MEDICAL MALPRACTICE: IS IT TIME FOR TORT REFORM IN MARYLAND?

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

So it goes. Not just tobacco, but guns, asbestos, and a cross section of American industry that has morphed into the Mass Tort Monster: “DDT, Bendectin, DES, swine flu vaccine, Copper-7, PCBs, the Dalkon Shield, Shiley heart valves, heart catheters, blood products, silicone breast implants, pedicle screws, penile implants, intraocular lenses, . . . latex, dietary supplements, Fen-Phen, Rezulin, L-tryptophan, Duract, Parlodel, Synthroid, Propulsid and so forth almost ad infinitum.”¹

The manufacturers of those products, and the physicians who recommended them, are targeted.

The U.S. Chamber of Commerce charges that the tort system is wrecking our economy. It is not disputed that, since 1930, growth in litigation costs has been four times the growth of the overall economy. The Chamber reports that federal class actions have tripled over the past 10 years, while similar filings in state courts ballooned by more than 1,000 percent.² The estimated aggregate cost of the tort system in 2002 was $233 billion, or roughly $1,000 for every man, woman, and child in America, according to Tillinghast–Towers Perrin, a respected actuarial firm that works for many insurance companies. The share of this cost going to trial (i.e., plaintiffs') lawyers—roughly $40 billion in 2002—is 150 percent of the annual revenues of Microsoft or Intel, and twice those of Coca-Cola.³ The cost of our tort system represented 2.23 percent of the nation's gross domestic product, or the equivalent of a 5 percent tax on wages.⁴ This cost of nearly $1,000 per American in 2002 compares to a cost of $12 per person in 1950.⁵ Even adjusting for inflation, the cost of tort has increased by more than 900 percent over 50 years. Over the next 10 years, Tillinghast predicts that the total “tort tax” will be $3.6 trillion.⁶

⁵. Ibid.
⁶. Ibid.
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On the other hand, some scholarship maintains that there have been too few tort suits, and that litigation is only now beginning to catch up to the harms wrongfully inflicted on some Americans by others. One 1991 study, for example, concluded that for every eight instances of medical errors leading to harm in America, only one malpractice suit is filed—and that one suit, likely as not, was launched in a case without merit.  

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

WHY HAVE TORT LIABILITY ANYWAY?

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

Private law (roughly, rules regulating the allocation of rights and obligations, or in other words the sharing of risks among citizens) and private ordering (the possibility for people to “self-determine” through interaction amongst themselves) are arguably what distinguish free societies from totalitarian ones. All countries have public law institutions—prisons and police and legislatures, for example. But only in free countries does the private law of contract, property, tort, and family law dominate the acquisition and exchange of rights and obligations. Private law does this by allowing citizens to transfer entitlements (i.e., to assume risks) voluntarily (through contract law) or involuntarily (for one of two reasons: when one’s choices wrongfully cause harm to another, and when family ties impose duties.) Most of us will never have a serious run-in with the police, or with any government agency. But all of us interact daily in the private law legal forum—we work, we buy, we sell, we parent families, and sometimes we “collide” with others who are doing the

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6. Center for Legal Policy.
same thing. Tort law, which assigns private obligations to wrongdoers who cause harm to others in those “collisions,” is an essential component of private ordering.

WHAT TORT IS NOT What is the essence of tort?11 This important question is perhaps best broached by sketching what tort law is not:

- **Tort law is not insurance against unfortunate losses.** Tort law does not exist in order to provide protection against risks. Free societies have a very “thick” (i.e., competitive) contractual market for insurance policies that do just that.12 Most losses that we suffer happen without any tort—lightning may strike us, we may get sick and miss work, or a medical procedure may fail through no fault of the physician. Homeowners’ insurance, health insurance, and life insurance (commonly called “first-party insurance” because they protect the insured party against loss) are widely available and relatively inexpensive.13 If, however, the loss is the result of a wrongful act by a third party, the victim may recover from the tortfeasor.14 If insurance against catastrophic loss is the desired goal, it can be obtained through contract law and a competitive first-party insurance market.

If “free insurance” (otherwise known as “social insurance”) for the poor, or for all, is the desired goal, then public law (including welfare law, tax law, and the like), not tort law, is the appropriate vehicle for the creation of a suitable plan. Public law can socialize risk, removing it from the realm of private ordering. But tort law is not insurance, nor is it a welfare plan.

- **Being an innocent victim is not sufficient to entitle one to tort recovery.** Tort’s essence is not the compensation of “casualties” (although tort does compensate some select innocent victims in certain circumstances). Rather, the essence of tort law is to reallocate risks when one person has wrongfully and without consent caused harm to another.15

Many innocent people suffer losses that, though tragic, should not lead to a tort recovery. Indeed, the vast majority of good people to whom bad things happen have no proper recourse in tort. The pedestrian struck by lightning, the merchant who loses everything she owns to a more efficient business competitor, the baby born with a congenital birth defect, the unintelligent or unattractive, and many, many others, are deserving of our compassion. But this compassion can and should find no solace in tort law. Just because something sad happened does not mean tort law should provide a remedy. Tort law is not an equalizer. Only a horrific use of public law could equalize everyone’s chances and outcomes.16

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13. The loading cost of first-party insurance is roughly 10 percent; that is, of every dollar in premium paid, about 90 cents go to cover losses. The remainder covers administrative fees and profit.
14. Of course, the victim may not recover from the tortfeasor if the victim has already been paid by her first-party insurer and has transferred her tort entitlement to that insurer. If that transfer has not taken place, the victim has a suit against the person who has wrongfully harmed her.
16. See, e.g., Kurt Vonnegut’s *Harrison Bergeron*. 
TORTS AND CONTRACTS  It is of the essence of private ordering that tort be properly subjugated to the contractual transfer of risks. If I assume a risk voluntarily, through contract, I cannot sue my contract partner in tort if the risk materializes. If I purchase a home in a one-industry town, I may not blame my seller two years later after the factory has shut down and my house has lost most of its value. I assumed that risk through contract by buying the house.

When a victim expressly or implicitly assumes a risk of loss through contract, tort must decline to shift that risk elsewhere. Medical procedures are inherently risky; the mere fact that an operation is not successful is not sufficient basis for a tort remedy.

