

LINDSAY J. STAMM\*

## *Comments*

### The Current Medical Malpractice Crisis: The Need for Reform to Ensure a Tomorrow for Oregon's Obstetricians

Unpredictable and exorbitant jury awards have prompted insurers to charge increasingly high rates to insure doctors in high-risk practice areas. Specialties that are typically at high-risk for medical malpractice lawsuits include obstetrics, surgery, and orthopedics. The current crisis in medical malpractice litigation has forced clinics and doctors unwilling to pay high insurance rates to close their practices. Part I of this Comment discusses the medical malpractice crisis and how it has affected obstetricians in Oregon. Part II provides an overview of existing medical malpractice law. Part III explores possible reforms within the current system, notably placing caps on non-economic damages. This Part also discusses reforms outside the existing malpractice system, specifically mandatory alternative dispute resolution or adoption of a no-fault scheme.

This Comment emphasizes the need to reform the current system by focusing on a narrow subset, specifically obstetricians in Oregon. The medical malpractice system exists to serve two primary goals: compensation of those injured, and deterrence of negligence.<sup>1</sup> As this Comment describes today's medical mal-

---

\* J.D., University of Oregon School of Law, 2005. Notes & Comments Editor, *Oregon Law Review*, 2004-05. The author would like to thank Professor Caroline Forell for her inspiration and valuable insight. The author would also like to thank her parents, Walter and Peggy Stamm, for their infinite love and encouragement.

<sup>1</sup> VICE CHAIRMAN JIM SAXTON, JOINT ECON. COMM., 108TH CONG., LIABILITY

practice crisis in Oregon, it is clear that the current malpractice system fails these goals. Oregon's failure to consistently compensate victims of negligence or deter negligence is representative of the national problem.<sup>2</sup> This discordant system imposes costly burdens on the health care system. Lack of access to services most adversely affects women, low-income earners, and rural residents.<sup>3</sup> Insurance rates for practicing physicians have skyrocketed. Rates are so high in certain specialties that services have been discontinued. This is especially true in the practice of obstetrics, which has been subject to a high rate of claims and payments largely stemming from neurological birth-related injuries.<sup>4</sup> A detailed examination of the effect of the current crisis on Oregon's obstetricians illustrates many of the medical malpractice system's shortcomings.

## I

### AN OVERVIEW OF THE CURRENT MEDICAL MALPRACTICE CRISIS

#### A. *Medical Malpractice in Oregon*

The adverse experience of doctors and insurance providers, as well as limited availability of patient services in Oregon, are some of the major negative effects of the existing malpractice system. Oregon is one of nineteen states in the nation currently in a medical malpractice crisis, according to a recent American Medical Association report.<sup>5</sup> Indicators used to determine this include: increased insurance premiums, limited availability of services, increased size of jury awards in malpractice cases, and frequency of physicians relocating or closing their practice.<sup>6</sup> As of January 2003, there was a total of 465 suits pending against doctors in Oregon.<sup>7</sup> Nationally, the average jury award in a mal-

---

FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE 1 (2003), available at <http://www.house.gov/jec/tort/05-06-03.pdf>.

<sup>2</sup> See *id.*

<sup>3</sup> *Id.*

<sup>4</sup> Frank A. Sloan et al., *The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ*, 60 LAW & CONTEMP. PROBS. 35, 37 (Spring 1997).

<sup>5</sup> AMERICAN MEDICAL ASS'N, AMERICA'S MEDICAL LIABILITY CRISIS: A NATIONAL VIEW 1 (2003), available at <http://www.ama-assn.org/ama1/pub/upload/mm/378/backgrounders1.pdf> [hereinafter NATIONAL VIEW].

<sup>6</sup> *Id.* at 14-15.

<sup>7</sup> Videotape: Medical Malpractice Meltdown (Oregon Health Forum 2003) (on file with Oregon Health Forum) [hereinafter Oregon Health Forum] (quoting speaker Jim Dorigan, CEO, Nw. Physicians Mut. Ins. Co.). Mr. Dorigan stated the total

practice case increased 176% between 1994 and 2001, while insurance premiums doubled from 1991 to 2001.<sup>8</sup>

To limit jury awards, the Oregon legislature in 1987 imposed a \$500,000 cap on all non-economic damages for pain and suffering.<sup>9</sup> But in 1999, the Oregon Supreme Court held the limits were unconstitutional.<sup>10</sup> Since the caps were struck down, statistical evidence indicates that awards have increased 65%.<sup>11</sup> In 2002, the average jury malpractice award in Oregon was \$3.4 million.<sup>12</sup>

Oregon's increasing jury award size and rising insurance premiums, among the worst in the nation, have caused many doctors to limit the services they provide. Between 2001 and 2002, the *Medical Liability Monitor* reported that Oregon doctors experienced one of the nation's highest premium increases among at-risk specialties—80%—which was surpassed only by Arkansas, Mississippi, and Virginia.<sup>13</sup>

### *B. Neurologically Impaired Infant Claims*

Obstetricians have been especially impacted by medical malpractice litigation. On average, obstetricians face two lawsuits per career, more than any other medical specialty.<sup>14</sup> In Oregon, one insurer reported the average damage claim for obstetric cases was \$9.5 million, versus an average damage claim for other

---

demand for these suits was \$1,506,264,712. *Id.* If all suits were to be cleared, the average cost per doctor would be \$334,726. *Id.* However, it is unrealistic to assume this amount would be paid, because the majority of suits are dismissed or settled. Additionally, settlements will not necessarily be for the amount demanded.

<sup>8</sup> SAXTON, *supra* note 1.

<sup>9</sup> OR. REV. STAT. § 18.560 (1987), *partially invalidated by* *Lakin v. Senco Prods., Inc.*, 329 Or. 62, 987 P.2d 463 (1999). The statutory cap remains valid for wrongful death claims. The legislature also sent an initiative to voters to reinstate caps, but voters rejected this. *See infra* notes 91-92.

<sup>10</sup> *Lakin*, 329 Or. 62, 987 P.2d 463; *see also* NATIONAL VIEW, *supra* note 5, at 14.

<sup>11</sup> OREGON MEDICAL ASS'N, TOP TEN THINGS TO KNOW ABOUT OREGON'S MEDICAL LIABILITY CRISIS, at [http://www.theoma.org/Files/top\\_ten\\_things\\_to\\_know.doc](http://www.theoma.org/Files/top_ten_things_to_know.doc) [hereinafter TOP TEN] (last visited June 12, 2005).

<sup>12</sup> NATIONAL VIEW, *supra* note 5, at 14; *see also* OREGON MEDICAL ASS'N, FACT SHEET ON MEDICAL LIABILITY REFORM, at <http://www.theoma.org/Files/Fact%20Sheet.doc> (last visited June 12, 2005).

<sup>13</sup> U.S. DEP'T OF HEALTH & HUMAN SERVS., ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 18 (2003), *available at* <http://aspe.hhs.gov/daltcp/reports/medliab.pdf> [hereinafter QUALITY OF HEALTH CARE]. "At-risk" practice areas experiencing the highest premium increases are internal medicine, general surgery, and obstetrics/gynecology. *Id.* at 17-18.

<sup>14</sup> *Id.* at 8.

medical malpractice suits of only \$2.8 million.<sup>15</sup> Consequently, insurance premiums for obstetricians have risen dramatically in recent years. Analyzing this data per medical specialty, Oregon obstetricians experienced the nation's second-highest premium increase.<sup>16</sup> Oregon obstetricians' increased premiums of 126% were only surpassed by Ohio's.<sup>17</sup> In 1999, the average premium for an obstetrician was \$21,000, and by 2003 that figure had risen to \$61,000.<sup>18</sup>

The American College of Obstetricians estimates claims for neurologically impaired infants compose 30% of all lawsuits filed against obstetricians.<sup>19</sup> Neurological injuries typically occur when the baby's brain receives too little oxygen at birth, a condition known as "asphyxia."<sup>20</sup> The consequences of asphyxia include stillbirth delivery, neonatal death, nerve damage, vision impairment, mental retardation, and cerebral palsy.<sup>21</sup> Treatment for injured babies that survive can be costly and span a long period.<sup>22</sup> However, asphyxia-related injuries are not always the result of negligence. Thus, some "bad baby" cases may be caused by other conditions present at birth. As one doctor explained, "the outcome in these cases is always tragic—an injured or dead baby. But the fault for such a result does not always lie with the doctor."<sup>23</sup> A January 2003 study found that:

[D]octors are often sued for brain damage that can result from oxygen deprivation during delivery, even though the vast majority of such cases actually stem from infections and causes that are beyond the control of physicians . . . suits are being brought against doctors for brain damage and cerebral palsy that were not caused by negligent care.<sup>24</sup>

---

<sup>15</sup> Oregon Health Forum, *supra* note 7.

<sup>16</sup> U.S. DEP'T OF HEALTH & HUMAN SERVS., SPECIAL UPDATE ON MEDICAL LIABILITY CRISIS tbl.6 (2002), available at <http://aspe.hhs.gov/daltcp/reports/mlupd1.htm> (showing Oregon obstetrician premiums rose from \$21,680 in 1998 to \$48,942 in 2002) (last visited June 12, 2005).

<sup>17</sup> *Id.*

<sup>18</sup> Oregon Health Forum, *supra* note 7.

