

# Reforming the Tort Reform Agenda

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## I. INTRODUCTION

A fresh start in a game of cards requires us to reshuffle the deck. In so doing, we mix cards previously in play with new ones to approach the game from a new perspective. Although the current longstanding impasse over the U.S. health care system in general and the 46.6 million uninsured Americans in particular<sup>1</sup> is no game, a reshuffling of the issues may open an opportunity to solve what seems to be an intractable problem. To date, it seems every political solution has been tried and has failed.<sup>2</sup> In this Article, I argue that one way to gain political traction on the problem is to integrate the health care issue into the agenda for tort reform. At first blush, the issues may seem disconnected: recovery through the tort system is admittedly a narrower issue than health care access, affecting only those injured through tortious conduct of others. However, closer examination reveals connections between these topics as yet unrecognized by the groups with the strongest interests in them. Through a reshuffling that reveals these links and harnesses the political capital in the tort reform movement, the powerful interest groups that comprise the stakeholders in both debates may realize new benefits through solving the problems created by the inaccessibility of health care for the uninsured. At the same time,

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1. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & CHERYL HILL LEE, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, P60-231, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005 30 (2006) available at <http://www.census.gov/prod/2006pubs/p60-231.pdf>.

2. See *infra* notes 18–33 and accompanying text.

resolution of this issue may make it easier to effectuate changes that lower the costs of the tort system.

While real progress in achieving a solution to the health care mess has been elusive, tort reform<sup>3</sup> is another story. Although tort reform has stagnated at the federal level,<sup>4</sup> it has been implemented with a vengeance in many states.<sup>5</sup> Members of the public and many elected officials see tort reform as a cure for a civil justice system that is unfair, out-of-control and extremely costly.<sup>6</sup> The same adjectives

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3. Tort reform generally refers to legislative proposals or enactments that modify the common law rules of torts. As professor Gary R. Smith observes, tort reform can also occur through judicial decisions, as it did when courts created defenses such as contributory negligence or the fellow servant rule. Gary R. Smith, *The Future of Tort Reform: Reforming the Remedy, Re-balancing the Scales*, 53 EMORY L.J. 1219 (2004). The first wave of legislative tort reform occurred in the late 1800s in Germany and the United Kingdom and in 1910 in the United States, when workers' compensation legislation was enacted in New York. *Id.* at 1220. The second wave occurred in the 1970s, when automobile no-fault legislation was adopted in numerous states. *Id.* The later waves of tort reform in the 1970s through 1990s have addressed medical malpractice and product liability and virtually all have had the effect of reducing plaintiffs' access to the courts. *Id.*

4. President Bush has called for medical liability reform in numerous State of the Union messages. In 2007 he has asked Congress for action to "curb junk lawsuits." George W. Bush, President of the United States, 2007 State of the Union Address, *available at* <http://www.msnbc.msn.com/id/16672456/page/2/>. He made the same appeal in the 2006 State of the Union, George W. Bush, President of the United States, 2006 State of the Union Address, *available at* <http://www.cnn.com/2006/POLITICS/01/31/sou.transcript/index.html>, and again in 2004, when he urged elimination of "wasteful and frivolous medical lawsuits." George W. Bush, President of the United States, 2004 State of the Union Address, *available at* <http://www.whitehouse.gov/news/releases/2004/01/20040120-7.html>. Former Majority Leader Bill Frist blamed the cost of health care on the medical liability system and on trial lawyers in particular. Bill Frist, Remarks at 2004 Republican Convention, *available at* <http://www.washingtonpost.com/wp-dyn/articles/A50446-2004Aug31.html>. Despite Frist's interest in making this a legislative priority, no medical reform legislation was submitted to President Bush for signature. In 1995, Congress sent a bill to President Clinton containing limited reforms, but the President vetoed it. The Class Action Fairness Act ("CAFA"), Pub. L. No. 109-2, 119 Stat. 4 (2005) is the only significant tort reform legislation that has been enacted into law. Congress believed that state court class actions were overly generous and that they were hurting American business interests. The resulting statute gave federal courts more original and removal jurisdiction over class actions. The statute is so complex that, in the view of one group of casebook authors, it will require at least a decade to interpret it in the courts. THOMAS D. ROWE, JR., SUZANNA SHERRY & JAY TIDMARSH, CIVIL PROCEDURE, 2006 SUPPLEMENT 14-15.

5. See MARC A. FRANKLIN, ROBERT L. RABIN & MICHAEL D. GREEN, TORT LAW AND ALTERNATIVES 813 (8th ed. 2006). For an excellent and current database cataloguing tort reform in effect in the states, see Ronen Avraham, Database of State Tort Law Reforms, [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=902711](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=902711) (last visited Apr. 13, 2007).

6. Studies indicate that the public relations campaign of politicians and other tort reform proponents has affected the public perception that the civil justice system is out of control and that injured plaintiffs do not deserve compensation. Stephen Daniels & Joanne Martin, *The*

apply to the U.S. health care system, and the same players are affected by it. Would it be possible to capitalize on the eagerness for tort reform and the political ability to accomplish it to find solutions to the broader issues of health care accessibility?

Although tort reform legislation is not limited to the medical malpractice issue, it is undeniable that much of the political impetus for reform has been spurred by the perception that tort law is hurting doctors and the delivery of health care.<sup>7</sup> The irony of this premise is that some tort reform legislation itself appears to worsen access to health care for America's uninsured, a group that comprises approximately 16% of the population,<sup>8</sup> as well as the much greater

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*Texas Two-Step: Evidence on the Link Between Damage Caps and Access to the Civil Justice System*, 55 DEPAUL L. REV. 635, 640 (2006) (citing studies indicating that there is a high level of public support for limits on pain and suffering, and a fairly high level of support for general limits on medical malpractice actions). Stephen Daniels & Joanne Martin, *The Strange Success of Tort Reform*, 53 EMORY L.J. 1225 (2004); Stephen Daniels & Joanne Martin, *The Impact that it has had is Between People's Ears: Tort Reform, Mass Culture, and Plaintiffs' Lawyers*, 50 DEPAUL L. REV. 453 (2000). There are studies indicating Americans are not particularly litigious as compared with people in other countries. See David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1086–87 (2006) (discussing several empirical and comparative studies).

7. In a speech given in January 2005 in Collinsville, Illinois, President Bush mounted a podium in front of an audience of cheering doctors in white coats and a banner that read "affordable health care." He announced, "I'm here to talk about how we need to fix a broken medical liability system." Other comments included, "lawyers are filing baseless suits against hospitals and doctors . . . . They know the medical liability system is tilted in their favor." Professor Tom Baker describes and quotes the speech, offering it as an example of an "effective, succinct, and powerful statement of the medical malpractice myth." TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 12–13 (2005). The White House website continues to list medical liability reforms as a key to the President's affordable health care agenda. The White House, <http://www.whitehouse.gov/infocus/healthcare> (last visited Sept. 27, 2006). See also Paul C. Weiler, *Reforming Medical Malpractice in a Radically Moderate—And Ethical—Fashion*, 54 DEPAUL L. REV. 205, 205–08 (2005) (describing malpractice's role as a central issue in the political arena).

8. Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL'Y 1, 3 (2005). These numbers do not include people who have limited and inadequate access to care due to issues involving coverage type or ability to pay. Although we think of insurance as tied to employment in the United States, a "sizeable minority" of jobs do not provide health insurance. *Id.* at 17. Employees not offered health care tend to be more likely to be low-income, part-time, minority, female, or under thirty. *Id.* at 18. Eighty percent of uninsured Americans are employed or live within a household where someone is employed. Timothy Stolzhus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 540 (2006). Health insurance is unavailable to the people in worst health who are not aligned within a large group, such as pools of employees, and it is very expensive. *Id.* at 41. According to a report recently released, the number of individuals without health insurance rose from 15.5% in

number who periodically lack coverage, are underinsured, or lack coverage for long-term disabilities. These individuals are forced to rely on the tort system for their medical needs when they are injured by the torts of others. This is an expensive and inefficient way to obtain medical care, but many of these individuals have no other choice. Litigation is generated when they are forced to sue to obtain the treatment and care necessary to restore them to health. Once they sue, tort reform legislation makes it less likely they will be made whole, and more likely that they must rely on public benefits,<sup>9</sup> use emergency rooms for basic care,<sup>10</sup> or delay return to the workforce.<sup>11</sup> Although physicians and other interest groups want tort reform,

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2004 to 15.9% in 2005. The proportion of people covered by employment-based health insurance decreased between 2004 and 2005 from 59.8% to 59.5%. U.S. blacks and Hispanics are uninsured at higher percentages than non-Hispanic whites. The percentage and number of children in poverty increased from 10.8% to 11.2%. Children in poverty are more likely to be uninsured than other children, with a reported rate of 19%. CENSUS BUREAU, *supra* note 1, at 21. For a sense of who the uninsured are, and why they are uninsured, see Profiles of the Uninsured, available at [http://www.cmwf.org/General/General\\_show.htm?doc\\_id=256036](http://www.cmwf.org/General/General_show.htm?doc_id=256036) (last visited July 10, 2006) (the stories of 120 uninsured men and women interviewed by a physician and an anthropologist).

9. Federal and state sponsored insurance in the form of Medicare and Medicaid assists people with disabilities. Medicare provides health insurance benefits to people over age sixty-five as well as to younger people with a statutorily specified chronic disability. The Medicaid program was established in 1965 as a companion to Medicare and focuses on the poorest segments of the population—single parents with dependent children and the aged, disabled, and blind. Nonetheless, only 40% of those deemed “poor” under federal poverty guidelines are covered by Medicaid, only 21% of the near poor, and only 20% of the people with severe disabilities. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, KEY MEDICARE AND MEDICAID STATISTICS (2005), available at <http://www.kff.org/medicaid/upload/key%20Medicare%20and%20Medicaid%20Statistics.pdf>. Disability benefits are also available from Social Security, although the requirements to qualify are very strict. Disability Benefits, <http://www.ssa.gov/pubs/10029.html#part1> (last visited Oct. 16, 2006).

10. The uninsured are often treated in emergency rooms, which, by law, must provide care without promise of reimbursement. The Emergency Medical Treatment and Active Labor Act (“EMTALA”), Consolidated Omnibus Budget and Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 164 (codified as amended at 42 U.S.C. § 1395dd (2003 and Supp. 2006)), imposes a duty to provide treatment, and was enacted in response to widespread reports of patient-dumping. Hospitals were reportedly sending the indigent and uninsured away to charity hospitals without even cursory examination. The costs associated with EMTALA are significant: In 1998, total direct expense for physician services to the uninsured approached \$1 billion, and hospital facility costs were around \$2 billion. See Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, 85 N.C. L. REV. 223, 234–38 (2006).

11. The uninsured receive fewer services than the insured as they navigate emergency rooms and make ad hoc arrangements for care. They get less preventive care, and are diagnosed later than the insured. JULIUS B. RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS* 231–32 (2005).

implementing reforms that exacerbate the obstacles to return to health and employment for a subgroup of plaintiffs is counterproductive.<sup>12</sup>

The adverse effects of tort reform legislation on the uninsured that are discussed here affect other discrete groups similarly,<sup>13</sup> but I focus on the uninsured for several reasons. First, the group of uninsured is broad, cutting across the other groups and including a very diverse segment of society. Second, the focus on this large group's status as lacking access to health care and its resulting reliance on the tort system for medical and long-term care relate to the most fundamental purposes of the tort system. Third, it is by looking at the nexus between tort reform, the uninsured, and the health care problems that plague the U.S. that interest groups that are currently unallied might be brought into some agreement to begin working in the same direction.

The current course of the debate about tort reform is too narrow to allow a genuine discussion and resolution of the problem of health care accessibility. Tort reform issues have been spun narrowly to justify approaches that are desirable to some groups but not necessarily good from a policy standpoint. The highly politicized character of the discussion has placed wedges between groups that should be natural allies, such as consumers and physicians. From a policy standpoint, society seems to be caught between the "Scylla" of maintaining an inefficient system out of concern for the medical needs of a minority of the population, and the "Charybdis" of modifying the system without regard to those who need it most.<sup>14</sup>

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12. As one scholar frames the question, there is an "undiscussed public policy issue [as to] whether taxpayers should bear the burden of medical malpractice." Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System, Juries, and Social Policy*, 38 LOY. L.A. L. REV. 1217, 1220 (2005). Of course, the issue is broader than taxpayer payment for malpractice injuries, and includes all tort related injuries for which plaintiffs are forced to rely on public benefits for care.