TORT LAW AS PRIVATE LAW  Tort suits are adjustments of risks between private parties. They are very different from public law, both criminal and regulatory, in several important ways:

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

- **Tort suits are about private adjustments of risks; they should not be a mechanism to express public outrage.** Vindication of public outrage is the province of criminal law, a principal component of public ordering.\(^\text{17}\)

- **Tort law is not about punishment.** Criminal adjudication punishes the culprit; common law torts require compensation only.\(^\text{18}\)

- **Common law tort suits are not properly concerned with the enactment of “public policy.”** Instead, public policy is a quintessential yield of public ordering. Every citizen has the right to intervene in the legislative process that produces public policy, but only the parties directly involved in a tort suit are permitted to intercede in that suit. Our legislative process, which guarantees to all the right to voice their views, is the only constitutional forum for policymaking. But common law judges must not make public policy.

- **Tort suits were not designed as, and are inappropriate vehicles for, coerced redistribution of resources.** Redistribution is the province of tax and welfare law, which are components of public ordering. Coerced transfer through public ordering is typically based on conceptions of distributive justice—the view that certain citizens have “too much” and others “not enough.”\(^\text{19}\) In tort law, however, forced transfers are based on notions of corrective justice—the notion that when a defendant has wrongfully caused a loss to this plaintiff, the plaintiff should have recourse to receive compensation for that loss. The notion of corrective justice has no distributive punch; that is, if a defendant—no


\(^{18}\) It is true that modern-day products liability suits are often characterized by huge punitive damages. But punitive damages are extremely rare in tort adjudication in general. Only about 3 percent of victorious tort suits adjudge punitive damages, and most of those are cases involving intentional tort. See the Bureau of Justice Statistics study *Civil Justice Survey of State Courts, 1996 Tort Trials and Verdicts in Large Counties* (2000).

matter how poor and pitiful—wrongfully\textsuperscript{20} harms a victim—however rich and power-
ful—the victim is owed compensation in tort.

Tort law is essential to private ordering. To see this, imagine that tort was replaced by social insur-
ance, i.e., that every loss was deemed a public loss because government provided total protection
against all risks in life. Imagine also that government proceeded to sue (i.e., prosecute) all those
who caused “claims” on its resources. In such a society there would be no need for tort law—gov-
ernment recovery of its payouts would use tax or criminal law. There would also be no meaning-
ful contract law in such a world; if all risks are borne by government, then private individuals
could not really own property because ownership would mean the assumption of the risk of loss.\textsuperscript{21} Socialization of risks substitutes public for private ordering.

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

THE GENERAL MEDICAL MALPRACTICE PROBLEM

Medical malpractice has been more prone to cries of “crisis” than other areas of tort law. Manifes-
tations of the alleged med-mal crisis are, among others:

- **Relatively brutal increases in tort liability** Since 1975, when insurers first began to
  itemize tort costs attributable to med-mal, med-mal costs have grown at a compound
  annual rate of 11.9 percent, which is fully 25 percent more rapidly than the 9.5 percent
  annual increase already bemoaned for all U.S. tort costs.\textsuperscript{22} Those medical liability costs
  have been translated into uneven, sometimes drastic, increases in med-mal premiums, as
  liability insurers periodically hemorrhage money—for every dollar of premium earned in
  2001, for example, insurers paid out $1.38 nationally. In addition, the much-publicized
decision by St. Paul, the biggest single med-mal insurer in the nation, to cease writing new
med-mal policies contributed to a drop of approximately 15 percent of the premium-writ-
ing capacity of the industry.\textsuperscript{23}

\textsuperscript{20} Some may object that strict liability does not require wrongdoing for tort liability. But when the term “strict
liability” is invoked in products cases, the court is in fact assigning liability for negligence (in defective
design cases) or for breach of contract (in defective manufacturing and “failure to warn” cases).

\textsuperscript{21} “Owners” would in fact become “tenants” of government in such a system; the only party that would truly
absorb a loss would be government. But a new risk would emerge in such a system: the risk that govern-
ment would decide that one's holdings more properly belonged to someone else. This political risk of pub-
licly ordered societies has proven to be one of the downfalls of Marxist collectivism.

\textsuperscript{22} U.S. Tort Costs–2003 Update, published by Tillinghast–Towers Perrin.

magazine). Medical Mutual of Maryland, today the largest single med-mal insurer in the state, was formed
by Maryland physicians with their own money in part as a result of St. Paul's actions. Today over two-thirds
of all practicing physicians in Maryland are assured by this non-profit.
• **An increase in mammoth claims** According to one database, the percentage of payments over $1 million doubled, to slightly more than 7 percent of med-mal claims, from 1995 to 2001 alone. Today over 10 percent of med-mal payments are over $1 million nationally. In some specialties, such as OB-GYN, the average claim is now over $1 million. Mammoth claims affect med-mal insurance rates and insurability much more than do smaller claims, as they drastically increase risk for insurers and greatly increase their desire to engage in “nuisance settlements” of invalid claims (in order to avoid the small risk of an unjustified massive award).

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

• **Exacerbation of medical inflation** This is said to occur not only because high liability awards are factored into insurance premiums, but also and most importantly because redundant and expensive tests, procedures, and referrals are said to be performed by physicians (and in fact indirectly required by malpractice insurers) as costly prophylactics against med-mal liability. One telling example of this is highlighted immediately below.

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

The study found that over seven in 10 obstetricians had been sued at least once. Suits in modern times invariably followed “imperfect” births, which constitute (depending on one’s definition of “imperfect”) upwards of 5 percent of all births today. Plaintiffs usually claim that had the obstetrician delivered the baby earlier, by caesarian section, the baby would have been “perfect.” Claims like that are rampant; the NIM committee found, for instance, that in Massachusetts fully 80 percent of obstetrical malpractice claims included a charge of failure to perform a caesarian section.

Such comparatively empty claims, in the absence of any individualized evidence of wrongdoing or causation, never would have reached a jury in early times. But of late, they are allowed to go to juries who know full well that the defendant physician is insured against liability. That knowledge, and fear of mammoth awards of “free money” to parents, leads insurers to propose hefty settlements and substantial increases in med-mal premiums even when the physician has done nothing wrong.

