

THE MEDICAL MALPRACTICE CRISIS: BANDAGING OREGON'S WOUNDED SYSTEM AND PROTECTING PHYSICIANS

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I. INTRODUCTION

Since 1999, physicians have seen their premium rates for medical malpractice insurance increase considerably.¹ The consequences of such steep increases are dire, hitting hard both physicians and the communities in which they practice. Physicians serving rural communities are hardest hit; many are forced to move their practice to another state or into early retirement, leaving rural communities with little or no medical services.² States are left to pick up the pieces.

Currently, twenty states are identified by the American Medical Association as experiencing a medical malpractice liability crisis.³ In response, states have made various attempts to address the medical malpractice crisis, including tort reform, enacting shorter statutes of limitation periods for malpractice claims, peer review boards, and the

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1. UNITED STATES GENERAL ACCOUNTING OFFICE REPORT TO CONGRESSIONAL REQUESTERS, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE LED TO INCREASED PREMIUM RATES 1 (June 2003), *available at* <http://www.gao.gov/new.items/d03702.pdf> [hereinafter GAO REPORT]. “Premium rates for medical professional liability insurance in Oregon have increased [one hundred sixty] percent since 1999, with especially steep increases for high-risk specialties such as obstetrics.” Press Release, Governor Ted Kulongoski, Governor’s Plan Cuts Rural Doctors’ Professional Liability Insurance Costs (Mar. 1, 2004), *available at* http://governor.oregon.gov/Gov/p2004/press_030104.shtml.

2. AMERICAN MEDICAL ASS’N, MEDICAL LIABILITY REFORM—NOW! 19-20 (July 19, 2006), *available at* <http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnw.pdf> [hereinafter AMERICAN MEDICAL ASS’N].

3. *Id.* at 9. (Other states currently in crisis are: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, Nevada, West Virginia, and Wyoming.)

encouragement of increased doctor/patient communication.⁴ California, perhaps the state most successful in alleviating the pressures of the medical malpractice liability crisis, enacted the Medical Injury Compensation Reform Act of 1975 (MIRCA).⁵ California's "gold standard" of tort reform "largely eliminates the lottery aspect of medical liability litigation" by capping non-economic damages, resulting in less expensive litigation, rapid recovery to injured patients, and lower medical liability premium rates.⁶ Many crisis states however, Oregon among them, have rejected non-economic caps on medical malpractice liability lawsuits.⁷

This paper examines the medical malpractice liability system and crisis, thoroughly exploring the problem in an effort to get at a workable solution. Part II discusses medical malpractice and the liability system in general. Next, Part III examines the medical malpractice crisis in depth, covering the history of the crisis and its causes. Part IV examines the physicians most affected by the crisis, focusing on differences in liability insurance policy types, specialty, and location. The relationship between the malpractice crisis and insurance companies is analyzed in Part V. Part VI discusses the crisis in Oregon, including the history of the crisis, the effort made to resolve it, and an assessment of current endeavors. Finally, Part VII looks at possible solutions to the crisis, examining the possibility of a physician's professional liability fund, a medical review and screening panel, and a reformation of Oregon's apology statute.

II. MEDICAL MALPRACTICE

Medical malpractice is the term given to "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."⁸ The medical malpractice liability system is the product of two goals: first,

4. *Id.* at 2.

5. *Id.* at 44.

6. *Id.*

7. Oregon held a statutory cap on noneconomic damages to be unconstitutional as an infringement on a jury's right to resolve the all factual issues in a personal injury action. *Lakin v. Senco Prods., Inc.*, 987 P.2d 463, 475 (Or. 1999) ("The determination of damages in a personal injury case is a question of fact The legislature may not interfere with the full effect of a jury's assessment of noneconomic damages, at least as to civil cases in which the right to jury trial was customary in 1857, or in cases of like nature.").

8. BLACK'S LAW DICTIONARY 978 (8th ed. 2004).

the system compensates the negligently injured patient; second, it deters negligent behavior.⁹ Medical malpractice tort suits, by allowing individuals injured by the negligent act of a physician to seek compensation, theoretically deter physician negligence by forcing the doctor to bear the burden of the award.¹⁰

However, the link between malpractice incidents and the filing of malpractice claims is not as strong as one might expect.¹¹ In fact, most occurrences of malpractice fail to result in a malpractice claim.¹² In examining the relationship between injuries resulting from negligence and subsequent medical malpractice claims, one study reveals that a mere 1.53% of patients injured as a result of physician negligence filed malpractice claims.¹³

Additionally, many claims have no connection to any act of physician negligence¹⁴ because perfection is unattainable in a profession that deals with the “vagaries of biology and human behavior.”¹⁵ Error is unavoidable.¹⁶ Experiencing an adverse result from physician treatment does not necessarily mean the physician was negligent.

Error, in addition to being unavoidable, is also astonishingly high in the medical field.¹⁷ According to the Harvard Medical Practice study, the error rate for hospitalized patients suffering permanent disability or death is as high as four percent, and roughly one percent of hospitalized patients experience an injury resulting from negligent care.¹⁸

9. LIABILITY FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE, A JOINT ECONOMIC COMMITTEE STUDY 2 (May 2003), available at <http://www.house.gov/jec/tort/05-06-03.pdf> [hereinafter JOINT ECONOMIC COMMITTEE STUDY].

10. *Id.*

11. *Id.* at 3.

12. *Id.*

13. Ken Marcus Gatter, *The Continued Existence and Benefit of Medicine's Autonomous Law in Today's Health Care System*, 24 U. DAYTON L. REV., 217, 249 (1999) (citing Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 245 (1991)).

14. JOINT ECONOMIC COMMITTEE STUDY, *supra* note 9, at 3.

15. Gatter, *supra* note 13, at 245 (citing Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients*, 324 NEW ENG. J. MED. 377, 381 (1991)).

16. *Id.* at 246.

17. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 473 (5th ed. 2004) [hereinafter FURROW ET AL. 2004].

18. *Id.*

However, because most occurrences of medical malpractice do not result in a malpractice claim and many claims have no connection to an act of physician negligence, it is hard to argue that the current malpractice tort system provides the solution needed to meet the goals of the system.¹⁹ According to some, “the medical-malpractice system fulfill[s] its social objectives ‘crudely’ at best.”²⁰

III. THE MEDICAL MALPRACTICE “CRISIS”

Although medical malpractice is a relatively small portion of the United States insurance industry, representing a meager 1.9% of total net written premiums in 2001, it has been among the most underperforming segments for several years.²¹ Though similarly cyclical in nature as compared to the overall insurance business, the medical malpractice sector produces more volatility than the rest of the market.²²

A. *The History of the Medical Malpractice Crisis*

The early 1990s saw the medical malpractice sector as one of the most profitable.²³ Unfortunately, underwriting results and profitability began deteriorating in the late 1990s, an unfortunate trend that continued through 2001.²⁴ The pretax operating loss in 2001 alone cost the insurance industry an estimated \$528 million.²⁵

The recent string of poor profitability and reduction in capital took a considerable toll on the medical malpractice sector.²⁶ Casualties of this slump, companies forced into insolvency, include Frontier Insurance Group, PHICO, and Reciprocal Group of

19. CONGRESSIONAL BUDGET OFFICE ECONOMIC AND BUDGET ISSUE BRIEF, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 6 (Jan. 8, 2004), available at <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf> [hereinafter CBO BRIEF].

20. Gatter, *supra* note 13, at 249 (citing Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 250 (1991)).

21. James B. Auden, *Medical Malpractice Insurance: In Intensive Care*, FITCH RATINGS, at 2 (2003) (on file with author).

22. *Id.*

23. *Id.* at 3.

24. *Id.*

25. *Id.* at 2.

26. *Id.* at 4.

America—all companies with medical malpractice specialties.²⁷ These insolvencies, along with St. Paul's announcement that it was exiting the sector, caused a damaging market dislocation that seriously affected the availability of coverage in previously served markets.²⁸

These events resulted in considerable changes in the insurance marketplace.²⁹ Cost is one such change.³⁰ In 2001, medical malpractice insurance premiums topped twenty-one billion dollars, a cost more than double the amount ten years prior.³¹

B. Causes of the Medical Malpractice Crisis

The medical malpractice crisis is the result of a variety of factors, including the increase in medical malpractice lawsuits, significant increases in tort claim recovery, the rising cost of medical procedures, physician anger, defensive medicine, considerable increases in insurance expenses, and increased claims loss.

1. Increase in Medical Malpractice Lawsuits

There are many reasons for the rise in medical malpractice litigation over the past fifty years.³² Following World War II, Americans came to regard the increasing regularity of lawsuits against physicians as a “source of medical cost inflation,” and the cost of malpractice insurance coverage escalated.³³

When the federal government took on the financial aspects of American health care via the Medicaid and Medicare programs in the 1960s, medical malpractice became a national concern as Americans questioned health care quality and expense.³⁴ By the following decade, the importance of malpractice had become evident, as evidenced by the fact that “80% of the malpractice suits filed between 1935 and 1975 were filed in the last five years of that forty year

27. *Id.*

28. *Id.* (St. Paul was the largest writer of medical malpractice in the United States.).

