THE MEDICAL MALPRACTICE CRISIS IN OBSTETRICS: A GESTALT APPROACH TO REFORM

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INTRODUCTION

Imagine you are pregnant, poor, and unmarried. You are living in rural Georgia[1] and your baby is due soon. You have not had a check-up since you found out you were pregnant, you have had no access to prenatal care or education,[2] and you cannot find an obstetrician to deliver your baby.[3] Some people would say this is not surprising. This is a high-risk pregnancy with, at best, Medicaid reimbursement.[4] Why would an obstetrician who already works seven days a week put herself and her career on the line for you when eighty to ninety percent of obstetricians can expect to be sued during their career,[5] and malpractice rates have risen by up to 113 percent in a four-year period.[6]

Now imagine you are a young upper middle-class couple living in a major city in the Northeast. You just found out you are preg-

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1 According to an article in the Washington Times, 17 counties in Georgia did not have an obstetrician in 1986. *See Risky Business Delivering Babies*, WASH. TIMES, Oct. 20, 1989, at F2; *see also* Sharman Stein, *Gaining Options For Giving Birth — Legal Exemptions Could Allow State's First Midwife Centers*, CHI. TRIB., Apr. 19, 1995, at 1 (noting that fourteen contiguous counties in southern Illinois were without an obstetrician).

2 *See generally* Roger J. Bulger & Victoria P. Rostow, *Medical Professional Liability and the Delivery of Obstetrical Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 81, 83 (Spring 1990) [hereinafter *Medical Professional Liability*] (remarking that the problem of professional liability most adversely impacts the delivery of obstetrical services to disadvantaged women, women living in rural areas, and those with high risk pregnancies).

3 *See id.*

4 *See id.; see also infra* Part I.A (discussing the problems that can arise during a high- and low-risk delivery and the technologies used to combat these complications).

5 *See* Ruth Gastel, *Medical Malpractice*, INS. INFO. INST. REP., Mar. 1997, at 12, *available in* LEXIS, Insure Library, Allnews File ("In a 1992 survey, the American College of Obstetricians and Gynecologists found that . . . [e]ighty percent of [OB/GYNs] have been sued, an increase of 71 percent over the prior five years."); *see also* Laurel Brubaker Calkins, *Who'll Deliver the Babies?*, HOUS. BUS. J., July 24, 1989, at 4, *available in* 1989 WL 2547489 (noting that ninety percent of OB/GYNs can expect to be sued).

6 *See* Mary Jane Fisher, *Obstetrical Liability Worries Doctors*, NAT'L UNDERWRITER, LIFE & HEALTH/FIN. SERVICES ED., Oct. 23, 1989, at 14, *available in* LEXIS, News Library, Nulife File (reporting the findings of the Institute of Medicine that obstetricians are reluctant to accept high-risk patients because of the 10% rise in all malpractice claims filed against United States doctors between 1982 and 1986, and the fact that claims against obstetricians are two to three times higher than other specialties resulting in increased malpractice insurance rates).

nant and your obstetrician/gynecologist ("OB/GYN" or "OB") just informed you that she no longer delivers babies.[7] Most people would say this is surprising. You are a well-educated professional couple who will have the best of technology, nutrition, and health counseling at your disposal. You will probably have an uneventful pregnancy and consequently a low-risk delivery. So why has your OB stopped delivering babies? And where are you supposed to go to find prenatal care?

Unfortunately, the situations outlined above are not uncommon. Doctors all over the United States are pulling out of practice.[8] Obstetricians are getting hit with more lawsuits than any other medical specialty.[9]

> Of those [OB/GYNs that have been] sued, almost twenty-five percent [have] been sued four or more times. . . . The malpractice environment in New York State is the worst in the nation — one third of all [OB/GYNs have] been sued four or more times, and the size of malpractice jury awards [is] three times larger tha[n] the national average.[10]

According to the Medical Liability Mutual Insurance Company, New York OBs had 264 lawsuits filed against them in 1992, compared to 176 for internal medicine practitioners, 125 for orthopedic physicians, 72 for family practitioners, and 35 for neurosurgeons.[11] One study revealed that during 1990-91, 53.9% of all malpractice claims involved obstetrical care.[12]

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7 *See generally* Aimee Lee Ball, *The Baby Bust,* N.Y. MAG., Jan. 25, 1993, at 28 (discussing the refusal of obstetricians to deliver babies due to the risk of lawsuits and high malpractice insurance rates).

8 *See generally* Maxwell J. Mehlman, *Quality of Care and Health Reform; Complementary or Conflicting, Bad Baby Bills,* 20 AM. J. L. & MED. 129, 131 (1994) ("In response to [the pressures of rising malpractice liability], it is widely reported that obstetricians are leaving practice, retiring early, shifting their practice from obstetrics to gynecology so that they no longer deliver babies, refusing to treat the poor, and relocating from rural to urban areas."); *see also* Dianne Schleuning et al., *Addressing Barriers to Perinatal Care: A Case Study of the Access to Maternity Care Committee in Washington State,* 106 PUB. HEALTH REP. 47-52, Jan.-Feb. 1991, *available in* LEXIS, News Library, AsapII File (discussing the formation of a committee in Washington of private sector obstetrical providers and government representatives to improve access to obstetrical services for poorer women in order to make up for the decrease of obstetricians as a result of the increase in malpractice suits and the cost of insurance).

9 *See* Ball, *supra* note 7, at 32.

10 Gastel, *supra* note 5, at 12. *See also Obstetrician-Gynecologists Warn Legislators that New York State's Maternity Care Delivery System is Threatened,* P.R. NEWSWIRE ASS'N, INC., July 2, 1993, *available in* LEXIS, News Library, Prnews File (reporting that women in New York State may be unable to obtain obstetric services if the state legislature fails to enact legislation which would curb excessive awards).

11 *See* Ball, *supra* note 7, at 32.

12 *See* Bill Clements, *Don't Get Sued, Dangerous Deliveries, Part IV, Avoiding Medical Malpractice,* AM. MED. NEWS, Aug. 1, 1994, at 21 ("A 1992 survey of 4,100 of the 20,986 members of

Axiomatically, the increasing frequency with which OBs get sued is causing malpractice premiums to increase.[13] Indeed, doctors "overwhelmingly . . . cite soaring malpractice rates and an atmosphere of litigation as deterrents to practice."[14] Moreover, doctors have to work harder and longer to make the same salary as they did ten years ago, before the dramatic increase in the cost of malpractice insurance premiums.[15] As a result, OBs are facing substantial economic strife in providing care.[16]

According to a study conducted in 1987 by the American College of Obstetricians and Gynecologists ("ACOG"), nearly one-fifth of the OBs in Massachusetts quit their practice between 1984 and 1988.[17] In that time frame, the average insurance premium in the state increased by $12,000, but annual income remained the same.[18] Statistics reveal that annual premiums in some large cities exceed $100,000.[19] In 1994, insurance premiums increased an average of 9.5 percent per insured OB/GYN, and 53.1% of carriers raised rates for OB/GYNs.[20] One report indicated that malpractice premiums in Washington D.C. had skyrocketed 550 percent since 1980.[21] By 1992, according to ACOG, one out of every six obstetri-

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the American College of Obstetricians and Gynecologists found that during 1990-91, 53.9% of all claims involved obstetrical care.").

13 *See, e.g.*, Ball, *supra* note 7, at 28; *OBs Flee Massachusetts, Citing Insurance Rates*, WASH. POST, Jan. 5, 1988, at Z5 [hereinafter *OBs Flee Massachusetts*] (recognizing that the increase of lawsuits has led to rising malpractice insurance rates).

14 Ball, *supra* note 7, at 29.

15 *See, e.g.*, Rochelle Tigner, *Casa Grande's Last Cry: Obstetricians' Final Day Cluttered With Politics of Malpractice Insurance Reform*, 7 BUS. J.-PHOENIX & VALLEY SUN, July 20, 1987, at 3, *available in* 1987 WL 2324224 (discussing the circumstances surrounding the resignation of three Arizona obstetricians).

16 *See* Donald H. Taylor, Jr., MPA, et al., *One State's Response to the Malpractice Insurance Crisis: North Carolina's Rural Obstetrical Care Incentive Program*, 107 PUB. HEALTH REP. 523, 523 (Sept.-Oct. 1992) ("The 1980s crisis was one of affordability — malpractice insurance was more available than in the '70s, but premiums increased at a very rapid pace, especially for obstetrical coverage. This increase left some physicians unable or unwilling to pay the costs necessary to cover obstetrical care."); *see also* Calkins, *supra* note 5, at 4 ("As a result [of the rise in malpractice litigation,] . . . doctors are increasingly reluctant to pay the financial and emotional price of delivering babies.").

17 *See OBs Flee Massachusetts*, *supra* note 13, at Z5.

18 *See High Costs in Massachusetts Thin Ranks of Obstetricians*, N.Y. TIMES, Jan. 17, 1988, at 38.

19 *See* Susan Okie, *'Serious Threat' to Obstetrical Care Seen; Insurance Costs, Fear of Lawsuits Are Scaring Off Doctors, Report Says*, WASH. POST, October 12, 1989, at A25; *see also* Berkeley Rice, *Where Doctors Get Sued The Most; Malpractice Claims in Texas.*, 72 MED. ECON. 98, 99, 108 (Feb. 27, 1995) (noting that malpractice insurance for OB/GYNs can cost $88,000 per year in Houston, Texas, and cost as much as $141,000 per year in Detroit, Michigan).

20 *See Reform Proposals: Effect of Malpractice on Costs Hard to Pin Down, Researchers Say*, BNA PENSION & BENEFITS DAILY, Apr. 5, 1995 (setting forth common arguments in favor of and against medical malpractice reform).