As a result of this development, the National Institutes of Medicine committee documented a startling increase in the number of caesarian section births. By 1990, caesarians accounted for 25 percent of all deliveries in the country, easily the highest rate in the world and a fivefold increase from the 5 percent rate in 1970. The nationwide billing for unnecessary caesarian section deliveries was estimated at $750 million per year in 1990 dollars, not including the costs of negative
side-effects of surgery. The NIM study found a distinct relationship between the med-mal system and caesarian sections.

The desire for a “normal” baby is overwhelming, yet about 5 percent of babies are handicapped, usually neurologically. This tragedy has been with us from time immemorial, except that in earlier days relatively primitive medical equipment meant that the survival rate for “bad babies” was relatively low. A stillborn baby was quickly buried, and the terrible grief from the baby’s death slowly faded. Today, thank God, very few babies die at birth, but babies with neurological problems have high maintenance costs and limited prospects for earning a high income when they reach adulthood.

Whereas in the past parents were wont to conclude that divine will, or in some cases the parents’ own misbehavior during pregnancy, was likely the cause of their child’s “defect,” today very large amounts of money are at stake and it is easy to convince a reeling parent that someone must be to blame. Plaintiffs’ lawyers are most anxious to get before a jury and ask for “compensation” for the innocent baby from the doctor’s large, faceless med-mal insurer. Infant neurological damage accounted for the absolute majority of suits against OB-GYNs in many states by the time the NIM study was published, and was second (to breast cancer claims against gynecologists) in other states. Today it is clear that neurological obstetric suits have captured the #1 rank in the med-mal hit parade.

Typically, OB-GYN med-mal suits run into millions and often the tens of millions (the cost of rearing a “defective” child). Classically, the plaintiff’s claim is that the obstetrician failed to monitor the fetus adequately, which in turn led to the failure to perform the caesarian section.

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

Consider, for example, the largest med-mal case in Connecticut history: Sabia v Humes. Despite a total lack of evidence of any causal negligence, an OB-GYN and her insurer were led to a multimillion dollar settlement of a “bad baby” case.24 Nothing unique about Connecticut law allowed Sabia to happen—the state’s common law of med-mal is essentially identical to Maryland’s. Indeed, Sabia happens, writ large, across the country every year.

The NIM committee found that in every state, sizeable numbers of family practitioners had eliminated OB-GYN from their practice by 1990. They were compelled to do so because the huge discrepancy in liability insurance premiums made the obstetric part of their practice unprofitable. Obstetrical specialists, for their part, reduced or eliminated their services to high-risk women. One common way for OB-GYNs to screen out high-risk pregnancies is to cut their Medicaid caseloads, because Medicaid

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patients are more likely to have engaged in poor prenatal care and because the pro-rata cost of malpractice insurance all by itself is often greater than Medicaid reimbursement for the delivery.

This is clearly perverse. The purpose of private ordering is not achieved by transferring a risk from a possibly innocent parent to an almost certainly innocent doctor. What is achieved by this forced insurance is a frustration of many doctors’ idealistic career goals. The doctor who has been sued (and, recall, an absolute majority of OB-GYNs have now been sued) learns to treat his or her patients as future adversaries. The doctor who treats his patients as potential adversaries cannot provide the caring healing, which itself increases cure rates. In this way, the med-mal explosion, used in the United States as a financing mechanism for gravely injured children, contributes to the injury rate. Overuse of knowingly needless and expensive procedures and equipment (like EFMs) is one of many ways in which med-mal’s costs filter down to the entire population. Demoralization of the healing arts is another way in which this misdeed is done.

In general, advances in technology constantly provide new ammunition for those in search of a reason for a bad medical result. (“Why didn’t you use this device? It might possibly have made a difference.”) The ubiquity of third-party malpractice insurance eases jurors’ pain, as they decide that the doctor will not really “feel” the tort award, which will be paid by a faceless corporation. But third-party insurance has a load effect of over 100 percent—that is, it costs over $2 in premiums to get $1 to a needy person. The real losers are, thus, doctors and patients alike, who suffer a decline in supply and an increase in the price of medical services. In ways similar to that afflicting obstetrics, other specialties and even general practice have been afflicted by this desire of juries to turn tort law into future health insurance. This is a perversion of private ordering and only tort reform can cure it.

IS MARYLAND IN A “CRISIS”?

It would be astonishing if Maryland were somehow immune from the tendencies described above. According to the Maryland Hospital Association and Medical Mutual (the state’s largest malpractice insurer), the Old Line State has very recently become a poster child for the problem. Here are some representative factoids highlighting the MHA claim:

- The average settlement for a med-mal case has risen 99 percent in the last four years, and now exceeds $410,000.

- For OB-GYNs, the average settlement exceeds $1 million. This year, the average malpractice premium will reach $150,000 despite the lack of evidence that the state’s obstetricians are careless or negligent.

- There are no high-risk pregnancy obstetricians left on the Eastern Shore.25

- Kent County lost its only back surgeon as a result of malpractice fears.26

It is difficult to argue that the premium increases are the result of “gouging” by insurers. Each year, nationwide, the Department of Justice concludes that the insurance industry is among the most competitive in the land—there is simply no chance to “gouge” when any pricing inefficiency

would be competed away by another firm. As stated above, it is estimated that 66–75 percent of all practicing Maryland physicians are insured by their own mutual insurance company (Medical Mutual). If insurance was “gouged” in Maryland, there would be an influx of new companies looking to take a big piece of this sweet pie from Medical Mutual. But whereas in 1996 there were 14 carriers actively writing new physician med-mal policies in the state, today Medical Mutual is virtually alone.27

It is likewise difficult to argue that “a few bad apples” among the doctors are causing the problem in Maryland. A 2003 position paper by the lobbying group Public Citizen alleged that this is the case, noting that 3 percent of Maryland physicians had 2 or more claims against them between 1990 and 2002.28 That argument is not persuasive, however; a chance distribution of lawsuits against all Maryland physicians would result in 4 percent of doctors having two or more claims during the same period.29 The data in fact support the view that liability has little or nothing to do with talent, and strikes Maryland doctors randomly.