<sup>19</sup> QUALITY OF HEALTH CARE, *supra* note 13, at 8; see also Mary A. Cavanaugh, *Bad Cures for Bad Babies: Policy Challenges to the Statutory Removal of the Common Law Claim for Birth-Related Neurological Injuries*, 43 CASE W. RES. L. REV. 1299, 1312 (1993).

<sup>20</sup> Cavanaugh, *supra* note 19, at 1312.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.* at 1313.

<sup>23</sup> Telephone Interview with Anna Daniel, M.D., Seattle OB/GYN (Feb. 11, 2004).

<sup>24</sup> QUALITY OF HEALTH CARE, *supra* note 13, at 8.

The frequency and severity of malpractice liability for obstetricians has significantly impacted the practice. Damage awards in obstetric-related cases tend to be higher than other malpractice claims, which means insurers must protect high-risk physicians by charging correspondingly high insurance.<sup>25</sup> The American Medical Association has also linked higher premiums to increasing fees for obstetric services.<sup>26</sup> Soaring premiums have prompted many Oregon obstetricians to discontinue services. A recent Oregon Health Sciences University study of obstetric doctors found that during the past four years, 125 physicians – 22% of all those delivering in Oregon – stopped delivering babies.<sup>27</sup> With continuing high risk of lawsuits and insurance rates increasing, the trend of limited obstetric services is sure to continue. Over the next five years, one in three delivering physicians in Oregon is planning to quit delivering babies.<sup>28</sup>

### C. *Obstetric Services in Rural Oregon*

Rural Oregon has been especially devastated. Services have been entirely eliminated in certain areas. Rural patients in communities such as John Day, Hermiston, and Roseburg have been among the hardest hit.<sup>29</sup> Many rural patients have no access to obstetric services in their town, and of those that do have services, such services are often limited.<sup>30</sup> After an \$8.5 million malpractice judgment against one of its doctors, Roseburg Women's Healthcare closed its offices at Mercy Medical Center.<sup>31</sup> Insurance rates were so astronomical for obstetricians that they were simply unable to afford to deliver babies. As one doctor explained, “[w]e were paying \$17,000 per physician in 2001. We paid \$24,000 for each doctor for the first six months of 2002, and were quoted \$80,000 to \$100,000 per doctor per year going forward. Dr. Hollander would have to deliver 100 babies just to cover malpractice insurance costs.”<sup>32</sup>

---

<sup>25</sup> See Cavanaugh, *supra* note 19, at 1304.

<sup>26</sup> Roger J. Bulgar & Victoria P. Rostow, *Medical Professional Liability and the Delivery of Obstetrical Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 81, 84 (1990).

<sup>27</sup> TOP TEN, *supra* note 11.

<sup>28</sup> *Id.*

<sup>29</sup> Robin J. Moody, *Doctors Taking Action on Premiums*, BUS. J. OF PORTLAND, Jan. 10, 2003, at <http://www.bizjournals.com/portland/stories/2003/01/13/story1.html>.

<sup>30</sup> See NATIONAL VIEW, *supra* note 5, at 14.

<sup>31</sup> David Raths, *Insurance Crisis Hits Oregon Doctors*, BUS. J. OF PORTLAND, June 21, 2002, at <http://www.bizjournals.com/portland/stories/2002/06/24/story1.html>.

<sup>32</sup> *Id.*

The risk of liability affects not only obstetricians but insurance providers as well. Northwest Physicians Mutual, which insures 40% of doctors in Oregon, specializes in healthcare insurance for doctors, clinics, and dentists in Oregon.<sup>33</sup> Although it is one of Oregon's largest medical insurers, and the previous insurer of Roseburg Women's Healthcare, Northwest Physicians Mutual will not write new policies to cover obstetric physicians.<sup>34</sup> Such policies have proven too costly; Northwest Physicians Mutual reported losses of \$12.5 million in 2001 and also reported losses in 1999 and 2000.<sup>35</sup> Oregon's medical insurers have felt the pinch from increased losses paid out: in 1998, all Oregon insurers paid a total of \$15 million in losses, but in 2001 they paid over \$60 million in losses.<sup>36</sup>

With no affordable insurance, doctors in rural communities are often forced to close their doors. A recent survey of Oregon physicians found that nearly one-third of eastern Oregon physicians are considering relocating their practice.<sup>37</sup> Furthermore, nearly 12% of those surveyed reported they have closed, or plan to close or sell their practice due to high liability insurance rates.<sup>38</sup> This was the highest rate in the state, followed by southwest Oregon.<sup>39</sup> As Robbie Law, M.D., a family practice physician, explains, patients in many smaller communities are forced to seek medical care in other towns or cities:

Four family physicians were providing all the OB care in our community. During the past five years, we have delivered more than 200 babies with no claims, then our local surgeon, who was backup for cesarean sections, relocated. We were unable to recruit another surgeon because of high premiums and fear of increasing risk of litigation. We were forced to stop delivering babies in Reedsport. Now our patients have to travel 30 to 40 minutes to get care—often in labor. Many are worried about getting there in time for delivery. Many delay getting timely prenatal care. We are very concerned about the loss of timely care and the risks to our community's pregnant

---

<sup>33</sup> *Id.* For background and details of Northwest Physicians Mutual Insurance Company's policies, see generally Northwest Physicians Mutual Insurance Co., <http://www.npmic.com> (last visited June 12, 2005).

<sup>34</sup> Raths, *supra* note 31.

<sup>35</sup> *Id.*

<sup>36</sup> Oregon Health Forum, *supra* note 7.

<sup>37</sup> OREGON MEDICAL ASS'N, IS THERE A DOCTOR IN THE HOUSE?, <http://www.theoma.org/Files/OMA%20Packet.pdf> [hereinafter IS THERE A DOCTOR IN THE HOUSE?] (last visited June 12, 2005).

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

mothers and children.<sup>40</sup>

Oregon's high insurance rates have driven Oregon obstetricians to states with lower premiums, such as Idaho.<sup>41</sup> As one doctor who left Eugene for Idaho stated, "[b]ecause of the high-risk work I do, I am a target. In this state, it's open season on doctors – neurosurgeons and obstetricians are a big-time market for medical lawsuits, whether they're just or not."<sup>42</sup> In neighboring Idaho, a state with caps on non-economic damages, obstetricians can obtain insurance policies at the "bargain" price of \$20,000.<sup>43</sup>

Rural obstetricians who stay in Oregon are likely to refer the complex, and potentially higher liability risk cases—those that could lead to a large medical malpractice suit capable of closing their entire practice—to physicians in urban areas who are able to obtain insurance to perform high-risk procedures.<sup>44</sup> In contrast, physicians in larger hospitals, typically located in urban areas, are less likely to lose insurance as a result of a single malpractice incident. Consequently, referral rates are highest in rural parts of Oregon: central Oregon (18.8%), southwest Oregon (25.5%), mid-Willamette Valley (28.2%), northwest Oregon (29.2%), eastern Oregon (30%), and southern Oregon (30.9%).<sup>45</sup>

Perhaps most troubling about the current crisis in Oregon obstetric care is that there is no sign of improvement. The increased risk of litigation for obstetricians practicing in the state has also affected the next generation of doctors. Concern over litigation has adversely affected the opportunities in obstetrics and gynecology for medical students and residents by limiting the responsibilities they are given in training.<sup>46</sup> Even more sobering, at a recent medical school graduation in Oregon only two of 150 students were specializing in obstetrics.<sup>47</sup>

---

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> Berkeley Rice, *Malpractice Rates: How High Now?*, MED. ECON., Jan. 9, 2004, at 57, available at [http://www.memag.com/memag/article\\_articleDetail.jsp?id108357](http://www.memag.com/memag/article_articleDetail.jsp?id108357).

<sup>44</sup> IS THERE A DOCTOR IN THE HOUSE?, *supra* note 37. Physicians in larger hospitals, typically teaching hospitals located in urban areas, are less likely to lose insurance as a result of a single malpractice incident. Doctors in these hospitals are usually covered by a comprehensive hospital insurance policy, which can better absorb a large judgment than an individual or a small clinic.

<sup>45</sup> *Id.*

<sup>46</sup> Bulgar & Rostow, *supra* note 26, at 86.

<sup>47</sup> Rath, *supra* note 31.

With the growing population and continuing need for obstetric services, it is clear that the current system is failing both patients and physicians. The next section of this Comment examines the current medical malpractice tort system and its effectiveness at addressing the goals of deterring negligent conduct, preventing medical error, limiting damages, and curbing high insurance rates.

## II

### BACKGROUND LAW

#### A. *The Current Medical Malpractice Tort System*

Medical malpractice is a tort in which the party bringing suit has suffered a medical injury and seeks to recover from the doctor, hospital, or care provider. Medical malpractice liability arises when a doctor engages in negligent conduct, defined as conduct “which falls below the standard established by law for the protection of others against unreasonable risk of harm.”<sup>48</sup>

Medical malpractice claims are mainly governed by state law, but similar legal standards apply across states. Generally, there are four elements to a malpractice claim: first, a duty of care established by a physician-patient relationship; second, negligence in failing to meet the proscribed standard of care; third, a causal link between injury and the negligent act; and fourth, a resulting actual injury.<sup>49</sup>

The most common basis for a medical malpractice tort suit is failure to diagnose, which comprises an estimated 28% of all claims.<sup>50</sup> The next two most common grounds for a claim are surgically-related injuries and improper treatment claims.<sup>51</sup> Although far less common than medical negligence, patients in some cases sue doctors for negligent infliction of emotional distress (NIED).<sup>52</sup>

---

<sup>48</sup> RESTATEMENT (SECOND) OF TORTS § 282 (1965). Medical malpractice liability also arises when a nurse or health care professional engages in negligent conduct. However, for the purposes of this Comment, discussion is limited to medical malpractice against doctors.