21 *See* Melanie Wells, *Obstetricians Quit City Because of Insurance Rise*, WASH. BUS. J., April 2, 1990, at 1, *available in* 1990 WL 2575056 (discussing that this increase in premiums led to the development of a lobby by Washington D.C. physicians for legislation that would impose a $250,000 cap on the amount that can be awarded for pain and suffering).

cians in New York State had stopped delivering babies — this rate increased from one in ten in 1990.[22]

One obstetrician's situation ironically reveals the alarming nature of the crisis.[23] At one point in her career, Dr. Merri Morris of Pinal County, Arizona could not leave town because she was the town's only practicing OB.[24] She was on call twenty-four hours a day, seven days a week.[25] At the time, Dr. Morris was also five months pregnant.[26]

This Article analyzes the medical malpractice crisis in obstetrics in an effort to identify mechanisms to alleviate a growing problem with access to medical care. Part I provides a detailed explanation of the myriad causes of the malpractice crisis, including the use of advanced technologies, problems with the doctor-patient relationship, and the involvement of the tort system. Part II analyzes how the malpractice crisis has impacted the delivery of obstetrical services. This section also discusses the adverse consequence of the practice of defensive medicine and its concomitant impact on health care costs. Part III provides an analysis of the tort-reform legislation from Virginia and New York aimed at reducing jury awards in perinatal injury lawsuits. Part IV presents the Author's suggestions for alleviating the medical malpractice crisis in obstetrics. This section includes discussion of the benefits to be derived from the improvement of the doctor-patient relationship, the re-training of physicians, the use of state-certified nurse-midwives, the formation of Administrative Review Boards to pre-screen malpractice suits, and the use of compensation funds to define and regulate the system of compensating birth-related injuries.

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22 *See* Ball, *supra* note 7, at 29; *see also* Mehlman, *supra* note 8, at 131 (noting that one out of every six obstetricians have given up obstetrics because of high jury awards); *Obstetrician-Gynecologists Warn Legislature that New York State's Maternity Care Delivery System is Threatened*, *supra* note 10 (noting that one out of every six OB/GYNs, and seventy percent of family physicians, have stopped delivering babies due to liability concerns).

23 *See* Pamela Stutts, *High Insurance, Lawsuits Forcing Doctors to Stop Delivering Babies*, ARIZ. BUS. GAZETTE, Aug. 17, 1987, at 1A, *available in* 1987 WL 5950874 (recounting the plight of the last obstetrician in Pinal County, Arizona, as a result of the stress of heightened malpractice litigation and increased liability insurance and jury awards).

24 *See id.* (stating that her ability to continue to provide obstetrical care was a result of her employer, a Medical Center, paying her malpractice insurance premiums).

25 For the OBs who stay in practice, their workload is often unmanageable. *See generally* Allan S. Warwaruk, *Obstetricians Facing Horrendous Workload*, WINDSOR STAR, Feb. 4, 1995, at A7, *available in* 1995 WL 3611769 (noting that in 1995 each obstetrician providing care in Windsor County was responsible to deliver approximately 400 babies annually — a horrendous individual workload in light of a study by the American College of Obstetrics and Gynecology, which indiciated that the delivery of 200 babies annually represented a busy obstetric practice).

26 *See* Stutts, *supra* note 23, at 1A.

I. CAUSES OF THE MEDICAL MALPRACTICE CRISIS IN OBSTETRICS

There is no one cause of the malpractice crisis in obstetrics. Rather, the interrelationship of a variety of problems — which problems are not exclusive to the practice of obstetrics — have converged on this specialty, and have created one of the largest access-to-care problems ever seen in the medical profession.

A. The Use of Advanced Technology

Advanced perinatal technology, such as electronic fetal monitors ("EFMs"), is increasingly used in hospitals as a mechanism to manage the risks inherent in childbirth.[27] The use of advanced technology, however, may create as many problems (that could ultimately result in litigation) as it may prevent.[28] Many of the complications that arise in a hospital birth are not found as frequently in a home birth or in a birth that takes place in an alternate birthing center.[29] Accordingly, there are lower rates of malpractice litigation for births that take place in such an environment.

In a routine low-risk delivery, many complications may arise from the inability of the mother to move around during labor.[30] Routine use of IV and fetal monitoring devices restricts the mobil-

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27 *See infra* Part II.B (discussing the use of advanced technologies as an aspect of the practice of defensive medicine); *see also* Charles Wolfson, *Midwives and Home Birth: Social, Medical, and Legal Perspectives*, 37 HASTINGS L.J. 909, 921 (May 1986) (remarking that the "mechanization" of birth by use of EFMs, IVs and other medical apparatus may lead to the use of such technology in both low- and high-risk patients).

28 *See, e.g.*, Wolfson, *supra* note 27, at 918-919.

> Current obstetric practice relies heavily on technology. Home birth proponents view the dramatic increase in perinatal technology as one of the prime disadvantages of hospital birth. They argue that new technology is often rushed into use without rigorous testing and applied prophylactically to all patients without consideration of individual needs.

Id.

29 *See generally* PENNY ARMSTRONG AND SHERYL FELDMAN, A WISE BIRTH 231-41 (1992) (remarking that hospital births generally provide a cold, distant atmosphere, and require the laboring woman to display "superwoman behavior"); CONSTANCE A. BEAN, METHODS OF CHILDBIRTH 270-82 (rev. ed., 1990) ("[M]ost of the studies done of home and hospital birth . . . show that the incidence of birth injuries and obstetric mortality was greater in hospitals. . . ." (quoting Neal Devitt, MD, a resident in family practice at the University of California)); Wolfson, *supra* note 27, at 915 ("From a medical perspective, it is well established that a relaxed, undisturbed environment and positive emotional support promote the smooth progress of labor. Hospital surroundings and attendants, in focusing on the detection of symptoms of abnormality, may produce anxiety-induced complications that would not have occurred in a more favorable environment.").

30 *See, e.g.*, MYLES TEXTBOOK FOR MIDWIVES 171 (V. Ruth Bennett & Linda K. Brown eds., 12th ed. 1993) (citing C.M. Andrews and M. Chrzanowski, *Maternal Position, Labor, and Comfort*, 3 APPLIED NURSING RESEARCH 7-13 (1990)); Kay Kakol, *Position in Labour — Does Mother Know Best?*, 4 PROF. NURSE 482 (July 1989) (discussing the growing demand of women for alternative labor positions).

ity of the mother.[31] The use of these devices, combined with some hospitals' policies that the mother must stay in bed, often make it more difficult for the fetus to move down the birth canal, which can stall or prolong labor.[32] Inability of a laboring woman to move around freely may also hinder the baby's turn from a posterior position to the normal "face down" delivery position.[33] This can lead to a forceps delivery or Cesarean section.[34] The slowing of labor increases the likelihood that Pitocin will be used to speed delivery or make contractions "more effective."[35] The use of Pitocin can also increase the risk of a forceps delivery or Cesarean section.[36] All of these factors increase the risk of injury to both mother and child.[37]

Additional beliefs that mother should not eat during labor can lead to excessive fatigue, either slowing labor or making contractions less effective, for which IV glucose solutions generally cannot compensate.[38] The use of the aforementioned devices can also increase the tension of the mother, resulting in complications during labor and delivery.[39]

There are many legitimate justifications for the use of perinatal technologies, especially in a high-risk pregnancy. In a routine, normal delivery, however, their use is frequently misplaced and may lead to complications during delivery, which ultimately can result in litigation. It is worth comparing the success rates — both in terms of lower birth-related injuries and greater birth-experience satisfaction — and the lower rates of malpractice litigation arising from births which take place either at home, in an alternate birthing center, or those attended by a certified nurse-midwife in a hospital under the supervision of a certified nurse-midwife.[40] Even

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31 *See generally* BEAN, *supra* note 29, at 67, 137-40 (discussing epidural anesthesia); 175-80 (discussing external EFMs); 180-82 (discussing internal EFMs); 184-92 (discussing IVs).

32 *See* Kakol, *supra* note 30, at 481-83.

33 *See* BEAN, *supra* note 29, at 65, 82, 83, 119, 137-40, 175, 178-79, 180-82, 190, 191; *see also* Bob Condor, *Drugs Make For Happy Birth Days*, CHI. TRIB., Nov. 12, 1995, at 1 (reporting the impact of monitoring devices and drugs on the progress of women's labor).

34 *See* BEAN, *supra* note 29, at 65, 205.

35 *See id.* at 139.

36 *See id.* at 137-39, 164-65.

37 *See supra* notes 27-36 and accompanying text (reciting some of the factors that may increase the risk of birth injury).

38 *See* BEAN, *supra* note 29, at 189-91.

39 *See id.*; *see also* Wolfson, *supra* note 27, at 918-23 ("[C]ritics [of hospital birth] counter that [the increased use of C-sections represents] the cumulative effect of obstetric inventions that act to make the woman tense, stymie her physiological process and prevent her from laboring normally.").

40 *See* BEAN, *supra* note 29, at 189-91; *see also* Allan Richards, *The Rebirth of Midwives*, SUN-SENTINEL, Feb. 5, 1995, at 12 (recounting the decision of several women to deliver in midwife-operated birth centers, and discussing the overall increase in women opting to deliver in such centers).

when the use of perinatal technologies does not adversely impact on a woman's ability to labor effectively, these devices may dehumanize the birth process, thereby leading to lower rates of birth-experience satisfaction[41] and damage to the physician-patient relationship.