29. *Id.*

30. *Id.*

31. JOINT ECONOMIC COMMITTEE STUDY, *supra* note 9, at 1.

32. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST & ROBERT L. SCHWARTZ, HEALTH LAW 344 (2d ed. 2000) [hereinafter FURROW ET AL. 2000].

33. *Id.*

34. *Id.*

period.”³⁵ And as the Medicaid and Medicare programs increased access to the health care system, the amount of negligent injuries increased.

Progress in medical technology has also caused an expanding number of malpractice lawsuits.³⁶ The increased power to treat and diagnose illness caused medicine to become more complex, adding considerations of possible side-effects resulting from the use of new drugs and instrumentalities to already intricate procedures and treatments.³⁷ New drugs and instrumentalities also carry with them a “learning curve—the rate of maloccurrence will be higher early in the introduction of a new medical device, drug, or technology.”³⁸ In fact, according to a report issued by the Institute of Medicine, “one of the largest classes of errors involved the utilization of prescription drugs.”³⁹

In addition to increased risk to patients, there exists the unrealistic belief that all ailments are successfully treatable.⁴⁰ Patients, encouraged by new medical developments, may find extreme disappointment and bring suit when faced with an unanticipated outcome.⁴¹ As William Sage wrote:

Foremost, improvements in the clinical capabilities of medicine increase expectations of success, redefine success upwards, and foster the belief that failure is the result of negligence rather than misfortune. The first wave of medical malpractice suits in the late 19th century involving nonunion of limb fractures, arose only because medical science had developed an alternative to amputation. Malpractice litigation has become as specialized as the medical care it attacks.⁴²

35. *Id.*

36. FURROW ET AL. 2004, *supra* note 17, at 473; FURROW ET AL. 2000, *supra* note 32, at 344. *See also* LARS NOAH & BARBARA A. NOAH, LAW, MEDICINE, AND MEDICAL TECHNOLOGY 608-609 (Robert G. Clark ed., Foundation Press 2002); Mark F. Grady, *Why Are People Negligent? Technology, Nondurable Precautions, and the Medical Malpractice Explosion*, 82 NW. U. L. REV 293, 298-99, 312 (1988).

37. FURROW ET AL. 2004, *supra* note 32, at 344.

38. *Id.*

39. NOAH, *supra* note 36, at 608-09.

40. FURROW ET AL. 2004, *supra* note 17, at 473.

41. FURROW ET AL. 2000, *supra* note 32, at 345. (While physicians inform patients of potential adverse outcomes to treatment as part of obtaining informed consent, many patients do not take such warnings to heart, thus the adverse outcome is, to the patient, unanticipated despite prior warnings and information given by their doctor.)

42. FURROW ET AL. 2004, *supra* note 17, at 473.

Further, the complexity in medicine, resulting from a combination of medical progress and industrialization, may produce more adverse events and errors than would otherwise be the case.⁴³

Finally, studies relying on hospital records for data, such as the Harvard Study, may be underestimating the problem due to a failure to record patient injuries as required—a phenomenon more prevalent when the responsible party is a senior physician.⁴⁴ The trend of under-recording due to fear that the information will be used against them is understandable given the current litigious climate which, in addition to corrupting hospital records, serves to impede quality improvement efforts.⁴⁵

2. *Significant Increases in Tort Claim Recovery*

The most significant cost a malpractice insurer faces is the payment of claims, which account for approximately two-thirds of all expenses.⁴⁶ An average claim payment made in 1986 cost a malpractice insurer roughly \$95,000.⁴⁷ In 2002, the average claim payment cost an insurer \$320,000⁴⁸—more than three times what it cost just sixteen years earlier. While inflation accounted for some of the increase, the value of a malpractice insurance claim “represents an annual growth rate of nearly eight percent—more than twice the general rate of inflation.”⁴⁹

However, plaintiffs in many instances do not receive a payout following a malpractice lawsuit.⁵⁰ Of those claims that do result in a

43. *Id.* at 474.

44. *Id.*

45. U.S. DEP'T OF HEALTH & HUMAN SERVICES., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 6 (2002).

According to many experts, the “#1 barrier” to more effective quality improvement systems in health care organizations is fear of creating new avenues of liability by conducting earnest analyses of how health care can be improved. Without protection, quality discussions to improve health care provide fodder for litigants to find ways to assert that the status quo is deficient Quality improvement efforts must be protected if we are to obtain the full benefit of doctors' experience in improving the quality of health care. *Id.*

46. CBO BRIEF, *supra* note 19, at 3.

47. *Id.*

48. *Id.*

49. *Id.*

50. U.S. DEP'T OF HEALTH & HUMAN SERVICES., *supra* note 45, at 8 (finding that

monetary award for the plaintiff, there exist a only few instances in which a jury conferred an enormous award. This encourages other lawyers and their plaintiffs, who hope to share in the “litigation lottery,” and influences all subsequent settlement negotiations.⁵¹ Further, these “mega-verdicts” have rapidly increased,⁵² a fact all the more disconcerting considering the negligible connection between malpractice litigation and physician negligence.⁵³ According to one study, the only factor indicating a strong correlation with the outcome of malpractice litigation is the degree of patient injury, suggesting “that our system of medical-legal jurisprudence does not identify ‘bad’ physicians and fails to contribute to attaining the ideal of improved medical outcomes.”⁵⁴

3. *Rising Cost of Medical Procedures*

Raiding the wallet of every American are the litigation and malpractice insurance problems, because “[m]oney spent on malpractice premiums (and the litigation costs that largely determine premiums) raises health care costs.”⁵⁵ However, increases in health care spending contribute to the growth of the average value of a medical malpractice claim,⁵⁶ thus creating a vicious cycle and exacerbating the malpractice crisis. On a per-person basis, the cost of health care has risen at an average rate of almost seven percent between the years of 1986 and 2002.⁵⁷

Additionally, the cost of medical liability protection contributes to the increase of health care costs each year, leading to higher health insurance premiums and medical costs for all Americans.⁵⁸

between fifty-seven and seventy percent of claims result in no payment to the patient).

51. *Id.*

52. *Id.* at 9.

In the period 1994-1996, 34% of all verdicts that specified damages assessed awards of \$1 million or more. This increased by 50% in four years; in 1999-2000, 52% of all awards were in excess of \$1 million. There have been 21 verdicts of \$9 million or more in Mississippi since 1995—one of \$100,000,000. Before 1995 there had been no awards in excess of \$9,000,000. *Id.*

53. Richard A. Anderson, Commentary, *Defending the Practice of Medicine*, 164 ARCH. INTERN. MED. 1173, 1177 (2004).

54. *Id.*

55. U.S. DEPT OF HEALTH & HUMAN SERVICES, *supra* note 45, at 7.

56. CBO BRIEF, *supra* note 19, at 7, n.4; FURROW ET AL. 2004, *supra* note 17, at 473-74.

57. CBO BRIEF, *supra* note 19, at 7, n.4.

58. AMERICAN MEDICAL ASS'N, *supra* note 2, at 6.

4. *Physician Anger*

Physician anger may also play a role in the medical malpractice crisis, or at least the perception that a crisis exists.⁵⁹ According to Barry R. Furrow, “[p]hysicians are angry because malpractice litigation focuses on the errors of specific individual providers. This personalization of liability produces anger and anxiety in physicians. The legal system has become the lightning rod for changes physicians find unwelcome.”⁶⁰ In addition, there also exists an increase in jury disapproval of physicians perceived negligent, which may further drive up a malpractice verdict and thus contribute to the malpractice crisis.⁶¹ Lack of sympathy is especially pronounced for those physicians practicing in groups due to a patient perception that less time spent with the physician equates to lower quality care.⁶²

5. *Defensive Medicine*

As Judge Learned Hand pointed out in *United States v. Carroll Towing*, there is no general rule setting forth the socially optimal level of precaution against accidental injury, as any liability determination will vary according to the surrounding circumstances.⁶³ Instead, one’s duty to protect against injury is a function of three variables: the probability of harm, the gravity of the resulting injury if the harm occurs, and the burden of adequate precautions.⁶⁴ Thus, as physicians encounter a variety of patients having various ailments, the duty to each patient will necessarily differ; a physician’s duty to order expensive tests will be greater toward a seriously ill patient whose diagnosis is undetermined than toward a teenaged patient exhibiting the non-deadly symptoms of the flu in January.

The existing medical malpractice liability system encourages physicians to operate at the optimal level of precaution; i.e., to practice defensive medicine.⁶⁵ Defensive medicine refers to the

59. FURROW ET AL. 2000, *supra* note 32, at 345.

60. *Id.*

61. *Id.*

62. *Id.* at 345, n.11.

63. *U.S. v. Carroll Towing, Co.*, 159 F.2d 169, 173 (2d Cir. 1947). See also Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians’ Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS. 81, No. 1, 82 (1997).

64. *Carroll Towing*, 159 F.2d at 173.