It seems highly unlikely that most state doctors are incompetent. In fact, the rate of lawsuits is not increasing; it is the amount of the awards that is exploding, for the technological (not the legal) reasons outlined above. Mimicking nationwide trends, 55 percent of Medical Mutual’s emergency room physicians, 62 percent of its OB-GYNs, and 70 percent of its general surgeons have been sued for malpractice.

Consider the story, as reported in the Annapolis Daily Record, of OB-GYN Dr. Samuel Akman, who saw his five-doctor practice’s insurance premium increase to $600,000 per year, or fully 25 percent of the practice’s gross income, after the 28 percent rate hike enacted in 2003. The 2004 premium will be about $900,000 if the 2005 rate increase goes into effect. Those increases come at a time when insurance reimbursements for services have been dropping, especially for delivering babies. Dr. Akman received $3,000 for a normal delivery in 1990, compared with about $1,800 today. That is a drop of over 50 percent when inflation is taken into account.30

It is not surprising, therefore, to learn that many Maryland physicians concede that they often order more medical tests for their patients than they would have requested based on their professional judgment of what is medically needed. The excessive testing is both “defensive medicine” to protect against med-mal claims and a way to increase their revenues to balance out their rising costs. How many Maryland family practitioners make what they themselves believe to be needless referrals to specialists for the same reason?

**OPPOSING VIEW** The data tend to corroborate the claim that Maryland is caught up in the same torts outburst that afflicts much of the rest of the nation. But the Public Citizen 2003 report makes some important countervailing arguments that we should examine:

27. A number of the providers of medical malpractice coverage in Maryland are insolvent or of dubious solvency, including PIE Mutual, PHICO, Legion, Frontier, Reciprocal of America, Reciprocal Alliance, and Western Indemnity.
29. See Medical Mutual Liability Insurance Society of Maryland’s response to the Public Citizen paper. The 4 percent figure falls to 3 percent if one adjusts the total number of physicians to account for those who are retired or who are licensed in Maryland but practice in another state.
The number of physicians registered in the state has not diminished. Objective data tend to indicate, at a very basic level, that the number of registered physicians per capita in Maryland has remained stable from 1997 (when 22,559 active physicians were registered in the state) to 2002 (when 24,101 active physicians worked here). That leads to the question, if Maryland has such an inhospitable med-mal climate, then why are doctors not leaving the state?

But those data may not present an accurate picture. Registration figures with the state medical association are not a good proxy for extent of practice. For instance, a physician who scales down her practice, who refuses to take new patients, who refuses to take high-risk patients, or who “unofficially” retires while maintaining her active status in case she changes her mind in the future, would still show up on the register.

This is not a mere theoretical possibility: There is some indication that the torts crisis has made formally leaving the profession more expensive than staying in for many physicians. The problem is the cost of so-called “tail coverage”—coverage for claims about alleged negligence in prior years. Tail coverage is necessary for exiting physicians because the med-mal crisis has caused virtually all liability insurance to shift from “act” insurance (insurance for a given year covers all acts accomplished that year, regardless of when a claim involving those acts is filed) to “claims-made” insurance (insurance for a given year covers only acts resulting in a claim that same year). Tail coverage typically costs 200 percent or more of one year’s premiums, which could mean more than $300,000 in a lump sum for obstetricians desiring to leave the profession in 2005. The huge “tail coverage” premium problem is exacerbated in Maryland because of the state’s incredibly long period in which plaintiffs can sue for certain medical “injuries.”

Physicians paid “too little” in premiums in the early 1990s, or their insurer lost money in the stock market. Public Citizen claims that prior losses by insurers and inaccurate submission of loss data explain the huge increases in malpractice premiums. But those claims seem problematic.

There is some evidence to support the proposition that liability insurance premiums do not increase at a slow, steady rate, but in a staccato-like fashion. In brief, this is because liability insurance premiums are calculated as a function of two factors: the amount the insurer expects to have to pay out in liability awards (including legal fees) and the amount the insurer expects to reap in investment income on the “float” (the premium retained before liability is incurred). If real interest rates and stock market returns are quite high, insurers can afford to lose some money on underwriting—they will more than make up for that loss as a return on investment. It is true that bond yields have declined and equity values have come down from their highs of the 1990s. Returns for liability companies like Medical Mutual must (under state regulation) derive principally from bond returns (as of September 2003 the company had no stock market investments), and a reduction of interest rate assumptions from (say) 6.5 percent to 5.5 percent leads to a rate increase of approximately 3 percent. An increase in interest rate assumptions would lead to a corresponding decrease in premiums.
But this is a minor factor in insurance premium calculations. Assume the projected payout cost (administrative plus claims-related costs) of a policy is $1,000. If the average payout time is three years (that is, if premiums collected in 2004 will on average be paid out to claimants in 2007), then the premiums can be invested for three years. At a 5.5 percent interest rate, a premium of $855 is required to cover this expected payout. At a 6.5 percent interest rate, the annual premium would have to be $830.

Hence, investment returns explain only a small part of the movement of liability insurance premiums. Without the distortion caused by the vagaries of investment returns, it is likely that we would have witnessed more regular, steady increases in med-mal premiums over the past few decades. Instead, periods of slight premium increase (or even premium decreases, as new entrants into the liability insurance industry tried to profit from high investment returns on the “float” of premiums) have alternated with periods of huge increases.