B. Problems with the Physician-Patient Relationship and Communication

The modern relationship between a physician and her patient is paradoxical. Patients no longer put their physician on a pedestal, and yet they have unrealistic expectations about what a doctor can do.[42] As a consequence, when something goes wrong the patient is more willing to sue.[43] Concomitantly, the attitudes of OBs have contributed to the number of claims brought against them.[44] Obstetricians "have convinced themselves, and the public, that healthy newborns are the result of their good obstetrical care. However, a corollary of that thinking is that a less-than-healthy newborn must be the obstetrician's fault."[45] Recent studies, however, refute the belief that a less-than-perfect newborn is the OB's fault. For example, cerebral palsy, one of the more frequent diagnoses attributed to physician negligence and resulting in malpractice litigation, is no longer considered to result exclusively from complications during delivery.[46]

Problems with the way in which doctors and patients view each other have become so apparent that some physicians now report

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41 *See* Wolfson, *supra* note 27, at 918-923; *see also* Kakol, *supra* note 30, at 483 ("Women appear in a more holistic way than a medical frame of reference allows. If they fail to realise their expectations, they may experience a sense of failure in an act that is culturally held to be the primary achievement of womanhood.").

42 *See* ARMSTRONG AND FELDMAN, *supra* note 29, at 127-28 ("When one thinks of all the factors that contribute to birth outcome — genetics, nutrition, exercise, family, psychological preparedness, birth climate, and so on, the burden accepted by obstetricians is preposterous. It implies that they should be able to reverse all that has compromised a woman's birth beforehand.").

43 *See* Rice, *supra* note 19, at 99-100 ("Patients come [to the Medical Clinic of Houston] with the highest of hopes, because this is the mecca of health care. When things don't work out well, their level of disappointment is equally high. A sophisticated lawyer can take advantage of that feeling. . . ." (quoting Carlos Hamilton, an internist at the Medical Clinic of Houston)).

44 *See infra* pp. 7-11 and accompanying notes (examining the ways in which the physician-patient relationship impacts a patient's decision to bring a malpractice claim).

45 John M. Freeman, MD & Andrew D. Freeman, JD, *Cerebral Palsy and the 'Bad Baby' Malpractice Crisis: New York State Shines Light Toward the End of the Tunnel*, 146 AM. J. DIS. CHILD. 725, 725 (June 1992) [hereinafter *Bad Baby*] ("Because cerebral palsy is a result of damage to the brain and because a lack of oxygen at birth *can* cause brain damage, many physicians still wrongly believe that perinatal asphyxia is a common cause of [cerebral palsy].").

46 *See id.* at 725-26.

that a rift has developed between themselves and their patients. With increasing frequency, "the doctor and patient view each other as potential adversaries."[47] Doctors blame what they perceive as "overzealous patient-plaintiffs for a litigation-powered malpractice crisis," while patients are more willing to challenge their doctors' competence.[48]

Statistics confirm that "[t]here [are] significant differences in the way in which the sued physician and the suing patient viewed their relationship prior to the malpractice claim."[49]

> Two thirds of the sued physicians thought that they had been open and honest with their patients, but only one third of patients agreed, and one fifth stated that their physicians had been dishonest. While many of the sued physicians and suing patients agreed that their doctor-patient relationships were characterized by good communication, 33% of patients and 11% of physicians said a low level of communication existed. In . . . one fourth of the patient responses, there was a lack of respect for the physician and a lack of confidence in the treatment plan — critical deficits for the success of any regimen and obvious precursors to a malpractice claim.[50]

It is clear that patients want information and most physicians intend to provide it, but what the physician says may not be exactly what the patient hears. Physicians who are pressed for time may rush the visit, thereby causing the patient to perceive a lack of concern on the physician's part.[51] Or worse, a rushed visit may cause the patient to feel that the physician might have missed something, thereby eroding a sense of trust and competence in the care she is receiving.[52] If a physician uses excessive medical jargon, or underestimates the patient's desire for information and provides too little discussion of the patient's condition, she may be perceived by the patient as patronizing or paternalistic.[53] Hence, doctors are no longer being told to "soothe patients ['Everything is going along

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47 Thomas P. Hagen, Note, *"This May Sting A Little" — A Solution To The Medical Malpractice Crisis Requires Insurers, Doctors, Patients, And Lawyers To Take Their Medicine*, 26 SUFFOLK U. L. REV. 147, 165-66 (1992) (noting that physicians who have undergone malpractice litigation view patients' lawyers as the source of their suffering).

48 *Id.* at 166.

49 Robyn S. Shapiro, JD, et al., *A Survey of Sued and Nonsued Physicians*, 149 ARCH. INTERN. MED. 2190, 2192 (1989) (assessing the impact of malpractice litigation on the doctor-patient relationship).

50 *Id.* at 2194.

51 *See* Wendy Levinson, *Physician-Patient Communication; A Key to Malpractice Prevention*, 272 J. AM. MED. ASS'N. 1619, 1620 (1994) (discussing common factors that put physicians at risk of being sued for malpractice).

52 *See id.*

53 *See id.*

fine'] if a minor problem appears."[54] This approach, researchers have found, tends to increase a patient's surprise and anger when something serious develops, often leading to litigation.[55] "Once an adversarial element creeps into the interchange, the deterioration of the relationship perpetuates the potential for misunderstanding and anger, and sets the stage for a lawsuit. Moreover, the dissolution of the therapeutic alliance enhances the likelihood that a doctor will avoid high-risk patients."[56]

Research clearly demonstrates that a troubled doctor-patient relationship and inability to communicate effectively are pivotal factors in malpractice litigation.[57]

> Researchers at Vanderbilt University in Tennessee who studied Florida obstetricians concluded that difficulty in communicating effectively increased vulnerability to lawsuits. In one study, researchers found that women who recalled being dissatisfied with their obstetricians were treated by doctors who had the highest number of claims against them — an average of five per year. Women treated by those doctors said that they spent less than 10 minutes per visit with them, and the women felt ignored and rushed. In contrast, women who reported being satisfied with their doctors were treated by doctors who were never sued. In a second study, researchers examined the quality of medicine practiced by the Florida obstetricians. They found that the doctors who had high rates of malpractice claims had the same level of ability as the doctors who had never been sued. The absence of a connection between the quality of care and the number of lawsuits led the researchers to conclude that obstetricians' behavior is a dominant factor in malpractice lawsuits.[58]

Consistently, a recent study published in the Journal of the American Medical Association (the "Satisfaction With Care Study") revealed that the degree of dissatisfaction a patient experienced with her physician was highly correlated with malpractice litigation.[59] The patients of physicians who had never been sued ap-

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54 Andrew H. Malcolm, *Fear of Malpractice Suits Spurring Some Doctors to Leave Obstetrics*, N.Y. TIMES, Feb. 12, 1985, at A1 (discussing the types of behavior found in the doctor-patient relationship that can increase the chance of a lawsuit).

55 *See id.*

56 *Medical Professional Liability, supra* note 2, at 86.

57 *See* Gastel, *supra* note 5, at 12.

58 *Id.*

59 *See* Gerald B. Hickson et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction With Care*, 272 J. AM. MED. ASS'N. 1583, 1588 (1994) [hereinafter *Satisfaction With Care*] (concluding that patient dissatisfaction results largely from a physician's poor communication skills, and that such poor skills frequently result in malpractice litigation); *see also* Stephen S. Entman, MD, et al., *The Relationship Between Malpractice Claims History and Subsequent Obstetric Care*, 272 J. AM. MED. ASS'N 1588, 1590 (1994) (concluding that there is

peared to be the most satisfied.[60] The results of the Satisfaction With Care Study indicated that:

> Women were most likely to complain about aspects of patient-physician communication. The most frequently cited problem was the perception that a physician would not offer information or that they would not listen. Closely related were complaints about the human aspects of the care provided, often a perceived lack of concern or respect for the patient. . . . Patients whose deliveries were attended by High Frequency physicians offered the largest number of complaints. Almost a third of these patients expressed dissatisfaction concerning some aspect of physician-patient communication. Patients in the High Frequency group were particularly critical of their physicians' interpersonal skills. Many indicated that they had been yelled at and that they believed their physicians had no concern for them.[61]

The two groups of physicians who had never been sued were more likely to be seen by their patients as concerned, accessible, and willing to communicate.[62]

The Satisfaction With Care Study also demonstrated that the theory that high malpractice rates in obstetrics are attributable to physicians who serve high-risk populations of medically or demographically vulnerable patients is not supportable.[63] The physicians in the Satisfaction with Care Study served populations that were similar with respect to socio-demographic and medical variables. Indeed,

> the patients whose deliveries were attended by No Claims and All Others physicians should have been more dissatisfied. [The]

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not necessarily a relationship between prior claims, experience, and the technical quality of a physician's current practice).

60 *See Satisfaction With Care, supra* note 59, at 1585-86.

61 *Id.* at 1585.

> Almost a third of mothers seeing High Frequency physicians claimed they spent less than 10 minutes on average with their physician during a visit. Perhaps as a result, more of these mothers indicated that they felt rushed while obtaining prenatal services. Mothers who saw High Frequency physicians also were the most critical of the care they received during labor and delivery. More than any other group, they felt that they were ignored and that no one would tell them what was really happening. . . .

Id. The Satisfaction With Care study defined High Frequency as:

> [Physicians] with at least 0.57 closed claim per exposure-year but whose payments per exposure-year were less than the mean. Overall, physicians in the High Pay and High Frequency groups averaged 5.04 claims each during the target years. Most of the physicians in the High Pay and High Frequency groups (73.6%) had more than eight suits during the 7-year period, with 10 having 11 claims filed against them.

Id. at 1584.

62 *See id.* at 1586.

63 *See id.* at 1586-87.

