisdiction without a rule prohibiting an apology from being used as evidence, the healthcare provider will likely hear her words being used against her if a medical malpractice claim is filed and the case does not settle. Without an evidentiary rule explicitly prohibiting the admissibility of such evidence, any competent plaintiffs' lawyer would do everything possible to ensure the jury hears the apology and admit it as an admission of liability.

Federal Rule of Evidence 408 was enacted to overcome a similar impediment and encourage private settlement by creating a protected space for open dialogue between parties during negation. Rule 408 provides that evidence of "conduct or a statement made during compromise negotiations about the claim" is not admissible to "either to prove or disprove the validity or amount of a disputed claim or to impeach by a prior inconsistent statement or a contradiction."[359] As the Senate Judiciary Committee notes explain, "The exception for factual admissions was believed by the Advisory Committee to hamper free communication between parties and thus to constitute an unjustifiable restraint upon efforts to negotiate settlements—the encouragement of which is the purpose of the rule."[360] Indeed, the underlying policy rationale for such a rule "is to encourage settlements which would be discouraged if such evidence were admissible."[361] Because evidence of an apology (if admissible) would certainly be used as a sword throughout litigation, it could also impede negotiation and prevent the parties from reaching a settlement in a medical malpractice case.

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356. *See* Boothman et. al., *supra* note 346, at 132.

357. *See* Brent T. White, *Say You're Sorry: Court-Ordered Apologies as a Civil Rights Remedy*, 91 CORNELL L. REV. 1261, 1294 (2006); Lee Taft, *Apology Within a Moral Dialectic: A Reply to Professor Robbennolt*, 103 MICH. L. REV. 1010 (2005); Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135, 1156–57(2000).

358. Michael B. Runnels, *Apologies All Around: Advocating Federal Protection for the Full Apology in Civil Cases*, 46 SAN DIEGO L. REV. 137, 140–41 (2009) (advocating for protection of full apologies through an amendment to Federal Rule of Evidence 408, which applies to evidence of conduct or statements made in compromise negotiations).

359. FED. R. EVID. 408(a).

360. S. Rep. No. 93-1277, at 10 (1974).

361. *Id.*

In states without a medical apology law that provides full protection to an apologizing healthcare provider, "it would scarcely be sound legal advice for a defense attorney to advise a client to deliver an apology that would leave the client open to liability."[362] Enacting protection of full apologies in medical malpractice cases thus is critical to obtain the benefits that an open dialogue between physicians and their patients provides—both improving healthcare quality and encouraging private settlement. For this reason, the remedy includes an evidentiary rule that would mitigate physicians' fears and deflate defense attorneys' reliance on deny and defend by prohibiting apologies made to an injured patient from being used against healthcare providers in a medical malpractice action.

3. Insurance Reform: Merit-Based Premiums

The remedy also proposes insurance reform—a more effective measure to control medical malpractice premiums—as an alternative to noneconomic damages caps. Many analysts consider the problem of escalating malpractice premiums as the product of an "insurance company accounting and investment crisis" rather than a medical malpractice crisis.[363] Nevertheless, medical malpractice insurers have not changed pricing methods and continue to base premiums almost entirely on a doctor's specialty and geographic location.[364] This approach results in "small yet volatile risk pools vulnerable to huge premium spikes subsequent to a handful of large payouts in a particular location or practice specialty."[365]

Malpractice premiums—unlike the cost of automobile insurance, which increases following an accident caused by the driver—rarely takes into account a physician's history of past claims or payouts.[366] Thus, in most cases, a physician's "prior claim or payout history does not affect [their] premium rates."[367] This remains the standard for most malpractice insurers despite the fact that statistics demonstrate a physician's payout history is highly accurate in

362. Runnels, *supra* note 358, at 140.

363. Williams, *supra* note 31, at 482.

364. *Id.*

365. *Id.*; *see also* Robert B. Leflar & Futoshi Iwata, *Medical Error as Reportable Event, as Tort, as Crime: A Transpacific Comparison*, 12 WIDENER L. REV. 189, 203 (2006).

366. *See* Kara M. McCarthy, *Doing Time for Clinical Crime: The Prosecution of Incompetent Physicians as an Additional Mechanism to Assure Quality Health Care*, 28 SETON HALL L. REV. 569, 582 (1997).