65. Kessler & McClellan, *supra* note 63, at 83.

practice of ordering excessive tests and procedures for a patient in an attempt to prevent any feasible oversight in diagnosis and treatment.⁶⁶ Physicians practicing defensive medicine take every precaution available to protect the patient, even when the benefits of doing so are extremely small.⁶⁷ Practicing defensive medicine helps protect against the threat of liability—especially when neither the doctor nor the patient will bear a substantial share of the cost; i.e., when the patient’s health insurance provider is picking up the tab.⁶⁸

In addition to reaping some benefit for the patient, albeit small, defensive medicine also has its drawbacks. One such drawback is the effect on quality of care, which suffers as the total amount of resources dwindles proportionate to the amount of defensive medicine practiced, leaving some doctors struggling to provide adequate care.⁶⁹ In fact, according to one survey, malpractice litigation has left over 76% of physicians concerned about their ability to provide quality patient care.⁷⁰ “Every test and every treatment poses a risk to the patient, and takes away funds that could better be used to provide health care to those who need it.”⁷¹

Secondly, defensive medicine leads to higher health care and insurance expenses as insurers pass the added cost on to consumers.⁷² As medical malpractice awards take into account health care costs incurred by the patient, damages awarded against a doctor may rise due to the increased cost of attempting to prevent malpractice. Finally, as malpractice becomes more expensive, “accessibility becomes an issue when escalating costs of malpractice liability

66. MARCIA MOBILIA BOUMIL, CLIFFORD E. ELIAS, & DIANE BISSONETTE MOES, *MEDICAL LIABILITY IN A NUTSHELL* 250 (2d ed., West 2003).

67. U.S. DEPT OF HEALTH & HUMAN SERVICES, *supra* note 45, at 4-5 (citing HARRIS INTERACTIVE, COMMON GOOD, FEAR OF LITIGATION STUDY: THE IMPACT ON MEDICINE, FINAL REPORT, Apr. 11, 2002 available at <http://cgood.org/assets/attachments/68.pdf>).

Due to fear of a malpractice lawsuit, 79% of physicians ordered more tests than they would otherwise have and 91% have noticed others doctors doing the same; 74% have referred patients to specialists more often than necessary; 51% have suggested invasive procedures to confirm a diagnosis when they believed it unnecessary; and 41% reported prescribing more medications and antibiotics than believed required; 73% report other doctors doing the same. *Id.*

68. Kessler & McClellan, *supra* note 63, at 82.

69. BOUMIL ET AL., *supra* note 66, at 259.

70. U.S. DEPT OF HEALTH & HUMAN SERVICES, *supra* note 45, at 4.

71. *Id.* at 5.

72. BOUMIL ET AL., *supra* note 66, at 259.

insurance drives physicians out of certain practice areas.”⁷³

While some may argue for an effort at limiting medical malpractice liability in order to reduce rising health care costs attributable to defensive medicine, the Congressional Budget Office disagrees.⁷⁴ According to the Congressional Budget Office, this may not be an effective solution.⁷⁵ Some so-called defensive medicine may actually be a physician's attempt at generating additional income or an effort at providing positive (though small) benefits to a patient.⁷⁶ On the basis of its own studies and the Harvard Medical Practice Study,⁷⁷ the Congressional Budget Office determined that savings resulting from a reduction in defensive medicine practices would be very small.⁷⁸

6. Significant Increases in Insurance Expenses

One-third of an insurance carrier's expenses⁷⁹ result from legal costs incurred due to lawsuits, underwriting, and administrative expenses—costs which have also increased over the years.⁸⁰ Legal defense costs in 1986 averaged around \$8,000 per claim.⁸¹ In 2002, a medical malpractice claim cost an insurer approximately \$22,000 to defend when a payment did not result, while the cost for a defense resulting in a payment was roughly \$39,000.⁸² Thus, the cost to defend against a malpractice claim rose by about eight percent annually during the sixteen year period between 1986 and 2002.⁸³

In addition, underwriting costs also increased as a result of the general tightening of the reinsurance market following such catastrophic events as Hurricane Andrew in 1992, the Northridge earthquake in 1994, the terrorist attacks of September 11, 2001,⁸⁴ and presumably hurricanes Katrina and Rita in 2005.

73. *Id.*

74. CBO BRIEF, *supra* note 19, at 6.

75. *Id.*

76. *Id.*

77. Localio et al., *supra* note 13, at 245.

78. CBO BRIEF, *supra* note 19, at 6.

79. *Id.*

80. *Id.* at 4.

81. *Id.*

82. *Id.* at 7, n.6.

83. *Id.* at 4.

84. *Id.*

7. *Increased Claims Loss*

Increased claim losses significantly contribute to higher medical malpractice premium rates.⁸⁵ To fully understand why increased claim losses are an important factor in the medical malpractice crisis, a brief introduction to the calculation of insurance loss may be helpful.

There are two different ways by which an insurance company views its loss experience, both of which are important in understanding any company losses.⁸⁶ Paid losses refer to the payments an insurance company makes in a given year, regardless of when the alleged malpractice occurred or was reported; the majority of payments made in a given year are reported in previous years.⁸⁷ The average medical malpractice claim spends between four and five years winding its way through the legal process,⁸⁸ and some claims take much longer. For instance, the Harvard Study followed fifty-one medical malpractice claims for a period of ten years;⁸⁹ five claims had yet to be resolved by the end of the study.⁹⁰

Incurred losses, by contrast, indicate the insurer's expectations of future losses based on claims reported throughout the current year.⁹¹ This amount may fluctuate as the insurer makes adjustments based on new information; information indicating the original estimate was too high decreases the incurred loss, while information indicating the original estimate was too low increases the incurred loss.⁹²

Incurred losses comprise a large portion of medical malpractice insurers' costs.⁹³ In 2001, the fifteen largest medical malpractice insurers budgeted roughly 78% toward covering incurred losses.⁹⁴ Due to the fact that insurance companies base premium rates on

85. GAO REPORT, *supra* note 1, at 15.

86. *Id.* at 16.

87. *Id.*

88. Kessler & McClellan, *supra* note 63, at 81.

89. Gatter, *supra* note 13, at 250 (citing Troyen A. Brennan et al., *Relationship Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963 (1996)).

90. *Id.* at 250, n.175.

91. GAO REPORT, *supra* note 1, at 16.

92. *Id.*

93. *Id.*

94. *Id.* (Calculations for incurred losses included the payments made to plaintiffs to resolve claims as well as the costs associated with defending claims.)

expected costs, incurred losses are the primary determinant of premium rates.⁹⁵

Looking at the recent history of the medical malpractice insurance market, specifically the trend toward larger damage awards,⁹⁶ the cost of medical malpractice insurance will likely continue to rise as insurers project higher incurred losses in an attempt to avoid unanticipated losses in the future. The increases in cost are already reflected in the cost of liability insurance coverage as premiums for all specialties are rising.⁹⁷

The crisis in the malpractice system, especially in non-reform states such as Oregon, is also affected by the difficulty in finding and obtaining malpractice insurance at any price.⁹⁸ Demonstrating this problem is the fact that many major carriers of medical malpractice insurance have ceased selling this type of insurance.⁹⁹

IV. FEELING THE PINCH: DOCTORS MOST EFFECTED

A. Policy Differences

Differences in the amount a physician will pay for liability insurance depend partly on whether the shareholder's policy is an occurrence policy or a claims-made policy.¹⁰⁰ An occurrence policy will provide a physician with coverage for professional liability claims that occur during the time in which the policy is in force, regardless of when the claimant reports the claim.¹⁰¹ Since the policy covers an extended period of time, these policies are more expensive

95. *Id.*

96. See Auden, *supra* note 21.

97. AMERICAN MEDICAL ASS'N, *supra* note 2, at 6.

98. U.S. DEPT. OF HEALTH & HUMAN SERVICES., *supra* note 45, at 14.

99. *Id.* ("St. Paul Companies, which was the largest malpractice carrier in the U.S., covering 9 percent of doctors, announced in December 2001 that it would no longer offer coverage to any doctor in the country; MIXX pulled out of every state; PHICO and Frontier Insurance Group have also left; Doctors Insurance Reciprocal stopped writing group specialty coverage beginning in 2002.")

100. OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, FACT SHEET ON MEDICAL MALPRACTICE INSURANCE 4 (Jan. 7, 2005), available at http://www.cbs.state.or.us/ins/consumer/medical-malpractice/medicalmalpractice_factsheet.pdf [hereinafter OREGON FACT SHEET].

101. *Id.*

at the outset than claims-made policies.¹⁰²

Claims-made policies, on the other hand, protect the policyholder against claims that occur and are reported while the policy is in force.¹⁰³ Due to the fact that there is often a delay of several years between the alleged negligent treatment and the filing of a claim, premiums are less expensive at the beginning of the policy.¹⁰⁴ However, as the policy matures, the premium increases; at the policy's fifth birthday, it is considered mature and the premium becomes equivalent to that of an occurrence policy.¹⁰⁵

B. Specialty Differences

Differences in the amount a physician will pay for liability insurance also depend on the specialty the physician practices and will generally increase in proportion to surgical complexity.¹⁰⁶ This affects what specialty a physician chooses, according to a 2002 survey, which found that one-third of physicians "shied away from going into a particular specialty because they feared it would subject them to greater liability exposure."¹⁰⁷

According to the Insurance Division, based on rates filed as of May 1, 2004, the following represent the average annual premiums per specialty:¹⁰⁸

Internal medicine	\$7-9,000
Family practice	\$9-11,000
Family practice w/ Ob-Gyn	\$19-37,000
Emergency medicine	\$17-19,000
General surgery	\$33-41,000
Obstetrics	\$61-70,000
Neurosurgery	\$63-72,000

These rates are based on the premiums charged for a mature

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.* (Claims reported after the policy is terminated are not covered unless the policyholder purchases additional coverage known as tail coverage.).