> study design led those groups to have more than twice as many perinatal and neonatal deaths, and analysis of patients' responses revealed that satisfaction decreased in the face of an adverse outcome. Yet, these women, despite their disproportionately more frequent adverse outcomes, tended as a group to be more and not less satisfied with the care they received.[64]

The authors of the Satisfaction With Care Study concluded that it appeared that the patients' assessment of the technical quality of the care they received may have been affected by their perceptions of their physicians' interest and concern.[65] The fact that "physicians are sued frequently, but relatively unsuccessfully, suggests that the higher level of their patients' interpersonal complaints is the source of their malpractice experience."[66]

A similar study which examined deposition transcripts from malpractice litigation involving obstetrical care (the "Litigation Study") demonstrated that four types of communication problems were consistently present in more than seventy percent of the depositions: deserting the patient, devaluing patients' views, delivering information poorly, and failing to understand patients' perspectives.[67] Perhaps most revealing, however, both the Litigation Study and Satisfaction With Care Study demonstrated that there was little or no objective evidence of malpractice in the cases reviewed, yet physicians were sued for malpractice.

Statistics, however, demonstrate that there are some positive aspects to the fear of malpractice liability. "Among the changes reported were the increased use of . . . written informed consent, more frequent consultations with other physicians, increased attempts to provide written or tape-recorded information to patients, and more frequent explanations of the potential risks of a recommended procedure."[68] While this may be evidence of the defensive nature of the particular physician's practice, it may also be evidence of an open dialogue between the doctor and patient.

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64 *Id.*

65 *See id.* at 1586 ("The . . . results [of the study] support [the] hypothesis that the frequency with which physicians are sued is related in part to patients' satisfaction with interpersonal aspects of medical care.").

66 *Id.*

67 *See* Levinson, *supra* note 51, at 1619 ("Breakdowns in communication between patients and physicians and patient dissatisfaction are critical factors.").

68 *Medical Professional Liability, supra* note 2, at 86 (discussing the findings of a 1985 survey conducted by ACOG).

C. The Plaintiff Attorney and the Tort System

While the physician-patient relationship may be one factor contributing to the malpractice crisis, so may be the plaintiff's attorney.[69] As jury awards have increased in obstetrical malpractice cases — as high as 90 million dollars[70] — the incentive to bring these actions increases for the malpractice attorney working on a contingency basis.[71] According to one source, one of the nation's leading malpractice lawyers, Jack Olender, made fifteen million dollars without setting foot in a courtroom.[72]

Lawyers may be tempted to bring weak or frivolous claims, aware of the fact that many OB/GYNs would rather settle than spend time and money defending even a meritless claim.[73] Many doctors are insured only for two or three-million-dollar awards and cannot afford to cover the difference if the jury award exceeds their coverage.[74] Thus, many doctors won't take the risk of going to trial and are willing to settle. The plaintiff's attorney will recover a sizeable fee in settlement when there may never have been physician negligence in the first place. A quick $10,000 - 20,000 settlement, for very little work, can provide the resources (as well as the profit) for an attorney to prosecute a complex million-dollar malpractice claim. Axiomatically, the number of settlements an insurer must pay will ultimately drive up the premium for the

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69 *See* Calkins, *supra* note 5, at 4 ("Obstetrics say there are two main villains in the malpractice crisis — lawyers and the insurance industry. Opinions vary as to which villain should be considered most to blame.").

70 *See* Annemarie Franczyk, *OB/GYN Doctors Back Bill to Limit Malpractice Suits*, BUS. FIRST-BUFF., Feb. 1, 1993, at 6, *available in* 1993 WL 3277544. High awards are not uncommon in jury trials. *See, e.g.* Wells, *supra* note 21, at 1 (discussing the case of Edward Leahy, Jr., who was born in Virginia in 1984 with brain damage, and was awarded a $10 million verdict, which was then believed to be the largest jury verdict in Washington, D.C. history); *Ayes v. Shah*, 997 F.2d 762, 766 (10th Cir. 1993) (affirming a jury verdict in the amount of $21 million for birth-related injuries).

71 *See* Isaiah J. Poole, *Doctors Bet on Trials in Malpractice Cases*, WASH. TIMES, March 26, 1991, at B3 ("What's really happening is that this has turned out to be a big bonanza for the lawyers. . . ." (quoting Lawrence Mirel, a lobbyist)); *see also* Franczyk, *supra* note 70, at 6 (reporting that doctors are backing a bill that would call for a compensation board to review complaints against doctors and limit the number of cases proceeding to court).

72 *See* Poole, *supra* note 71, at B3.

73 *See* Rice, *supra* note 19, at 104. *But see* Kirk B. Johnson et al., *A Fault-Based Administrative Alternative For Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1368 (1989) ("Significant evidence suggests that a substantial number of potential claims are never brought into the civil justice system.").

74 *See generally* Stutts, *supra* note 23, at 1A ("The obstetrician's insurance covers $3 million in liability. If the case goes to court, and the plaintiff is awarded $5 million, $2 million comes out of the doctor's pocket.").

physician, just as if he had gone to trial and been required to pay a large jury award.[75]

One advantage, however, to litigating malpractice claims is the ability to have a neutral third party hear the grievance. High jury awards may also be seen as an advantage to the tort system.[76] These awards are presumed to provide lifetime care for the most seriously injured.[77] Additionally, these awards are seen as a deterrent to future malpractice, and can compensate families for unnecessary and avoidable pain and suffering.

Statistics, however, reveal that less than one third of the award or settlement actually goes to the injured victim or family.[78] In addition, high jury awards do not effectively serve as a deterrent to malpractice when they are viewed as providing an incentive for plaintiffs' attorneys to bring claims. Instead of trying to improve practice as a result of legitimate malpractice claims, so many claims are being brought that OBs have become overly defensive in their practice of medicine.[79] And as noted, the high jury awards may only serve to induce physicians to settle claims, rather than litigate real issues of liability.

Another problem with the tort system and the obstetrical malpractice crisis, according to some commentators, is the use of expert witnesses. For example,

> [e]xpert witnesses in these cases may or may not have documented expertise in the relationship of perinatal hypoxicischemic injury to brain damage. The witnesses' expertise is rarely documented in the literature where it could be subjected to peer review. The courts permit these alleged experts to offer opinions that may be idiosyncratic and far from the mainstream.[80]

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75 *See, e.g., Vasquez v. Marks,* Index No. 26776/85 (Sup. Ct. N.Y. Co., April 14, 1993), *cited in* 13 VERDICTS, SETTLEMENTS & TACTICS 169 (1993) (awarding the plaintiff-patient a settlement in the amount of $2.9 million).

76 *See* David L. Sieradzki, *Throwing Out the Baby with the Bathwater: Reform in the System for Compensating Obstetric Accidents,* 7 YALE L. & POL'Y REV. 538, 540-41 (1989) ("As tort law provides some plaintiffs with higher and higher damage awards, malpractice insurance carriers have raised their premiums to obstetric care providers in order to cover their costs.").

77 *See id.* at 540 ("Infants with birth injuries usually need expensive, comprehensive medical care and often require life-long care and assistance.").

78 *See id.* at 556 ("[O]nly 30% to 40% is received by injured patients in compensation for injuries; in other words, 66 cents out of every dollar recovered by plaintiffs is consumed by attorneys' and expert witnesses' fees and court costs." (citing P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE & PUBLIC POLICY 186-87 (1985))).

79 This aspect of the problem is not, of course, limited to obstetricians.

80 *Bad Baby, supra* note 45, at 725.

Many of these experts "work exclusively as professional advocates for the plaintiff or for the defense, rather than as experts for the courts. . . ."[81] Thus, an expert witness may inadequately inform the jury awarding damages, may serve to increase confusion of liability issues, and may serve to increase the bias in the system.

If deterrence is the primary goal of malpractice litigation, there are more effective systems which ensure that competent OBs can continue to provide care, and which compensate those who have suffered an injury as a result of medical malpractice.[82]

II. The Effects of the OB Crisis

A. *Access to Care and the Delivery of Obstetrical Services*

High malpractice rates and issues of professional liability adversely affect the delivery of obstetrical services, especially to disadvantaged women, those living in rural areas, and those with high-risk pregnancies.[83]

> According to surveys undertaken by the National Governors Association in all fifty states, sixty percent of Medicaid programs and almost ninety percent of maternal and child health programs are having trouble ensuring participation of maternity care providers in sufficient numbers. Nine out of ten report that the rising costs of malpractice insurance have contributed to their problems. . . . [D]ata supported the conclusion that the cost of malpractice insurance further reduced the already low Medicaid participation rates of obstetrical providers in most jurisdictions. . . . [T]he allocated cost of insurance exceeded Medicaid's reimbursement rate in most areas. Medicaid reimbursement rates were lower than malpractice premiums alone, not counting other overhead costs. . . .[84]

Moreover, according to the New England Journal of Medicine, the fear of being sued has "caused academic medical centers to change the ways in which medical students are taught and evaluated, and to reassess the amount of hands-on experience medical students and house staff should be allowed. . . ."[85]

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81 *Id.*

82 *See infra* Part IV (setting forth a novel paradigm for reform).

83 *See Medical Professional Liability, supra* note 2, at 83-84 (discussing the findings of the Institute of Medicine's Study Committee); *see also* Taylor, *supra* note 16, at 523 ("In many rural areas where a large portion of the patient base is poor and uninsured, the return of obstetrical providers is not likely without some form of subversion or incentive.").

84 *Medical Professional Liability, supra* note 2, at 83-85.

85 Gastel, *supra* note 5, at 12 (discussing a study by the New Engalnd Journal of Medicine); *see also infra* note 177 (discussing the defensive paradigm embraced by many physicians and attitudes prevalent in medical training).