13. It has also been argued that tort reform proposals have a significant adverse impact on women and the elderly, and a disparate impact on cases involving death, especially the death of a child from medical malpractice. Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1265 (2004), and that racism plays a huge unstated role in the operation of the tort system, recognition of which should be taken into account in tort reform proposals. Frank M. McClellan, *The Dark Side of Tort Reform: Searching for Racial Justice*, 48 RUTGERS L. REV. 761 (1996). See *supra* note 8 for data regarding the presence of racial minorities and women among the uninsured.

14. Charybdis was a whirlpool off the coast of Sicily personified in Greek myth as a

For these reasons, the tort reform agenda should be merged with the issue of health care for the uninsured, producing a much broader and more imaginative debate and ultimately, new legislative solutions. The hope is that by broadening the discourse, some key stakeholders will begin to realize that finding a solution serves their own interests and furthers the common good.<sup>15</sup> If we face the fact that uninsured Americans are forced by need to seek de facto health coverage through the tort system when they are injured and that the current framework of federal laws serving the poor is inadequate to remove the pressure on the system,<sup>16</sup> it should become easier to see the need for a solution.

To be clear, I am not advocating wholesale replacement of the tort system with a no-fault plan; I continue to see much value, in terms of corrective justice, deterrence, and the righting of wrongs in the tort system.<sup>17</sup> Rather, I am suggesting that, by examining the linkage between tort reform and the uninsured, a more comprehensive understanding of the flaws in our health system and our reliance on the tort system to provide coverage emerges. With newfound clarity, perhaps the political gridlock that plagues the system can be broken and solutions that represent moderate, rational, and effective public policy as to health care access and the costs of the tort system can be developed.

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female monster, while Scylla was a nymph who terrorized mariners in the same area by changing into a monster. Mariners navigating between Scylla and Charybdis were faced with two equally hazardous and undesirable alternatives. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 228, 1057 (1983).

15. See *infra* notes 150–80 and accompanying text.

16. Jost, *supra* note 8, at 556–73. Half of the cost of health care in the United States is paid by public insurance programs, such as Medicare, Medicaid, public hospitals, and through the cost of tax subsidies provided to finance private health insurance. *Id.*

17. John Goldberg argues compensation and deterrence are not the primary goals and that the tort system is best theorized as “a special kind of victims’ rights law.” John C. P. Goldberg, *What Are We Reforming? Tort Theory’s Place in Debates over Malpractice Reform*, 59 VAND. L. REV. 1075, 1077–78 (2006).

## II. THE TORT REFORM AGENDA AND ITS INFLUENCE ON THE UNINSURED

To explore the validity of the assertion that tort reform hurts uninsured individuals who must use the tort system for medical and other care expenses when they are injured through negligence or other torts, it is essential to discuss specific features of tort reform legislation. Before doing so, however, it is helpful to realize that the current silence about the intersection of tort reform and health care access issues did not always exist. Fifteen years ago, when universal health care seemed likely, scholars were contemplating the changes to the tort system that could and should result from its enactment.

### *A. Thoughts from the Clinton Years*

When Bill Clinton was first elected President, one of the first issues he sought to tackle was health care reform.<sup>18</sup> He was concerned not only about cost containment, but also about the devastating impact of the high cost of medical services on those without medical insurance.<sup>19</sup> There appeared to be bipartisan support for some change in the direction of universal coverage.<sup>20</sup> Perhaps this was overly optimistic given the fact that universal health care had been seriously debated through much of the twentieth century but never had come to fruition through the legislative process.<sup>21</sup> Many

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18. PHILLIP FUNIGIELLO, CHRONIC POLITICS, HEALTH CARE FROM FDR TO GEORGE W. BUSH 218–19 (2005) (recounting Clinton's pledge to make universal medical coverage a major public policy initiative of his first hundred days and explaining the poor political environment for such a major change).

19. *Id.* Annual medical costs were approaching a trillion dollars and nearly 40 million Americans lacked insurance by choice or by necessity. *Id.*

20. *Id.* at 249–53. The issue was one that had engaged public attention during the campaign. In October of 1993, two Republicans, John Cooper of Tennessee and Fred Grandy of Iowa, had introduced a bipartisan managed-care bill that was co-sponsored by twenty-six Democrats and eighteen Republicans. Ultimately, leaders in the Democratic and Republican parties viewed compromise as undesirable and the Republican leadership saw Clinton's health care initiative as a way to portray the administration as big-spending liberals. Although Senate Democratic leader Mitchell and House Democratic leader Gephardt tried to introduce rescue bills that would attract bipartisan support, and although these bills were far less bureaucratic and intrusive than Clinton's plan, the momentum was gone by August of 1994. *Id.* at 255–56.

21. JILL QUADAGNO, ONE NATION UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE (2005).

theories explain why universal health care initiatives have failed in the past: opposition to big government; the absence of a strong political labor party; racial politics that for the first two-thirds of the century led to opposition to any government intrusion out of fear it would lead to intervention on racial practices; and the political structure of the United States, both nationally and at the state level.<sup>22</sup> Professor Jill Quadagno makes a powerful case that none of these theories really accounts for our failure to provide universal health care, although all may play a role. Instead, she argues, “we have failed to grasp how much we have ceded our health care to private interests.”<sup>23</sup>

The story of Clinton’s failure is illustrative of the role those private interests played in opposing health care reform as well as how a President who won only 43% of the vote failed to mobilize against those interests in timely fashion. Eleven days after Clinton took office, the Health Insurance Association of America hired the ranking Republican on the House Committee on Ways and Means, Bill Gradison, as its president and chief lobbyist, and the group immediately began to raise money and run ads questioning government involvement in health care.<sup>24</sup> Attack ads began to run, including the famous “Harry and Louise” spot, which featured a husband and wife who sat around the table worrying about having to use a health plan picked by “bureaucrats” and planting the suspicion that this was just an excuse to expand big government.<sup>25</sup> The Health Insurance Association then organized a coalition to enlist local business leaders in opposing Clinton’s plan.<sup>26</sup> Although initially there was some support for health care reform from some insurance companies, they eventually endorsed managed competition as a solution and ultimately turned against the Clinton plan.<sup>27</sup> Manufacturers with large retiree benefit commitments, such as the auto industry, had initially supported Clinton’s plan but later reversed their position because they were satisfied that managed care could

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22. *Id.* at 6–16.

23. *Id.* at 16.

24. *Id.* at 189.

25. *Id.* at 189–90.

26. *Id.* at 190.

27. QUADAGNO, *supra* note 21, at 190.



contain costs.<sup>28</sup> Drug companies feared the regulation of prices and opposed the plan.<sup>29</sup> Small businesses, mobilized by the National Federation of Independent Business, joined the opposition fearing a high tax burden and in turn deluged members of Congress with their disapproval.<sup>30</sup> The American Medical Association (“AMA”), which had long been the strongest voice against universal health care,<sup>31</sup> was not as active in this fight and physician groups splintered, with some organizations supporting health care reform and others opposing it.<sup>32</sup> Thus, physicians failed to speak with a strong and united voice about their views on health care reform. The media blitz and money poured into fueling the opposition caused public approval of a national health system to decline from 67% when first announced by Clinton to 44% by February 1994. This decline is credited with enabling the Republican Party to take control of the House of Representatives on an anti-big government platform in the 1994 election.<sup>33</sup>

Given this history of failure, one might wonder why professor Gary Schwartz, a luminary in the field of torts, predicted in 1992 that, by the end of the century, the United States would adopt a national health care program.<sup>34</sup> His sense was that a broad consensus had emerged among “Democrats and Republicans alike, that it is awful to face, without insurance, the massive bills produced by modern medicine, and even more awful for Americans to be denied health care because of a lack of insurance or wealth.”<sup>35</sup> Although by the time his article was published in 1994, Clinton’s plan was dead, Schwartz was still optimistic enough to write a piece about the

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28. *Id.* at 191.

29. *Id.*

30. *Id.*

31. As Drs. Richmond and Fein recount the history of the AMA, the last time it spoke in favor of health insurance for the population was 1917. There were physicians who deviated from the AMA’s view, including a distinguished committee that in 1937 forwarded a statement of principles and proposals for a national health policy, but they were publicly attacked by the AMA and eventually the group disbanded. The AMA thwarted Harry Truman’s plan for national health insurance. RICHMOND & FEIN, *supra* note 11 at 12–22.

32. QUADAGNO, *supra* note 21, at 192.

33. *Id.* at 194.

34. Gary T. Schwartz, *A National Health Care Program: What its Effect Would be on American Tort and Malpractice Law*, 79 CORNELL L. REV. 1339 (1994).

35. *Id.* at 1339.

impact of national health insurance on tort law.<sup>36</sup> Other noted scholars joined the debate, including professor Jeffrey O'Connell, who predicted that the availability of health insurance would increase tort suits.<sup>37</sup> O'Connell, long a champion of no-fault plans, urged that federal health insurance reform should be coupled with auto insurance reform that would offer motorists the option of being paid promptly for unreimbursed out-of-pocket losses on a no-fault basis and the right to opt out of suing and being sued for pain and suffering.<sup>38</sup> O'Connell also would have reformed other personal injury claims by offering defendants the choice of eliminating pain and suffering when an offer is made to pay periodically for an injured party's actual economic losses, plus a reduced claimant's attorney's fee.<sup>39</sup> Professors Ken Abrams and Lance Liebman commented on the need to perceive the relationships between tort law and private and social insurance systems and to develop reform proposals that take into account these various systems.<sup>40</sup> These were bold visions that looked at the tort system as part of a larger whole and resisted the temptation to focus exclusively on one issue, such as medical malpractice.

As it became clear that the Clinton plan and any offshoots were dead, torts scholars tended to concentrate on tort reform<sup>41</sup> and health and policy scholars continued to write about whether universal health care would be desirable and what it would look like if implemented.<sup>42</sup> There is some life left in the debate about universal health care, as

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36. *Id.*

37. Jeffrey O'Connell, *Blending Reform of Tort Liability and Health Insurance: A Necessary Mix*, 79 CORNELL L. REV. 1303 (1994).

38. *Id.* at 1310.

39. *Id.*

40. Kenneth S. Abraham & Lance Liebman, *Private Insurance, Social Insurance and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75 (1993).

41. See, e.g., Symposium, *Who Feels Their Pain? The Challenge of Noneconomic Damages in Civil Litigation*, 55 DEPAUL L. REV. 249-792 (2006); Symposium, *Starting Over?: Redesigning the Medical Malpractice System*, 54 DEPAUL L. REV. 203-655 (2005); Symposium, *The Future of Tort Reform: Reforming the Remedy, Re-balancing the Scales*, 53 EMORY L.J. 1220 (2004).

42. See, e.g., Symposium, *Rethinking Health Law*, 41 WAKE FOREST L. REV. 341 (2006); Symposium, *National Health Reform and America's Uninsured*, 32 J. L. MED. & ETHICS 386, 386-473 (2004).

evidenced by the Commonwealth of Massachusetts requiring it.<sup>43</sup> California has passed legislation only to have it vetoed by Governor Schwarzenegger,<sup>44</sup> but he has now proposed his own plan to remake health care.<sup>45</sup> Most of the public debate about health care accessibility and cost has centered on other government programs such as Social Security and prescription drug coverage.<sup>46</sup> Legal scholarship about tort reform is broad and thorough in its attention to a wide array of issues; however, tort reform issues, as reflected in states' legislation and presented in the public domain, are narrow and "fueled by the economic self-interest of those who perceive themselves as adversely affected by the tort system."<sup>47</sup>

Acknowledging a debt to the scholarly insights of Schwartz and others, it is time to revisit the issue they were concerned about from the opposite angle. That is, rather than considering what the effect of national health insurance on the tort system is likely to be, we need to analyze the wisdom and effectiveness of enacting tort reform without dealing with losses caused by the lack of health insurance and other social support. In the present state of political gridlock, our choices

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43. Daniel Weintraub, Commentary, *Taking First Steps Toward Health Coverage for All*, SACRAMENTO BEE, Aug. 15, 2006, at B7 (describing the bipartisan compromise that was enacted in Massachusetts in 2006).