106. FURROW ET AL. 2000, *supra* note 32, at 347.

107. U.S. DEPT. OF HEALTH & HUMAN SERVICES., *supra* note 45, at 4.

108. OREGON FACT SHEET, *supra* note 100, at 4.

claims-made policy by Continental Casualty Company and Northwest Physicians Mutual Insurance Company with limits of \$1 million / \$3 million.¹⁰⁹ Credits or surcharges reflected on a physician's premium, based on his or her specific loss history, are not calculated into these figures.¹¹⁰

C. Location Differences

Malpractice insurance rates also vary depending on the geographic location of the physician's practice—varying from state to state as well as within each state.¹¹¹ Within a state, the “crisis in medical professional liability insurance costs [is] most acute in rural communities.”¹¹² An investigation conducted by the United States General Accounting Office (GAO) found reduced availability to access to emergency surgery and newborn delivery in rural communities,¹¹³ an effect that is especially dangerous for poor women.

V. INSURANCE COMPANIES—CLOSE TO THE CRISIS

As Barry R. Furrow and others agree, “any serious analysis of a malpractice ‘crisis’ must begin with the insurance industry.”¹¹⁴ Each state, through state insurance departments and state law, regulates medical malpractice insurance.¹¹⁵ This means that every insurance company selling medical malpractice within the state of Oregon is subject to Oregon's regulations for operations within the state, and all claims are subject to Oregon's tort laws.¹¹⁶

Setting malpractice insurance rates is an extremely complicated process, as explained by Barry R. Furrow:

First, changes in the legal and economic environment affect the number (frequency) of claims or the dollar amount (severity) of losses. Inflation increases the average severity of claims, and changes in legal theories may increase the frequency and severity

109. *Id.*

110. *Id.*

111. FURROW ET AL. 2000, *supra* note 32, at 347.

112. OREGON FACT SHEET, *supra* note 100, at 5.

113. CBO BRIEF, *supra* note 19, at 6.

114. FURROW ET AL. 2000, *supra* note 32 at 346.

115. GAO REPORT, *supra* note 1, at 8.

116. *Id.*

of claims. Second, use of historical statistics to predict future losses is based on the law of large numbers—as the number of insured physicians and hospitals increases, actual losses will approach expected losses. The medical malpractice insurance market is small, making the statistical base for making estimates of future losses relatively small. As a result, it is difficult to set accurate premium prices. The “long tail” of malpractice insurance (the length of time that may elapse after an injury occurs before a claim is filed and settled) is a further complicating factor because the data base used for estimating future losses may not reflect current actual losses. Many claims are filed in the second, third, or later year after treatment.¹¹⁷

Recent trends have reduced revenues and increased costs, causing medical malpractice to become one of the most unprofitable insurance lines.¹¹⁸ In 2001, an insurance company in the medical malpractice sector paid out \$1.34 in claims and costs for every \$1.00 it received in revenue (including investment income).¹¹⁹

According to James Hurley of the American Academy of Actuaries, four factors contributed to the current dismal state that is the medical malpractice insurance industry: the escalating size of malpractice claims, increased reinsurance costs, deteriorating returns on the investment assets of insurers, and the end of favorable reserve development caused by overestimating incurred costs.¹²⁰

Deteriorating profitability, reduced supply, and structural changes in the market combined to create an environment where obtaining insurance coverage is extremely difficult and significant price increases are common.¹²¹ The fact that this situation is likely to be permanent, rather than the symptom of the short-term insurance cycle, is evidenced by St. Paul’s exit from the market.¹²² Large

117. FURROW ET AL. 2000, *supra* note 32 at 347.

118. JOINT ECONOMIC COMMITTEE STUDY, *supra* note 9, at 2.

119. *Id.* at 5 (citing James Hurley, American Academy of Actuaries, Prepared Testimony to the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, 2/27/2003).

120. JOINT ECONOMIC COMMITTEE STUDY, *supra* note 9, at 5. *See generally* FURROW ET AL. 2000, *supra* note 32, at 347 (“[I]nsurers set their rates at a premium level that generates funds to cover losses occurring during the period, the administrative costs of running the company, and an amount for unknown contingencies, the reserve, which may become profit if not used.”).

121. JOINT ECONOMIC COMMITTEE STUDY, *supra* note 9, at 6.

122. *Id.* (“St. Paul (the largest insurance carrier, covering 42,000 doctors) has ceased writing or renewing policies for malpractice.”).

insurance carriers do not exit a market due to short-term cycles—they do so only when “the long-term outlook is so bleak as to make continued business operation untenable.”¹²³ Additionally, if the crisis were indeed “nothing more than the natural ‘insurance cycle,’” all states would be experiencing a crisis.¹²⁴ Further, insurers are not leaving other insurance markets—only the medical malpractice liability sector is experiencing the phenomenon of fleeing insurers.¹²⁵

Another claim made against insurance companies blames the crisis on the lack of state regulation.¹²⁶ However, according to the American Association of Health Plans, “all state insurance departments and other state governmental agencies heavily regulate and monitor the solvency of medical malpractice carriers . . . and require extensive reporting.”¹²⁷

Under Oregon law, the Insurance Division of the Oregon Department of Consumer and Business Services is responsible for reviewing any rate changes made by insurers admitted in Oregon.¹²⁸ Any changes submitted by an insurer in Oregon must comply with all state statutes, rules, and Insurance Division bulletins.¹²⁹

Among these rules exists the requirement that any professional liability rate change of more than fifteen percent be subject to the approval of the Insurance Division before the insurer may implement the new rate.¹³⁰ Further, regardless of what percentage of change the insurer proposes, it must demonstrate that “its rates are appropriate given how much it expects to pay in claims and administrative costs, how much it expects to earn in investment income, and what if any profit it should reasonably expect to make.”¹³¹ In addition, each

123. *Id.*

124. AMERICAN MEDICAL ASS'N, *supra* note 2, at 47 (citing Raghu Ramachandran, *A Note on Investment Income of Medical Malpractice Companies*, Feb. 4, 2003, available at <http://salsa.bbh.com/news/Articles/medmal2.html>).

125. AMERICAN MEDICAL ASS'N, *supra* note 2, at 47.

126. *Id.*

127. *Id.* (citing AMERICAN ASS'N OF HEALTH PLANS, “LAWSUIT LOTTERY” CAUSES MEDICAL MALPRACTICE CRISIS—SUGGESTIONS THAT POOR INVESTMENTS LED TO CRISIS DON'T PASS SMELL TEST 1, available at <http://www.americanbenefitscouncil.org/documents/refutingstockmarketargument.pdf> (last visited Mar. 11, 2006)).

128. OREGON FACT SHEET, *supra* note 100, at 2.

129. *Id.*

130. *Id.* (Rate changes of less than fifteen percent do not require Insurance Division approval before the insurance company can use the rate.).

131. *Id.*

insurer is also required to charge policyholders enough to maintain appropriate reserve and surplus funds in order to safeguard the company and its policyholders against unanticipated losses.¹³²

The Insurance Division requires insurers who fail to meet the requirements set out above, or those who violate Oregon law, to make necessary changes or provide additional actuarial supporting information and demonstrate compliance.¹³³ However, much to the disappointment of Oregon physicians, the “Insurance Division does not have the authority to deny a rate change based on policyholders’ real or perceived hardship in the face of increased rates. A rate denial can only be based on inadequate actuarial support for the rate or on failure to comply with Oregon law.”¹³⁴

Insurance companies’ participation in the stock market is also criticized.¹³⁵ However, according to the American Medical Association (AMA) and American Association of Health Plans (AAHP), the stock market is not to blame.¹³⁶ The AAHP points to states that are not in crisis to support its argument: “[I]f the stock market were to blame, the crisis would resonate across the country to all medical liability insurers.”¹³⁷ Rather, “it is mostly physicians that practice in states without meaningful medical liability reform who are significantly affected.”¹³⁸ Furthermore, “insurers do not heavily invest in the stock market,” investing instead in “mostly bonds and other positive-yield markets.”¹³⁹

On the other side of the coin, some argue that insurance companies are blameless for the medical malpractice crisis; not only is the insurance industry not to blame, but the claim that insurers are able to remain financially viable without raising rates is a vicious myth.¹⁴⁰ On this point, the AMA writes:

Insurance is not magic. Large underwriting losses are not sustainable over the long term, and will merely result in less competition as insurers exit the market. Over the past decade, the

132. *Id.*

133. *Id.*

134. *Id.*

135. AMERICAN MEDICAL ASS’N, *supra* note 2, at 51.

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.* at 57-58.

profitability of medical liability insurers has been on the decline and was lower than that of other property casualty insurers. Underwriting profitability is measured by the combined ratio after policyholders' dividends. A ratio less than 100 indicates that an insurer is earning an underwriting profit. The lower the ratio, the higher the profit rate. In 2004 the combined ratio of medical liability insurers was 112.3. This means that for every \$1 insurers received in premiums in 2004 they paid out \$1.12. In comparison, the 2004 combined ratio of all property casualty insurers was 98.1.¹⁴¹

VI. OREGON: A "CRISIS" STATE

Oregon is one of twenty states identified by the AMA as currently experiencing a medical liability crisis.¹⁴² Twenty-two additional states, and the District of Columbia, are exhibiting warnings signs, signaling an impending crisis if ignored.¹⁴³

According to Oregon Health and Science University (OHSU), there were 8,292 active physicians in Oregon in 2004, excluding those physicians engaged in military service or overseas mission work and those who only consult in Oregon.¹⁴⁴ Of these physicians, 5,081 are insured through the admitted market in Oregon.¹⁴⁵ Nearly eighty-four percent (4,265) of these physicians are insured by two entities that dominate the Oregon medical malpractice insurance market: Northwest Physicians Mutual Insurance Company (NPMIC) and the Oregon Medical Association Risk Purchasing Group.¹⁴⁶ Remaining physicians are insured by six other insurance companies: The Doctors' Company, Physicians Insurance, National Union, GE MedPro, Preferred Professional, and Ophthalmic Mutual.¹⁴⁷

Active Oregon physicians not insured by one of the above insurance carriers are either insured through their employer, insured by a surplus lines insurer,¹⁴⁸ or without insurance altogether.¹⁴⁹

141. *Id.*

142. *Id.* at 9.