<sup>49</sup> SAXTON, *supra* note 1, at 2 (citing W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 164-65 (5th ed. 1984)).

<sup>50</sup> *Id.* at 8.

<sup>51</sup> *Id.*

<sup>52</sup> See *Simons v. Beard*, 188 Or. App. 370, 72 P.3d 96 (2003). Although NIED claims against doctors are relatively rare, they are used where the patient suffered solely or mainly psychological injury. Oregon does not require that the patient suf-



There are typically two types of damages that may be awarded in a medical malpractice case:

[E]conomic damages for the actual monetary losses due to negligence such as medical expenses, lost wages, rehabilitation costs or any other economic out of pocket loss suffered as the result of a health care injury; and non-economic damages for things such as pain and suffering, disfigurement, and loss of companionship.<sup>53</sup>

### B. *Assessing the Standard of Care*

The jury often serves as the decision-maker in medical malpractice litigation. The right to trial by jury is guaranteed by the Seventh Amendment to the U.S. Constitution.<sup>54</sup> The rationale behind this guarantee is that a jury of laypersons brings collective experience which allows them to resolve disputes in a manner that reflects community values.<sup>55</sup> The modern jury has no requi-

fer a physical injury in order to bring an NIED claim. In *Simons*, the plaintiff sued an obstetrician and a hospital for negligent care that resulted in a miscarriage. *Id.* at 372, 72 P.3d at 98. The trial court granted defendant's motion to dismiss, and on appeal the court, viewing the facts most favorably to the plaintiff, found that a reasonable fact finder could find that:

[B]ecause of defendants' negligence, plaintiff began labor with the abnormal transverse lie uncorrected and the fetus in unmonitored distress, exposing plaintiff to a "greatly increased" risk of death; and (2) but for defendants' negligence, plaintiff could have, and would have, either experienced a vaginal delivery of a live child or undergone an emergency Cesarean section—and, thus, plaintiff would not have experienced the physical trauma of her unnecessarily protracted and ultimately futile labor.

*Id.* at 377, 72 P.3d at 100. The court held the plaintiff had an actionable claim regardless of physical harm:

We are persuaded that, when the claim is that a medical practitioner breached a professional duty to guard against a specific medical harm, the fact that that harm is psychological rather than physical is not a bar to liability. Our holding should not be read to mean that medical professionals operate under a general duty to avoid any emotional harm that foreseeably might result from their conduct. . . . But, where the standard of care in a particular medical profession recognizes the possibility of adverse psychological reactions or consequences as a medical concern and dictates that certain precautions be taken to avoid or minimize it, the law will not insulate persons in that profession from liability if they fail in those duties, thereby causing the contemplated harm.

*Id.* at 381, 72 P.3d at 102-03 (quoting *Curtis v. MRI Imaging Servs. II*, 327 Or. 9, 15-16, 956 P.2d 960, 963 (1998)).

<sup>53</sup> EMILY V. CORNELL, NGA CTR. FOR BEST PRACTICES, ISSUE BRIEF: ADDRESSING THE MEDICAL MALPRACTICE INSURANCE CRISIS 5 (2002) (emphasis omitted).

<sup>54</sup> U.S. CONST. amend. VII. ("In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved . . .").

<sup>55</sup> Jody Weisberg Menon, *Adversarial Medical and Scientific Testimony and Lay*

site educational or training background. Instead, the jury is called upon not for its expertise, but to use its common sense to assess the evidence brought forth at trial.

Historically, juries assessed the standard of care by accepted local community norms, which in medical cases were usually defined by expert medical witnesses practicing in the same locality.<sup>56</sup> But today, many jurisdictions, including Oregon, have abandoned the locality standard of care and adopted a modified locality rule.<sup>57</sup> The modified locality rule allows experts practicing in a similar community to testify.<sup>58</sup> A few states have abandoned the locality rule entirely, and adopted a national “reasonable physician” standard.<sup>59</sup> “In these states . . . the jury decides whether the physician behaved reasonably, not whether she complied with custom.”<sup>60</sup> By statute, Oregon mandates a modified locality rule:

A physician or podiatric physician and surgeon licensed to practice medicine or podiatry by the Board of Medical Examiners for the State of Oregon has the duty to use that degree of care, skill and diligence that is used by ordinarily careful physicians or podiatric physicians and surgeons in the same or similar circumstances in the community of the physician or podiatric physician and surgeon or a similar community.<sup>61</sup>

The modified locality rule is generally favored by doctors because it limits the number of possible experts who may testify to those doctors practicing in a similar locale, whereas the national standard allows any certified expert before the jury. This national standard can greatly disadvantage doctors from smaller communities where fewer specialists and sophisticated equipment are available.

---

*Jurors: A Proposal for Medical Malpractice Reform*, 21 AM. J.L. & MED. 281, 283 (1995).

<sup>56</sup> HENRY COHEN, CRS REPORT FOR CONGRESS, MEDICAL MALPRACTICE LIABILITY REFORM: LEGAL ISSUES AND FIFTY-STATE SURVEY OF CAPS ON PUNITIVE DAMAGES AND NONECONOMIC DAMAGES 1 (2003).

<sup>57</sup> See *Creasey v. Hogan*, 292 Or. 154, 165, 637 P.2d 114, 121 (1981); see also Jay M. Zitter, Annotation, *Standard of Care Owed to Patient by Medical Specialist as Determined by Local, “Like Community,” State, National, or Other Standards*, 18 A.L.R. 4TH 603 § 4 (1982) (defining the modified locality rule).

<sup>58</sup> *Creasey*, 292 Or. at 165, 637 P.2d at 121.

<sup>59</sup> Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 913-14 (2002).

<sup>60</sup> *Id.* at 916.

<sup>61</sup> OR. REV. STAT. § 677.095(1) (2003).

### C. Assessing Damages

Generally, the goal of damages is to restore a party, as much as possible, to the position they were in before the injury.<sup>62</sup> Medical malpractice damage awards typically consist of economic and non-economic damages, and although uncommon, patients may also seek punitive damages.<sup>63</sup> Juries are typically advised by experts regarding life expectancy, lost earnings, and other factors that guide them in determining economic damages. In contrast, juries' determination of non-economic damages, paid to compensate pain and suffering, are far more discretionary and unpredictable. Non-economic damages in most neurological obstetric injury cases constitute nearly half the damage award.<sup>64</sup> There are several possible explanations for consistently high non-economic damage awards: first, both the parents and infant are being compensated; second, the jury lacks guidance in determining non-economic damages; and third, the jury is sympathetic to a severely injured infant.<sup>65</sup>

### D. Critiquing the Tort System

Proponents of the existing tort system contend that it allows for severely injured patients to be adequately compensated for injuries caused by medical negligence. However, several studies of jury verdicts and settlements indicate the medical malpractice system fails on this count. "A defining feature of the medical liability system is that most events of malpractice do not result in a legal claim, and most claims of malpractice are not tied to any act of negligence."<sup>66</sup> The comprehensive Harvard Medical Practice Study found that 3.7% of all hospitalizations result in an adverse event, and 27.6% of adverse events were caused by

---

<sup>62</sup> 3 WEST'S ENCYCLOPEDIA OF AMERICAN LAW 331 (2d ed. 2005).

<sup>63</sup> Punitive damages "can be awarded to a plaintiff in addition to compensatory damages where a defendant's conduct is particularly willful, wanton, malicious" and are "awarded not as compensation, but to punish the wrongdoer and act as a deterrent to others who might engage in similar conduct." *Id.* Punitive damages are extremely rare in medical malpractice cases, and between 1999 and 2001 they occurred in only 2% of all cases. SAXTON, *supra* note 1, at 8. However, despite their infrequency, punitive damages have a significant impact because they are typically very large. *Id.* A survey of punitive damages awarded in one year found that the average amount awarded was \$2.5 million. *Id.*

<sup>64</sup> Cavanaugh, *supra* note 19, at 1304.

<sup>65</sup> *Id.* at 1341 n.287.

<sup>66</sup> SAXTON, *supra* note 1, at 3.

negligence.<sup>67</sup> Current evidence suggests that nearly 40% of malpractice claims are non-meritorious.<sup>68</sup> The inference to be drawn from these findings is that the tort system does not ensure claims will be filed in the most egregious negligence cases, nor does it keep frivolous claims based on an adverse event, but not negligence, from being filed.<sup>69</sup>

This prompts the question of what motivates a claimant to go to trial where negligence is not the cause of injury. One possible answer is that miscommunication between doctor and patient leads to a lack of trust. Thus, in cases where there is an unintended result and little communication between the patient and doctor, trust breaks down and the frustrated patient blames the doctor. One study confirmed that “erosion of trust is both one of the causes and one of the consequences of the medical professional liability crisis in obstetrics.”<sup>70</sup> As with many other surgical practices, obstetricians are subject to ever-increasing record-keeping and regulatory demands, as well as unpredictable interruptions for deliveries and procedures, which may prevent them from having adequate time to spend with all of their patients. A recent study found 86% of physicians felt they were not able to spend adequate time with their patients.<sup>71</sup> Despite the fact that the average physician works longer hours today than five years ago, most physicians today feel pressed for time between the increased procedures, tests, and paperwork they must manage.<sup>72</sup>

Another explanation, more likely held by many doctors, is that the practice of medicine is an imperfect and sometimes dangerous science. Because what doctors do is risky but also necessary, adverse events will inevitably occur even among the best of doctors. The problem is how to assure good doctors continue to practice while adequately compensating negligently injured pa-

---

<sup>67</sup> Abstract, T.A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 *NEW ENG. J. MED.* 370 (1991), available at <http://content.nejm.org/cgi/content/abstract/324/6/370>.