B. The Practice of Defensive Medicine

The practice of defensive medicine is another effect of the malpractice crisis.[86] Fear of being sued if complications arise in a vaginal delivery has contributed to the rising number of Cesarean sections.[87] A study published in the Journal of the American Medical Association indicated that "insurance premiums were almost triple in some regions [in New York state] what they were in others, and odds of Cesarean delivery in the high-premium areas were three times greater than in low-premium areas."[88] Experts admit that, while there are legitimate reasons for doing Cesarean sections, those reasons alone do not support the rate at which Cesareans are performed.[89]

A 1989 study by the Committee to Study Medical Professional Liability and Delivery of Obstetrical Care conducted by the Division of Health Promotion and Disease Prevention of the Institute of Medicine indicated that many academic obstetrical departments have implemented a mandatory policy of delivering all breech fetuses by Cesarean, "mainly because of the medical liability climate."[90] A recent study by the Office of Technology Assessment (the "OTA Study") determined that while there was only limited evidence that fear of malpractice litigation induced the overall practice of defensive medicine, it also concluded that the strongest evidence for the existence "of liability-induced defensive medicine was found in a study of [C]esarean deliveries in New York State. [The OTA Study] examined the impact of malpractice risk on [C]esarean deliveries and found that a systematic relationship between the rate of [C]esarean surgical procedures and malpractice

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86 The practice of defensive medicine is both a cause and effect of the problem. Initially, defensive medicine was thought to lead to a lower incidence of malpractice claims. The more careful a doctor was the less likely he was to make a mistake and be sued. However, the practice of defensive medicine is now leading to birth injuries and serves to weaken the doctor-patient relationship, thus increasing the adversarial nature of the relationship. *See* supra Part I.B. *But see* Sieradzki, *supra* note 76, at 555 ("[Problems of defensive medicine] are traceable to distortions from fee-for-service health insurance rather than malpractice lawsuits.").

87 *See* Okie, *supra* note 19, at A25; *see also* Clements, *supra* note 12, at 24 ("[A]t the first sign of potential trouble from the EFM, physicians tend to opt for the C-section." (citing Kenneth V. Heland, head of ACOG's Department of Professional Liability)); Emmet B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice Between Vaginal Delivery and Cesarean Section*, 71 MILBANK Q. 365, 365 (1993), *available in* LEXIS, News Library, AsapII File [hereinafter *Economic Incentives*] ("In 1989[,] . . . Cesarean section . . . was the most common . . . surgical procedure in the United States, accounting for 24 percent of all deliveries, more than four times the 1970 rate of 5.5 percent.").

88 *Frequency of C-Sections Linked to Legal Claims*, SACRAMENTO BEE, Jan. 20, 1993, at A1, *available in* 1993 WL 7420737.

89 *See id.*

90 Clements, *supra* note 12, at 24.

claim frequency exists."[91] Researchers at Pennsylvania State University similarly found that "the odds of Cesarean deliveries at hospitals were fifteen percent higher if doctors there, as a group, had been sued more than a certain number of times in the previous four years."[92] This data supports the conclusion that Cesareans are being performed out of a practice of defensive medicine and fear of lawsuits.[93]

Cesarean delivery is not the only unnecessary technique frequently used out of fear of lawsuits. The use of EFMs, IVs, ultrasound, Pitocin, and a variety of other medical tools are generally used to avoid both complications and malpractice litigation.[94] The benefit imparted by perinatal technology, however, is questionable, and often leads to further medical interventions.

> [L]egal pressure to create a record that can be defended has made EFM the standard of care in many places. [However,] EFM may result in false positive identifications of fetal distress, thereby starting a technological cascade that ends in a C-section. [Estimates indicate] that an additional 96,500 C-sections were performed for this reason in 1978.[95]

While the number of Cesarean sections is increasing, recent studies have demonstrated that this procedure has done little to decrease the number of babies born with cerebral palsy or other types of brain damage.

> We've been up to 26% C-sections, with the cases of cerebral palsy not decreasing at all. . . . CP incidence stays exactly the same. . . . If one believes we should have fewer cases of cerebral palsy or brain damage with C-sections, that's just not the case.[96]

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91 Michael Daly, *Attacking Defensive Medicine Through The Utilization of Practice Parameters*, 16 J. LEGAL MED. 101, 105 (1995).

92 *Frequency of C-Sections Linked to Legal Claims*, *supra* note 88, at A1.

93 *See* Clements, *supra* note 12, at 24 ("So why are so many babies still being delivered by C-section with EFM? It's called defensive medicine."); *Bad Baby*, *supra* note 45, at 725 (remarking that, as a result of the malpractice crisis, many OB/GYNs will perform a C-section just to preempt a future malpratice suit for wrongful birth).

94 *See supra* Part I.A (setting forth the technology commonly used in hospital births, and discussing the ways in which such technology influences labor).

95 *Economic Incentives*, *supra* note 87, at 365 (citations omitted).

96 Clements, *supra* note 12, at 22 (quoting Norman R. Schindler, Senior Claims Officer in Medical Liability for the St. Paul Fire and Marine Insurance Co.). *See also Economic Incentives*, *supra* note 87, at 365.

> Electronic fetal monitoring (EFM) is a prime example in obstetrics of the technological imperative to use new devices, without much consideration of costs or of their marginal advantage over older methods. EFM use skyrocketed in the 1970s because of the promise of identifying fetal problems in time for successful interventions. Unfortunately, EFM has failed to live up to that promise. In the eight published clinical trials, EFM did not help outcomes, whether for normal or for high-risk preterm deliveries.

One commentator's statement exemplifies the concerns regarding the relationship between the use of perinatal technology and the practice of defensive medicine.

> Obstetricians have developed technology such as fetal monitoring that 'reassures' them that the fetus is fine. They then respond to a fetal monitoring strip that is less than reassuring by performing a cesarean section. If they do not intervene, and if that infant later has [cerebral palsy], then their colleagues freely state, 'I would have done a cesarean section earlier and the infant would not have suffered brain damage.'[97]

Thus, the practice of defensive medicine as evidenced by the increasing use of perinatal technologies may not be effective to prevent or reduce the number of birth injuries, and may create a tense or hostile environment that may ultimately result in litigation.

C. Rising Health Care Costs

The defensive use of perinatal technologies also drives up the overall cost of health care.[98]

> Because a C-section requires a surgical cut to the abdomen, women typically must spend about five nights in the hospital instead of two. There are also the added costs of using an operating room and anesthesiology, as well as the additional fee that an obstetrician will charge for doing a Cesarean. . . . Of the four million live births in 1990, there were approximately 949,000 Cesarean births. Almost half of those operations were unnecessary and led to $1.3 billion in [extra] costs. . . .[99]

The widespread use of EFM increases cost as well. In 1989, direct charges for EFM were approximately $100 per monitored delivery. In contrast, two studies showed that matched patients supervised by certified nurse-midwives had lower charges for hospital services, be-

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Id. (citations omitted).

97 *Bad Baby, supra* note 45, at 725. *See* Clements, *supra* note 12, at 24 ("[D]octors will continue using EFM, because most (two-thirds) claims against obstetricians cite improper use of EFM, according to a recent study of 54 closed obstetrical claims by the Risk Management Foundation of the Harvard Medical Institutions Inc.").

98 *See* Tigner, *supra* note 15, at 3 ("[T]he medical center charges about $1300 for a normal delivery and $4000 for a Cesarean section delivery.").

99 *Frequency of C-Sections Linked to Legal Claims, supra* note 88, at A1. *See* Clements, *supra* note 12, at 24 (noting one study which estimated the annual cost attributable to EFM and associated C-sections exceeded $750 million). *But see* Eleanor D. Kinney, *Malpractice Reforms in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99, 124 (Spring 1995) ("[A] recently completed study of defensive medicine by the [OTA] suggests that defensive medicine does not greatly affect health system costs.").

cause they were less frequently given EFM and anesthesia services.[100]

Doctors report other subtle changes in the way they treat patients as a result of their fear of malpractice liability, which changes serve to increase health care costs. In a 1983 study by the American Medical Association ("AMA Study"), "seventy percent of physicians surveyed claimed to have recently modified their medical practices in response to liability risks. . . ."[101] For example, the AMA Study indicated that doctors increased time spent with patients by 2.4 percent, had 2.6 percent more follow-up visits, prescribed 3.2 percent more tests and treatment procedures and spent 2.9 percent more time on record-keeping.[102] Those practice changes increased health care costs an average of $4,600 per physician — more than three times the average increase in malpractice premiums.[103]

III. Reforming the System

Despite the statistics, some critics still claim there is no malpractice crisis.[104] Instead, these commentators believe that malpractice claims are legitimate, that doctors need to practice better medicine, and that there needs to be more peer review and supervision in the delivery of medical care.[105] According to one survey, "[a]pproximately 96% of the patients and 66% of nonsued physicians said that physician error and/or negligence was an important or major factor in malpractice actions."[106] As one malpractice at-

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100 *See Economic Incentives, supra* note 87, at 365.

101 Scott Norris, *Doctors on the Defensive*, 6 Rochester Bus. J. 13, 13-14 (Sept. 17, 1990), *available in* 1990 WL 271004 [hereinafter *Doctors on the Defensive*] (discussing the ways in which professional liability has changed the patterns of medical practice).

102 *See id.* at 14. This extra time spent with patients could improve the malpractice crisis in obstetrics if the physician uses the time to enhance her relationship with her patient. *See supra* pp. 11-18 and accompanying notes (examining the high correlation between dissatisfied patients and malpractice litigation).

103 *See Doctors on the Defensive, supra* note 101, at 14.