143. *Id.*

144. OREGON FACT SHEET, *supra* note 100, at 1.

145. *Id.*

146. *Id.*

147. *Id.*

148. A surplus line insurer is one that is not admitted in Oregon (meaning they are not certified to sell insurance in the state), but they can still insure physicians unable to get

A. Oregon's History

Oregon has been laboring under the pressure of a medical malpractice crisis for years. In 1987, as part of the "Tort Reform Act," the Oregon State Legislature enacted Oregon Revised Statute (ORS) 18.560,¹⁵⁰ limiting noneconomic damages to \$500,000.¹⁵¹ The purpose of imposing the half-million dollar damages cap was to "stabilize insurance premiums and to decrease the costs associated with tort litigation."¹⁵²

Twelve years later, *Lakin v. Senco Products, Inc.* questioned the constitutionality of ORS 18.560.¹⁵³ On July 15, 1999, the Oregon Supreme Court invalidated the statute, finding it to be in violation of

coverage in the regular, admitted market. *Id.*

149. *Id.* According to the Insurance Division of the Oregon Department of Consumer and Business Services, professional liability insurance is not mandatory. *Id.*

150. Oregon Revised Statute 18.560 provided in full:

(1) Except for claims subject to ORS 30.260 and ORS chapter 656, in any civil action seeking damages arising out of bodily injury, including emotional injury or distress, death or property damage of any one person including claims for loss of care, comfort, companionship and society and loss of consortium, the amount awarded for noneconomic damages shall not exceed \$500,000.

(2) As used in this section:

a. "Economic damages" means objectively verifiable monetary losses including but not limited to reasonable charges necessarily incurred for medical, hospital, nursing and rehabilitative services and other health care services, burial and memorial expenses, loss of income and past future impairment of earning capacity, reasonable and necessary expenses incurred for substitute domestic services, recurring loss to an estate, damage to reputation that is economically verifiable, reasonable and necessarily incurred costs due to loss of use of property and reasonable costs incurred or for replacement of damaged property, whichever is less.

b. "Noneconomic damages" means subjective, nonmonetary losses, including but not limited to pain, mental suffering, emotional distress, humiliation, injury to reputation, loss of care, comfort, companionship and society, loss of consortium, inconvenience and interference with normal and usual activities apart from gainful employment.

(3) This section does not apply to punitive damages.

(4) The jury shall be advised of the limitation set forth in this section.

151. *Tenold v. Weyerhaeuser Co.*, 873 P.2d 413, 418 (Or. Ct. App. 1994).

152. *Id.*

153. *Lakin v. Senco Prods., Inc.*, 987 P.2d 463, 467 (Or. 1999). A jury awarded John Lakin \$2,000,000 in noneconomic damages, and gave his wife, Ann Marie Lakin, \$876,000 in noneconomic damages, after John was seriously injured by a nail gun manufactured by the defendant. The Lakin's successfully appealed following the reduction of their awards pursuant to the statutory cap. *Id.*

Article I, section 17,¹⁵⁴ of the Oregon Constitution¹⁵⁵ because “[the] legislature may not interfere with the full effect of a jury’s assessment of noneconomic damages, at least as to civil cases in which the right to jury trial was customary in 1857, or in cases of like nature.”¹⁵⁶

By 2000, Oregon saw a four hundred percent increase in malpractice indemnity as compared with 1998.¹⁵⁷ In response to the continuing controversy over medical malpractice insurance rates, the November 2, 2004 ballot included Measure 35, a measure that, if passed, would have amended the state constitution to limit noneconomic damages to \$500,000 in medical malpractice cases.¹⁵⁸ Oregon voters rejected Measure 35 by approximately 17,000 votes—a margin of less than one percent.¹⁵⁹

The president of the Oregon Medical Association, Dr. John Moorhead, observed that rural voters generally approved of Measure 35, while residents in Multnomah County were not supportive, likely because these residents do not experience a shortage of doctors.¹⁶⁰

Dr. Ronald G. Worland, a surgeon in southern Oregon, warned Oregonians of the consequences that will result from the defeat of Measure 35.¹⁶¹ Worland advised pregnant women traveling to southern, central, and eastern Oregon in the future to be very careful, as there will be no one there to deliver their babies.¹⁶² Additionally, Worland recommended “wearing a helmet at all times, as two days out of the week we do not have neurosurgical coverage in Southern Oregon.”¹⁶³

Worland’s message rings true. According to the Oregon Health and Science University Center for Rural Health, in 2004, the Portland area had 302 physicians available for each 100,000 residents, while

154. Article I, section 17, of the Oregon Constitution provides: “In all civil cases the right of Trial by Jury shall remain inviolate.” OR. CONST. art. I, § 17.

155. *Lakin*, 987 P.2d at 467.

156. *Id.* at 475.

157. Anderson, *supra* note 53, at 1177.

158. James Mayer, *Battle Brews Over Caps in Malpractice Verdicts*, THE OREGONIAN, Sep. 7, 2004, at A1.

159. James Mayer, *Election 2004: Medical Malpractice Initiative on Losing Pace*, THE OREGONIAN, Nov. 4, 2004, at D4.

160. *Id.*

161. Editorial, *Strengthen Rape Reporting Rules*, THE OREGONIAN, Dec. 17, 2004, at C4.

162. *Id.*

163. *Id.*

rural Oregon residents had only 104 physicians per 100,000 residents.¹⁶⁴ Adding to the problem of physician availability in rural parts of Oregon is the presence of older physicians who may soon retire and the reduction of incoming physicians to the area.¹⁶⁵ To illustrate, as of September 28, 2003, an internist position at the Pioneer Memorial Hospital located in Prineville, Oregon, had been vacant for more than one year and “fourteen hospitals, four clinics and two health departments in rural areas are short a total of seventy physicians.”¹⁶⁶

Oregon is also experiencing a shortage in “several specialties, including rheumatology, nephrology, gastroenterology, cardiology, allergy-immunology and pediatrics”¹⁶⁷ This shortage is likely to continue worsening. The Oregon Medical Association reported in April 2003 that “43% of Oregon neurosurgeons, 27.1% of orthopedic surgeons, and 23.5% of obstetrician-gynecologists reported they have already stopped providing certain services or would do so.”¹⁶⁸ Dr. Katherine Merrill, an obstetrician in Astoria, stopped delivering babies altogether in August of 2003, in part because of the rapidly rising costs of medical liability insurance.¹⁶⁹ Roseberg Women’s Healthcare delivered eighty percent of the babies born in the area until a single lawsuit forced it to close its doors in May 2002; rural patients may now be forced to drive between sixty and ninety minutes for obstetrical services.¹⁷⁰ The situations of Dr. Merrill and Roseberg Women’s Healthcare illustrate the disadvantage to which female

164. OREGON HEALTH AND SCIENCE UNIVERSITY CENTER FOR RURAL HEALTH, PHYSICIAN WORKFORCE IN OREGON 2004: A SNAPSHOT 1-2, *available at* <http://www.ohsu.edu/oregonruralhealth/workforce%20snapshot1.pdf> (last visited Mar. 16, 2007) [hereinafter OHSU SNAPSHOT]. (The Portland area is defined by OHSU to include Multnomah, Clackamas and Washington counties; rural Oregon is comprised of Clatsop, Columbia, Lincoln, Polk, Tillamook and Yamhill counties.)

165. *Id.* at 3. Illustrating “the decline in growth of the rural practitioner tax credit program administered by the Office of Rural Health” from roughly nine percent in 1997-1998 to slightly over one percent in 2002-2003, and the simultaneous decrease in Oregon physicians occupying the 41-50 age group and the rise of those in the 51-60 age group between 1994 and 2004. *Id.* at 2-3.