<sup>68</sup> Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 *WAKE FOREST L. REV.* 203, 207 (1996).

<sup>69</sup> The increase of managed care, in which patients are likely to be treated by multiple doctors instead of one, is believed to be one reason for the high number of non-meritorious claims.

<sup>70</sup> Bulgar & Rostow, *supra* note 26, at 90-91.

<sup>71</sup> Michael D. Sorkin, *Doctors Feel Pinched on Time with Patients*, *ST. LOUIS POST-DISPATCH*, May 12, 2003, at A1. This may be partially attributed to the rise of managed care.

<sup>72</sup> *Id.*

tients. As one doctor explained, “[i]f error were due to a subset of dangerous doctors, you might expect malpractice cases to be concentrated among a small group, but in fact they follow a uniform, bell-shaped distribution.”<sup>73</sup> Many commonly performed procedures are difficult and complicated, sometimes involving a team of doctors and medical students. While this is no excuse for negligent behavior, the problem does not seem to be one of “repeat offenders.”<sup>74</sup> The teaching hospital system certainly is not perfect, but as one doctor explains it is not the likely culprit of the negligence crisis:

In medicine, we have long faced a conflict between the imperative to give patients the best possible care and the need to provide novices with experience. Residencies attempt to mitigate potential harm through supervision and graduated responsibility. And there is reason to think patients actually benefit from teaching. Studies generally find teaching hospitals have better outcomes than non-teaching hospitals.<sup>75</sup>

While medicine will never be a perfect science, medical training presents a great opportunity for doctors in training to learn from others’ errors and prevent repeat mistakes. Increased error reporting and quality assessment programs enable doctors to learn from mistakes, but such programs widely vary between hospitals.<sup>76</sup>

Another feature of the malpractice tort system, according to proponents, is that it purportedly identifies bad behavior by negligent physicians, often removing them from practice. Conversely, some physicians favor litigation as a method to “clear their names” and avoid disciplinary consequences.<sup>77</sup> Disciplinary consequences include employment termination, license revocation, and limitation of services or practices.

Since 1990, all malpractice settlements and judgments are reported to the National Practitioner Data Bank.<sup>78</sup> The Data Bank provides a record of malpractice claims that may be searched by hospitals, doctors, and other interested parties.<sup>79</sup> The effectiveness of the Data Bank in identifying and leading to the removal

---

<sup>73</sup> ATUL GAWANDE, *COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE* 56 (2003).

<sup>74</sup> *Id.*

<sup>75</sup> *Id.* at 24.

<sup>76</sup> Interview with Anna Daniel, M.D., *supra* note 23.

<sup>77</sup> Metzloff, *supra* note 68, at 205.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*

of negligent doctors is dubious. Consequently, physicians may be hesitant to reach a settlement that will be reported to the Data Bank, and may prefer to go to trial in cases when evidence of negligence is questionable.<sup>80</sup> It is important to note that the Data Bank covers only incidents that are litigated or settled. Thus it does not include all known medical errors, and does not encourage doctors to report all mistakes. A better and more transparent model would be a reporting system that allowed doctors to identify and learn from common mistakes, even those that were not litigated or settled, thereby more effectively deterring negligence.

Tort claimants who have filed claims have several criticisms of the existing system. One comprehensive study of medical claimant's satisfaction with the tort system found these major criticisms: high overhead in claim resolution, typically due to high lawyer's fees; delays associated with court resolution; and an increase in the practice of defensive medicine.<sup>81</sup>

In summary, the medical malpractice tort system too often fails to meet its goals: to deter negligence, to punish the wrongdoer, and to compensate the injured. Its inconsistent application leads to disparate results that are often frustrating to involved doctors and patients, especially the most severely injured. Finally, the tort litigation system fails to encourage reporting of mistakes and does not promote improved healthcare services. These shortcomings indicate the need for an improved system that more effectively meets these goals and seeks improved delivery of health care services.

### III

#### MEDICAL MALPRACTICE REFORM PROPOSALS

Numerous state and federal reforms have been proposed in response to the current medical malpractice crisis. Among the most common are caps limiting the amount of damages that may be awarded. This section will examine proposals to reform the existing medical malpractice system by enacting caps on non-economic damages. This section will also discuss reform proposals

---

<sup>80</sup> *Id.* at 206.

<sup>81</sup> Sloan et al., *supra* note 4, at 36. Defensive medicine is "understood to mean unnecessary care given by physicians in response to the filing of lawsuits by patients." *Id.*

outside the existing medical malpractice system: mandating alternative dispute resolution or enacting a no-fault structure.

### A. *Non-Economic Damages Caps*

One common medical malpractice reform is to limit the amount of damages that a prevailing party may receive. Caps are the most tested medical malpractice reform currently in use among states and have been enacted at varying levels in several states. In 1987, the Oregon Legislature enacted Oregon Revised Statutes section 18.560, which imposed a \$500,000 cap on non-economic damages.<sup>82</sup> Then in 1999, in *Lakin v. Senco Products*, the Oregon Supreme Court struck down the \$500,000 cap on non-economic damages as violating the constitutionally protected right to trial by jury.<sup>83</sup> However, the cap survived for wrongful death actions because no common law right to a jury trial exists for this statutorily-created action.<sup>84</sup>

The effectiveness of non-economic damage caps in reforming the medical malpractice system is widely debated. Many supporters of caps argue they are effective in preventing huge and unpredictable jury awards. By limiting liability exposure, caps encourage scientific innovation and prevent excessive deterrence of valuable medical research.<sup>85</sup> Critics respond that caps only restrict damage awards for the most seriously injured claimants. As one critic of caps noted, there is an “inherently regressive nature of caps on damages, particularly for pain and suffering. Such caps give rise to vertical inequity among plaintiffs by imposing their limits only upon the damages awarded to the most severely injured victims.”<sup>86</sup> While it is clear that the most seriously injured suffer the most under caps, the American Medical Association defends reasonable caps as an effective method of limiting insurance premiums, thereby ensuring patients have access to healthcare services.<sup>87</sup>

---

<sup>82</sup> OR. REV. STAT. § 18.560 (1987), *partially invalidated by* *Lakin v. Senco Prods., Inc.*, 329 Or. 62, 987 P.2d 463 (1999).

<sup>83</sup> *Id.* at 81, 987 P.2d at 474.

<sup>84</sup> *Id.* at 77, 987 P.2d at 472.

<sup>85</sup> Kimberly A. Pace, *Recalibrating the Scales of Justice Through National Punitive Damage Reform*, 46 AM. U. L. REV. 1573, 1622 (1997).

<sup>86</sup> David M. Studdert et al., *Can the United States Afford a “No-Fault” System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1, 17 (Spring 1997).

<sup>87</sup> Donald J. Palmisano, Letter to the Editor, *AMA to The Wall Street Journal Online: Caps on Non-Economic Damages Can Work*, WALL ST. J. ONLINE, Sept. 19, 2003, at <http://www.ama-assn.org/ama/pub/article/3289-8023.html>.

The effectiveness of caps in limiting insurance premiums and preventing doctors from closing their practices or limiting services is hotly debated. However, comparisons of average doctor premium rates between states with caps and without caps indicates that, as one would expect, caps do affect insurance premiums. The *Medical Liability Monitor* divided states into three groups: states with caps on damages over \$250,000, states with caps at \$350,000, and states without caps. The comparison results showed the average premium increase between 2001 and 2002 for the first group with caps was 26%, and for the second group with slightly higher caps was 18%.<sup>88</sup> The third group, states without caps, had the highest average premium increase, at 45%.<sup>89</sup> Thus, caps very likely limit doctors' premiums.

While caps prevent exorbitant awards, it is difficult to measure the effect of caps on doctors' practices and the availability of services. It is clear that awards in Oregon have increased since caps were removed in 1999. The Oregon Medical Association found that since caps were struck down, the average court settlement has increased 65%.<sup>90</sup> Many doctors believe caps were effective in lowering the amount of their liability risk, and a strong tort reform lobby continues to push for reinstatement of damage limits.

Twice in the past five years Oregon voters have weighed in on this issue. Voters were given an opportunity to reinstate non-economic damages caps, but rejected this proposal—Measure 81—in the May 2000 primary election.<sup>91</sup> Despite strong support from the Oregon Medical Association, the measure failed by a landslide, but a group of Oregon physicians continued to raise money to lobby the state legislature for tort reform.<sup>92</sup> Two McMinnville doctors contacted other interested physicians to raise \$50,000 for tort reform.<sup>93</sup> Dr. Klaus Martin, who has

---

<sup>88</sup> QUALITY OF HEALTH CARE, *supra* note 13, at 23.