104 *See, e.g.*, W. John Thomas, *The Medical Malpractice "Crisis": A Critical Examination of a Public Debate*, 65 Temp. L. Rev. 459, 485-86 (1992) (discussing findings of the Harvard Study and noting that

> [t]he Harvard Study . . . compared the incidence of negligence with the number of malpractice claims made by lawsuit or written or oral demand and concluded that 'the number of negligent adverse events was eight times the number of tort claims.' . . . [T]he Harvard Study's findings indicate that 'we do not now have a problem of too many claims; if anything, there are too few.'

(quoting Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York 11-4 (Report of the Harvard Medical Practice Study to the State of New York 1990))).

105 *See, e.g., Tougher Peer Review of Doctors Urged*, N.Y. Times, June 18, 1985, at C3 ("The president of the American Medical Association has called for the nation's doctors to police their colleagues better. . . .").

106 Shapiro, *supra* note 49, at 2192.

torney described the tension, "[t]he medical industry is using money to change the law rather than to eliminate unacceptable practice. . . . If they would put their great brains toward eliminating malpractice, it would solve the problems of the patients and themselves."[107] However, the OTA Study recently confirmed that there is evidence of a malpractice crisis in the obstetric industry, and numerous other studies reveal — at the very least — significantly higher rates of malpractice litigation for OBs. Indeed, even if there were no statistical evidence to support such a conclusion, the fear of a crisis is a self-fulfilling prophecy: if doctors believe a crisis exists, they may drop out of practice or alter their procedures as a result of their misplaced fear.[108]

There are many ways to reform the system. Both the Bush and Clinton Administrations proposed federal legislation designed to improve the delivery of healthcare services, lower healthcare costs and reform the system.[109] Virginia[110] and Florida[111] have enacted no-fault tort systems. Virginia's system incorporates a medical review panel[112] and the use of a trust fund-like system, known as a "Compensation Fund."[113] The use of such funds provides a single source of money to reimburse birth-related injuries.[114] Often this money is pooled from physicians, hospitals, clinics, and insurance companies.[115] Florida, as well as other states, has enacted legislation which encourages the use of nurse-midwives.[116] Some states are attempting to cap physician liability, while others are establishing review committees that are designed to determine whether certain birth injuries should be compensated and in what amount.

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107 Wells, *supra* note 21, at 1.

108 One commentator has pointed out: "[T]o the extent that a crisis is in fact widely perceived, it has the quality of a self-fulfilling prophesy: if doctors believe, rightly or wrongly, that malpractice suits are out of control, they will practice more defensively, which will further fuel rampant health care spending." Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 LAW & CONTEMP. PROBS. 119, 119 (Spring 1991).

109 For comprehensive discussion of this legislation, see Ann C. McGinley, *Foreword: Aspirations and Reality in the Law and Politics of Health Care Reform: Examining a Symposium on (E)qual(ity) Care for the Poor*, 60 BROOK. L. REV. 7, 18-27 (1994) (discussing the Clinton plan and other national programs); W. John Thomas, *The Medical Malpractice "Crisis"; A Critical Examination of a Public Debate*, 65 TEMP. L. REV. 459, 503-526 (1992) (discussing the Bush administration proposal).

110 *See* VA. CODE ANN. §§ 38.2-5000-21 (Michie 1994 & Supp. 1997).

111 *See* FLA. STAT. ANN. § 467.001-004 (West 1991).

112 *See* VA. CODE ANN. § 38.2-5008(B).

113 *Id.* § 38.2-5015. *See* Sieradzki, *supra* note 76, at 538 (suggesting that the liability crisis would improve if states adopted alternative compensation systems).

114 *See* Sieradzki, *supra* note 76, at 549.

115 *See id.*

116 FLA. STAT. ANN. § 467.001-004. *See generally* Katherine Simmons Yagerman, *Legitimacy For the Florida Midwife: The Midwifery Practice Act*, 37 U. MIAMI L. REV. 123 (1982) (discussing Florida's enactment of the Midwifery Practice Act).

Maine is attempting to use practice paradigms to reform its tort system.[117]

A. Virginia No-Fault Tort Reform

In 1988, Virginia enacted the Virginia Birth-Related Neurological Injury Compensation Act (the "Act").[118] This legislation was designed to alleviate the obstetric malpractice crisis in that state.[119] Not only had Virginia experienced high jury awards, record numbers of malpractice claims and high premiums, but two of the state's major malpractice insurance carriers had refused to issue any new policies for obstetricians.[120] A third carrier had threatened significant limitations on obstetrical coverage.[121] Since nearly one fourth of the state's OBs would have lost insurance coverage, the Medical Society of Virginia drafted legislation designed to bring the existing insurance carriers back into the market by limiting the risk attached to the delivery of certain profoundly injured newborns.[122] The legislation removed the most catastrophic injuries from the tort system in an effort to reduce awards and increase the predictability of the tort system. The goal was to effectuate increased and renewed coverage, and ultimately lower premiums for OBs.[123]

The Act narrowly defines the type of injury for which recovery is available. Only "birth-related neurological injur[ies]" are covered by the Act.[124] These injuries are defined as:

> [I]njury 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) . . . cognitively disabled, . . . [and] in need of assistance in all activities of daily living. This definition shall apply to live births only. . . .[125]

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117 *See generally* Mehlman, *supra* note 8, at 143-44 (discussing Maine's plan to reduce patient injuries by prescribing practice standards).

118 VA. CODE ANN. §§ 38.2-5000-21. *See also* Peter H. White, Note, *Innovative No-Fault Tort Reform For an Endangered Specialty*, 74 VA. L. REV. 1487, 1487-88 (1988) [hereinafter *Innovative Reform*] (examining the passage of the Virginia Birth-Related Neurological Injury Compensation Act, which was the nation's first no-fault compensation law dealing exclusively with medical liability).

119 *See* White, *supra* note 118, at 1487.

120 *See id.*

121 *See id.* at 1488.

122 *See id.* at 1489.

123 *See id.*

124 VA. CODE ANN. § 38.2-5001.

125 *Id.*

The Act does provide for a civil action against a "physician or a hospital where there is clear and convincing evidence that such physician or hospital intentionally or willfully caused or intended to cause a birth-related neurological injury, provided that such suit is filed prior to and in lieu of payment of an award. . . ."[126]

The Act also creates a Compensation Fund (the "Compensation Fund")[127] and Board of Directors (the "Board").[128] The Board members are appointed by the Virginia State Governor.[129] Physicians and hospitals voluntarily participate in the program. Voluntary participants pay $5,000 per annum into the Compensation Fund,[130] while nonparticipating OBs pay $250[131] and hospitals pay a sum equivalent to $50 per number of births for the previous year.[132] Each non-participating hospital has a contribution cap of $150,000 per year.[133] There are additional mechanisms to obtain money if this fails to adequately maintain the Compensation Fund.[134] No money for the Compensation Fund comes from state revenues.

Claims are evaluated by the Virginia Workers' Compensation Commission (the "Commission").[135] A panel of three physicians appointed by the deans of the state's medical schools review each claim, and report to the Commission on whether the injury falls within the statutory scheme.[136] This provision establishes objective professional review and evaluation, in lieu of expert medical testimony.[137] Each claim is also sent to the state licensing board for a determination on physician competence and standard of care.[138]

Injuries are compensated only for "net economic loss," including medical expenses, rehabilitation, residential and custodial care and services, special equipment, and related travel.[139] There is a provision for loss of wages (limited to 50% of the average weekly state wage),[140] but there is no compensation for pain and suffer-

126 *Id.* § 38.2-5002(C).
127 *See id.* § 38.2-5015.
128 *See id.* § 38.2-5016.
129 *See id.* § 38.2-5016(C).
130 *See id.* § 38.2-5020(A).
131 *See id.* § 38.2-5020(D).
132 *See id.* § 38.2-5020(C).
133 *See id.*
134 *See id.* § 38.2-5020(E).
135 *See id.* § 38.2-5003.
136 *See id.* § 38.2-5008(B).
137 *See id.*
138 *See id.* § 38.2-5008(A)(6).
139 *See id.* § 38.2-5009(1).
140 *See id.* § 38.2-5009(3).

ing.[141] The Act also provides for medical care for low-income women.[142]

There are several problems with the Act. First, the definition of injury is so small as to create a negligible number of claims in any given year. In fact, according to one source, "only a handful of claims have qualified each year under the statute, and no claim has been filed."[143] Second, the injuries described by the Act are so severe that many of the newborns will die shortly after birth.[144] Although this is a no-fault system, the compensable injuries are so severe and the filing of claims so minimal that defensive practices are likely still operative. While the Act provides for automatic review by the state's licensing board[145] if the number of claims is as small as suggested, effective quality of care will not take place, because so few physicians will be reviewed. Nor is there enough incentive for physicians to participate in the program. After the Act was passed by the Virginia Legislature, however, one insurance carrier lifted its moratorium on new policies and a new carrier entered the market.[146] The Act, therefore, ensured, to an extent, that OBs would not quit practicing due to lack of malpractice coverage.

B. The New York Legislation

On March 2, 1993 and again in the summer of 1995, New York State Senator, Michael J. Tully, Jr., introduced legislation to amend the public health law in relation to compensation of neurologically impaired infants.[147] This legislation provides a system whereby a corporation (the "Corporation") with a Board of Directors (the "Board") comprised of appointed medical and legal professionals will evaluate claims of neurological injury allegedly resulting from physician negligence or other birth injury.[148] The Corporation will utilize a neurological impairment scale to determine which claims qualify for compensation.[149] A compensable event is defined as:

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141 *See* Sieradzki, *supra* note 76, at 549-50.

142 *See* VA. CODE ANN. § 38.2-5001.