367. Carrie Lynn Vine, *Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps*, 26 N. ILL. U. L. REV. 413, 427 (2006).

predicting the risk of future negligent behavior.[368] Physicians who have not incurred a significant medical malpractice payout in recent years are subjected to an increase in premium each year despite their record of performance. The current insurance system in most states thus provides little incentive for physicians to make diligent efforts to provide the best possible care to their patients.

Studies have revealed that the majority of dollars paid for malpractice claims derive from only a small fraction of physicians.[369] As noted earlier in this section, these studies have found that less than 2% of all physicians account for 50% of medical malpractice payouts.[370] Despite the statistical evidence indicating small number of healthcare providers are responsible for the majority of medical malpractice claims, malpractice insurers elect not to place the burden of escalating premiums on those who are responsible for the majority of payouts and will most likely cause rates to increase in the future.[371] Rather, insurance companies spread the costs associated with defending claims and payouts—and medical errors for that matter—evenly among doctors even though the "vast majority of physicians practice responsibly."[372]

These statistics have led commentators to suggest a merit-based rating system that takes into account the physician's history and likelihood for future payouts—similar to how automobile insurance generally operates—is a viable solution to the malpractice insurance crisis.[373] A merit-based rating system has potential to reinforce non-negligent healthcare by rewarding low-risk medical practitioners—those least likely to file malpractice claims and incur payouts.[374] Fear of premium increases could deter physicians from engaging in negligent behavior. Accordingly, implementing a merit-based insurance system for medical malpractice arguably "would have the effect of decreasing the amount of claims, increasing the availability of affordable healthcare, and increasing patient safety."[375]

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368. *See id.* at 427–28.

369. Zevalking, *supra* note 302, at 419.

370. *See supra* notes 339–41 and accompanying text.

371. Zevalking, *supra* note 301, at 418.

372. *Id.* at 419.

373. *See, e.g.*, Lindenfeld, *supra* note 8, at 123, 128.

374. Randall P. Ellis, *Should Medical Professional Liability Insurance Be Experience Rated?*, 57 J. OF RISK & INS. 66, 73 (1990). This merit-based system is modeled after automobile insurance, which uses accident history and traffic violations as critical factors in determining premium prices. *See* Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 564–65 (1983).

375. Lindenfeld, *supra* note 8, at 129.

Critics of using merit-based insurance for medical malpractice argue that the dissimilarities between medical incidents and automobile accidents render the analogy inapposite.[376] While it is usually clear when an automobile accident has occurred, identifying a medical error following an injury is a more difficult task.[377] This concern can be mitigated by considering additional factors as part of the analysis for determining insurance rates. Similar to how automobile insurance companies usually consider age, so should medical malpractice insurers. Although this factor likely would result in pushback from the healthcare industry, the bottom line is that age matters—older physicians are more likely to commit malpractice and incur significant medical malpractice payouts.[378] Other factors, including specialty and whether the physician is an international medical graduate, should also be taken into account in determining premiums. This short of list of factors is not exhaustive, but merely illustrates a few of the considerations that should be considered.

The efficacy of a merit-based medical malpractice insurance would depend on accurate and detailed reporting of a physician's claim history.[379] To be effective, the compilation and maintenance of a physician's payout history would require a joint, coordinated effort by insurance companies, lawmakers, and regulators.[380] If a physician can acquire a clean history report by simply relocating or changing insurers, such a system cannot succeed.[381] The logistics behind such an endeavor could make such a system more difficult to implement than other types of reform. The healthcare industry, however, is already a heavily regulated area. Many states, such as Texas, have a robust licensing and reporting system that provides publicly available information such as a physician's disciplinary and malpractice history. In these states, attaching a medical malpractice history to a physician's credentials for purposes of determining insurance premium rates should be feasible. Insurance reform that takes into account prior physician payouts and other pertinent factors thus represents a plausible method to lower medical malpractice premiums and deter medical negligence.

A related suggestion some commentators have offered in place of traditional malpractice insurance reform is the substitution of captives for conventional

376. *See* MacCourt & Bernstein, *supra* note 317, at 530.