<sup>89</sup> *Id.*

<sup>90</sup> Robin J. Moody, *Doctors Eye Malpractice Ballot Measure*, BUS. J. OF PORTLAND, Jan. 7, 2003, at <http://www.bizjournals.com/portland/stories/2003/01/06/daily12.html>.

<sup>91</sup> Oregon State Measure 81, Primary Election, May 16, 2000, at <http://www.sos.state.or.us/elections/may162000/m81.htm>.

<sup>92</sup> Ass'n of Trial Lawyers of Am., *Oregon Voters Reject Caps on Civil Damage Awards*, at <http://www.atla.org/homepage/oregon.aspx> (last visited Mar. 3, 2003). The measure's vote totals: Yes votes: 219,009 and No votes: 650,348. Oregon State Measure 81, *supra* note 91.

<sup>93</sup> Moody, *supra* note 90.



spearheaded the lobby fundraising, explained the effort was to prevent a situation where a doctor says “by the way, we are no longer delivering babies.”<sup>94</sup> Many obstetricians believe caps are the only way to continue offering all services.

Measure 35, a proposed state constitutional amendment imposing a \$500,000 cap on non-economic damages, was recently defeated in the November 2004 election by a narrow margin of 51% to 49%.<sup>95</sup> The close result in the Measure 35 race was not surprising given the millions that were spent leading up to the November election. Those in support of Measure 35 spent over \$5 million, while the opposition reportedly raised nearly \$2 million.<sup>96</sup> The arguments advanced by each side were familiar to voters. Trial lawyers and others opposed to the measure advocated that the imposition of caps would remove the patient’s right to full compensation.<sup>97</sup> Doctors and other Measure 35 supporters argued that without caps, high malpractice risk and rising insurance premiums would restrict access to medical care, especially for doctors providing high-risk services such as delivering babies.<sup>98</sup> Consequently, the recent rejection of Measure 35 indicates alternative reforms must be considered in Oregon.

Although the Oregon Legislature has not been able to reinstate caps since *Lakin*, they have responded with limited relief. In 2003, the Oregon House of Representatives unanimously passed House Bill 3630, a bill that limits premiums for rural doctors.<sup>99</sup> It offers relief to 1000 of Oregon’s 7500 rural physicians.<sup>100</sup> For those who receive relief under the bill, it is significant: “premium rates [are reduced 80%] for doctors specializing in obstetrics, [60%] for family-practice doctors who provide obstetric care and [40%] for all other rural physicians.”<sup>101</sup>

---

<sup>94</sup> *Id.*

<sup>95</sup> Oregon State Measure 35, General Election, Nov. 2, 2004, at <http://www.sos.state.or.us/elections/nov22004/abstract/m35.pdf>. The vote total was 896,857 No votes and 869,054 Yes votes. *Id.*

<sup>96</sup> *Friends, Foes of Oregon Ballot Measures Pull Out Wallets to Influence Outcome*, THE REGISTER-GUARD (Eugene, Or.), Oct. 22, 2004, at A1.

<sup>97</sup> David Steves, *Physicians’ Push and Lawyers’ Pull Leaves Patients in Middle*, THE REGISTER-GUARD (Eugene, Or.), Oct. 3, 2004, at A1.

<sup>98</sup> *Id.*

<sup>99</sup> H.B. 3630, 72nd Leg., 2003 Sess. (Or. 2003) (amending OR. REV. STAT. § 656.632 (2003)); Robin J. Moody, *Relief on the Way for Rural Docs*, BUS. J. OF PORTLAND, June 20, 2003, at <http://www.bizjournals.com/portland/stories/2003/06/23/story2.html>.

<sup>100</sup> Moody, *supra* note 99.

<sup>101</sup> *Id.*

The bill aims to provide temporary relief and contains a sunset provision so the program expires four years from the date of passage.<sup>102</sup>

House Bill 3630 has been criticized by the state's private insurers because it requires that the State Accident Insurance Fund (SAIF) provide medical insurance to doctors. SAIF was chosen because it is state owned and has the ability to administer payments.<sup>103</sup> Under the bill's language, SAIF pays a fee to the state's Department of Consumer and Business Services for operating costs, and \$10 million from those fees would fund the reinsurance account.<sup>104</sup> Jim Dorigan, CEO of Oregon's largest physician insurance provider, criticizes the bill as being nothing more than a state subsidy.<sup>105</sup> Oregon's private healthcare insurers are concerned the bill will eventually push private insurers out of the market, replacing them with a state agency. While this bill does provide some relief, it is criticized for being too temporary and limited in its coverage to bring significant relief to Oregon obstetricians.

It is clear caps on non-economic damages affect insurance rates, especially for doctors in high-risk liability practices. However, caps will continue to be strongly criticized as most significantly impacting recovery for the most severely injured. Although the Oregon Legislature has had some success in more specialized legislation, it has focused on limiting premiums, not damages. This will provide some much needed immediate relief, but due to state budgetary constraints it is not a promising long-term solution. Given the Oregon Supreme Court's strong language regarding caps in *Lakin*, efforts to reinstate caps on non-economic damages would likely face future challenges in the courts and prove to be a short-lived, and thus ultimately inadequate reform.

### *B. Alternative Dispute Resolution*

Another proposal to limit medical malpractice litigation is to enact authorization for binding decisions through alternative dispute resolution (ADR). While many medical malpractice cases today settle out of court, there is no requirement in Oregon that

---

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

parties even attempt to reach an agreement through binding mediation or arbitration. There are several states that have enacted legislation to allow or require ADR.<sup>106</sup> ADR may be an excellent mechanism for removing from tort litigation some cases that do not involve major negligence.<sup>107</sup>

Two methods of ADR could be used in medical malpractice cases: mediation or arbitration. Mediation is a method of resolving disputes where the parties, and in some cases their attorneys, meet with a disinterested mediator to resolve their dispute.<sup>108</sup> Mediation emphasizes the parties' understanding of the dispute and possible solutions, but does not rely on applicable principles of law.<sup>109</sup> The mediator's role in this process is one of a facilitator, not a judge or evaluator of the merits of the dispute.<sup>110</sup> Typically, mediation is more effective between disputants with a long-standing prior relationship and a desire to continue their relationship.<sup>111</sup> There are varying models in mediation: in the judge-led model, parties are in separate rooms, and the judge serves as a negotiator between the parties; in the interest-based model, parties are typically in the same room, and the mediator's role is to facilitate communication and allow them to develop a resolution.

In contrast, an arbitrator's role is more like that of a judge or jury. Arbitration is typically a binding process, often court-ordered, in which the arbitrator evaluates the merits of the case.<sup>112</sup> Arbitration may vary based on the following variables: length of the arbitration hearing, the number and qualifications of arbitra-

---

<sup>106</sup> Micheal Ahearn, Student Piece, *Medical Malpractice Arbitration*, WIDENER UNIV. ONLINE J. ARB., MEDIATION, NEGOT. & COMPLEMENTARY DISP. RESOL. TECHNIQUES (2001), available at <http://www.adrlawinfo.com/medmal.html>. States allowing some form of arbitration are: Alabama, California, Colorado, Connecticut, Florida, Georgia, Illinois, Kansas, Minnesota, New York, Ohio, South Dakota, Tennessee, Texas, and Wisconsin. Jurisdictions requiring some form of arbitration: Alaska, Delaware, District of Columbia, Hawaii, Idaho, Indiana, Louisiana, Maine, Michigan, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Utah, Vermont, Virginia, and Washington.

<sup>107</sup> Leonard J. Marcus & Barry C. Dorn, *Mediation Before Malpractice Suits?*, NEWSWEEK, Mar. 27, 2000, available at 2000 WLNR 6244699.

<sup>108</sup> Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429, 440 (1992).

<sup>109</sup> Metzloff, *Unrealized Potential*, *supra* note 68, at 218.

<sup>110</sup> *Id.* at 218.

<sup>111</sup> *Id.* at 219. However, with the growth of managed care, patients are less likely to have an ongoing relationship with one doctor, and are instead treated by a team of doctors.

<sup>112</sup> *Id.* at 204 & n.5.

tors, and the amount of discovery conducted in the arbitration.<sup>113</sup>

There are several advantages to ADR over litigation. A major advantage of ADR is that it provides parties the freedom to reach a more creative solution than mere economic and non-economic damages. One study of mediation in medical malpractice cases found that patients have three desires, which are not always met in tort suit: first, a complete explanation of the event at issue and why it happened; second, an acknowledgement or even apology from the caregiver; and third, an assurance that steps will be taken so that the event will not happen again.<sup>114</sup> ADR may produce a more satisfying result for the parties by addressing the patient's desires. Finally, ADR saves both parties the costs of going to trial, and provides parties with a better opportunity to discuss the event and its outcome.

The main disadvantage of ADR is that it may be disastrous in cases where parties are very emotional and unwilling to listen to each other. It also removes the stigmatic blame element, which some parties may be so driven by that they are unwilling to settle any issues outside court. Some critics of mandatory ADR posit that it would merely serve as a "band-aid" for the inadequate tort system, and it would not effectively address the malpractice crisis.<sup>115</sup>

Another consideration in evaluating mandatory ADR is that its constitutionality would likely be challenged under the Seventh Amendment right to trial by jury and the Oregon Constitution as a deprivation of the right to trial.<sup>116</sup> However, states could allay this constitutional concern by merely requiring that parties attempt ADR, instead of requiring that they reach an agreement

---

<sup>113</sup> *Id.* at 204.