166. Andrew Kramer, *Doctor Shortage Takes Toll in Rural Areas*, STATESMAN JOURNAL, Sep. 28, 2003, at 1.

167. OHSU SNAPSHOT, *supra* note 164, at 3-4.

168. AMERICAN MEDICAL ASS’N, *supra* note 2, at 19.

169. *Id.*

170. *Id.* at 20.

patients are put in the current system.¹⁷¹

B. Oregon's Effort

Rural physicians are the hardest hit by the medical malpractice crisis in Oregon¹⁷² due to a variety of factors, including the nationwide rise in Medicaid rates and the minimal payments made to doctors for Medicare, which are among the lowest in the United States.¹⁷³ Medicare and Medicaid rates are important matters for rural physicians because "lower Medicaid and Medicare rates affect country doctors more than urban and suburban doctors, [as] the percentage of public health recipients is greater in rural areas."¹⁷⁴ According to Don Wee, director of the Pioneer Memorial Hospital in Prineville, between fifty and sixty percent of patients are elderly, while patients receiving Medicare and Medicaid comprise another twelve to fifteen percent.¹⁷⁵

In an effort to assist rural physicians with professional liability insurance costs—whose cost of equipment and malpractice insurance are the same for city physicians¹⁷⁶—Oregon implemented the Rural Medical Liability Financial Reinsurance Plan.¹⁷⁷ The reimbursement program, proposed by Oregon Governor Theodore Kulongoski and adopted by the legislature as part of House Bill 3630, is designed to keep insurance costs manageable so that rural doctors can afford to practice and continue to offer vital services, such as obstetrical care, to rural communities.¹⁷⁸ The State Accident Insurance Fund (SAIF) is responsible for funding the Reinsurance Plan.¹⁷⁹

171. See JOINT ECONOMIC COMMITTEE STUDY, *supra* note 9, at 18. (Those living in low-income households and rural residents also are put to a disadvantage in the current system due to a lack of private health insurance and lowered access to area physicians respectively.)

172. Kramer, *supra* note 166, at 2.

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.* at 3.

177. See RURAL MEDICAL LIABILITY FINANCIAL REINSURANCE PLAN (Jan. 28, 2004), available at <http://www.ohsu.edu/oregonruralhealth/ruralliabilityreinsuranceplan.pdf>. The Plan went into effect January 1, 2004. Press Release, *supra* note 1.

178. Press Release, *supra* note 1. (In the five year period between 1999 and 2004, Oregon physicians paying premium rates for medical malpractice liability have watched the price increase 160 percent. Doctors practicing high-risk specialties, such as obstetrics, experienced especially steep increases in liability insurance payments.)

179. See RURAL MEDICAL LIABILITY FINANCIAL REINSURANCE PLAN, *supra* note 177.

Physicians and surgeons wishing to take part in the Reinsurance Plan must be “certified as eligible under ORS 442.563, licensed under ORS chapter 677, . . . engaged in the practice of medicine, and [have] a rural practice that amounts to [sixty] percent of the individual’s practice.”¹⁸⁰

The Insurance Division of the Oregon Department of Consumer and Business Services reports that, as of October 1, 2004, 1,063 rural physicians were participating in the Reimbursement Program, distributing over three million dollars to offset the high cost of insurance premiums.¹⁸¹ Of these physicians, fifty-seven were obstetricians, receiving \$669,880, and sixty-eight were family practice physicians that also offer obstetrical services, receiving \$424,135.¹⁸²

C. Criticism: Why Oregon’s Effort Will Not Be Enough

Generally, malpractice tort reforms attempt to affect the system by “1) reducing the frequency of claims, 2) lowering the amounts recoverable, and 3) curbing the costs of the legal process.”¹⁸³

Oregon’s attempt to aid rural practitioners in the payment of medical malpractice liability insurance merely addresses a symptom of Oregon’s medical malpractice crisis, not its cause. The aid simply cushions the blow of insurance payments and does not solve the overall problem. Oregon’s effort is akin to the prescription of pain medication to a patient suffering from cancer; while helpful in reducing pain and complaints, it does nothing to solve the underlying problem.

An effort toward creating effective reform will lead to the significant reduction of malpractice premiums and go a long way toward quelling the crisis.¹⁸⁴ Effective reforms must address the “crux of malpractice litigation.”¹⁸⁵ California’s MICRA statutes provide a prime example of effective reforms by reducing malpractice

180. OR. REV. STAT. ANN. § 315.613(1) (West 2006).

181. OREGON FACT SHEET, *supra* note 100, at 5.

182. *Id.*

183. Stephen Zuckerman, Randall R. Bovbjerg, & Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167, 170-71 (1990).

184. Anderson, *supra* note 53, at 1176.

185. *Id.*

premiums by forty percent since 1975; premiums now rise at a rate roughly one-third the national average.¹⁸⁶ Facing a malpractice crisis similar to Oregon's, and desiring a more predictable and rational medical liability system,¹⁸⁷ California enacted four major reforms: a \$250,000 noneconomic damages cap, a collateral source rule,¹⁸⁸ a provision for periodic payments, and limitations on attorney's contingent fees.¹⁸⁹ Reforms in California have been incredibly successful, saving Californians "billions of dollars in health care costs and sav[ing] federal taxpayers billions of dollars in the Medicare and Medicaid programs."¹⁹⁰

VII. OREGON'S OPTIONS: SUGGESTIONS FOR A CRISIS-FREE TOMORROW

According to the United States Department of Health and Human Services, "[t]he insurance crisis is less acute in states that have reformed their litigation systems."¹⁹¹

Oregon's citizens cannot afford a continuation of the current medical malpractice insurance situation—Oregon needs reformation. The following discussion centers on possible solutions to Oregon's situation as it now exists, evaluated according to feasibility and fairness. According to Maxwell Mehlman:

[Fairness] is generally accepted [as] an important attribute of a properly functioning system of medical liability If changes to the malpractice system are viewed as fair, they are more likely to be enacted and retained In malpractice, what matters most is fairness to patients and potential patients. However, the relational aspect of health care implies that the system must also be fair to physicians.¹⁹²

186. *Id.*

187. U.S. DEPT. OF HEALTH & HUMAN SERVICES, *supra* note 45 at 17.

188. Anderson, *supra* note 53, at 1176. (The collateral source rule prevents collecting damages for the same injury more than once.)

189. *Id.* ("MICRA provides a sliding scale; a plaintiff's attorney keeps 40% of the first \$50,000 of an award but 'only' \$221,000 (plus expenses) of a \$1,000,000 judgment." This allows more of an award to actually reach the injured patient.)

190. U.S. DEPT. OF HEALTH & HUMAN SERVICES, *supra* note 45, at 17. Physicians are not fleeing California and premiums have risen much slower than premiums in other states, absent adverse effects on the quality of patient care. To illustrate, premium rates rose 167% over the last twenty-five years, while other states experienced increases of 505%. *Id.*

191. U.S. DEPT. OF HEALTH & HUMAN SERVICES, *supra* note 45, at 14.

192. FURROW ET AL. 2000, *supra* note 32, at 479 (quoting MAXWELL J. MEHLMAN,

Common reforms include shortening the statute of limitations, limiting the plaintiff's award, and altering the plaintiff's burden of proof.¹⁹³ However, given that Oregon's statute of limitations is already only two years,¹⁹⁴ the unfairness of altering the plaintiff's burden of proof (i.e., creating a heavier burden for the plaintiff to meet), and the fact that Oregon recently rejected the proposal to limit a plaintiff's noneconomic award, this section will focus on alternative remedies.¹⁹⁵

A. *Physician's Professional Liability Fund*

The Oregon Professional Liability Funds Law allows the Director of the Department of Consumer and Business Services to appoint a commission to establish a professional liability fund for qualified members upon a determination of need.¹⁹⁶ A professional liability fund will be determined a necessity if "qualified members of any profession are unable to obtain insurance for damages arising out of professional negligence or that such professional liability insurance is not available at a reasonable cost to such members."¹⁹⁷ Under this standard, Oregon physicians should have no problem evidencing need. The situation of rural doctors provides a prime example of qualified members to whom professional liability insurance is unavailable at a reasonable cost.

However, a finding of need shall be precluded if legitimate insurance underwriting considerations are the reason for unavailability, existing rates are set responsibly by private insurers, the enactment of a professional liability fund would not ultimately reduce premium rates, *and* "there is not an adequate number of potential insureds to fund a professional liability fund."¹⁹⁸

Despite these statutory preclusions, it is likely that Oregon physicians will be able to successfully advocate for the creation of a professional liability fund for physicians by demonstrating the

RESOLVING THE MEDICAL MALPRACTICE CRISIS: FAIRNESS CONSIDERATIONS (June 2003), available at <http://mediabilitypa.org/research/mehlman0603>.

193. FURROW ET AL. 2000, *supra* note 32, at 482-83.

194. OR. REV. STAT. § 12.110(4) (2005).

195. See AMERICAN MEDICAL ASS'N., *supra* note 2.

196. OR. REV. STAT. §§ 752.005-.055 (2005).

197. OR. REV. STAT. § 752.015 (2005).

198. *Id.* (emphasis added).

striking similarities between the current situation faced by physicians and the situation as it existed in 1977 for attorneys. According to the Committee on Professional Liability Insurance in August 1977, implementation of a Lawyer's Professional Liability Fund was the result of years of consideration resulting from "substantial premium increases by private insurers and the withdrawal of several insurers from the state."¹⁹⁹

The anticipated benefits upon operation of a professional liability fund for Oregon lawyers practicing in the late 1970s are also comparable to the desired benefits of physicians currently practicing in Oregon. In August 1977, the Oregon State Bar Bulletin wrote of three expected benefits: "[G]reater protection to the clients and the public; greater protection to the lawyer; and continued availability of professional liability protection at a reduced cost."²⁰⁰ Replace "clients" with "patients" and "lawyer" with "physician" and what remains are goals that, if realized, would do wonders for Oregon physicians feeling the pinch of the current malpractice crisis.