44. California State Senator Sheila Kuehl carried a bill that would have provided every Californian with coverage under a single payer plan with choice of doctor and the legislature passed it, but the governor vetoed it. Frank D. Russo, *Schwarzenegger Announces Veto of Universal Health Care Bill SB 840*, CAL. PROGRESS REP., Sept. 5, 2006, available at [http://www.californiaprogressreport.com/2006/09/schwarzenegger\\_21.html](http://www.californiaprogressreport.com/2006/09/schwarzenegger_21.html).

45. M. Gregg Bloche, *It's Up to You: The Governor's Healthcare Plan Would Reward the Fit with Lower Premiums*, L.A. TIMES, Jan. 21, 2007, at 3. Professor Bloche describes the California governor's plan as relying on "an elaborate scheme of subsidies from employers, doctors, hospitals, and the federal government," but its signature item is people's responsibility for their own health. He states that the "radical promise" of the plan is its potential to move beyond the metaphor of a handout toward the idea that health is an "individual and common duty." The proposal bears some similarity to one forwarded by Senator John Chafee in 1994, which would have required individuals to buy coverage. Republicans initially supported Chafee but ultimately concluded there was greater political benefit in defeating health care reform entirely. *Id.*

46. For example, Federal Reserve Chairman Ben Bernanke has called for urgent reforms of Medicare and Social Security, predicting that absent quick action, there will need to be tax increases, deep cuts in benefits, cuts in other federal programs, and an increase in national debt. Kevin G. Hall, *Fed Chief: Quickly Reform Medicare, Social Security*, SACRAMENTO BEE, Oct. 5, 2006, at D3.

47. Joseph A. Page, *Deforming Tort Reform*, 78 GEO. L.J. 649, 654 (1990) (reviewing PETER W. HUBER, *LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES* (1988)).

are limited, inefficient, and potentially unfair. We can try to constrain the costs of tort liability through piecemeal reforms without regard to how such reforms adversely affect the uninsured, or we can retain the common law rules without reform so that we protect that subgroup of uninsured persons who become plaintiffs in tort cases and rely on the tort system for the health care they need to return to the status quo. But, neither is a wise choice from a public policy standpoint. What is needed, rather, is a way to reframe the debate and reengage the stakeholders in thoughtful dialogue.

At the present time, with terrorism, war, illegal immigration, and other pressing issues competing for the federal dollar, national health insurance may seem unlikely. The powerful political barriers that make national health insurance particularly difficult to enact remain strong,<sup>48</sup> as do the powerful interest groups that have opposed it. Nonetheless, the issue has been raised by 2008 presidential hopefuls who have indicated it would be part of their agenda if elected.<sup>49</sup> The cost of delivering medical care and the impact of uninsured persons remain relevant at the federal and state levels, as does an interest in cutting costs that are added to medical care by the inefficiency of the tort system. We owe it to ourselves and to coming generations to think through these issues in a comprehensive fashion.

### *B. Exposing Some Preliminary Assumptions About Tort Reform*

Given the amount of tort reform that already has been enacted by states and the ongoing pressure to enact more, it appears there are many who take the first option set forth above: “fix” perceived problems of the tort system in piecemeal fashion without regard to

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48. Theodore R. Marmor & Jonathan Oberlander, *Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future*, 2004 U. ILL. L. REV. 205, 208 (describing barriers created by the political system). The internal organization of Congress, its fragmented structure and weak political parties, and the divergent individual agendas of members of Congress make reform extremely difficult. *Id.*

49. Nedra Pickler, *Obama Calls for Universal Health Care*, SACRAMENTO BEE, Jan. 25, 2007, available at <http://dwb.sacbee.com/24hour/politics/v-print/story/3481911p-12730042c.html>. Senator Barack Obama indicated he expected universal health coverage would be in effect by the end of the next President's first term. Senator Hilary Rodham Clinton and former Senator John Edwards have also promised to offer plans. *Id.*

the impact on the uninsured.<sup>50</sup> I will explore the problems with that approach with attention to particular pieces of the tort reform agenda but first address some premises and assumptions that underlie tort reform generally.

Although there is enormous substantive and procedural diversity in the tort reform that has been enacted, there is commonality in its premise. Most tort reform is designed to minimize the number of personal injury actions that are filed or to mitigate the damages that would be paid in a settlement or an eventual trial. The assumption, based on that premise, is that lower numbers of tort actions mean a lower risk of litigation and high payouts, which should have the effect of lessening the costs of liability insurance.<sup>51</sup> The beneficiaries of reform legislation—businesses, medical practitioners, or the insurance industry itself—should see cost savings and the intangible, psychic benefits of less litigation. In theory, these benefits would then be passed along to the ultimate consumers of various services and the American economy generally.

In fact, many studies and articles that question every one of the assumptions made in the paragraph above. The literature is so voluminous that full exposition here is impossible, but several points are key. First, many scholars do not agree that the tort system is “broken” and needs to be fixed through tort reform.<sup>52</sup> They dispute the underlying data and its interpretation by tort reform proponents.<sup>53</sup>

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50. See Finley, *supra* note 13, at 1264–66 (arguing that the proponents of caps on noneconomic damages have given “little or no thought” to their effects on the ability of the injured to find lawyers and gain access to the justice system, and arguing that, in addition to being ineffective to control insurance rates, caps on noneconomic damages have a disparate impact on women and the elderly and in wrongful death cases).

51. See DAN B. DOBBS, *THE LAW OF TORTS* 1094 (2000) (noting that critics believe Americans are lawsuit-prone and greedy, and that they sue for every little injury, driving up the cost of insurance or even making it unavailable and that lawsuits drive useful products from the market).

52. See, e.g., Thomas C. Galligan, Jr., *The Tragedy in Torts*, 5 CORNELL J.L. & PUB. POL’Y 139, 172 (1996) (defending the common law’s focus on individualized justice for the particular plaintiff and arguing that tort reform proposals will undercut it); BAKER, *supra* note 7, at 68–117 (analyzing research that indicates jurors do not favor medical malpractice plaintiffs and do a good job in assessing medical malpractice damages and if biased at all, are biased in favor of doctors, and that without malpractice lawsuits, people would not know about the extent of medical mistakes or injuries). He argues malpractice suits improve patient safety in addition to providing needed compensation. *Id.*

53. See, e.g., Finley, *supra* note 13, at 1270–80 (citing various studies that suggest the

As Anthony Sebok recently noted, “any discussion about civil litigation in America is treacherous because we have so little solid statistical data.”<sup>54</sup> Michael Saks documented the lack of reliable data in a seminal piece in 1992.<sup>55</sup> To the extent one questions or contradicts the assumption that tort judgments are responsible for adverse economic impacts on certain groups, such as doctors, the entire premise of tort reform is undercut.<sup>56</sup> In his recent book, professor Tom Baker characterized the frenzy about medical malpractice suits as a “myth” that is part of a larger story that is told about “the litigation explosion, the litigiousness of Americans, and the debilitating effect that lawsuits have on the U.S. economy.”<sup>57</sup> Even if one gives credence to data indicating the existence of increased claim rates and payout amounts, it still does not necessarily follow that the system needs reform. As Professor Sebok notes in the context of noneconomic damages, it is premature to view those increases as symptomatic of a problem until we understand how they came about.<sup>58</sup>

The other assumption implicit in discussions of tort reform is that its various revisions of the common law actually work as intended. In fact, we lack dispositive evidence that tort reform legislation is causally responsible for lower rates of litigation or lower premiums<sup>59</sup>

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empirical reality is the complete opposite of the way it is portrayed by tort reform proponents); PAGE, *supra* note 47, at 649 (1990) (describing anecdotes supporting tort reform as untrue).

54. Anthony J. Sebok, *Translating the Immeasurable: Thinking About Pain and Suffering Comparatively*, 55 DEPAUL L. REV. 379, 381 (2006).

55. Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?*, 140 U. PA. L. REV. 1147, 1149 (1992).

56. Many attribute insurance premium increases to reduced investment income in a slow economy. *See* DOBBS, *supra* note 51, at 1095–96.

57. BAKER, *supra* note 7, at 1–14. Baker’s views are based on numerous empirical studies and are supported by other scholars. *See* Hyman & Silver, *supra* note 6, at 1094 (discussing Baker’s study and a subsequent study that strongly supports his views).

58. *See* Sebok, *supra* note 54, at 383. Sebok considers possible reasons why noneconomic damages may have risen faster than economic damages. He offers the possibility that more women, minorities, and working-class people have been brought into the tort system through an innovative bar or changes in civil procedure, and given the gendered quality of noneconomic damages, the numbers may reflect their inclusion. *Id.* at 385–86. If this scenario is true, then it may be a reflection of a healthier and fairer civil justice system instead of a system gone awry.

59. A report issued in 2003 by the independent financial analyst Weiss Ratings Inc. concluded that while damage caps produce a 15.7% reduction in median insurer payouts, they do not cause insurance companies to reduce the premiums they charge doctors, and in fact, that caps may be inversely correlated to medical malpractice premium levels. MARTIN D. WEISS ET

when it is enacted and indeed, there is fairly strong evidence that much tort reform does not result in its intended effect.<sup>60</sup> For example, a symposium addressing possible improvements to medical malpractice insurance<sup>61</sup> included two articles that discussed the effects of California's MICRA legislation, some provisions of which were viewed as models for proposed federal legislation. One writer attributed decreases in medical malpractice insurance premiums to the enactment of MICRA,<sup>62</sup> while another argued that California's increased regulation of the insurance industry at exactly the same time was responsible.<sup>63</sup> There is considerable scholarship attributing pricing of medical malpractice insurance to the cyclical nature of the insurance industry's underwriting cycle.<sup>64</sup>

For purposes of this Article, I will assume that, in fact, some tort reform measures can and actually do decrease the number of claims and the cost of settlements or judgments.<sup>65</sup> Thus, those who stand to benefit from tort reform are not likely to abandon their agenda based

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AL., WEISS RATINGS, INC., MEDICAL MALPRACTICE CAPS: THE IMPACT OF NONECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS, AND THE AVAILABILITY OF COVERAGE 7–13 (2003), available at <http://www.weissratings.com/medicalmalpractice.pdf>.

60. See, e.g., Daniels & Martin, *supra* note 6, at 642–43 (summarizing the connection between caps and insurance rates and finding a mixed picture). The Center of Justice & Democracy, an organization with a pro-trial-lawyers agenda, provides numerous examples where insurance rates have risen dramatically following enactment of caps. CENTER FOR JUSTICE & DEMOCRACY, CAPS DON'T WORK, available at [http://www.centerjd.org/free/mythbusters-free/MB\\_CapsDontWork.htm](http://www.centerjd.org/free/mythbusters-free/MB_CapsDontWork.htm).

61. Symposium, *Case Study Question, How Can the Current State of Medical Malpractice Insurance Be Improved?*, 5 YALE J. HEALTH POL'Y L. & ETHICS 341 (2005).

62. Donald J. Palmisano, *Health Care in Crisis*, 5 YALE J. HEALTH POL'Y L. & ETHICS 371, 379 (2005) (strongly endorsing California's MICRA legislation as the model to pursue to fix the medical liability crisis).

63. Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 357, 369 (2005).

64. See, e.g., Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393 (2005) (discussing the factors that contribute to the underwriting cycle generally, as well as risks that make medical malpractice insurance particularly likely to be influenced by pressures of the underwriting cycle and reviewing other studies on the topic).