<sup>114</sup> Marcus & Dorn, *supra* note 107.

<sup>115</sup> Metzloff, *supra* note 68, at 216.

<sup>116</sup> See HENRY COHEN, CRS REPORT FOR CONGRESS, FEDERAL TORT REFORM LEGISLATION: CONSTITUTIONALITY AND SUMMARIES OF SELECTED STATUTES 7-8 (2003).

Traditional tort actions, however, such as medical malpractice and products liability, are not federal causes of action; they are governed by state law, even when they are brought in federal court on diversity grounds. State laws generally provide for jury trials in tort cases brought in state courts, and the Seventh Amendment to the United States Constitution generally provides for jury trials of cases arising under state law that are brought in federal court. The question has arisen, therefore, as to the extent to which the Constitution permits Congress to require alternative dispute resolution in federal or state forums, of tort claims arising under state law.

*Id.*

by ADR. Thus, parties may reserve the option to go to trial after attempting resolution through ADR if they are unable to reach agreement.

There are few studies comparing the effectiveness of ADR versus litigation in resolving medical malpractice disputes, reducing costs, and saving time. One recent study conducted by the United States General Accounting Office compared litigation and arbitration results.<sup>117</sup> The study found that plaintiffs prevailed slightly more often in arbitration than litigation, and that arbitration was less time consuming.<sup>118</sup> In addition to this study, health care provider Kaiser Permanente in California has used arbitration for its subscribers since the 1970s, and its general results indicate arbitration leads to faster and more just resolution of disputes than litigation.<sup>119</sup> However, there are no comprehensive comparisons proving that ADR is significantly more successful than litigation.

Encouraging parties to use ADR would have the positive effect of removing from the tort litigation system those cases which can be resolved between the parties. Additionally, as one physician explained from experience, mandatory ADR would facilitate and encourage parties to communicate, which in turn improves medical care and a patient's emotional recovery.<sup>120</sup> Dr. Anna Daniel, an obstetrician, explained that she supports mandatory ADR because she has seen the effect of litigation on many doctors in her field:

There are occasional cases where it is clear the wrong decision was made. But in most cases, patients are unable to accept that outcomes are unpredictable. Lawsuits after unexpected outcomes may have more to do with miscommunication or poor patient-physician relationships than the actual event. It is an exhausting, destructive experience for both the patient and the doctor. Physicians involved in lengthy trials often choose to leave clinical medicine or retire so that they never have to repeat the experience.<sup>121</sup>

At a minimum, a well-designed mandatory ADR program may provide parties with an option other than settlement to avoid

---

<sup>117</sup> U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: FEW CLAIMS RESOLVED THROUGH MICHIGAN'S VOLUNTARY ARBITRATION PROGRAM, GAO/HRD-91-38 (1990), available at <http://archive.gao.gov/t2pbat8/143016.pdf>.

<sup>118</sup> *Id.* at 8; Metzloff, *supra* note 68, at 214.

<sup>119</sup> Metzloff, *supra* note 68, at 214.

<sup>120</sup> Interview with Anna Daniel, M.D., *supra* note 23.

<sup>121</sup> *Id.*

trial. It is difficult to imagine replacing tort litigation entirely with ADR because there are cases that will not be resolved or settled without litigation. But there is a role for ADR in many cases to “encourage the type of constructive talking and listening that we need if we are going to help our health system heal itself.”<sup>122</sup> ADR is more likely than tort to encourage good behavior by allowing patients and doctors an opportunity to effectively communicate.

Mediation and arbitration are successfully used in many cases today, where the parties voluntarily participate. One judge who frequently mediates medical malpractice cases in Lane County, Oregon, questions whether it is necessary to enact legislation making mediation or arbitration mandatory because forcing parties into ADR before trial will have little effect if the parties are unwilling.<sup>123</sup> Judge Lyle Velure explained “arbitration can be ineffective because neither party wants to make their case if they are going to trial” and will have to make their case a second time.<sup>124</sup> Thus, in Judge Velure’s experience, insurers will only participate in arbitration if it is non-binding and they can appeal the decision.<sup>125</sup> Similarly, mediation is most effective when the parties are both voluntary participants, motivated by a desire to both spare the cost of trial and settle the case more quickly. As Judge Velure noted, any case for less than a quarter-million dollars will not be worth trying because of the costs associated with trial, and therefore ADR is an effective alternative.<sup>126</sup>

ADR may enable parties a chance to revisit the facts, acknowledge where missteps and miscommunications were made, and it tends to limit the strain on courts by weeding out some cases that may be resolved without litigation. One commentator’s recommendation is to implement an ADR model that is specifically designed to address malpractice claims.<sup>127</sup> Such a model would: (1) be tailored to produce decisions on the merits; (2) focus upon early identification of non-meritorious claims; (3) utilize decision-makers skilled in understanding the evidence; (4) promote consistent damage awards; and (5) reduce costs through

---

<sup>122</sup> Marcus & Dorn, *supra* note 107.

<sup>123</sup> Interview with Judge Lyle Velure, Lane County Cir. Ct., Eugene, Or. (Mar. 8, 2004).

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> Metzloff, *supra* note 108, at 447-48.

efficiency.<sup>128</sup>

To encourage arbitration or mediation, many jurisdictions have enacted legislation to mandate that parties attempt or agree to resolve their dispute through such a process.<sup>129</sup> While some hospitals do mandate private arbitration to resolve disputes, a more comprehensive state statute requiring attempted mediation or arbitration before trial would have a greater effect. This would ease the strain on courts, alleviate the physician's concern about liability, and most importantly, allow injured parties to reach a reasonable settlement without the cost and time associated with trial. Finally, depending upon the structure of mandatory ADR legislation, the goals of deterring negligence and adequately compensating the most injured may be more appropriately met than under tort. It is likely that in successfully resolved ADR cases both parties will be more satisfied with a solution they helped create.

### C. *No-Fault*

The final proposal discussed in this Comment is to impose a no-fault system, similar to workers' compensation. Of all the proposals discussed, this proposal requires the most radical overhaul of the current tort litigation system. This could be accomplished in one of two ways: first, by removing all cases from tort litigation, as is the practice in Sweden; or second, the no-fault system could be structured to divert certain types of cases to no-fault compensation while reserving the litigation option for other cases. As will be discussed, the latter is a more realistic option given the litigious environment in the United States.

#### 1. *Advantages and Disadvantages*

There are several advantages of no-fault compensation systems as compared with traditional litigation. First, no-fault appropriately compensates by allowing more people to collect, and by reducing the cost and time for filing a claim.<sup>130</sup> Second, claimants in a no-fault system are likely to receive payment faster.<sup>131</sup>

---

<sup>128</sup> *Id.*

<sup>129</sup> See Ahearn, *supra* note 106; see also Note, *Mandatory Mediation and Summary Jury Trial: Guidelines for Ensuring Fair and Effective Processes*, 103 HARV. L. REV. 1086, 1090 n.33 (1990).

<sup>130</sup> Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 70 (1998).

<sup>131</sup> *Id.* at 71.

Third, claimants are more likely to get an award reflecting the severity of their injury.<sup>132</sup> Fourth, compensation is more efficiently managed through an administrative agency that is able to make periodic payments of benefits.<sup>133</sup> Finally, replacing the existing malpractice structure with a no-fault system would likely ease the burden of high insurance premiums on physicians. The imposition of no-fault would have a significant impact on practice areas that involve high-risk procedures and require high premiums. Thus, a justification for limiting no-fault exclusively to obstetric cases is the “unique impact of the increased frequency and severity of obstetric injury claims on the practice of obstetrics.”<sup>134</sup>

Critics of no-fault, notably plaintiff’s attorneys, argue it would shortchange victims who could fare better under the existing tort system. Critics also argue that imposition of a no-fault system would remove the fault-finding aspect of a tort case, which compels physicians to act with due care.<sup>135</sup> Consequently, a no-fault system would not deter negligence, because obstetricians and other doctors’ liability would not be tied to mistakes.<sup>136</sup> Additionally, no-fault would prove unsatisfactory in comparison to tort suits for those patients seeking retribution.

Another criticism of no-fault is its feasibility. Specifically, would all medical acts or omissions be compensated as medical events, or merely those listed as medical negligence injuries?<sup>137</sup> There are a number of potential factors that might influence the answer to this question: pre-existing conditions, experimental procedures, residents or medical students at teaching hospitals, and complexity of the procedure. Unlike workers’ compensation, the range of potentially compensable events in a broad medical malpractice no-fault system makes implementation of such a system a daunting task. One response to this is to narrow possible compensable events, and list those injuries that will be compensated, a process similar to no-fault automobile compensation.

The cost advantages of a no-fault medical malpractice compensation system have been widely disputed. Critics of the no-fault

---

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> Cavanaugh, *supra* note 19, at 1303.

<sup>135</sup> Bovbjerg & Sloan, *supra* note 130, at 73.

<sup>136</sup> Cavanaugh, *supra* note 19, at 1304.