As was true for the Lawyer's Professional Liability Fund, a Physician's Professional Liability Fund would be a national first.²⁰¹ However, despite being innovative for the medical field, the process of organizing a professional liability fund would not be without guidance—Oregon's Professional Liability Fund for lawyers provides not only a template, but also the value of thirty years experience.

Not only does the prospect of a Physician's Professional Liability Fund appear logistically feasible, it is also fair to both physicians and patients. Patients are likely find the fund fair because it will help provide local access to affordable health care and rapid recovery following a lawsuit, should one arise.

Physicians will likely find the fund fair for a couple reasons. First, the fund enables the removal of the ever-needy insurance

199. *Professional Liability Fund Report Due at Convention*, OR. ST. BAR BULLETIN, Aug. 1977, at 6. (Between 1975 and 1977, the Oregon State Bar Bulletin reported a premium increase from \$256 to \$904 and the current existence of only two insurers writing new business.).

200. *Id.* Other physician-owned insurance companies do exist and comprise as much as sixty percent of national physician coverage. FURROW ET AL. 2004, *supra* note 17, at 481. However, no state requires all private physicians to obtain insurance through one particular, physician or state managed, insurance company.

201. Edwin J. Peterson, *OSB Liability Fund First in Nation*, OR. ST. BAR BULLETIN, Mar. 1978, at 6.

company from the pockets of physicians, allowing physicians to spend extra monies on supplies, equipment, or even a salary increase for themselves. Second, physicians may find a professional liability fund fair simply due to the impression that it is better than the alternative.

B. Medical Review & Screening Panel

Currently, Oregon has a mandatory dispute resolution statute, requiring all parties to an action brought against a health practitioner and their attorneys to participate “in some form of dispute resolution within 270 days after the action is filed unless: [t]he action is settled or otherwise resolved within 270 days after the action is filed; [o]r all parties to the action agree in writing to waive dispute resolution under this section.”²⁰² Parties may comply with this statute by taking part in either arbitration, mediation, or a judicial settlement conference.²⁰³ Further, the failure of any party to comply and/or act in good faith may result in court imposed sanctions.²⁰⁴

This statute, while encouraging pretrial settlement and the conservation of money otherwise spent on litigation, does not provide any incentive to settle. Rather, it seems that with the rise in “mega-verdicts,”²⁰⁵ the incentive is to take the case to the jury or to use the threat of a potential mega-verdict to bully the defendant into agreeing to a settlement that unfairly favors the plaintiff, relying more on a risk assessment attitude of the defendant and his insurance company than what will make the injured patient whole.

Medical review and screening panels, on the other hand, attempt to “weed out nonmeritorious cases and encourage prompt settlement before parties incur the costs of a trial”²⁰⁶ (thus lowering malpractice insurance costs as projected future costs would decrease). A typical panel is comprised of a physician or other professional health care worker, a legal professional, and a lay member.²⁰⁷ The panel members craft findings regarding fault and sometimes damages on the basis of testimony and other evidence presented by the parties, using

202. OR. REV. STAT. § 31.250 (2005).

203. *Id.*

204. *Id.*

205. U.S. DEPT. OF HEALTH & HUMAN SERVICES, *supra* note 45, at 9.

206. Zuckerman et al, *supra* note 183, at 171.

207. *Id.*

evidential rules more flexible than those used in formal court proceedings.²⁰⁸ Review of a panel decision is typically mandatory and conclusions reached are often admissible in a subsequent trial, should one be necessary.²⁰⁹

Oregon should consider the institution of a medical review and screening panel as a method to address the current malpractice crisis plaguing Oregon's citizens and physicians. The evidence suggests that this reform type significantly affects medical liability premiums, though the extent to which it does so varies by physician specialty.²¹⁰ For instance, a study conducted by Stephen Zuckerman, Randall R. Bovbjerg, and Frank Sloan, found that "[e]stablishing pretrial screening panels reduces obstetrics/gynecology premiums by about 7% the year after they are introduced; in the long run, this effect is 20%."²¹¹ These results imply that the use of pretrial screening panels may be more effective at screening out nonmeritorious cases and the promotion of out-of-court settlements in other cases, as illustrated above in claims involving Ob-Gyns.²¹² As the Ob-Gyn specialty experiences one of the highest premium rates for liability insurance, and is frequently a driving force behind reform proposals, the Oregon legislature may view panels as an effective option for alleviating the malpractice crisis (at least in part) and subduing the continuing physician outcry for reform.²¹³

Other studies support these conclusions. One such study found that screening panels alone demonstrate a considerable statistical relationship to lower malpractice insurance premiums.²¹⁴ Another found that "the panel system had reduced the number of claims requiring formal adjudication in the courts and decreased the average length of time for resolution . . . [panels] also were more likely to find in favor of claimants."²¹⁵

208. *Id.*

209. *Id.*

210. *Id.* at 175.

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

215. *Id.*

C. *Giving Teeth to the Apology Statute*

Oregon, along with twenty other states,²¹⁶ has enacted a statute explicitly proclaiming that an apology or similar expression of sympathy offered by a physician to a patient following an adverse medical event may not be used as an admission of liability in a civil action.²¹⁷ These “apology statutes” are a sign that the perspective regarding the impact of physician apologies are changing; it used to be that “insurers and hospital lawyers . . . discouraged doctors from apologizing to harmed patients for fear that such apologies might fuel lawsuits.”²¹⁸ The traditional approach, known as “defend and deny,” is facing criticism as malpractice premiums soar and efforts mount to require full disclosure.²¹⁹ As stories hailing the positive influences of the apology increase, many are coming to realize that an apology provides a means to reduce the exorbitant amounts required to settle and defend against malpractice disputes.²²⁰

216. ARIZ. REV. STAT. ANN. § 12-2605 (2006); CAL. EVID. CODE § 1160 (West 2007); COLO. REV. STAT. ANN. § 13-25-135 (West 2006); CONN. GEN. STAT. ANN. § 54-184d (West 2006); FLA. STAT. ANN. § 90.4026 (West 2006); GA. CODE ANN. § 24-3-37.1 (West 2006); LA. REV. STAT. ANN. § 13:3715.5 (2006); ME. REV. STAT. ANN. tit. 24, § 2907 (2006); MASS. GEN. LAWS ANN. ch. 233, § 23D (West 2006); MO. ANN. STAT. § 538.229 (West 2006); MONT. CODE ANN. § 26-1-814 (2005); N.H. REV. STAT. ANN. § 507-E:4 (2006); OHIO REV. CODE ANN. § 2317.43 (West 2006); OKLA. STAT. ANN. tit. 63, § 1-1708.1H (West 2006); TENN. R. EVID. § 409.1 (West 2006); TEX. REV. CIV. STAT. ANN. § 18.061 (Vernon 2005); VA. CODE ANN. § 8.01-52.1 (West 2006) (statements of sympathy made to patient inadmissible in wrongful death actions only); WASH. REV. CODE ANN. § 5.66.010 (West 2006); W. VA. CODE ANN. § 55-7-11a(b)(1) (West 2006); WYO. STAT. ANN. § 1-1-130(a) (2005).

217. OR. REV. STAT. ANN. § 677.082 (West 2006). Oregon’s statute provides:

(1) For the purposes of any civil action against a person licensed by the Board of Medical Examiners, any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability for any purpose.

(2) A person who is licensed by the Board of Medical Examiners, or any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Board of Medical Examiners, may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct.

218. Rachel Zimmerman, *Doctors’ New Tool To Fight Lawsuits: Saying ‘I’m Sorry’*, WALL ST. J., May 18, 2004, at A1.

219. *Id.*

220. *Id.* To illustrate the power of an apology, the Wall Street Journal reports Linda Kenney’s decision not to bring a medical malpractice action following the receipt of a personal

Still, due to either feelings of embarrassment, disgrace, or shame, or advisements made by an attorney, insurance company, or the hospital's risk management board, many physicians remain silent when confronted with a possible medical error or adverse event.²²¹ "Yet it is precisely that silence . . . that can prompt a lawsuit," as the refusal to talk with a patient negatively effects three aspects of the patient-physician relationship.²²² According to Jonathan R. Cohen, J.D., Ph.D:

First is in regard to information. Patients who experience adverse medical events almost inevitably, and quite rightly, desire to know what happened. If the medical provider does not offer that information, some patients or their families will sue to get it. Apologies qua information vehicles may prevent these suits Second is the issue of betrayal of trust. To be effective, the physician-patient relationship must be rooted in trust Hence, the anger prompted when a trusted medical caregiver becomes silent can be tremendous. Third is simply the matter of dignity. When a person injures another, whether on purpose or by accident, the respectful course is for the injurer to apologize. Failing to apologize after injury can itself be a second form of injury.²²³

While it may be difficult to ascertain with specificity the percentage of medical malpractice claims that would be waived or settled as the result of a physician-proffered apology, it may be as high as "ten to thirty percent."²²⁴ In fact, a recent survey indicates that legal advice is 1.5 times more likely to be sought when

letter from the anesthesiologist who'd made an inadvertent mistake during her ankle surgery:

When a medical mishap turned Linda Kenney's routine ankle surgery into a chilling brush with death, the family quickly paid a visit to a lawyer's office. A jury, the family suspected, would likely show little mercy to the anesthesiologist, Frederick van Pelt, who inadvertently injected a painkilling drug in the wrong place, causing Ms. Kenney's heart to stop. To restart it, doctors . . . sliced into her chest and cracked open her rib cage But then, Dr. van Pelt broke with convention. Against the hospital's advice, he wrote Ms. Kenney a personal letter saying he was "deeply saddened" by her suffering. Later, over coffee at a suburban dinner, he apologized for the terrible accident. "I found out he was a real person," Ms. Kenny says. "He made an effort to seek me out and say he was sorry I suffered." Moved by the doctor's contrition, Ms. Kenney dropped her plans to sue.