65. For empirical research indicating that some reforms have affected claim frequency and severity, and thus premiums, see PATRICIA DANZON & L. LILLARD, THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS: RESEARCH RESULTS AND POLICY IMPLICATIONS (1982); the American Association of Tort Reform certainly takes the view that tort reform works, touting successes in Texas, Mississippi, and New Jersey, among others, on its website. See American Association of Tort Reform, *How Tort Reform Works*, [http://www.atra.org/wrap/files.cgi/7964\\_howworks.html](http://www.atra.org/wrap/files.cgi/7964_howworks.html) (last visited Oct. 16, 2006).

on statistical inaccuracy, unavailability of better data, lack of causality, or even the proposition that increases in claiming rates or judgments are actually salutary because they deter unsafe practices.<sup>66</sup>

### *C. Dissecting the Tort Reform Agenda*

Although there is enormous variety in both the issues addressed and the approaches taken in state tort reform legislation,<sup>67</sup> some attributes of the tort system are the focus of particular attention across jurisdictions. Noneconomic, or general damages are frequently criticized because these are seen as intangible and, hence, extremely difficult for jurors to value, leading to inflation and wide variability.<sup>68</sup> A common means of curbing these damages is to impose caps, such as \$250,000 in any malpractice suit filed in California.<sup>69</sup> These caps have a much more significant impact on the uninsured, as well as the poor generally, than is readily apparent. Although punitive damages are also viewed as problematic, both because they are unpredictable and because they raise the settlement value of a case, their rarity<sup>70</sup> and the fact that they supplement compensatory damages minimize the relevance of their reform as a burden on the uninsured. Joint and

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66. BAKER, *supra* note 7, at 94–117 (arguing that medical malpractice claims are far less numerous than actual malpractice that occurs in society and that malpractice lawsuits improve patient safety). Baker illustrates this principle by referring to the example of anesthesiologists, who have responded to high premiums and malpractice claims by identifying unsafe practices, and developing new equipment and procedures to reduce injury. *Id.*

67. For a comprehensive analysis of major legal reforms of the 1970s and 1980s affecting medical malpractice, including insurance reforms, reforms aimed at improving medical quality, and tort reforms, see Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499, 542 (1989).

68. Joseph Sanders, *Why Do Proposals Fall on Deaf Ears?*, 55 DEPAUL L. REV. 489, 490 (2006). Empirical research substantiates the variability of noneconomic awards. See, e.g., Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908, 923, 941 n.156 (1989); David W. Leebron, *Final Moments: Damages for Pain and Suffering Prior to Death*, 64 N.Y.U. L. REV. 256 (1989).

69. CAL. CIV. CODE § 3333.2 (West 1997).

70. There is a perception that punitive damages are awarded frequently, but empirical studies do not support this. See Theodore Eisenberg et al., *Judges, Juries and Punitive Damages*, 87 CORNELL L. REV. 743 (2002) (finding no evidence judges and juries react differently in awarding punitive damages and finding that punitive damages are awarded less frequently in products liability cases than in intentional tort and employment cases); Theodore Eisenberg et al., *The Predictability of Punitive Damages*, 26 J. LEG. STUD. 623 (1997) (punitive damages awarded in less than 10% of jury trials, with a median award of \$50,000 and a mean of \$534,000).



several liability,<sup>71</sup> however, has been the focus of major legislative change<sup>72</sup> and remains an important issue in terms of delivering full compensation to plaintiffs. Although it may seem counterintuitive, reform of the collateral source rule, which in its common law form created the possibility that a plaintiff may recover twice for the same injuries,<sup>73</sup> is also relevant, at least as an illustration of how complicated reform is when the pool of plaintiffs includes both insured individuals with many collateral sources and uninsured individuals with few.<sup>74</sup> Tort reform of attorneys' fees is also common, the theory being that a contingent fee may skew lawyers' incentives to litigate.<sup>75</sup> This too has dramatic effects on plaintiffs' ability to obtain representation, which particularly hurts those who must use the legal system to be made whole. Finally, certain statutes, such as the Class Action Fairness Act,<sup>76</sup> seek to reform the tort system by changing procedures that are believed to contribute to

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71. Joint and several liability is a doctrine that protects the plaintiff from the risk of a defendant's insolvency by providing in the terms of the judgment that each co-defendant is responsible for the entire amount. While not all tort judgments impose joint and several liability, it is very common because one of the grounds for doing so is the occurrence of an indivisible injury. DOBBS, *supra* note 51, at 413.

72. About a dozen states have abolished the doctrine, and another dozen have abolished it when the defendant is less than a certain percentage at fault. Several states, such as California, retain joint and several liability for economic damages and abolish it for noneconomic damages. Some retain the doctrine only when the plaintiff is not at fault. Others retain the doctrine but reallocate the percentage share of insolvent defendants to the other parties in the case in proportion to their fault. Some retain the doctrine for cases falling within certain subject areas and abolish it elsewhere. FRANKLIN ET AL., *supra* note 5, at 372.

73. DOBBS, *supra* note 51, at 1058–59 (explaining that in many instances the collateral source rule only operates to protect an insurer's subrogation rights, and in these instances, it is sometimes justified to prevent insurance premiums from rising).

74. In California malpractice actions, if all or a part of a victim's medical bills have been paid by the victim's own insurance or some source unrelated to the defendant, the jury will be informed. CAL. CIV. CODE § 3333.1. Some states handle the issue as a matter of law. For example, New York will deduct money already received from most collateral insurance sources, but the plaintiff will receive credit for having paid up to two years' premiums. FRANKLIN ET AL., *supra* note 5, at 784.

75. For example, the American Tort Reform Association expresses the opinion that contingent fees give attorneys incentives to seek cases that can be settled easily with little work or can be decided under no-fault laws. American Tort Reform Association, Contingent Fee Reform, <http://www.atra.org/issues/index.php?issue=7354>. California has addressed this issue by modifying the traditional contingent fee structure in its MICRA legislation. CAL. BUS. & PROF. CODE § 6146(a) (West 2003) (sliding fee scale in medical malpractice cases).

76. See *supra* note 4.

excessive litigation or other abuses of the system,<sup>77</sup> but in the process may make it harder for people of less means to recover for injuries.

### 1. Limitations on Plaintiffs' Attorneys' Fees

Depending on one's view, contingent fee financing of tort litigation is either the key to allowing people without means access to the legal system or the cause of many of the perceived ills of the tort system.<sup>78</sup> This highly controversial yet common way of compensating plaintiffs' attorneys continues to prompt many objections, including that it is unethical for an attorney to have a vested interest in the amount of a client's recovery, that it promotes litigation of cases that are not likely winners but which may lead to a grudging settlement, and that attorneys are overpaid relative to the time they invest.<sup>79</sup> It is tolerated, notwithstanding these objections, because it is a means of promoting access to justice even for people who lack the means to pay an hourly rate.<sup>80</sup> Although there is a possibility of overpayment in a given case, an attorney's caseload is viewed as a whole, with recognition of the risk of non-payment in other cases.<sup>81</sup>

Tort reform legislation addresses the contingent fee in several ways, including requiring the court to determine the fee,<sup>82</sup> and imposing a ceiling on fees,<sup>83</sup> requiring court approval of fees,<sup>84</sup> or by

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77. Other hurdles in the same vein include shortening the statute of limitations, imposing preconditions to suit, and raising the burden of proof. DOBBS, *supra* note 51, at 1071.

78. See HERBERT M. KRITZER, RISKS, REPUTATIONS, AND REWARDS, CONTINGENT FEE LEGAL PRACTICE IN THE UNITED STATES 1 (2004).

79. Richard M. Birnholz, Comment, *The Validity and Propriety of Contingent Fee Controls*, 37 UCLA L. REV. 949, 952-54 (1990); Elihu Inselbuch, *Contingent Fees and Tort Reform: A Reassessment and Reality Check*, 64 LAW & CONTEMP. PROBS. 175, 179-80 (2001).

80. Inselbuch, *supra* note 79, at 178. The contingent fee evens a victim's odds of a fair recovery against tort defendants, who, unlike the plaintiff, are able to spread the risk of losing any one case among them all; the plaintiff's attorney plays a role not unlike the defendant's insurer, which leads to a level of risk adversity that is more in line with that of the defendants and likely to yield a fair settlement of the claim.

81. *Id.*

82. ARIZ. REV. STAT. ANN. § 12-568 (2003) (court determines fee in medical liability cases in Arizona); HAW. REV. STAT. § 607-15.5 (1993) (same in Hawaii).

83. See, e.g., M.C.R. § 8.121 (West 2003) (contingent fee not greater than one-third in medical liability cases in Michigan).

84. See, e.g., HAW. REV. STAT. § 707-15.5 (1993) (providing that either party may request that attorney fees are subject to court approval); WASH. REV. CODE ANN. § 4.24.005 (West 1988) (providing that any party charged with attorney's fees in any tort action may request a

imposing a scale on fees that is intended to influence particular litigation behavior.<sup>85</sup> For example, a statute like California's lessens the percentage an attorney receives in a medical malpractice case as the amount of recovery increases.<sup>86</sup> Medical malpractice litigation is more difficult than the ordinary tort case in that often liability is unclear and there are significant costs entailed in litigation.<sup>87</sup> Even without tort reform in place, the substantive difficulty and the monetary outlay for experts tends to reduce interest in representing clients with lower damages and less fee potential, thus denying plaintiffs in that situation a ready means of litigating disputes.<sup>88</sup> Once fee constraints are added, a rational attorney in California may well decide not to undertake medical malpractice cases at all, particularly given the lack of fee constraints in other types of personal injury cases.<sup>89</sup> Ironically, a statute like California's, which scales fees down as the amounts recovered get higher, may make higher damage cases less desirable as well.

Tort reform of contingent fees clearly influences attorneys' decisions about which cases to take, which in turn has major

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determination of reasonableness by the court).

85. See, e.g., N.J. R.C.R. 1:21-7 (West 1996), which establishes a schedule of maximum percentages that can be charged unless prior approval of the court is obtained. The schedule applies to any claim for damages based on tort and includes a special provision to increase fees payable by minors or incompetent persons to 25% in cases settling for less than \$50,000.

86. CAL. BUS. & PROF. CODE § 6146 (West 2003). In upholding the constitutionality of this provision, the California Supreme Court explained that the legislature believed this scale reducing the attorneys' fee as damages climb would induce plaintiffs to agree to a lower settlement, since the plaintiff would obtain the same net recovery from the lower amount. *Roa v. Lodi Medical Group, Inc.*, 37 Cal.3d 920 (1985).

87. KRITZER, *supra* note 78, at 81 (discussing the practices of attorneys in case study).

88. Hyman & Silver, *supra* note 6, at 1117.

89. A recent article in the ABA Journal indicates that Texas's extensive package of tort reform has led to steep reductions in medical malpractice litigation. Between 1997 and 2002, the average number of cases filed was 435, in 2004 only 204 cases were filed, and in 2005 there were 256. Those who continue to file medical malpractice cases have sustained huge losses in income. Tort reform proponents state that more doctors have applied for licensure in Texas since the reforms. A Texas consumer group indicates areas of the state with large indigent or Medicaid-dependent populations continue to lack the access to physicians they need, despite these supposed increases. Terry Carter, *Tort Reform Texas Style*, 92 ABA JOURNAL 33-34 (Oct. 2006). Professor Kritzer's study similarly indicated the caution with which attorneys approach malpractice claims; in three months of observation of three practices, not one retainer for medical malpractice was signed. KRITZER, *supra* note 78, at 87. Professor Baker's studies and others discussed in his book indicate that there is an epidemic of medical malpractice, not of malpractice lawsuits. BAKER, *supra* note 7, at 22-36.

implications for potential plaintiffs hoping to obtain legal representation. The effects of fee limits are magnified if a plaintiff injured by medical malpractice lacks health insurance or has inadequate coverage. For such individuals, a personal injury recovery may be the only means to finance desperately needed ongoing care.<sup>90</sup> Unless liability is so clear that the insurance carrier or defense attorney authorizes immediate payments as part of a defendant's liability coverage, expenses for present treatment for personal injuries must be borne by the individual, and future care will be contingent on recovering through the tort system or qualifying for benefits under a social welfare provision. Because the uninsured will not necessarily qualify for even the limited benefits available to the poorest Americans, there is a realistic possibility that they will be unable to afford medical care.<sup>91</sup> A fee scale like California's, which arguably disadvantages the severely injured, has even more devastating effects when one realizes that high damages probably reflect the greatest need for expensive care.