<sup>137</sup> See Bovbjerg & Sloan, *supra* note 130, at 74.



model argue that the system would be too costly because it would compensate a larger pool of recipients.<sup>138</sup> Although a no-fault system would inevitably compensate a larger pool, proponents of the system argue it would more equitably distribute awards and would still cost less than litigation because of lower administrative costs.<sup>139</sup>

## 2. *Varying Models of No-Fault Compensation*

Two no-fault models are used in the United States today: workers' compensation and automobile compensation.<sup>140</sup> Workers' compensation applies to all injuries and illnesses occurring in the course of employment.<sup>141</sup> The system was adopted to protect employers from unpredictable litigation, deter injury in the workplace, promote workplace safety, and ensure compensation for all injured.<sup>142</sup> One model of a no-fault medical malpractice compensation system parallels workers' compensation:

Claims are filed with an expert panel of impartial physicians who review claims and to determine if the injury fits the definition established. Set time periods are established for the panel to make a determination. Compensation is limited to net economic losses only (i.e. no pain and suffering), which includes medical expenses, hospital and rehabilitative costs, lost wages, and reasonable attorney fees. These systems are designed for a specific type of injury such as birth-related injuries. All injured patients are compensated regardless of the culpability of the provider. This system removes narrowly defined catastrophic injuries from the tort system. It can be funded with state dollars and assessments on doctors and hospitals.<sup>143</sup>

Programs adopting this or similar models exist in Virginia, Florida, Sweden, and New Zealand. One variation among no-

---

<sup>138</sup> Studdert et al., *supra* note 86, at 2.

<sup>139</sup> *Id.* at 3.

<sup>140</sup> Bovbjerg & Sloan, *supra* note 130, at 65-67. Automobile no-fault compensation varies by state, but usually covers injuries arising out of operating a motor vehicle. However, unlike workers' compensation, automobile no-fault does not compensate all events, but instead is narrowed to cover only certain injuries. Automobile injuries are measured on a severity threshold, in which the most severely injured are not constrained by the no-fault system. Instead, those severe injuries above the threshold fall within the tort system. The rationale behind automobile no-fault is to reduce the high costs of tort law and insurance in automobile accident cases. *Id.* at 66-67.

<sup>141</sup> *Id.* at 66.

<sup>142</sup> *Id.* at 64-66, 76-78.

<sup>143</sup> CORNELL, *supra* note 53, at 6-7.

fault models is damages for pain and suffering, which are not compensable under workers' compensation.<sup>144</sup>

The first no-fault medical compensation system established in the United States was the Virginia Birth-Related Neurological Injury Compensation Program, also known as the Birth Injury Fund.<sup>145</sup> Virginia's no-fault system was implemented in the late 1980s, amidst concern over large, unpredictable awards for severely brain-damaged newborns that came to be known as "bad baby" cases.<sup>146</sup> Previous to its current no-fault system, Virginia had a \$1 million cap on damages that was struck down as unconstitutional in a case that awarded \$8.3 million in damages.<sup>147</sup> Medical malpractice insurers reacted by withdrawing from the market, saying they would not insure obstetricians unless they were insulated from the bad baby cases.<sup>148</sup> In response, the Virginia legislature enacted legislation to create a no-fault compensation system for specific neurological birth-related injuries.<sup>149</sup> One year after Virginia enacted this legislation, Florida enacted similar legislation to create a no-fault compensation system for neurological infant injuries.<sup>150</sup>

Virginia's program was created to ensure that lifetime payments would be guaranteed to eligible children without litigation, and additionally to allow Virginia obstetricians to continue providing full services.<sup>151</sup> The system limits compensable injuries by definition:

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled. In order to constitute a "birth-related neurological injury" within the meaning of this chapter, such disability shall

---

<sup>144</sup> See MICHAEL J. ZIMMER ET AL., *CASES AND MATERIALS ON EMPLOYMENT DISCRIMINATION* 6 (6th ed. 2003).

<sup>145</sup> Bovbjerg & Sloan, *supra* note 130, at 82-83.

<sup>146</sup> *Id.* at 83.

<sup>147</sup> Cavanaugh, *supra* note 19, at 1315; *see also* Boyd v. Bulala, 647 F. Supp. 781, 789 (W.D. Va. 1986) (mem.) (holding that a damage cap infringed the state and federal constitutional right to jury trial).

<sup>148</sup> Cavanaugh, *supra* note 19, at 1316.

<sup>149</sup> *Id.*

<sup>150</sup> *See generally* Sloan et al., *supra* note 4, at 38-39.

<sup>151</sup> CORNELL, *supra* note 53, at 7.

cause the infant to be permanently in need of assistance in all activities of daily living.<sup>152</sup>

Additionally, the Act was limited to live births, and specifically disqualifies injuries caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse.<sup>153</sup> Although the program does not provide compensation for pain and suffering, it does compensate for lost earnings.<sup>154</sup>

For qualifying injuries, the Birth Injury Fund covers: “‘medically necessary and reasonable expenses’ of medical and hospital, rehabilitative, residential and custodial care and service, special equipment and facilities.”<sup>155</sup> The Fund also pays lost wages to eligible recipients upon reaching age eighteen.<sup>156</sup> It is important to note that the Virginia system does not cover all obstetric injuries. Instead, it was created with the purpose to remove only the bad baby cases from liability, which were the cases that prompted insurers to withdraw coverage and led to limited access to obstetric services.<sup>157</sup> This leaves open the option of tort liability for other obstetric injuries that fall outside the neurological injuries outlined in the statute.<sup>158</sup>

To understand the benefits of a no-fault system, a close examination of the more comprehensive Swedish no-fault compensation is helpful. In the early 1970s, Sweden developed a no-fault system designed to adequately compensate patients injured in medical treatment.<sup>159</sup> Sweden’s Patient Insurance Compensation Fund distributes awards to those who have suffered iatrogenic injury, regardless of fault.<sup>160</sup> The system operates most similarly to the United States workers’ compensation system. All patients receiving medical care are informed of the Fund, and given infor-

---

<sup>152</sup> Cavanaugh, *supra* note 19, at 1317 (citing VA. CODE ANN. § 38.2-5001 (1990)).

<sup>153</sup> *Id.*

<sup>154</sup> Sloan et al., *supra* note 4, at 39. In contrast, the Florida no-fault system does provide pain and suffering compensation, but caps those damages at \$100,000. *Id.* at 37.

<sup>155</sup> CORNELL, *supra* note 53, at 7.

<sup>156</sup> *Id.*

<sup>157</sup> Bovbjerg & Sloan, *supra* note 130, at 82.

<sup>158</sup> The Virginia no-fault system is intended as an exclusive remedy for eligible participants whose physicians are participating in the program. Sloan et al., *supra* note 4, at 39. Similarly, in Florida no-fault is intended as an exclusive remedy, but tort suits have been allowed where a family was not aware of the physician’s participation in the no-fault program. *Id.* at 38.

<sup>159</sup> Studdert et al., *supra* note 86, at 5.

<sup>160</sup> *Id.* Iatrogenic injury describes an injury that was induced by a doctor or treatment. See, e.g., WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 1119 (2002).

mation about what to do if they are injured.<sup>161</sup> Once a claim is filed, it is sent to a central office in Stockholm that oversees all claims.<sup>162</sup>

Once a claim is deemed eligible, a panel that includes adjusters and doctors reviews the claim.<sup>163</sup> The average claim is resolved within six months of the time it is filed.<sup>164</sup> Nearly 60% of compensation provided by the Fund goes toward pain and suffering.<sup>165</sup> Patients unsatisfied with the outcome of their claim have two options. Patients may file for a review of their claim, and subsequently participate in arbitration.<sup>166</sup> Patients are also free, at any time during the claims process, to file a lawsuit against their healthcare provider.<sup>167</sup> The Fund makes payments periodically to claimants, and is maintained through county tax contributions.<sup>168</sup> In 1996, the Fund distributed the United States currency equivalent of \$28 million, serving a nation of 8.75 million people.<sup>169</sup> The estimated administrative cost of operating the Fund was 18% of its budget.<sup>170</sup>

New Zealand operates a similar no-fault system, authorized by the Accident Compensation Act of 1972.<sup>171</sup> New Zealand's original system was similar to Sweden's, but has experienced recent reform to limit costs. Originally, the New Zealand Fund compensated bodily functions loss, pain and suffering, and loss of enjoyment of life.<sup>172</sup> In 1992, compensation for bodily function loss and non-economic loss were removed and replaced with an "independence allowance," which was given to those whose injury caused a degree of disability of 10% or more.<sup>173</sup> Additionally, compensation coverage was limited to require periodic physical assessments of claimants, and termination of compensation to injured patients deemed to be at 85% capacity for work.<sup>174</sup>

---

<sup>161</sup> Studdert et al., *supra* note 86, at 6.

<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> *Id.* at 10.

<sup>166</sup> *Id.* at 6.

<sup>167</sup> *Id.*

<sup>168</sup> *Id.* at 9.

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.* at 13.

<sup>172</sup> *Id.* at 15.

<sup>173</sup> *Id.*

<sup>174</sup> *Id.*

### 3. *Evaluating Current Models*

If Oregon were to adopt a no-fault liability system for obstetric related injuries like other jurisdictions, it may adopt a structure similar to a no-fault workers' compensation system or the Virginia Birth Fund. There are several benefits unique to a no-fault system: predictability, assurance that a majority of negligently injured patients will be compensated, weeding out frivolous claims, and allowing physicians in high-risk practice areas to continue offering services.