Contrary to what Public Citizen argues, insurance companies cannot simply raise their future premiums to make up for past investment losses. The market is too competitive. Even if regulators allowed rate increases based on investment losses (which they do not—rate filings consider only expected future income and expenses, not past income and expenses), new insurance firms without prior investment losses would enter the market to undercut any proposed increase. Thus, and as a matter both of regulation and fundamental economic theory, insurance firms must charge a premium that will allow them a competitive profit given future investment income and liability payout.32 Incompetently managed companies, as St. Paul was (it charged premiums that were far too low, actuarially, and was obliged to exit the med-mal market), do occasionally crop up.33 But the market exacts its own discipline against such companies. Med-mal insurance premiums, fairly priced from a competitive actuarial standpoint, are much higher than they used to be, and are much higher than they are in other countries, without procuring monopoly rents to insurers. (For example, Maryland med-mal awards are approximately 1,000 percent of those of Canada, and Maryland doctors are 500 percent more likely to be held liable than are Canadian doctors, yet I have read no claim that Maryland doctors are five or 10 times less competent than Canadian doctors.34) Maryland Mutual has substantial enough reserves to merit an A- rating from A.M. Best—which merits the firm an “excellent” rating from Best—but there are higher “excellent” ratings (A++, A+, A, and A-) Moreover, hospitals typically require physicians with residency privileges to have liability insurance from an “excellent” insurer. Maryland’s nonprofit seems to be competently run35 and there is no evidence of price gouging.

31. In 2002, the interest assumption in most states was in fact lowered from 6.5 percent to 5.5 percent. See, e.g., N.C. House Committee Blue Ribbon Task Force on Medical Malpractice, Physician Professional Liability Insurance Data, December 2, 2003.
32. This point was made quite lucidly by James Hurley, chairman of the Medical Malpractice Subcommittee of the American Academy of Actuaries, in a hearing by the Subcommittee on Health of the U.S. House Committee on Energy and Commerce, July 17, 2002.
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- **Payouts by medical liability insurers have dropped when compared with the rate of medical inflation.** The Public Citizen study concluded, on the basis of data from the National Practitioner Data Bank (NPDB) that from 1996 to 2002, after adjusting for medical inflation, the total amount of med-mal payouts in Maryland dropped about 17 percent. Thus, Public Citizen claimed, there has been no real increase in med-mal in the state. But this statistic is highly misleading, for a couple of reasons. First, NPDB data fluctuates wildly from one year to the next because reporting by lawyers varies tremendously; 1996 was an exceptional and unrepresentative year for med-mal reports in Maryland. Much of this discrepancy may have been the result of an unusually high number of claims filed in 1996 because of changes to state med-mal law as regards Health Claims Arbitration (HCA). HCA had existed for many years in Maryland as a mandatory (though nonbinding) process, but was changed in late 1995 to an optional (still nonbinding) practice. The pending change from mandatory to optional was known about six months prior to the effective date, which likely led to fewer claims reported in 1995 and more reported in 1996 when plaintiffs would no longer have to submit to arbitration. By using 1996 as the start date in determining the trend in filed claims, Public Citizen used an artificially high point as a starting point.36

Using NPDB's own data, payments increased by 26 percent more than medical inflation between 1999 and 2002, and 50 percent more than medical inflation between 1992 and 2002. 2003 payouts alone were approximately 47 percent higher than in 2002. The number of $1 million claims in 2003 was more than double that of any previous year.37

More importantly, even if Public Citizen were correct in arguing that medical practitioner liability has not increased faster than “medical inflation,” it would not follow that there is no med-mal crisis. There is no reason why practitioner liability should increase proportionately with the cost of medical care. The latter cost has increased largely because of new techniques, medical devices, and pharmaceuticals that enhance human longevity and reduce the rate of medical failures. Those developments reflect an increase in knowledge, which has led to increased longevity. Thus, if standards of med-mal liability had been held constant over time, one would expect med-mal claim frequency to decrease in absolute terms, or at least to increase far less than “medical inflation.”

That this has not occurred is evidence of an outburst in torts, contrary to what Public Citizen claims. There has surely been a real increase in both the chance a physician will be held liable and the extent of damages the physician will have to pay if held liable.

**CALIFORNIA** The experience of another state should be very instructive to Maryland policymakers. California, formerly a tort plaintiff's paradise but now with a $250,000 cap on non-economic loss and several other reforms thanks to its MICRA legislation, has among the lowest costs of states with 10,000 or more physicians. California’s average claim payment, reflecting MICRA, is consistently below Maryland's. California's malpractice insurance premiums, as compared to

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35. Medical Mutual's underwriting expense ratio is 18.1 percent, meaning that it spends 18 cents on administrative fees for every $1 of total income. That is slightly lower than the national average of 18.3 percent.
36. Medical Mutual noted this in its response to Public Citizen.
37. Again, Medical Mutual noted this in its response to Public Citizen.
average med-mal premiums across the nation, have been dropping ever since its courts upheld the constitutionality of its reforms in 1985.

Between 1985 and 2001, California malpractice premiums decreased from 16.9 percent to 9.1 percent of total malpractice premiums paid across the country. In the same time, California’s population increased slightly as a percentage of the national population, from 11 percent to 12 percent. In California, unlike Maryland, there has surely been a decrease in both the chance a physician will be held liable and the extent of damages the physician will have to pay if held liable.

What, then, to do about Maryland’s med-mal situation?

IS MEDICAL MALPRACTICE REFORM APPROPRIATE IN MARYLAND?

Almost all 50 states, including Maryland, have enacted some kind of tort reform applicable to med-mal. In some states, the tort reform enacted was general (i.e., it was applicable to all tort suits, including but not limited to med-mal), while in others the reform applied only to med-mal.

In this section I will canvass seven principal kinds of reforms that have been adopted, noting the advantages and drawbacks of the proposed reform as I see them.

1. **COMPULSORY ALTERNATIVE DISPUTE RESOLUTION** This reform typically mandates that would-be plaintiffs first seek relief through some alternative adjudication process (such as nonbinding arbitration of the claim by an expert panel of medical professionals) before a med-mal suit can be brought. The panel can recommend for or against compensation, but its sentence does not prevent the losing party from filing a tort suit de novo. The goal, presumably, is to nip in the bud the most frivolous lawsuits by showing the plaintiff’s lawyer that he has no hope of success, and to do this at low cost to innocent physician defendants. If the arbitration result is relatively certain and relatively cheap, the defendant’s insurer will be less likely to offer the generous “nuisance settlements” that drive up premiums. Moreover, with little prospect of a generous “nuisance settlement,” the contingent fee attorney will probably drop a losing claim rather than invest hundreds of his own hours of labor in it. Many states have incorporated a version of this reform. Maryland experimented with it, requiring nonbinding arbitration in med-mal cases until late 1995. Today, arbitration is not compulsory.