143 BARRY R. FURROW ET AL., *supra* note 104, at 443.

144 *See* Sieradzki, *supra* note 76, at 540.

145 *See* VA. CODE ANN. § 38.2-5004(C).

146 *See Innovative Reform*, *supra* note 118, at 1499 (examining the success of the Injured Infant Act).

147 *See* S. 4900, 218th Gen. Assembly, 1st Reg. Sess. (N.Y. 1995); S. 3177, 215th Gen. Assembly, 1st Reg. Sess. (N.Y. 1993); *see also* A. 5538, 220th Annual Legis. Sess. (N.Y. 1997); A. 8192, 218th Gen. Assembly, 1st Reg. Sess. (N.Y. 1995); A. 8793, 214th Gen. Assembly (N.Y. 1991), *cited in Bad Baby*, *supra* note 45, at 726. The text of these bills is identical. In the interest of space and clarity, in referring to the language of these bills, this article will cite to the 1995 version of the bill.

148 *See* N.Y. S. 4900 § 4902(1).

149 *See id.* § 4902(4).

> [A] non-progressive impairment of brain or spinal cord which occurred or which could have occurred during pregnancy, during labor, during delivery or in the immediate resuscitation period after delivery which results in a significant impairment in central nervous system function rendering infant substantially handicapped.[150]

Importantly, this is a much broader definition of a compensable event than that set forth by the Virginia Act. If the Board determines that physician negligence was responsible for the birth injury, the Board will refer those cases to the board of professional medical conduct for review.[151] The Board will compensate for all medically necessary and reasonable services, including medical, hospital, rehabilitation, residential, custodial care, incidental living expenses, prescription drugs, special equipment and facilities, and travel related to any of the aforementioned services and items.[152] Expenses not included are those the infant is entitled to receive or has received under the laws of the state or the federal government, or any items the infant is entitled to receive under any prepaid health plan, or for which the infant has been reimbursed.[153] Similar to the Virginia Act, the New York legislation establishes a trust fund, out of which compensation will be made.[154] Expenses incurred to establish the trust fund will be derived from a hospital excess liability pool enacted by another New York state statute.[155]

C. Caps on Liability

One proposal for reform is to enact a cap on liability.[156] Such a system maintains the traditional tort/litigation features but limits the amount and type of award recoverable for certain injuries. For example, limitations can be placed on jury awards to provide only for out-of-pocket losses, with no recovery for pain and suffering. When losses are subjective, as they are with pain and suffering damages, the cost of determining the extent of plaintiff's loss can be high. Jury awards for similar injuries tend to "vary precisely . . .

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150 *Id.* § 4901(1).

151 *See id.* § 4907(4).

152 *See id.* § 4909.

153 *See id.*

154 *See id.* § 4912.

155 *See id.*

156 This type of reform was included in several of the federal and many of the state tort reform proposals. *See, e.g.*, Kinney, *supra* note 99, at Appendix A & B (listing and analyzing state and federal tort reform proposals).

because of the subjectivity of both the suffering and [the] jury's valuation of it."[157]

Alternatively, or additionally as is the case with worker's compensation schemes, scheduled sums above out-of-pocket losses may be awarded.[158] A percentage system[159] may be established, whereby estimated percentages of physician fault weighed against estimated percentages for inability to determine cause of injury are utilized to ascertain the amount of damages above out-of-pocket losses, with a total cap on those damages not based on economic losses. Although a cap-based system is likely only to reduce insurance premiums, and not the practice of defensive medicine,[160] when used in conjunction with other mechanisms this method of reform may be highly effective.

IV. AUTHOR'S PARADIGM FOR REFORM

A. Improving the Doctor-Patient Relationship

Modern medical practice increasingly precludes physicians from taking the time to sit down and get to know their patients. Many doctors feel overburdened by the increased patient workload presented by managed care. Many public hospitals are closing, and private hospitals cannot accommodate the overflow of the uninsured and critically ill and still take time to "talk" to patients. However, it has never been more important than it is now for physicians, and OBs primarily, to take the time to establish a relationship with their patients.[161] Medicine, and obstetrics in particular, is

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157 BARRY R. FURROW ET AL., *supra* note 104, at 437.

158 *See id.*

159 Out-of-pocket losses awarded in medical malpractice actions may be calculated under a percentage system, which system is similarly used in comparative or contributory negligence schemes.

160 *See Defensive Medicine and Medical Malpractice*, 14 PEOPLE'S MED. SOC'Y NEWSL. 1, 8 (Feb. 1995) (discussing the findings of the 1994 OTA Study, and concluding that caps on damages and other traditional tort reforms would only negligibly reduce the practice of defensive medicine); *see also OTA Inconclusive on Defensive Medicine*, 20 HEALTH LEGIS. & REG. (June 29, 1994), *available in* 1994 WL 2615838 ("[I]n what may be a real blow to malpractice reformers, however, the report states that the traditional reforms being considered by Congress, such as caps on non-economic damage awards, 'reduce malpractice premiums but their effects on defensive medicine are largely unknown and are likely to be small.'" (quoting 1994 OTA Study)) .

161 Studies and anecdotal evidence consistently reveal that the relationship between doctor and patient is a critical element in determining whether a patient will sue. *See, e.g.*, Bonnie Henry, *Home Delivery and Naturopath Lauds Sense of Control in Family Setting*, ARIZ. DAILY STAR, July 23, 1995, at 1G, *available in* 1995 WL 3278391 ("Studies show the people who get sued are someone the patient doesn't know."); Rice, *supra* note 19, at 100 ("Most [plaintiffs] have no prior relationship with their doctors, and therefore little reluctance to sue if something goes wrong."); *see also supra* pp. 11-18 and accompanying notes (analyzing the ways in which the doctor-patient relationship influences a patient's decision to sue for malpractice).

an art as well as a service. Most American women have more than one child. Thus, the OB who can establish a good relationship with her patient has the promise of repeat business. Respecting the patient and treating her as you might a client therefore goes a long way toward ensuring a happy, healthy new family, securing future business and avoiding malpractice litigation.

One newspaper article recently instructed the medical consumer, when looking for a new physician, to consider

> how the doctor conducts the physical exam. . . . Does the doctor or nurse meet you before you are asked to undress? Does he or she call you by first name before asking permission? Look you in the eye? Seem comfortable answering questions, seem genuinely interested in you, and volunteer information about his or her practice style?[162]

If prospective patients can be persuaded or convinced to choose an OB based in part on the preceding criteria, then OBs are well advised to consider these factors when treating patients.[163] Consideration of these elements in the physician-patient dialogue ensures a comfortable, trusting relationship between the two which could ultimately sway or deter a patient from suing.[164]

Additionally, OBs can improve communication with their patients by better understanding patients' attitudes toward doctors. Patients have specific misconceptions about physicians and the practice of medicine,[165] while cultural and educational influences affect a woman's views and expectations about labor and delivery. Doctors, too, have misconceptions about patient motivations for

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162 Sue Scheible, *A Very Personal Choice, Choosing The Right OB-GYN is Crucial to Women's Comfort, Medical Care*, PATRIOT LEDGER, Oct. 25, 1994, at 19, *available in* 1994 WL 9470058 (discussing some of the common factors considered and questions asked by women selecting OB/GYNs).

163 "Patients also express a desire to have a relationship with their physician that feels personal, caring and respectful. . . . Dissatisfied patients may feel that physicians focus on them only as a disease process. . . . As demonstrated [in the *Satisfaction With Care* Study,] dissatisfied patients may perceive that their physicians did not show concern for them personally." Levinson, *supra* note 51, at 1620. *See also* Helen Varney Burst, CNM, MSN, *Issues and Concerns of Healthy Pregnant Women*, 102 PUB. HEALTH REP. 57-61 (July-Aug. 1987), *available in* LEXIS, News Library, AsapII File ("Angry, educated and articulate consumers . . . have written about their childbearing experiences and their belief that change can and must be effected in maternity care.").

164 "There are lots of qualified people out there, but if a woman isn't comfortable telling her doctor her problems, then you're not going to get very far." Scheible, *supra* note 162, at 19. *See also* Johnson, *supra* note 73, at 1372 (noting that "[s]ome patients refrain from suing because they rely upon and trust their medical care providers and do not wish to disrupt a longstanding physician-patient relationship").

165 *See supra* p. 7 and accompanying notes (asserting that patients have unrealistic expectations about what a doctors can do).

bringing malpractice suits. "Most misconceptions can be eliminated through education."[166]

Thus, the physician and the mother must discuss the type of pregnancy the mother expects to have, how she envisions her life while she is pregnant, and what is realistic in that view. They must reach an agreement about what is healthy and what is risky behavior for the mother to engage in, relative to that mother's lifestyle. The physician must also assess cultural differences as they may pertain to lifestyle and expectation, and evaluate the mother's support system. Additionally, and perhaps as important, there should be open and free discussion among all birth participants (those present during labor and delivery) about what type of experience each expects to have.

The physician and the mother should discuss the fears of each participant, and what can be done to alleviate that fear. Dialogue should certainly consider what type of medication or anesthesia is to be used and when, what type of authority structure will be established, and what the hospital or birthing center may impose as rules and policies. One commentator has stated that perhaps most important is

> taking enough time to listen to the patient or elicit enough of a history so that, according to the revered aphorism, [she] can provide you with the diagnosis. Equally important, listening provides the opportunity for identifying hostile, aggressive, or excessively passive patients and for evaluating the family support system and other aspects of the patient's background that are helpful in establishing good rapport. When communicating information to the patient, make sure that all instructions are given orally and, if possible, summarized in writing, in language that is clear, devoid of medical jargon or esoteric acronyms, and suitable to the linguistic and educational level of the individual.[167]

In addition to giving individual patients a thorough explanation of procedures and risks, one commentator has suggested that physicians should provide their community with consumer education seminars about their specialties, and that doctors should also prepare public service announcements for local television and radio

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166 Dorothy M. Allison, *Physician Retaliation: Can the Physician-Patient Relationship Be Protected?*, 94 DICK. L. REV. 965, 988-89 (1990) (advocating that doctors can shield themselves from malpractice if they restore patient trust by educating patients about procedures and risks).