Evaluation of the Virginia program indicates that the no-fault system has been successful in meeting many goals, but it is not a perfect system. The program has led to lower premiums, both in comparison with the state's previous system and the national rates.<sup>175</sup> Although it is not mandatory, over 90% of physicians in the state participate in the program.<sup>176</sup>

One study of the Virginia and Florida programs found that no-fault claimants were generally satisfied with the process, and that satisfaction varied depending on whether the claimant received compensation.<sup>177</sup> No-fault was also effective in lowering attorney costs as compared with tort.<sup>178</sup> The effectiveness of Virginia's no-fault system in deterring medical negligence is difficult to measure because data is not gathered on the types of claims filed, and injuries are not reported to the National Practitioner Data Bank (as medical malpractice claims are).<sup>179</sup> The most striking advantage to Virginia's system is its efficiency in the distribution and administration of compensation.<sup>180</sup>

Surprisingly, the no-fault system seems to have had little impact on the practice of obstetrics. Before the no-fault system was implemented, physicians reportedly quit due to fear of liability.<sup>181</sup> Consequently, those physicians who remained experienced a higher number of patients and more work. Although implementation of no-fault was expected to alleviate the burden

---

<sup>175</sup> Bovbjerg & Sloan, *supra* note 130, at 100.

<sup>176</sup> *Id.*

<sup>177</sup> Sloan et al., *supra* note 4, at 65.

<sup>178</sup> *Id.* at 65. Most claimants in the no-fault system retained a lawyer for the administrative hearings process. "Overall, it appears that no-fault claimants were more satisfied with their lawyers than tort claimants. This satisfaction may be a reflection of the low legal costs incurred in the no-fault process." *Id.*

<sup>179</sup> Bovbjerg & Sloan, *supra* note 130, at 103.

<sup>180</sup> *Id.* at 113.

<sup>181</sup> *Id.* at 105.

on obstetricians and increase their willingness to practice, this was not the case.<sup>182</sup> This may be explained by the small number of cases that were actually diverted from tort.<sup>183</sup>

The effect of Virginia's no-fault system on compensation is also surprising. On average, four cases are compensated per year.<sup>184</sup> The amount of compensation in no-fault cases was similar to that of comparable tort cases.<sup>185</sup> The lifetime estimated cost of care for one recipient covered by the Virginia Birth Injury Program is \$1.8 million.<sup>186</sup> The no-fault system was successful in lowering doctors' insurance premiums: compared with rates across the nation, obstetric liability premiums in Virginia declined remarkably more rapidly after the adoption of no-fault.<sup>187</sup> The most striking difference between the tort and no-fault systems was the efficiency of compensation, where no-fault was both faster and lower in cost in administering claims as compared with tort.<sup>188</sup>

#### 4. *Comparison and Implementation*

Basic differences in the size, health care coverage, and welfare systems of Sweden, New Zealand, and the United States mean that adoption of a national comprehensive no-fault system is unlikely in this country. As one commentator noted, it is difficult to imagine a no-fault system that also allows for a tort suit in the United States, a country "where considerably fewer public benefits are available to defray the costs of injuries and propensity to sue appears to be unrivaled."<sup>189</sup>

However, aspects of Sweden's and New Zealand's no-fault systems could likely be implemented in the United States. New Zealand's and Sweden's approaches to compensation favor those who have been most severely injured. New Zealand's recent reform, to reserve compensation for those who are at less than 85% of capacity for work, ensures that those most injured will be compensated. While this structure may fail to compensate every

---

<sup>182</sup> *Id.*

<sup>183</sup> *Id.*

<sup>184</sup> *Id.* at 106.

<sup>185</sup> *Id.* at 107.

<sup>186</sup> E-mail from Candace Thomas, CGFM, Deputy Director, Virginia Birth-Related Neurological Injury Compensation Program to author (Jan. 13, 2005) (on file with author).

<sup>187</sup> Bovbjerg & Sloan, *supra* note 130, at 120.

<sup>188</sup> *Id.* at 108.

<sup>189</sup> Studdert et al., *supra* note 86, at 33.

injury, it favors the most severely injured. In contrast, in the United States the influence of caps and attorneys' fees perpetuates a system that burdens the claimant<sup>190</sup> and is not designed to compensate the most severely injured. There is no incentive or feature of the tort system for plaintiffs' attorneys and insurers to ensure awards for the most severely injured. While it is difficult to know how Americans would respond to a no-fault obstetric injury system, the trends of claim reporting in Sweden and New Zealand suggest that under-claiming would be far less likely where negligence is not at issue, and where health care providers have incentives to report and individuals are able to recover without a lawyer.<sup>191</sup>

At a minimum, Oregon could dramatically lessen the impact of medical malpractice litigation on obstetricians through the implementation of no-fault compensation like that in Virginia. Critics of no-fault contend it would do no better than the current tort system in meeting the goals of compensating the most injured and deterring negligence. However, adoption of a limited obstetric no-fault compensation structure, like the one being used in Virginia, would ensure the most severely injured would be guaranteed some payment more promptly. If modeled similarly to the Virginia system, no-fault would apply to bad baby cases, and would effectively remove those cases from the tort system. However, the option of tort litigation would remain for other injuries. Removal of the bad baby cases from the tort system would likely reduce the burden on insurers and physicians by lowering the risk of liability. Another advantage of the no-fault system in obstetric cases is that it would ensure payments for those children who are severely injured and will require chronic care over their lifetime.

Alleviating the burden of the current litigation system is critical in states such as Oregon, where the future availability of obstetricians and their services are in jeopardy. As one doctor explained:

I really enjoy obstetrics, and you have to in order to continue to practice. We work unusual hours and are often exhausted and stressed. We are compensated for really pushing our-

---

<sup>190</sup> See Sloan et al., *supra* note 4, at 40. "[A]lthough the vast majority of claims are accepted by attorneys on a contingent fee basis, claimants ultimately bear the cost of such fees, whereas, in the no-fault system, the compensation plan pays lawyers' fees for claimants." *Id.*

<sup>191</sup> Studdert et al., *supra* note 86, at 34.

selves, sometimes with a cost to our health and families. It is therefore difficult to watch salaries decline and add the constant fear of liability or jury awards that exceed our policy limits.<sup>192</sup>

By removing the opportunity for a handful of claimants to receive large awards, adopting a no-fault structure that has been successful in other states and countries will ensure all deserving Oregon claimants are compensated and that critical services will be available.

### CONCLUSION

The latest medical malpractice crisis has arrived in Oregon with a vengeance, and this state's obstetricians face an increasingly hostile environment in which to practice. Premiums are rising, liability risks are increasing, and most importantly there appears to be no relief in sight. Although caps were enacted, they were overturned and twice rejected by state ballot measure, which indicates they are not a feasible method of reform. The legislature's action to limit premiums in rural areas through House Bill 3630 is a positive step, but more comprehensive reform will be necessary to reach the root of the medical malpractice crisis for obstetricians in Oregon. A variety of reforms are needed, and the legislature should consider enacting a limited no-fault scheme, as well as promoting the use of ADR in medical malpractice cases.

Adoption of a no-fault system for neurological infant injuries, similar to the system currently used in Virginia, would alleviate the burden of litigation on doctors by diverting some cases from the tort system, but still reserving the option for tort.<sup>193</sup> It would also ensure payments for more injured patients, and would ensure that the most seriously injured patients will receive long-term compensation for their chronic injuries. As compared with tort, a no-fault system provides doctors with more incentive to report incidents because doing so will not result in a great risk of

---

<sup>192</sup> Interview with Anna Daniel, M.D., *supra* note 23.

<sup>193</sup> It is likely that adoption of a no-fault system in Oregon would result in a removal of two to three cases from the tort system. This estimate is based on the data that Virginia removes four cases from tort litigation per year. Bovbjerg & Sloan, *supra* note 130, at 106. Compare Virginia's population of 7,459,827 with that of Oregon, which is 3,594,586. POPULATION DIV., U.S. CENSUS BUREAU, TABLE 1: ANNUAL ESTIMATES OF THE POPULATION FOR THE UNITED STATES AND STATES, AND FOR PUERTO RICO (2004), available at <http://www.census.gov/popest/states/tables/NST-EST2004-01.pdf>.



liability, but will likely result in compensation for the injured. Finally, adoption of a no-fault system is beneficial to the public because it will allow continuation of obstetric services, especially in rural areas of the state where liability risk poses a greater danger to small practices.

While imposition of a no-fault system would be a step in the right direction, it does little to improve the underlying communication problems between doctors and patients. One solution to improving communication is to require mandatory reporting of all medical errors to enable doctors and patients to better anticipate risk. Additionally, legislation requiring parties to attempt ADR before litigation may also help to improve communication between doctors and patients. In turn, medical training should utilize reported error information and focus on teaching medical students how to juggle the many demands of obstetric practice, while still allowing adequate time for patient interaction and minimizing error risk. With the trend toward managed care and more team-oriented medicine, in which a patient is treated by several doctors instead of one, effective communication between doctors and patients is critical and will continue to play an important role in preventing medical errors.

Finally, today's adverse environment for obstetric practice serves as a reminder that the status quo must be changed. The low number of medical students entering the field today indicates the future of obstetric services in Oregon will be very limited by the lack of interest in the field and the restricted availability of services if nothing is done. Policymakers, attorneys, and insurers must find some common ground to enact legislation that will improve the current climate of obstetric practice and risk in Oregon. Without change, patient care will not improve, but instead services will become concentrated in the few hospitals that are able to afford insurance to offer a full range of obstetric services. Our malpractice system should be structured to deter negligent conduct, improve the quality of and access to care, and ensure those negligently injured are compensated for their injury.