377. *Id.*

378. *See* Lisa Aliferis, *A Few Doctors Account for Outsize Share of Malpractice Claims*, NAT'L. PUB. RADIO (Jan. 28, 2016, 10:59 AM), https://www.npr.org/sections/health-shots/2016/01/28/464691741/a-few-doctors-account-for-outsize-share-of-malpractice-claims.

379. *See* Vine, *supra* note 367, at 431.

380. *See* Lindenfeld, *supra* note 8, at 129.

381. *See* Vine, *supra* note 367, at 431.

insurance.[382] Captives are a version of self-insurance where a parent company pays premiums to a subsidiary company—the captive—that the parent company creates and owns, and the captive handles claims asserted against the parent company.[383] "The primary difference between insuring with a captive versus a commercial insurer is that if the claims paid by the captive are less than the premium, then the captive has made a profit, and thus the parent company—rather than a commercial insurer—benefits."[384] Because captives would eliminate premium payments to third-party insurance companies, they would, at least in theory, reduce a healthcare provider's insurance cost.[385] A state, moreover, could encourage healthcare providers to replace their traditional insurance coverage with a captive system through financial incentives and regulatory assistance.

The implications of insurance reform are complex and will vary from state to state given the different economic and political landscape at play. A full analysis of what effective insurance reform—whether it be conventional reform such as basing premiums on a medical provider's payout record or nontraditional systems such as captives—could look like will have to come in future work. At a minimum, however, states generally should look into implementing some type of insurance reform as a viable alternative to capping noneconomic damages in medical malpractice cases.

This section has presented an alternative remedy to traditional, rigid caps on noneconomic damages. That remedy, as described above, consists of three global suggestions: (1) a flexible cap on noneconomic damages that exempts healthcare providers and medical institutions with poor malpractice claim payout records, (2) a medical apology law to establish an open dialogue between injured patients and their physicians, and (3) insurance reform that targets the actual cause for spikes in malpractice premiums. While the ideal version of the remedy would collectively deploy all three measures, each component offers unique benefits and could be implemented by itself.

States without any caps on damages in medical malpractice cases should not adopt a flexible noneconomic damages cap. But lawmakers in these states should consider insurance reform as an effective method for lowering malpractice premiums. Legislators would need to customize each component based on the current status of the law and particular circumstances in their respective state.

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382. *See* Talmadge, *supra* note 20, at 209

383. *Id.* at 203 (citing Paul Sullivan, *An Insurer of One's Own? It's Possible, With Caveats*, N.Y. TIMES (July 13, 2012), http://www.nytimes.com/2012/07/14/your-money/a-captive-insurance-company-offers-financial-benefits-if-not-abused-wealth-matters.html).

384. Talmadge, *supra* note 20, at 203; *see also* Nicole Williams Koviak, *An Insurance Perspective on the Medical Malpractice Crisis*, 13 ANNALS HEALTH L. 607, 609 (2004).

385. Talmadge, *supra* note 20, at 209 (citing Koviak, *supra* note 384, at 609).

The remedy offered in this article is not a one-size-fits-all solution to lowering medical malpractice premiums and healthcare costs. Rather, it is a template for reform that seeks to achieve what lawmakers purported to accomplish through conventional caps on noneconomic damages—reducing malpractice premiums and healthcare costs—without overly burdening victims of medical malpractice in the process.

CONCLUSION

While controlling healthcare costs and reducing malpractice premiums are undoubtedly important goals, lawmakers cannot turn a blind eye to the harm their decisions have on victims of medical malpractice. Any law that disproportionately shifts the burden of reducing malpractice insurance premiums and healthcare costs to victims of medical malpractice seeking relief in the civil justice system must be recognized as inherently suspect. Nor should legislatures rely on a tactic that has proven ineffective at accomplishing its asserted purpose. In thinking about medical malpractice reform, lawmakers must adopt a nuanced and contextual perspective that takes into accounts the needs of both sides in the debate—the healthcare industry and injured patients. Through such an approach, lawmakers will be better equipped to remedy the current system by implementing reform that alleviates physicians' concerns about escalating malpractice premiums without adversely impacting victims of medical malpractice and widening the social justice gap.