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

One state’s proposed reform, however, goes beyond the normal arbitration requirement. Bill 902, adopted by the North Carolina Senate in September 2003 but not yet dealt with by the House, allows a judge to order mandatory nonbinding arbitration at his or her discretion. The
legislation requires that a panel of three expert “referees” be chosen (one by each side, a third jointly or by the judge). After reviewing the med-mal case, the panel would either recommend that the defendant settle (if the panel decides the plaintiff’s case has merit) or that the plaintiff drop his or her suit (if the panel decides the case is without merit). The North Carolina bill states that if a party (the plaintiff in most cases) loses before the arbitration panel and again before the jury, that party must pay the court costs (including lawyers’ fees) of the winning side. This provision, if it is enacted and if it survives the expected constitutional challenge, would arguably dissuade a plaintiff’s lawyer from pursuing a dubious suit after an adverse arbitral sentence. Of course, settlements could not be easily subjected to the “loser-pays” rule, so I would expect lots of last-minute settlements of otherwise losing cases. On the other hand, insurers would be far less likely to advocate nuisance settlements when their bargaining position is increased by a fee-shifting threat. If this reform is enacted and survives judicial scrutiny, it would reduce insurers’ incentive to settle nuisance cases.

As an aside, I note that an even more useful reform might be to allow freedom of contract to select binding arbitration. Most jurisdictions do not allow physicians to refuse to treat patients who decline binding arbitration. The fear is that patients lack “equal bargaining power” with physicians, and therefore should not be allowed to renounce their right to a jury trial in return for receiving the physician’s services at a given price. But as the academic literature shows that juries have no accuracy when it comes to evaluating physicians’ behavior, it seems odd that parties would not be allowed, in advance, to choose a more expert (and accurate) forum. No judicial discretion to order arbitration would be needed if the parties could choose binding arbitration themselves. Physicians willing to subject themselves to juries would be free to do so, and patients would then presumably be free to pay the “tort premium” the physicians would require to practice their profession in this way.

2. LIMITING CONTINGENT FEES Some jurisdictions have capped plaintiffs’ lawyers’ med-mal contingent fees at 33 percent, or at some lesser figure derived from a sliding scale of the amount eventually obtained. Typically, the maximum marginal “commission” for the plaintiff’s attorney drops as the award or settlement amount increases. Such modifications have typically (though not invariably) been upheld by state courts applying their own constitutions—and the United States Supreme Court has not found fee caps to adversely affect any federal right to counsel.

But there is question of whether this reform results in a perverse incentive. Some researchers believe the caps lead attorneys to inflate the quantum they demand, especially of non-economic damages in order to emerge with the same fee the attorney now receives for similar work. There is not sufficient academic research, yet, to properly evaluate that claim, but it does seem likely that attorneys would endeavor to equalize past income one way or another.

38. I predict a litigant will claim that the fee-shifting provision “chills” the plaintiff's exercise of his right to a jury trial. Some states’ courts have upheld analogous challenges, others have not.
39. I assume that contingent fee attorneys will bear this cost, i.e., they will agree to “hold harmless” their clients against any claim of attorneys’ fees by the defendant physician.
Presumably, one real effect of such a reform, like all price controls, would be to induce unethical “side payments” made by a plaintiff to an attorney who is particularly in demand and who would otherwise equilibrate supply and demand by increasing the contingent fee. Money payments might be easy to trace, but barter arrangements (as where the plaintiff provides free or reduced-price services to the attorney) would be much harder to police.

Little known to tort reformers is that, even under current law, many and perhaps most contingent fees are already violations of states’ ethics codes. Virtually every state’s Rules of Professional Responsibility and case law tradition require that contingent fees be both “reasonable” (i.e., not too high, given the work invested by the lawyer and the true risk of non-recovery assumed by the attorney) and “subsidiary” (i.e., that the client preferring to pay an hourly or fixed fee be given that option). Most contingent fees fail one or both of those tests, and are therefore vulnerable to challenge as unethical and even illegal.42

3. MODIFYING THE “COLLATERAL SOURCE” RULE  To understand the current “collateral source” rule, assume a plaintiff is wrongfully injured by a defendant, and the plaintiff suffers $10,000 in damages. Before the plaintiff can sue, a third party intervenes to reimburse the $10,000 lost. Should the plaintiff nonetheless have the right to sue the defendant for that amount?

The common law of many states, including Maryland, does not allow a negligent defendant to deduct from what he owes his victim any sums given to the victim by third parties. Originally, this provision was meant to ensure that gratuities made to, or insurance policies purchased by, the victim truly helped the victim instead of helping the “bad guy.”43 Similarly, if a doctor negligently causes a patient to miss a day’s work but the patient’s employer paid the patient his salary for that day anyway, should the patient be able to recover that salary (a second time, as it were) by suing the physician? Yes, says the common law rule.44 Insurers who indemnify their clients (first-party insurance) are free to require subrogation as a condition of their policy, in which case the tortfeasor would be liable to reimburse the insurer for sums paid.

The proliferation of third-party payments has transformed the common law collateral source rule into what today looks like a real boondoggle for some plaintiffs. To take but one example: In a case from Virginia, an employee-doctor of Kaiser Permanente (the victim’s health care provider and insurer) botched an operation. A second operation was required to repair the damage caused by the doctor’s negligence. Kaiser Permanente offered this second operation free of charge to the victim. The victim accepted, had the second (successful) operation, then turned around and sued Kaiser Permanente for the commercial value of the second operation (i.e., what the victim would have had to pay if he had not been insured by Kaiser). Kaiser was ordered to pay, as it were, a second time for this operation under the collateral source rule.45


43. If the victim’s first-party insurance policy has a subrogation clause (i.e., a clause allowing the insurance company to recover its payment from any available tortfeasor), then that clause will be enforced and the insured will not be “paid twice.” The collateral source rule applies, therefore, to third-party payments that are not made subject to subrogation clauses.

44. Bullard v. Alfonso, 595 S.E.2d 284 (Va., 2004).
In other cases, plaintiffs have been allowed to sue hospitals for the very high “list price” cost of medical procedures, even though the costs they and virtually all patients pay for such procedures is far “under list” because their health insurer has obtained “discount” rates.