To be clear, some reforms of the contingent fee structure may not disadvantage those who need access to the tort system, and they might even benefit plaintiffs as a class.<sup>92</sup> It is also true that a lack of willing attorneys has a negative impact on insured plaintiffs as well, but the problem with a statute like California's is that it creates extra burdens for those who lack access to the type of health care and services they need and whose only chance of obtaining help is through litigation.

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90. Emergency care may be provided on credit on a provisional basis, but ongoing treatment requires funding, through insurance or other means, such as qualification for social welfare programs. *See supra* note 10.

91. It is estimated that the uninsured forgo between \$65 and \$130 billion a year in medical treatments, and that 18,000 more uninsured adults ages 25–64 die than insured adults in the same age range. Mortality is 5–15% higher among the uninsured. RICHMOND & FEIN, *supra* note 11, at 233.

92. *See, e.g.*, Lester Brickman, *Contingent Fees Without Contingencies: Hamlet Without the Prince of Denmark?*, 37 UCLA L. REV. 29, 115 (1989). Professor Brickman, a strong critic of contingency fees as currently used, proposed that a standardized retainer agreement be filed with the court at the onset of the professional relationship. This form would list various pieces of information that would help clients and the court understand whether there actually was any risk of nonrecovery in the litigation and how much the attorney is being paid for assuming that risk. *Id.*

## 2. Caps on Noneconomic Harm

Though noneconomic damages, which include pain, suffering, and loss of enjoyment of life, are a source of controversy, their curtailment through tort reform may jeopardize uninsured individuals' ability to obtain legal representation and pay for health care. Critics of these damages question whether they do anything to restore an injured person to health.<sup>93</sup> Even if one is willing to acknowledge that pain is an injury that should be compensated regardless of the effectiveness of money to reduce the pain, there is still the issue of how a jury should determine the amount of an award. There is a disturbing possibility that similarly situated individuals will recover vastly different amounts based on the jury's inability to anchor the recovery to something solid.<sup>94</sup> In some counties, variability of awards from plaintiff to plaintiff is reduced by the consistency of having judges, rather than juries, determine what should be awarded.<sup>95</sup> Published ranges of prior awards that give judges guidance as to amount are also a possibility to eliminate the potential differential in compensation among similarly situated plaintiffs.<sup>96</sup>

In the United States, the most common technique to limit noneconomic harm is the imposition of a cap.<sup>97</sup> Tort reform

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93. The classic article is Jaffe, *Damages for Personal Injury: The Impact of Insurance*, 18 LAW & CONTEMP. PROBS. 219, 222 (1953) ("To put a monetary value on the unpleasant emotional characteristics of experience is to function without any intelligible guiding premise."); Joseph H. King, Jr., *Pain and Suffering, Noneconomic Damages, and the Goals of Tort Law*, 57 SMU L. REV. 163, 165 (2004) (comparing awards of pain and suffering, and their acknowledged use to satisfy attorneys' fees, to the fable of the emperor's new clothes and urging their abolition). King would, instead, make attorneys' fees recoverable for prevailing plaintiffs. *Id.*

94. King, *supra* note 93, at 175–77 (discussing the difficulties jurors confront trying to determine awards).

95. Sebok, *supra* note 54, at 387 (juries are hardly used in any European civil justice system).

96. Professor Sebok describes various methods by which European judges may determine damages, other than testimony at trial. There are "brackets" or ranges of damages set up by an independent body in England, while, in Germany, private groups publish biannual summaries of reported personal injury awards. France and Italy require parties to present their cases in terms of a standardized point system. *Id.* at 389. See also BASIL MARKESINIS ET AL., COMPENSATION FOR PERSONAL INJURY IN ENGLISH, GERMAN AND ITALIAN LAW (2005).

97. DOBBS, *supra* note 51, at 1071 (well over half of the states have enacted some type of damage cap).

legislation imposing caps on noneconomic harm, whether in all tort cases or in certain types, removes the possibility that a jury will award a huge amount of damages for pain and suffering.<sup>98</sup> Caps have the ancillary effect of making cases less attractive to attorneys because the prospects for a high contingent fee are so limited.<sup>99</sup> Undoubtedly, caps also lower the settlement value of cases, an important factor since most cases will never go to trial. There are many objections to caps: the arbitrariness of whatever amount is selected, the seeming inequality of capping in certain areas of tort law and not in others, and the broader issue of whether caps disadvantage the most grievously injured.<sup>100</sup> Caps as a tool of tort reform fail to address the crucial issue of whether intangible harm should be recoverable at all or whether a proposal like professor King's to substitute attorneys' fees for pain and suffering is a plausible alternative.<sup>101</sup> Yet caps continue to be viewed as a panacea by states. Their impact on the un- and underinsured is notable and exacerbated by courts' refusal to grapple with the holes pain and suffering damages must plug in cases brought by those who lack access to health care.

The impact of caps on the uninsured and the poor is significant because, ironically, noneconomic damages serve several important purposes unrelated to actual compensation for pain and suffering.<sup>102</sup>

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98. California was the first state to enact a cap and did so as part of its medical malpractice reform package (MICRA), CAL. CIV. CODE § 3333.2 (West 1997). Texas also has enacted a \$250,000 cap in medical malpractice cases but excludes hospitals from it. TEX. CIV. PRAC. & REM. CODE ANN. § 74.301 (Vernon 2005). Colorado has a cap of \$250,000 applicable in all cases unless the plaintiff shows by clear and convincing evidence that the award should be higher, and then it cannot exceed \$500,000. COLO. REV. STAT. § 13-21-102.5(3)(a). See FRANKLIN ET AL., *supra* note 5, at 715–16.

99. ABA JOURNAL, *supra* note 89, at 30.

100. See Hyman & Silver, *supra* note 6 at 1087 (caps on non-economic damages and attorneys' fees will not reform the tort system and will worsen the problem of under-compensation by limiting the remedies available to patients with serious injury).

101. See King, *supra* note 93.

102. These are not revealed to the jury and are rarely acknowledged by courts, but they unquestionably affect the practice of personal injury representation. The California Supreme Court acknowledged the relationship between attorneys' fees and other related issues in *Helfend v. S. Cal. Rapid Transit Dist.*, 465 P.2d 61 (1970) (“[G]enerally the jury is not informed that the plaintiff's attorney will receive a large portion of the plaintiff's recovery in contingent fees or that personal injury damages are not taxable to the plaintiff and are normally deductible by the

Generally they buffer the plaintiff against the vagaries of damage awards. For example, although economic damages sound as though they would be fairly fixed and straightforward, they often present challenging issues on which jurors may disagree.<sup>103</sup> If a jury awards less in lost wages or future medical costs than the plaintiff really needs, recovery of the noneconomic damages can help bridge the gap. In some cases, the noneconomic damages award is the major item of recovery, particularly in cases where the plaintiff has little to show for lost earnings or future lost wages. This is not uncommon where a plaintiff is elderly, unemployed, or out of the work force for a period of time, for example, as a student or a stay-at-home parent.<sup>104</sup>

Another purpose of the noneconomic damage award is that it allows a plaintiff to pay the attorney the amount of the contingent fee without dipping into the money needed for medical care, lost wages and future economic harm.<sup>105</sup> Without this subsidy, the attorney's fee consumes some of what the plaintiff presumably needs to be made whole.<sup>106</sup>

Like limitations on the contingent fee, caps have a particularly devastating effect on plaintiffs who lack health insurance or have inadequate coverage and therefore incur large out-of-pocket expenses or long-term costs associated with disability. Even if a settlement offer or a jury verdict calculates all of the economic damages accurately and favorably to the plaintiff, after the deduction of the contingent fee, no money may remain for health-related costs. For a person without health insurance, this may mean forgoing needed care or the assistance required to live at home. The more devastating the injury and the higher the damages, the less the capped noneconomic

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defendant. Hence, the plaintiff rarely actually receives full compensation for his injuries as computed by the jury.

103. Wholly apart from intangibles such as how the jury perceives the plaintiff, there are questions about how much medical care will cost in the future, whether inflation is being anticipated accurately, how far the plaintiff would progress in a career, what the plaintiff would earn in the future, etc.

104. ABA JOURNAL, *supra* note 89, at 30, 33.

105. See King, *supra* note 93, at 207–08.

106. In addition, since a reduced recovery will mean a lower attorney's fee, some cases requiring extensive work and large expense may not be brought. DOBBS, *supra* note 51, at 1072.

harm subsidizes the attorney's fee. Thus, although fully insured plaintiffs may feel the effect of the loss of the subsidy, the people who will suffer most are the uninsured and the underinsured.

### 3. The Collateral Source Rule

At first blush, the collateral source rule<sup>107</sup> would seem not to affect the uninsured at all as an uninsured person does not have collateral sources on which to draw. Thus, one might think this is an area where tort reform could proceed without concern about distributional impact. I include the topic to exemplify the point that a society comprised of insured and uninsured persons makes it much more difficult to develop simple and efficient systemic reforms. The collateral source rule was one aspect of the tort system Schwartz thought about in particular depth in his 1994 article. Schwartz believed that, if a national health care system were enacted, common sense notions of fairness would dictate that the collateral source rule would have no place in the system.<sup>108</sup> He acknowledged that, from a deterrence perspective, there might be a reason to retain some form of the rule, and thought further study should focus on whether subrogating rights in favor of the victim's insurer against the tortfeasor would be useful.<sup>109</sup> But, he predicted uniform availability of insurance might well lead to abandonment of the rule and he estimated tort awards might decrease by approximately 20%.<sup>110</sup>

Schwartz's vision of a simple elimination of the collateral source rule certainly has not come to pass.<sup>111</sup> There is little uniformity or consistency in the states' approach to reform. Most jurisdictions with tort reform in place have not abolished the collateral source rule

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107. DOBBS, *supra* note 51, at 1058 ("The traditional rule is that compensation from 'collateral sources' is none of the defendant's business and does not go to reduce the defendant's obligation to pay damages, either in negligence or in strict liability cases.")

108. Schwartz, *supra* note 34, at 1346-47.

109. *Id.* at 1347.

110. *Id.* at 1349.

111. In fact, even in legal systems with universal health care, collateral source issues remain somewhat complex due to the need to distinguish among sources as to which a subrogation right exists in favor of the social security carrier and those as to which this is not applicable. See generally BASIL MARKESINIS ET AL., *supra* note 96, at 171-96 (chapter on collateral sources and subrogation rights in English, German and Italian systems).



completely.<sup>112</sup> Instead, they make a tortured series of distinctions among the sources of various benefits. Life insurance is different from public benefits, and public benefits differ from one another depending on their source. These are different from gratuitous services provided by relatives.<sup>113</sup> Litigation over whether to consider a benefit as a collateral source is not uncommon.<sup>114</sup>

Despite numerous critiques of the collateral source rule on efficiency and fairness grounds,<sup>115</sup> the existence of uninsured persons makes it difficult to completely abolish it. One can readily see the value of precluding a double recovery in the case of a plaintiff who is receiving a payment from an insurance company, or even the inefficiency of shifting the loss from one insurance pool to another.<sup>116</sup> But a complete abolition of the rule would work hardship in certain cases. A common scenario is that of gratuitous services rendered by relatives. Many times the plaintiffs in these cases lack adequate insurance for custodial care, which relatives then provide. In these instances, relatives fill an essential gap and courts generally agree that it would be bad policy to exclude recovery from the defendant.<sup>117</sup> Hence, it is not possible to move toward the simplicity Schwartz envisioned, with its accompanying benefits, because the rule is needed by a percentage of the population in certain situations.

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112. DOBBS, *supra* note 51, at 1059 (describing the range of modifications reflected in tort reform statutes).

113. *Id.* at 1059–60 (explaining various sources of benefits, exemption of direct benefits, and difficulties in applying the rules).

114. *See, e.g.*, *Calva-Cerqueira v. United States*, 281 F. Supp. 2d 270, 295–96 (D.D.C. 2003); *McLean v. Runyon*, 222 F.3d 1150, 1155–56 (9th Cir. 2000); *Amlotte v. United States*, 292 F. Supp. 2d 922, 924–31 (E.D. Mich. 2003).