221. Jonathan R. Cohen, *Toward Candor after Medical Error: The First Apology Law*, 5 HARV. HEALTH POL'Y REV. 21, 22 (2004).

222. *Id.*

223. *Id.* at 22.

224. *Id.*

explanations of medical errors and apologies are not given.²²⁵ A program instituted at the Veterans Affairs Medical Center in Lexington, Kentucky, serves as an example: Treating the “victims of medical errors as we would want to be treated if we found ourselves in their situation . . . decently and with honesty and reason” resulted in a significant reduction of time spent settling cases (from years to months) and only the occasional trial (approximately “one every five years”).²²⁶ Despite differences between Veterans and private hospitals, it is posited that similar results will flow from this approach if undertaken at private hospitals or by private physicians— “[t]he critical component is human nature, and in that, they are the same.”²²⁷

Notwithstanding the positive influence an apology or similar expression of sympathy may have on a potential malpractice suit, many physicians likely feel pressure to refrain from making such an offer. This may be so in spite of their insurance provider’s acclamation of the power of an apology. For example, “Northwest Physicians Mutual Insurance Co., of Salem, Ore., [(a major insurer of Oregon physicians)]²²⁸ has been offering its doctor clients a seminar on disclosing errors and apologizing, providing financial incentives to those who take the class. A slide in one such presentation reads: ‘Apology is psychologically expected when wrong has been done.’”²²⁹ Similarly, Physicians Insurance announces its experience with the positive consequences following an apology:

[A]n authentic and sincere apology or expression of caring and concern over [a] patient’s outcome . . . [has a] tremendous influence in strengthening the physician-patient relationship and promoting trust. Importantly, this enhanced trust *greatly reduces* the likelihood that the patient will seek answers through the financially and emotionally taxing legal system.²³⁰

225. Zimmerman, *supra* note 218, at A1.

226. Steve Kramen, *Medical Malpractice: When All Else Fails, ‘Sorry’ Works Wonders*, ST. LOUIS POST DISPATCH, Apr. 7, 2004, available at <http://www.sorryworks.net/media6.phtml>. “[T]he hospital’s average cost of error-related payouts -- including settlements and a jury verdict -- was \$15,622, putting the Lexington VA in the bottom quarter of 35 comparable VA hospitals.” Zimmerman, *supra* note 221, at A1.

227. *Id.*

228. See OREGON FACT SHEET, *supra* note 100.

229. Zimmerman, *supra* note 218, at A1.

230. THE POWER OF THE APOLOGY, 15 NO. 5 PHYSICIANS RISK MANAGEMENT UPDATE (2004), available at <http://www.phyins.com/pi/risk/pdf/sep0ct04.pdf> (last visited Mar. 19,

Contrary to the above proclamations, this purportedly positive attitude seems to undergo a sort of Dr. Jekyll and Mr. Hyde transformation following the reporting of an adverse incident. Subsequent to being advised of an incident involving a patient, Northwest Physicians Mutual Insurance Company sends a letter to the insured physician with instructions “NOT [to] engage in office conferences, letter writing or phone conversations with the patient, family or their attorney” and to “[n]ever make admissions of guilt, fault or liability about your acts or the acts of another.”²³¹ An assumption that other Oregon medical malpractice insurance companies respond with similar warnings and admonitions is not likely too far off the mark.

While “apology statutes” such as Oregon’s protect a physician from the introduction of “any expression of regret or apology . . . including an expression of regret or apology that is made in writing, orally or by conduct,” for use as an admission of liability,²³² such statutes do nothing to prevent or discourage malpractice insurance providers from discouraging physicians from offering such a statement. And while insurance companies may be justified in taking such an approach, due to fear that the expressions may only solidify a patient’s resolve to bring suit or concern that some doctors may inadvertently say too much, preventing physicians from tendering apologies and sympathy to patients does nothing to dissuade aggrieved patients from bringing suit and continues the path of those lawsuits that would have been dropped had the patient simply heard the words “I’m sorry” or its equivalent.

In an effort to discourage the practice of dissuading physicians from making apologies, I propose a public policy-based amendment to the apology statute. Public policy is broadly defined as “principles and standards regarded by the legislature or by the courts as being of fundamental concern to the state and the whole of society.”²³³ Narrowly, public policy represents “the principle that a person should not be allowed to do anything that would tend to injure the public at

2007).

231. Letter from Northwest Physicians Insurance Company to an anonymous insured physician (Feb. 17, 2006) (on file with author).

232. OR. REV. STAT. ANN. § 677.082 (West 2006).

233. BLACK’S LAW DICTIONARY 1267 (8th ed. 2004).

large.”²³⁴

The malpractice crisis being experienced in Oregon qualifies as a public policy issue because malpractice lawsuits against physicians result in significant expenditures by their insurers.²³⁵ Insurers are forced to pass this cost along to policyholders, which in turn raises the cost of practicing medicine and often results in either higher fees to the patient or a decision to cease practice or move it out of state. Because this threatens both the availability and reasonable cost of medical care, this issue is of “fundamental concern to the state and the whole of society” because it “tend[s] to injure the public at large.”²³⁶ A public policy amendment to the “apology statute” would impose a penalty on those seeking to restrain a physician from expressing regret or apology to a patient following an adverse medical outcome, thus allowing a doctor to offer an apology free from fear that the expression will be used as an admission of liability or as a basis for terminating her insurance policy. An example of such an amendment to the “apology statute” is as follows:

(3) The ability of a person who is licensed by the Board of Medical Examiners to offer an expression of regret or apology, and the ability of any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Board of Medical Examiners, shall not be interfered with.

(4) The court shall fine any person or entity determined, by a preponderance of the evidence, to have interfered with the ability to offer an expression of regret or apology, as provided in Sections (1)-(3) above, not more than \$20,000 for each violation, which shall be entered as a judgment and paid to the Oregon Health Plan. Each violation is a separate offense. In the case of continuing violations, the maximum penalty shall not exceed \$200,000.

(5) The court may award reasonable attorney fees to one licensed by the Board of Medical Examiners if he or she prevails in an action under this section.

234. *Id.*

235. *See* CBO BRIEF, *supra* note 19.

236. *See* BLACK’S LAW DICTIONARY, *supra* note 233. Thus, the malpractice crisis qualifies as a public policy issue under both the broad and narrow definition.

The above, amending ORS section 677.082 to include three additional provisions, serves three purposes: first, it discourages, through the use of severe monetary penalties, insurance companies from advising against or discouraging the use of an apology; second, it allows a physician to offer an apology or expression of regret free from interference, thus reducing the number and cost of malpractice lawsuits brought by aggrieved patients motivated by the desire to acquire sympathy and answers from their doctor; finally, it compensates those hurt most by the malpractice crisis by allocating amounts received as penalties to the Oregon Health Plan, the name given to Oregon's medical assistance program serving low-income families.²³⁷

In order for the apology statute to be optimally effective, the aforementioned amendments to Oregon's apology statute should be accompanied by a state-funded advertising campaign touting both the benefits of the physician-proffered apology and the ability of physicians to utilize the expression without being subjected to its use as an admission of liability or as a basis for insurance policy termination.

VIII. CONCLUSION

There exists no easy solution to the medical malpractice liability crisis. It is a complex problem; one in which states, insurance companies, physicians, and communities are deeply invested. Absent adoption of tort reform similar to California's "gold standard," Oregon and other crisis states will be hard-pressed to find solutions affording physicians lower insurance premiums and citizens local access to affordable healthcare and rapid recovery following a lawsuit. In the face of a refusal to adopt a noneconomic damages cap, alternative solutions must be pursued, however speculative their benefits may be. It is this author's position that a physician's professional liability fund, medical review and screening panel, and the enactment of a comprehensive apology statute will provide viable answers to the serious questions posed by the current medical malpractice liability crisis.

237. DEPT. OF HUMAN SERVICES, OREGON HEALTH PLAN CLIENT HANDBOOK 6 (2004), available at <http://www.oregon.gov/DHS/healthplan/clients/main.shtml#faqs> (last visited Mar. 19, 2007).