Blanket modification of the collateral source rule would reduce payouts—in the short run. But in the long run, some such receipts (for example, gifts to the victim or insurance payments received by the victim) would be contractually modified to require reimbursement to the giver/insurer if a solvent tortfeasor becomes available. That is because neither the donor nor the purchaser of first-party insurance wishes to benefit the tortfeasor in any way. In that sense, the basis of the collateral source rule reflects the situation that would likely prevail in its absence. That is a strong argument against its global repeal. On the other hand, where the benefit has been paid by the defendant itself (as in the Kaiser Permanente case) or accrues to virtually everyone (as in the hospital fee scenario), reform of the collateral source rule would seem appropriate.

4. **PERIODIC PAYMENTS** Under this very common reform, which is also known as “structured settlements,” a defendant may pay future economic damages (typically, medical payments) on a periodic basis, instead of paying an estimate in one lump sum as the common law provides. It is felt that this will reduce exaggerated damage claims by the plaintiff and overly generous lump-sum awards by the jury.

I confess that I am not a fan of periodic payment requirements. First, they must be accompanied by detailed bonding provisions because the defendant must give some kind of guarantee that he or she will not dissipate his or her assets between this year’s payment and next year’s. In practice, the guarantee is a bond or an annuity, which requires a lump sum payment by the defendant—but this payment goes to an insurance company, not to the plaintiff. This is cumbersome and costly administratively.

Additionally, periodic payments encourage plaintiffs to mangle (so as to maximize next year’s payment), and the payments come to have the same perverse incentive as welfare payments. Malingering is discoverable, but it is costly to discover it. On the other hand, lump sum awards encourage the plaintiff to get well as soon as possible—and sooner than was predicted when the award was made—so as to maximize recovery. Surely, it is in society’s interest to have productive members back in the workforce sooner rather than later. Periodic payment provisions have not really caught on where they have been enacted; I suspect the reasons I have just enumerated explain why, to a great extent.

Maryland currently allows judges to “structure” jury awards as periodic payments. The option is rarely invoked, however, in part because the defendant must guarantee the solvency of the annuity payer. That would oblige the defendant to place the entire debt on its books, as it were. Eliminating this requirement would remove that accounting issue, and we could see if structured settlements are truly popular.

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

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Medical Malpractice: Is it Time for Tort Reform in Maryland?

- **Non-Economic Damage Caps** Over half of all tort awards these days pay for non-economic damages, also known as “general damages” or “pain and suffering.” Pain and suffering are quite real phenomena, and a wrongdoer has no carte blanche to inflict them on innocent victims. On the other hand, pain and suffering are intrinsically tough to quantify: Is the pain caused by the loss of a hand “worth” $5,000, or $500,000, or $5,000,000, or $50,000,000 or some other sum? Is the suffering occasioned by a patient’s knowledge that he or she is disfigured for life “worth” $10,000 or $100,000, or $1 million or some other sum?

Despite ingenious attempts by economists to quantify pain and suffering, the fact remains that juries are not instructed on economic theory, and jury awards for non-economic damages vary tremendously. For economic damages, on the other hand, empirical evidence is “firmer” and it is easier for a judge to strike down a jury award that it beyond the pale of good objective analysis. If a patient loses a week of work because of a doctor’s negligence, the judge will not allow the jury to award the patient two weeks’ pay.

Only a cap, either judicial (as has been imposed as a matter of common law by Canada’s Supreme Court) or legislative (as has been done in many states including Maryland), can chop the tail off of the snake of non-economic damages. Since high variance awards have a very significant effect on expected liability and on willingness to settle, caps on non-economic damages are meaningful in the extreme. My own view is that a cap of $250,000, like the one in place in California, is clearly insufficient these days; not only are extreme cases of pain arguably “worth” more than that amount as a matter of corrective justice, but it also is the practical case that the lower the cap, the greater the likelihood that a state court will find that the tort plaintiff has been denied her constitutional right to seek redress for harm caused her.

At the time this paper is written in late 2004, Maryland had a cap of $635,000 on non-economic damages—one of the most generous caps in the country. Under state law, that cap increases by $15,000 each year. Maryland courts have interpreted the law such that the cap is applied separately to each of the two formally separate legal claims involved in a wrongful death suit. Thus, currently, the estate of a wrongfully killed decedent is entitled to up to $635,000 in non-economic damages (for the pain inflicted on the deceased) and the wrongful death survivors are entitled to as much as $952,000 (1.5 times the cap, according to statute) more in pain and suffering for their loss. Thus the total potential non-economic damage in a wrongful death suit can reach $1,587,000 — in addition to full reimbursement of economic damages. This “cap” is so high as to not really be a cap on damages. Modification of Maryland law to reinstate a realistic and meaningful cap (say, of $500,000 indexed for inflation) with no possibility of “doubling” is urgently needed to return the state to the original purpose of the cap.

In the many states with such caps, plaintiffs’ lawyers have challenged them on state constitutional grounds. In a few states (like Ohio), those challenges have been broadly sustained.

46. The higher the variance of awards, the greater the risk for the defendant and his/her insurer, and therefore the greater the likelihood of high nuisance settlements, for instance.
and the entire cap quashed. But in most states, this kind of tort reform has survived state constitutional scrutiny.

- **Comprehensive Caps**  Virginia and a few other states have no cap on non-economic damages. But they do have a cap on total med-mal damages, whatever their source. Thus, given a comprehensive med-mal cap of, say, $1 million, no judgment could be obtained for more than that amount, even if, say, a negligent physician caused a patient to require 10medial operations at a cost of $3 million. Under Virginia’s cap, the patient, and not the negligent physician, is on the hook for economic harm in excess of the cap.

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

Both because it denies basic tort principles and because it is open to challenge on “equal protection” grounds, I do not advocate Maryland adopting a Virginia-type cap.

6. **NO-FAULT COMPENSATION** One effort to stem the abuse of tort law in the OB-GYN field consists of removing recovery from tort law and treating the issue as one of insurance, having nothing to do with fault. Virginia implemented this solution in 1987, with its Birth-Related Neurological Injury Compensation Act. That act created the Birth-Related Neurological Injury Compensation Fund, often referred to as the “bad baby” fund. Participation in the program is not mandatory for either physicians or hospitals.