115. *See, e.g.*, 2 ALI STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 161–82 (1991) (recommending abolition of the collateral source rule, except for life insurance).

116. DOBBS, *supra* note 51, at 1059 (concluding it may be more efficient to achieve compensation without the collateral source rule).

117. *See, e.g.*, *Arambula v. Wells*, 85 Cal. Rptr. 2d 584, 587 (Cal. 1999) (stating that the majority of jurisdictions and many commentators do not think gratuitous benefits should reduce recovery); *Estate of Fleming*, 190 P.2d 611, 613 (Cal. 1948) (noting “charitable beneficences” benefit the state, which would otherwise directly or indirectly be providing the benefits).

#### 4. Joint and Several Liability

Joint and several liability is another example of a doctrine that, when modified, has a particularly large impact on those who lack access to health care. Tort reform proponents have attacked joint and several liability on the ground that it is a relic of the era preceding comparative fault and, as such, is a worthy candidate for extinction.<sup>118</sup> Arguably, as comparative fault principles have permeated the tort system, it is odd and unfair to impose liability on a defendant who has been allocated a minimal percentage of responsibility by a jury.<sup>119</sup> However, the historical purpose of protecting the plaintiff from the risk of a defendant's insolvency or immunity<sup>120</sup> remains valid because concern about the effect of insolvency of a defendant has not disappeared.

Eighteen states have abolished joint and several liability completely,<sup>121</sup> and in these states, a defendant will never be liable for more than her proportionate share of the damages. Even in a system where a plaintiff is insured, this may mean significant under-compensation. For example, if fault is apportioned 30:70 among two defendants and the 70% defendant is insolvent, only 30% of the total damages awarded are recoverable by the plaintiff. This may mean that substantial future lost wages or sizeable awards of pain and suffering are simply unrecoverable. Where a plaintiff lacks medical insurance, the effect is even more pronounced. After payment of the attorneys' fees and costs in a case, there may be an insufficient

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118. The doctrine has been recognized since the 1700s. As originally adopted, when a plaintiff enforced a joint and several judgment entirely against one party, that party could not recover contribution from co-defendants. The rule evolved at a time when joint and several liability applied only to tortfeasors acting in concert to commit intentional torts, and thus, the denial of contribution was a way of refusing to allow an intentional tortfeasor to take advantage of an equitable loss-sharing doctrine. DOBBS, *supra* note 51, at 1078, 1085–86.

119. *See id.* at 1081 (explaining that today contribution is applicable on a comparative basis).

120. The effect was to provide the plaintiff with more than one source of funds but not more than one recovery. In addition to insolvency, a judgment may be unenforceable because a defendant has an immunity or partial immunity. *Id.* at 1078.

121. Steven B. Hantler, Mark A. Behrens & Leah Lorber, *Is the "Crisis" in the Civil Justice System Real or Imagined?*, 38 LOY. L.A. L. REV. 1121, 1148 (2005). *See, e.g.*, ALASKA STAT. § 09.17.080 (2007); KY. REV. STAT. ANN. § 411.182 (Lexis Nexis 2005); WYO. STAT. ANN. § 1-1-109 (2005).

amount remaining to pay for basic medical expenses incurred already and needed in the future. Other states have adopted intermediate modifications.<sup>122</sup> California and several other states retain joint and several liability for economic harm.<sup>123</sup> That rule represents a better choice if uninsured plaintiffs are involved, but even then, given the vagaries of calculating economic loss, payment of attorneys' fees and the loss of the subsidy noneconomic loss provides, a plaintiff may be unable to afford long term medical care.

Admittedly, modifications of joint and several liability have an impact on virtually all tort plaintiffs, but a person with medical and disability insurance has a much better chance of returning to his pre-accident status quo. Insured persons have access to the care needed to get back on their feet in terms of health and reentry into the work world. Although they may be worse off for the accident because they are unable to recover fully legitimate damages like future lost wages, their prospects are much better than those of the uninsured.

## 5. Access to the System

Statutes such as the Class Action Fairness Act<sup>124</sup> and doctrines such as preemption, which increasingly displace state tort actions,<sup>125</sup> make cases harder and more expensive to litigate and accordingly create barriers for people who rely on the legal system to be made whole. With regard to the Class Action Fairness Act, the point was to make it more difficult to bring class actions that involve large amounts of money and persons or companies from different states.<sup>126</sup>

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122. These include abolishing joint and several liability when the defendant's comparative responsibility is below a certain level. *See* Hantler, Behrens & Lorber, *supra* note 121, at 1147–50.

123. CAL. CIV. CODE § 1431.2 (West 1982 & Supp. 2007).

124. Pub. L. No. 109-2, 119 Stat. 4 (2005). *See supra* notes 76–77 and accompanying text.

125. *See, e.g.,* FRANKLIN ET AL., *supra* note 5, at 504 (listing cases in many areas that were previously litigated as common law tort actions).

126. News Batch, <http://www.newsbatch.com/tort.htm> (last visited Aug. 28, 2006). The statute results in revisions to the diversity jurisdiction statute, 28 U.S.C. § 1332(d)(2), which make it much easier to satisfy the requirements of diversity of citizenship than in an ordinary diversity case. ROWE, SHERRY & TIDMARSH, *supra* note 4, at 14. The statute also affects settlement of federal class actions by creating disincentives to engage in so-called “coupon settlements” by limiting attorneys fees awardable in such cases and in several other ways. *Id.* at 17.

There has been increasing dismay over particular types of tort claims that fit this description, as they are thought to provide large pay-offs for attorneys and little for individual plaintiffs.<sup>127</sup> While it may be wise to take steps to be sure consumers are not being exploited, the original purpose of a class action—enabling joint representation on claims too small or insignificant to litigate individually—may be undercut. In the end, the people who are displaced from the legal system are those without the funds to finance relief on their own.<sup>128</sup> Presumably, many uninsured persons fall in that group.

Preemption displaces state courts and state tort law in numerous areas that have traditionally fallen within their province.<sup>129</sup> To the extent federal statutes may not permit suits for damages, injured persons have no compensatory remedy.<sup>130</sup> To the extent remedies are available, litigants must obtain an attorney with the requisite skill to litigate what has now become federal litigation. People with less access to legal representation will have less access to relief.

In addition to realizing that statutes or doctrinal developments that limit access to relief have a particularly harsh impact on the uninsured or underinsured, it is worth noting that the need for access to the legal system, as reflected in the volume and composition of torts cases occupying the dockets of the courts, might well differ if there were universal health coverage. If health coverage coincided

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127. *Id.*

128. STEPHEN M. SUBRIN, MARTHA L. MINOW, MARK S. BRODIN & THOMAS O. MAIN, CIVIL PROCEDURE, DOCTRINE, PRACTICE & CONTEXT 845 (2d ed. 2004) (discussing the tensions inherent in class actions and questioning whether there are viable alternatives to collective representation to enforce safety, environmental, consumer protection and other standards).

129. DAVID G. OWEN, PRODUCTS LIABILITY 919 (2005) (“because product safety is federally regulated to a large extent, widening the reach of the preemption doctrine erases more and more areas of products liability law”); FRANKLIN ET AL., *supra* note 5, at 504. *See, e.g.*, *Buckman Co. v. Plaintiffs’ Legal Comm.*, 531 U.S. 341 (2001) (holding that a claim against a medical device producer was impliedly preempted by FDA statutes and regulatory scheme).

130. OWEN, *supra* note 129, at 49–50 (noting that a shift toward safety regulation in substitution of compensating injuries, as is the preference in Europe, may make sense in that it emphasizes prevention over deterrence but that Europe is much more inclined to regulation than the U.S., and less reliant on tort litigation to achieve deterrence and compensation). Owen cautions that efforts to protect the common good through federal regulation must not trample state law compensatory rights of persons injured by defective products, and he asserts there is no reason why product safety regulation and products liability litigation could not co-exist. *Id.* at 919.

with modifications such as elimination of the collateral source rule, low-damage cases that currently occupy time and consume resources and settlement dollars might become so unnecessary that plaintiffs would opt not to file.<sup>131</sup> The rigors of litigation, including stress, loss of time, and costs, are not something one wants to endure for a very modest return, especially if the money is not needed for medical care. Litigation rates in countries with universal health care benefits are far lower than in the United States,<sup>132</sup> and the awards are much smaller.<sup>133</sup> Their legal systems differ enough from ours to make it difficult to find a causal relation between coverage and litigation rates, but it is not farfetched to think need plays a role in determining what gets litigated.<sup>134</sup>

### III. CHANGING THE FOCUS OF THE DISCUSSION

The prior section demonstrates that some reforms of the common law system disadvantage people who must rely on the tort system to obtain care when injured by others. This realization places thoughtful critics of the tort system in a dilemma. Even if one recognizes flaws in the common law or believes it can be improved, such change

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131. Hyman & Silver, *supra* note 6, at 1114 (citing studies indicating that health insurance reduces the incentive to sue, especially in jurisdictions that have abrogated the collateral source rule).

132. *See, e.g.*, Geraint G. Howells, *The Relationship Between Product Liability and Product Safety—Understanding a Necessary Element in European Product Liability Through a Comparison with the U.S. Position*, 39 WASHBURN L.J. 305, 307 (2000) (noting that American damage awards are higher than in Europe due to the lack of a social security system, high costs of medical treatment, lack of public healthcare services, generous pain and suffering awards, and punitive damages, and asserting that litigation is a surrogate for the European welfare state).

133. Professor Markesinis notes that American awards will invariably seem larger than they are in comparison with awards in other countries since many of the items in European and other systems are covered directly by the state or other social security carriers. MARKESINIS, *supra* note 96, at 202.

134. *See, e.g.*, SIMON DEAKIN, ANGUS JOHNSTON & BASIL MARKESINIS, MARKESINIS & DEAKIN'S TORT LAW 621 (5th ed. 2003) (citing Anita Bernstein, *A Duty to Warn: One American View of the EC Products Liability Directive*, 20 ANGLO-AM. L. REV. 224 (1991)) (discussing the need for strict liability in the European Community as opposed to the United States and noting that interests of victims are arguably better served by health care and social insurance provisions than a system that loads costs on product producers and thus that strict liability of the American variety could be viewed as unnecessary and a diversion of economic resources from more worthwhile uses).

should not come at the expense of the group that actually needs the system to obtain care. This should lead to rejection of the idea that the tort system should, or even can, be fixed without regard to these individuals. However, in the current debate, the only other choice is to maintain an inefficient system to provide needed benefits for the 16% of the population who lack them. There is no middle ground nor opportunity for nuanced discussion.

Would it be possible to change the focus of the debate by acknowledging the impact of tort reform on the un- and under-insured and working toward a solution where they need not rely on the tort system for basic medical care? A change of this magnitude would require educating lawmakers and stakeholders not only about the impact of certain tort reforms but also the costs associated with the U.S. health care system.<sup>135</sup> With regard to the health care system, the good news is that although reform has been the subject of political wrangling for the better part of a century,<sup>136</sup> there is now little debate that changes must be made.<sup>137</sup> If nothing else, the high amount the U.S. spends on health care<sup>138</sup> and its modest showing in statistical surveys of life expectancy and infant mortality<sup>139</sup> should propel us in the direction of change.<sup>140</sup>

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135. The United States spends more than any other developed nation on health care: 13.9% of its gross domestic product in 2000. Americans pay more out-of-pocket for health care than any other nation except Switzerland. See Hermer, *supra* note 8, at 60.

136. See, e.g., QUADAGNO, *supra* note 21 (tracing the policy debate regarding health insurance from the Progressive Era, commencing in the 1890s, to the present day).

137. Health care reform was front and center in the political campaigns of both John Kerry and George W. Bush in the 2004 presidential election. FUNIGIELLO, *supra* note 18, at 297. Then Senate majority leader Bill Frist, who is also a surgeon, told the National Press Club that “the status quo of health care delivery in this country is unacceptable today. It will further deteriorate unless the [health] care sector of 2004 is radically transformed, is re-created.” David S. Broder, *Our Broken Health Care System*, WASH. POST, July 15, 2004, at A21.

138. No other nation in the world spends as much as the U.S. Jost, *supra* note 8, at 546.

139. According to the Organization for Economic Co-Operation and Development (“OECD”) statistics for 2006, the U.S. leads the world in health spending, but has an infant mortality rate above the OECD average. (6.9 deaths per 1,000 live births). Japan and the Nordic countries have a rate below 3.5. Life expectancy is also less than the OECD average. Org. for Econ. Dev. OECD Health Data, <http://www.oecd.org/dataoecd/29/52/36960035.pdf>.

140. In addition, the real bill for the prescription drug benefits passed by Congress under the Bush administration will be exorbitant. The White House deliberately misled Congress as to projected costs, and shortly after the President’s reelection it revised cost estimates from \$400 billion to \$1.2 trillion over the decade from 2006 to 2015. FUNIGIELLO, *supra* note 18, at 298.

The only questions are what changes should be made, and how we should make them. In the 2004 election, John Kerry had a multifaceted plan that would have involved tax credits and government spending with projected costs of \$895 billion dollars over ten years.<sup>141</sup> George W. Bush's plan involved refundable tax credits that would not have cost the government much but would have reached only two to three million of the 43 million Americans without health insurance.<sup>142</sup> There were many objections to such a plan, and it appears to be dead.<sup>143</sup> However, neither the Kerry plan nor the Bush plan is the last word on ways to reform the U.S. health care system. A copious amount of legal and nonlegal scholarship addresses the issues of whether the United States would benefit or suffer from guaranteed access to health care and how it could best be achieved if it were a goal worth pursuing.<sup>144</sup> There is a vast amount of comparative data from countries all over the world.<sup>145</sup> The challenge is to get stakeholders to take the steps necessary to implement a feasible plan.

Scholars attribute the inability to take meaningful steps to reform health care to the strong vested interests in maintaining the status quo.<sup>146</sup> This of course includes economic benefits that flow from the

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141. *Id.* at 297.

142. *Id.*

143. Although the Bush administration argued that users would become more careful consumers if they had to pay the bills and that lower premiums on high-deductible plans would make insurance cheaper for uninsured people and small businesses, critics argued the plan would shift risks, costs, and the complex issues of health care reform to private individuals. *Id.* Other critics saw the plan as likely to produce tax savings for the rich and to worsen availability of quality health care for the middle class and poor. Hermer, *supra* note 8, at 49.

144. Hermer, *supra* note 8, at 78–79 (urging provision of primary basic health care to all Americans financed through taxes but not including catastrophic or specialty health coverage, which would be obtained separately through private insurance). The disabled, low-income, elderly and others would need a government entitlement for catastrophic and specialty coverage. *Id.*

145. *See, e.g.,* Richard F. Southby, *Is There Any Hope for Real Health Care Reform?*, 32 J.L. MED. & ETHICS 442 (2004) (focusing on the major characteristics of an ideal health care system and presenting comparative data); Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433 (2004) (discussing the two primary models found in the world and analyzing why our costs are so much higher.)

146. Marmor & Oberlander, *supra* note 48, at 212 (“... fundamental reform poses a tremendous threat to those institutions invested in maintaining the medical status quo. This includes a large proportion of U.S. hospitals and physicians. It includes almost all U.S. health insurers, pharmaceutical companies, and suppliers of medical equipment and technology.”).

system in place. Tort reform fits into the picture because it also affects the economic interests of stakeholders, and certain types of tort reform relate directly to major players in the health care debate, such as physicians, businesses, and consumers. The irony of the current stalemate is that positions of some stakeholders in the tort reform debate are inconsistent with their positions on health care reform. They do not perceive the inconsistency, perhaps because health care reform involves a much broader population than tort plaintiffs. Yet there is no doubt the issues are related. In his book on contingent fees, professor Herbert Kritzer notes the link, stating, “[t]he single change that would have the most impact on the need for a contingency fee representation would be the development of a [universal] health care system (particularly one that did not impose copays or deductibles for some or all accidental injuries).”<sup>147</sup>

If, as others have observed, the entrenched interests see change as antithetical to their well-being, how can a solution be found? Public choice theory, described as the “dominant vision of political life in late twentieth-century America,”<sup>148</sup> might indicate that this impasse merely exemplifies the private self-interest and public incoherence inherent in the democratic process and accordingly would suggest it is unlikely legislation could have any salutary effect. Jerry Mashaw describes the public choice vision of legislatures and bureaucracies as “downright depressing,” consisting principally of private groups who prefer to have social resources shifted from the general public to their members and politicians who support these groups.<sup>149</sup> This seems an apt characterization of both the debates over health care reform and tort reform.

Putting aside analytical or moral objections to a public choice model for the moment, it is possible to envision self-interest uniting some groups that are currently disconnected: physicians, businesses, labor, and consumers. Properly channeled, that self-interest could spur proposals that are economically advantageous as well as beneficial to a broader common good. There are other important and

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147. KRITZER, *supra* note 78, at 268.

148. JERRY L. MASHAW, GREED, CHAOS, & GOVERNANCE, USING PUBLIC CHOICE TO IMPROVE PUBLIC LAW 3 (1997).

149. *Id.* at 15.



powerful groups—notably insurers and plaintiffs’ attorneys—whose self-interests would likely never coalesce with others’ on issues of tort or health care reform. Fortunately, unanimity is not required.

*A. Understanding the Positions of Major Interest Groups*

Physicians are a major force in issues of tort reform and health care reform. Although the health industry is broader, including hospitals, labs, pharmaceutical companies, and others involved in the delivery of care, physicians remain the most respected and visible representatives of a group with inconsistent positions. To the extent that the AMA represents physicians, the group has opposed reform to the traditional fee for service model of health care delivery since the early twentieth century.<sup>150</sup> This opposition, motivated by fear that government intervention would inevitably lead to regulation of fees, used a multiplicity of arguments, ranging from interference with the doctor-patient relationship to the specter of socialism, communism, and incipient revolution.<sup>151</sup>

Today, the AMA speaks with less authority than it did at one time,<sup>152</sup> but its opposition to fundamental change remains. Although acknowledging the public health and economic burdens the uninsured cause, the AMA’s approach to change retains a strong endorsement of private health care financing, relying on monetary assistance to the uninsured in the form of tax credits and vouchers.<sup>153</sup> Ideally, the \$100 billion annual federal subsidy for employment-based health insurance would be eliminated and there would be a subsidy through tax breaks to allow individuals to purchase healthcare.<sup>154</sup> This echoes the Bush

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150. QUADAGNO, *supra* note 21, at 7. There are, however, other physician groups that believe there must be a change in the delivery of medical services. *Id.*

151. *Id.*

152. Richmond and Fein believe the AMA’s decline can be traced to its failure to engage in the process that led to passage of Medicare and Medicaid in the 1960s, a move that led policy makers in the public and private sector to be viewed as irrelevant. The AMA also failed to emerge as a force in the 1980s and 1990s, when power became concentrated in third party payers and the insurance industry. RICHMOND & FEIN, *supra* note 11, at 214–15. In 1972, 75% of all physicians belonged to the AMA, but in 1992 only 29% did. *Id.* at 216.

153. See AMERICAN MEDICAL ASSOCIATION, HEALTH POLICY GROUP, EXPANDING HEALTH INSURANCE: THE AMA PROPOSAL FOR TORT REFORM, 2006, available at <http://www.ama-assn.org/ama1/pub/upload/mm/363/ehi1012.pdf>.

154. *Id.* at 9.

administration's view that each person should select and pay for that individual's own health care preferences.<sup>155</sup> There are, however, physician groups that have declared their independence from the AMA on the issue of universal health care, making powerful arguments for change.<sup>156</sup>

On the topic of tort reform, particularly in the medical malpractice context, the voices of physicians are much less muffled. There is particular concern about medical malpractice liability, even though according to professor Tom Baker, the threats are not nearly as large as they are perceived to be.<sup>157</sup> Physicians attribute high insurance costs<sup>158</sup> to the tort system, and they believe it fuels counterproductive practices, such as defense medicine, as well.<sup>159</sup>

Consumers, meaning individuals who use both the health care system and the tort system, also have somewhat inconsistent positions. Many average Americans are unconvinced that health care reform would be a good thing, particularly if government is involved.<sup>160</sup> They fear that change would imperil the quality of care

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155. *Id.* at 20–21.

156. See Arnold S. Relman, *Reforming the U.S. Health Care System: What the Legal & Medical Professions Need to Know*, 15 HEALTH MATRIX: JOURNAL OF LAW-MEDICINE 423, 427–28 (2005). Dr. Relman, professor emeritus of medicine at Harvard Medical School and former editor, *New England Journal of Medicine*, spoke against “consumer-directed” health care on the ground that it puts the greatest financial pressure on those with limited incomes and that it will not save very much because large health care costs will be covered by catastrophic insurance. He urged adoption of a single efficient insurance system that should be funded by an earmarked tax base to which employers contribute appropriately. He argues doctors must receive salaries rather than payment for piecework, and that physician group affiliations promote the best care for the premium dollar.) *Id.* The Physicians for a National Health Program (“PNHP”) are among the groups that have sprung up to fill the void left by the AMA. RICHMOND & FEIN, *supra* note 11, at 216.

157. BAKER, *supra* note 7, at 68–92 (discussing research studies indicating there is far more medical malpractice than there are claims). In one study by Harvard researchers, 3% of patients found to have serious injury from malpractice brought suit. In a Chicago study, it was 4%. *Id.*

158. Medical malpractice premiums have risen for certain specialties in certain areas since 2000. *Id.* at 45.

159. RICHMOND & FEIN, *supra* note 11, at 208–09. Physicians complain that insurers sometimes settle claims that lack merit, thus injuring physicians' reputations. They feel caught between pressure from HMOs and other insurers to hold down prices while at the same time being pressured to practice defensive medicine to reduce claims and litigation, or to be able to establish a defense against claims should they arise. *Id.*

160. FUNIGIELLO, *supra* note 18, at 29. Jerry Mashaw uses universal health insurance as an example of how our beliefs about whether an end is achievable or within our reach alter our

that the 80% of the population with health insurance now enjoys or that there will be long waits for service, worse diagnostic equipment, and higher taxes.<sup>161</sup> Yet public opinion is also critical of the costs of health care, even when subsidized through employment, and there are many examples of individuals who have sought prescriptions or care in other countries because they were priced out of the market here.<sup>162</sup>

Consumers' positions may also be colored by a perception that those who lack insurance through an employer are unworthy of having it, that the uninsured have deliberately chosen not to pay into insurance plans their employer offers, or that they are not entitled to help because they are immigrants and noncitizens.<sup>163</sup> These assumptions enable many Americans to sleep just fine at night regardless of the fact that others lack access to health care. In fact, none of these perceptions is true, but the public is not well educated about who lacks insurance.<sup>164</sup> It is ironic that the American public, so

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view of its desirability. He quotes a former Bush administration official who stated, "national health insurance would combine the frugality of military procurement with the empathy of an IRS audit." MASHAW, *supra* note 148, at 2.

161. See, e.g., Judith Feder, *Crowd-out and the Politics of Health Reform*, 32 J.L. MED. & ETHICS 461, 462 (2004) (examining the potential disruption, both financially and in terms of the actual insurance benefits, that would result from a single-payer, or Medicare-for-all, system and explaining that Clinton's strategy had been based on avoiding redistribution and private to public coverage shifts).

162. See, e.g., *More Americans Seeking Surgery Abroad*, CBS NEWS, Oct. 18, 2006, <http://www.cbsnews.com/stories/2006/10/18/health/webmd/main2104425.shtml>. This article describes trips by Americans to India, Thailand, and Singapore for surgery. People who cannot afford U.S. health insurance are increasingly willing to travel to hospitals outside the U.S. Ironically, some insured patients are also receiving treatment outside the U.S. and paying lower premiums. *Id.*

163. See, e.g., Judith Feder, *supra* note 161, at 462. The simplest way to explain the nation's political failure to enact universal coverage is that the "'haves' have health insurance; it's the 'have-nots'—or more precisely the have-nots deemed 'undeserving'—who do not." Feder contends the primary political and policy problem is that it is almost impossible to insure the "have-nots" without in some way disrupting the status quo of the "haves." *Id.* But see Lisa Dubay, Christina Moylan & Thomas Oliver, *Advancing Toward Universal Coverage: Are States Able to Take the Lead?*, 7 J. HEALTH CARE L. & POL'Y 1 (2004) (asserting that the American public agrees with the goal of universal coverage, but it remains elusive because of entrenched interests and disagreement over the means to achieve the goal).