Obstetricians who want to participate pay $5,000 into the fund each year, while all other physicians licensed in the state, including those who do not practice any obstetrics at all and who do not participate in the fund, are nonetheless assessed $250 per year. Participating hospitals pay a sum equal to $50 multiplied by the number of deliveries made during the prior year, with a cap of $150,000 per hospital per year. If those assets are inadequate to maintain the fund on an actuarially sound basis, a premium tax of up to one-quarter of one percent of net direct premiums written in the state can be assessed on all liability insurance carriers in the state. All those payments go directly into the fund, which is designed to be self-sufficient. None of the money for the program is to come from the state’s general revenues.

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

Interestingly, the fund has not proven to be universally popular among OB-GYNs in Virginia. Many have opted not to pay the $5,000 per year for the protection the fund affords, perhaps because any med-mal award would be limited by the state's comprehensive med-mal cap while the fund awards are potentially open-ended. Many OB-GYNs may also believe that the hospital where they have privileges has fund protection.

Much litigation has centered on whether a given baby's injury qualifies as a “birth related neurological injury”47; a skilful plaintiff's attorney intent on obtaining tort relief can characterize a child's injury in ways that maximize the chance the commission (always intent on minimizing payoffs to ensure solvency of the fund) will turn down the physician's referral. Additionally, since a mother may sue her OB-GYN in tort for the mother's own alleged injuries (even if the physician is a participant in the fund), the statute has not been fully successful in thwarting access to common law courts. As a result, only a half dozen claims per year, on average, have been resolved through the fund.48 Those have tended to be mammoth suits, and the fund is currently in danger of insolvency, which would result in an increase in assessments.

In essence, Virginia has attempted to import notions of workers’ compensation insurance into medical malpractice. Such imports should be expected to be partial and very gradual in their effects.

7. STOP-LOSS FUND One reform that has received considerable attention in Maryland is the implementation of an “insurance stabilization” fund, often referred to as a “stop-loss” fund. The fund is to absorb costs in excess of the (presumably low) premiums insurers would charge physicians.

This proposal is a curious one in several ways. From a political standpoint, it suits both the physicians' lobby (it effectively caps their liability insurance premiums) and the plaintiffs' lawyers' lobby (it allows them to continue obtaining high judgments, subject of course to the other reform provisions of the bill). But from a torts perspective, the idea is extremely regrettable. If the problem is “excess verdicts,” it would be better to adopt more stringent caps than to have taxpayers shoulder the burden of the excesses. If the problem is that certain compassionate losses deserve payment from the public weal when no one is at fault, then leaving the realm of torts and entering the realm of no-fault insurance (as Virginia has done for birth-

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

related injuries) would likely be more efficient. And if the problem is that Maryland doctors are prone to excessive error, then the fund removes some of the cost of that error from the physicians and redistributes it to those who will provide revenue for the fund—either HMO customers (if Maryland chooses to use revenue generated by lifting a tax exclusion currently given to HMOs) or the taxpayer (if the state chooses to tap general revenues for the fund.)

Establishing a stop-loss fund would retain torts and place state government in the role of uberi-insurer. That seems to imply that private insurance companies are not doing their jobs adequately, but there is little if any evidence that this is so. So I must conclude that the excess liability fund and program is an incoherent answer to the med-mal problem. It certainly benefits lawyers and relieves pressure from doctors, but it retains tort while ordering payment by taxpayers, who surely have committed no wrong. This makes no sense.

STATUTE OF LIMITATIONS Every state has a statute of limitations that governs the time after an injury during which a civil suit may be filed. Maryland allows victims of medical malpractice to launch a suit up to three years from the date the injury was discovered or up to five years from when the injury occurred, whichever comes first. Allowing that much time is quite reasonable. But in the case of damage (including medical malpractice) to a child, the rules are different. Until 2002, the three- or five-year deadlines to sue did not begin until the child turned 11. In 2002, the state changed the age at which the clock begins ticking to 16. Then, the state Court of Appeals, in Piselli v 75th St. Medical, judged that the statutory requirement unreasonably burdened child victims, and thus violated Article 19 of Maryland’s Declaration of Rights. The effect of the judgment was to raise the statutory age to 18. Piselli has potentially devastating effects on OB-GYNs. Alleged negligence at birth can now be raised for the first time 21 years later, when a physician’s ability to defend himself or herself is much weaker. As Edward Wolfgram, chair of the obstetrics department of Shady Grove Adventist Hospital in Rockville, has stated, “Most of the time when a surgery is done, if there is a problem, it’s apparent very soon. In our case, it can drag on [undetected] for a very long time. I’ve known gray-haired obstetricians who were sued based on something they did during their residency—and the attending physician had long since died.” “Claims-made” insurance policies may not apply to long-distant alleged torts. In addition, “tail insurance” for retired physicians must now take into account the possibility of these much-delayed lawsuits. The changes serve to increase the risk and cost to insurers, and thus prompt the insurers to raise their rates to physicians.

Piselli protects children even when parents are aware of negligence and fail to act. But it accomplishes this at the expense of the judicial process and of fairness to physicians who are placed in the position of trying to explain and defend actions that were taken as long ago as two decades. The Maryland Court of Appeals has already held that statutes of limitation per se do not violate

50. Piselli v 75th St. Medical, 371 Md. 188 (2002)
51. Article 19 provides “that every man, for any injury done to him in his person or property, ought to have remedy by the course of the Law of the land, and ought to have justice and right, freely without sale, fully without any denial, and speedily without delay, according to the Law of the land.”
Article 19 of the Declaration of Rights; perhaps the article could be clarified to ensure that a reasonable statute of limitations applies to childhood med-mal.

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

Some reforms (such as caps on non-economic damages) seem fully compatible with the nature of tort law, while other reforms do not. Maryland’s past reforms (limiting non-economic damages and ordering—for a time—mandatory pre-trial arbitration) have for various reasons had little real impact on med-mal cases. My hope is that this paper will contribute to intelligent discussion and reform compatible with the common law of tort.

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