164. See Rick Mayes, *Universal Coverage and the American Health Care System in Crisis (Again)*, 7 J. HEALTH CARE L. & POL'Y 242, 251 (2004). Mayes states that the uninsured population is a dynamic group. *Id.* at 249. It tends to be younger, have somewhat lower income, to be more likely to include persons who are members of a minority group, and to include people who work in service industries or are self-employed. *Id.* at 249–51. People often move in and out of insured status depending on their employment status, marital status, age, and

widely viewed as litigious to a fault, seems also to favor tort reform. This is possibly a product of media exaggeration and misstatement of torts issues.<sup>165</sup>

Insurance companies, employers, and trade unions were all influential in assisting AMA efforts to derail earlier proposals for compulsory health insurance.<sup>166</sup> Today, their interests seem to have diverged. Insurance companies remain firmly opposed to compulsory insurance and indeed to any change in the status quo.<sup>167</sup> Insurance companies favor tort reform to the extent it saves money on what they must pay out in claims, but presumably they would not favor reform if it would replace the tort system and reduce or eliminate their source of profits.<sup>168</sup> Business and labor<sup>169</sup> both feel the impact of the extraordinary costliness of the American health care system. Indeed, labor disputes often center on the cost of health care.<sup>170</sup> Thus, these groups should embrace change if it could be brought about at a lower cost than they are currently paying.<sup>171</sup> Businesses are affected by litigation or threatened litigation and may therefore favor tort reform.

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income. *Id.* at 249. But even people who are employed and have insurance are often unable to cope with major health expenses, as is evidenced by the fact that nearly half of all bankruptcies involve a health expense problem and in one study of filings, 80% of the families filing had insurance. *Id.* at 251. David Himmelstein et al., *Marketwatch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>.

165. See Daniels & Martin, *supra* note 6, at 462–63.

166. QUADAGNO, *supra* note 21, at 9.

167. Jost, *supra* note 8, at 438 (claiming that the commercial insurance and managed care lobby is the most important impediment to universal coverage); RICHMOND & FEIN, *supra* note 11, at 246 (stating that the political strength of insurance and for-profits in the health care industry has increased over the years).

168. See BAKER, *supra* note 7, at 6–10 (discussing conversations with CEOs in the insurance industry and noting the irony of an industry asking the government to reduce the demand for its product).

169. Labor unions were a strong force politically and financially in passage of Medicare. According to Richmond and Fein, they are not a constituency that could be organized to support universal health care today, both because the labor movement is far weaker than it was and because there is ambivalence as to whether labor would benefit. RICHMOND & FEIN, *supra* note 11, at 247.

170. If one looks at health care expenditures already incurred on behalf of the uninsured, the total cost of offering universal health care should be less than a 3% increase. *Id.* at 233. The problem is that, while society should collectively benefit, individuals may doubt they would. *Id.*

171. If favorable collective bargaining agreements were in place, whether organized labor would view a new plan as equally advantageous would be questionable. *Id.* at 247.

Trial attorneys add yet another powerful dimension to the political mix. Their self-interests have to be in protecting against changes to the common law that affect the amount of recovery or the plaintiffs' ability to collect it, because this is how they make their living. It is unlikely that any form of compromise, even if it produced traction on health care reform, would outweigh this interest.<sup>172</sup>

### *B. Aligning the Interests by Broadening the Agenda*

Having examined the interests of various groups, it is apparent that there are some *quid pro quos* that could bring traditional opponents together if accompanied by accurate information about the issues. Physicians, for example, ought to favor this approach. Many physicians are enmeshed in health care bureaucracies that consume hours of administrative time to bill and collect money. They may receive underpayments from governmental agencies for some procedures and they are subject to rules and restrictions that interfere with their ability to serve patients to the extent many would like. At the same time, however, physicians are very concerned about medical malpractice premiums and the costs (monetary and emotional) of malpractice litigation. If physicians understood that some of the hard-fought objections to particular types of tort reform would be less persuasive if there were an assurance that injured parties would have access to health care, and that this access would benefit their own practices, perhaps they would, as a political force, push their leadership in a different direction.<sup>173</sup>

Consumers as a group ought to favor health care reform, even if they are not altruistic enough to worry about the fate of those who

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172. Professor Kritzer observes that, while lawyers who depend on contingency fees are strong defenders of the current system, they also see themselves as defenders of victims and protectors of future victims. Changes to the system could be made that could conceivably preserve the public service contingent-fee lawyers provide while addressing objections to contingent fee representation. They would likely be opposed not only by the plaintiffs' bar but also by corporate interests that would fear an increase in claims if more competition were introduced into the market for legal services. KRITZER, *supra* note 78, at 268–69.

173. See Marmor & Oberlander, *supra* note 48, at 226 (arguing that progressive voters favoring universal coverage must enlist physicians as allies). Given physicians' discontent with their increasing lack of clinical authority and unhappiness over corporate domination of medicine, they may see participation in a public health system as beneficial. *Id.*

lack coverage. As purchasers of insurance, most consumers would clearly benefit if costs could be lowered and services delivered efficiently. The extent to which it would be in consumers' interest to accept tort reform as a *quid pro quo* would depend on whether access to health services included care for long-term disability and other benefits that now are often available only by instituting a lawsuit. Consumer support would also depend on what form the reform took. However, the legal and psychological benefits consumers would gain from health care reform ought to mean there is less need to invoke tort remedies. There might be some changes to the legal system that are indeed beneficial or simply uncontroversial.<sup>174</sup> But like physicians and the AMA, consumers will have to realize that their true interests may diverge from that of the consumers' attorneys—which is by far the largest and most powerful group acting on their behalf.

Employers and businesses should certainly be in favor of health care reform. They already are enmeshed in the problems inherent in the delivery of health care through employers. They face increasingly expensive commitments to employees and the prospect of an unhappy and uncompetitive workforce if benefits are cut. They participate in subsidizing the costs associated with the uninsured. Any means that could be taken to simplify the system should be welcomed. If, as a subsidiary benefit, people would have less need and incentive to litigate because they would have greater access to care, businesses and employers should embrace a change. They are common defendants in tort cases.

### *C. Considering the Common Good*

Thus far, I have argued that the self-interests of major stakeholder groups ought to enable them to see the links between the tort system and the health care problem. Opponents of public choice theory

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174. See, e.g., KRITZER, *supra* note 78, at 263–65 (considering ways to design a system that would still permit access but reduce contingency fees, including opening the market so that some cases might be handled by claims brokers such as private insurance adjusters who could negotiate on behalf of the consumer in cases with clear liability and damages beyond policy limits); Weiler, *supra* note 7, at 216–21 (proposing damages reforms including guidelines for pain and suffering, rather than caps, reform of attorneys' fees, and a collateral source offset enacted as a package).

might worry that by encouraging policy choices that maximize the self-interest of these already-powerful groups, we declare that the democratic process is an “abject failure” and give these players an excuse to use the market to transform “private greed into social progress and harmony.”<sup>175</sup> Steven Kelman has argued that “cynical descriptive conclusions about behavior in government threaten to undermine the norm prescribing public spirit.”<sup>176</sup> However, even public choice theorists do not believe economic self-interest is the sole motive in political behavior.<sup>177</sup> It is certainly not my intent to endorse an abandonment of action in the public interest, but rather to acknowledge the role entrenched interests have played in both the tort and health reform contexts and to suggest that self-interest might cut in favor of change rather than against it. As Mashaw concluded after a careful examination of public choice and interest group theories, legislators and politicians sometimes pursue things that seem to be in the public interest with character and conviction, giving credence to the ideal of civic virtue and public spirit.<sup>178</sup> What makes the analysis difficult is that most legislation is likely to be explained as what is good for the majority, as well as a benefit to certain interests.<sup>179</sup>

There are moral and ethical reasons to believe that basic healthcare is essential in our society, and without a doubt, many groups of physicians, consumers, labor representatives and employers believe the same. Yet this belief has not been enough to fuel change. Even absent bad faith or unmitigated self-interest, change in this area has been very difficult to effectuate. Observers of public policy and politics have attributed part of the stalemate concerning health care reform to the incrementalism by which changes to the health care

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175. See, e.g., Mark Kelman, *On Democracy Bashing: A Skeptical Look at the Theoretical and “Empirical” Practice of the Public Choice Movement*, 74 VA. L. REV. 199, 202 (1988) (describing critique of the theory).

176. Steven Kelman, *Public Choice and Public Spirit*, 87 PUB. INT. 93–94 (1987).

177. Geoffrey Brennan & James M. Buchanan, *Is Public Choice Immoral? The Case for the “Nobel” Lie*, 74 VA. L. REV. 179, 181 (1988) (authors, including Nobel Prize winner Buchanan, characterizing their position as a belief that narrow self-interest is a significant motive and explaining that they categorically reject the view that promotion of the “public interest” is a satisfactory model for the behavior of political agents).

178. MASHAW, *supra* note 148, at 37.

179. *Id.* at 38.

system have occurred.<sup>180</sup> Once programs are in place, such as Medicare or prescription drug benefits, changes become extremely difficult. Reforming the tort reform agenda by squarely and honestly placing the lack of health care on the table might have the benefit of changing the dynamic enough to get major interest groups to break from their hardened positions. Their commitment to the public good will also be necessary to carry them forward, as it is clear some of these stakeholders can win their campaign for tort reform in certain states and would not have to take other considerations into account. The best chance for success occurs when physicians, consumers, employers, and business persons break free of the interest groups that purport to speak for them and confront the issue as individuals: as voters and as users of both the health care system *and* the tort system. It is then that they will realize their common interests and force a change.<sup>181</sup>

#### IV. CONCLUSION

The portrait of the tort system painted by politicians is often inaccurate and incomplete. Their efforts to push a tort reform agenda justifiably raise suspicions. This is unfortunate, because there are many insightful and thoughtful proposals about how to improve the tort system. Even if one were disposed to view some of these suggestions in a positive light, the presence of millions of uninsured individuals whose access to health care would be impacted makes it

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180. See, e.g., TED MARMOR, *THE POLITICS OF MEDICARE* 173–75 (2d ed. 2000) (stating that the focus on the indigent and elderly as the first steps toward publicly funded health care have made broader reform harder, not easier, to achieve); Dubay et al., *supra* note 163, at 3 (discussing how the incrementalist perspective, which results in public policy that is remedial rather than proactive and focuses on current discrete problems rather than reaching more fundamental policy goals, can have the positive result of learning through making small changes or it can stifle policy innovation).

181. There are signs that this kind of coalition is taking place. Immediately after President Bush's 2007 State of the Union address, physicians, registered nurses, and patients were convening to promote H.R. 676, the United States National Insurance Act, which is being reintroduced in the new Congress by Representatives John Conyers and Dennis Kucinich. Labor organizations also have indicated support. Press Release, Physicians for a National Health Program, Nurses, Doctors, Patients Respond to Bush Health Proposals, Unite in Call for Real Universal Health Care, Press Release (Jan. 23, 2007), available at [http://www.pnhp.org/news/2007/january/nurses\\_doctors\\_pat.php](http://www.pnhp.org/news/2007/january/nurses_doctors_pat.php).



very difficult to accept changes. Although pro-reform advocacy groups speak in broad generalities, much tort reform affects insured persons differently than the uninsured. It is only by looking at the link between tort reform and the uninsured that a comprehensive understanding of the system emerges. Universal access to health care would not eliminate the inequalities between the haves and have-nots, but it would make the impact of certain tort reform measures much clearer and minimize potentially devastating effects. Reforming the tort reform agenda might lead major stakeholders in society to see the benefits in addressing both of these issues, resulting in public policy that is moderate, rational, and effective.