167 Brad Cohn et al., *Protecting Yourself From Malpractice*, PATIENT CARE, at 53 (Aug. 15, 1990), *available in* 1990 WL 2637078 (enumerating the main reasons malpractice suits arise, and suggesting ways in which doctors can minimize the risks).

stations that encourage patients to ask questions of their doctors.[168] "A small amount of time donated by doctors to educate their patients [could] go a long way toward preventing future lawsuits and will help restore patient trust in the medical profession."[169]

A. Re-Training Physicians and the Use of Certified Nurse-Midwives

As the practice of defensive medicine becomes the omnipresent approach and paradigm to childbirth, it has been observed that mothers (and couples) who experience a high degree of technological innovation during the birth process concomitantly have a lower degree of birth-experience satisfaction.[170] While dissatisfaction with the birth experience is not in itself sufficient to get a family into court, it may be the final impetus when there is evidence of malfeasance. Additionally, lack of satisfaction with the birth-experience may damage the physician-patient relationship by destroying the underlying foundation of trust that must exist between the doctor and patient.[171] If a woman (or couple) feels that her doctor acted too aggressively or failed to intervene early enough, the woman's satisfaction with her birth experience is more likely to deteriorate over time.[172]

The discussion of birth-experience satisfaction seems to center on the premise that women and couples today are happier with the less aggressive birth environment.[173] According to this theory, women have an overall more positive feeling about the labor process when fewer diagnostic tools and other techniques characteristic of defensive medicine come into play.[174] Women and couples experiencing delivery in such an environment demonstrate higher rates of satisfaction with the delivery and birthing process.[175] Consistent

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168 *See* Allison, *supra* note 166, at 989 (suggesting methods with which physicians can improve communication with their patients).

169 *Id.*

170 *See supra* Part I.A (examining the high correlation between the use of extensive perinatal technology and low birth-experience satisfaction).

171 *See Medical Professional Liability*, *supra* note 2, at 86, 90-91 (discussing the erosion of physician-patient trust).

172 *See Bad Baby*, *supra* note 45, at 725; *see also Satisfaction With Care*, *supra* note 59, at 1585.

173 *See, e.g.*, Kakol, *supra* note 30, at 483 (discussing mothers' satisfaction with the process of labor and child-birth).

174 *See* ARMSTRONG AND FELDMAN, *supra* note 29, at 245-49 (discussing the transition of the Pennsylvania Hospital from a sterile hospital environment to a warm birthing center-like environment); *see also* Wolfson, *supra* note 29, at 918-19 ("Home birth proponents view the dramatic increase in perinatal technology as one of the prime disadvantages of hospital birth.").

175 "[P]arents complain about the high-tech atmosphere of many doctor-assisted hospital deliveries, which can strip a woman of her dignity and responsibility and turn childbirth into an event that more closely resembles a medical emergency than a natural occurrence."

with this theory, there are lower rates of malpractice litigation in alternative birthing centers, home births, and hospital births which are considered "normal" and require little interference from practitioners.[176]

The "normal" (*i.e.*, less technologically invasive) birth is more difficult to identify, because doctors are *trained to expect* a complicated birth requiring the utilization of EFM, IVs, and Cesarean sections.[177] Many hospitals in fact mandate the use of certain technologies as a mechanism to attempt the control of birth-related injury and malpractice. Both doctors and patients argue now that these techniques, traditional to those practicing defensive medicine, are both unnecessary and probably accrue no real benefit to the physician.[178] Furthermore, they serve to alienate the mother.[179] Hence, this theorist would posit that if doctors can be re-trained to expect a normal delivery, to avoid intervening in a routine delivery with expensive and intrusive technologies, and to attempt to de-medicalize the birthing experience, one aspect that may lead to malpractice litigation may be reduced.[180] If women and couples are happier with the birthing process, they may be

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Jane E. Brody, *Midwives Lead a Revolution in Quality of Obstetric Care*, N.Y. TIMES, Apr. 28, 1993, at C11.

176 *See supra* pp. 5-7 and accompanying notes (discussing the reportedly greater birth-experience satisfaction and lower rates of litigation derived from delivery in less technologically invasive settings).

177 *See Study: Obstetrics Suits Make Doctors Wary*, CHI. TRIB., Oct. 12, 1989, at 5 [hereinafter *Study: Obstetrics Suits Make Doctors Wary*].

> [T]here are medical schools in this country that are teaching students, 'don't do a vaginal breech delivery because if the baby turns out badly, you are at risk and you will be sued'. . . . Medical students are told they have a stronger legal position if they perform a cesarean section because of the perception that 'you've done everything that can be done.

Id. See also Wolfson, *supra* note 29, at 922.

> Virtually the entire focus of medical training is on the detection and treatment of complications of pregnancy and labor and related interventions. The result of this preoccupation is a continual narrowing of the concept of 'normality' as obstetricians seek ways to employ their skill at treating and correcting the abnormal. Technology is heavily emphasized; thus, routine use of technology increases, and manual skills are lost through disuse.

Id. See generally ARMSTRONG AND FELDMAN, *supra* note 29, at 129-141 (discussing the influence of medical textbooks, residency and day-to-day practice and its impact on obstetricians' perception of normal birth).

178 *See Defensive Medicine and Medical Malpractice, supra* note 160, at 8 ("The [OTA Study] did find . . . that the costs of defensive medicine are high and the benefits very small.").

179 *See id.*

180 *See* Hickson et al., *supra* note 59, at 1589.

> [P]rofessional societies and organizations should make interpersonal skills a focus of continuing medical education for all physicians. These organizations and perhaps even malpractice insurers might consider performing periodic surveys of patient satisfaction in various practices and offer more intensive evaluation or intervention to physicians who score poorly or experience high levels of claiming. Medicine needs to reaffirm its commitment to the truth that care involves more than technical expertise. Increasing patients' satisfaction with

more likely to view their doctor with normal degrees of respect and trust rather than the animosity that sometimes leads to litigation.

The use of nurse-midwives will also reduce the incidence of birth-related litigation, and lower the overall cost of obstetrical care.[181] OBs who utilize the services of nurse-midwives in their practice report reduced work-loads, and a significant percentage of the mothers express a high degree of satisfaction with the care they receive from the nurse-midwife.[182]

At the request of the Senate Committee on Appropriations, the OTA conducted a comprehensive review of two decades of studies which examined the efficacy of using advanced practice nurses in providing quality lower-cost care.[183] The OTA concluded that certified nurse-midwives can satisfy the medical needs of 50% to 90% of patients, and can provide care "whose quality is equivalent to that of care provided by physicians."[184] Other statistics clearly reveal that at least 75% of routine obstetrical care can be provided by nurse-midwives, and that less than 8% of nurse-midwives have been sued compared to 85% of OBs.[185]

In addition to reducing the work loads of practicing OBs, nurse-midwives can alleviate the crisis with respect to access to care. Medically underserved areas can utilize nurse-midwives as a low-cost, safe and effective means of providing care to pregnant women.[186] In fact, one economist has estimated that the cost to the welfare system of not utilizing nurse-midwives (and other advanced

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the care they receive should be a central goal of all efforts to improve health care.

Id. *See also* Clements, *supra* note 12, at 25 (noting that the study concluded that improved communication is one of the easiest ways of avoiding future malpractice claims).

181 *See The Cutting Edge; Vital Statistics — What Childbirth Costs*, WASH. POST, Aug. 30, 1994, at Z5 (reporting that the average cost of a mid-wife delivery in 1987 was $874, as opposed to an obstetrician delivery, which averaged approximately $3,983); *see also* Melissa Fletcher Stoeltje, *Born At Home*, HOUS. CHRON., Jan. 29, 1995, at 1 ("Studies have shown [certified nurse-midwives] provide care that is safe, high-quality and woman-centered. They spend more time with patients. They use far less technology. They have a cesarean-section rate less than half of doctors. They are sued far less. They cost less to train.").

182 *See generally* Leslie Kraft Nesse, *Managed Care Changing Obstetrics Practices*, S. FLA. BUS. J., Mar. 10, 1995, at B1, *available in* 1995 WL 8253947 (discussing obstetricians' employment of and reliability on nurse-midwives to reduce their workload and provide personalized attention to patients).

183 *See* Linda H. Aiken and William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 AKRON L. REV. 187, 195 (1992) [hereinafter *Advanced Practice Nurses*] ("Nurse anesthetists administer more than sixty-five percent of all anesthetics in the United States. Nurse practitioners diagnose illness, prescribe medications and provide comprehensive general health care in a variety of clinical settings."); *see also* Office of Technology Assessment, U.S. Congress, Health Technology Case Study 37, *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis* (1986).

184 *Advanced Practice Nurses*, *supra* note 183, at 195.

185 *See id.*

186 *See id.* at 196.

practice nurses) can cost up to $8.75 billion annually.[187] Current research indicates that the use of nurse-midwives can also reduce the cost to consumers by more than $4 million annually.[188] It thus appears that if the services of nurse-midwives are utilized, the cost of care will be reduced,[189] the rate of obstetric litigation will decrease, access to care will increase, malpractice insurance premiums will stabilize or be reduced, and more OBs will be able to provide care to those who need or want their services.

C. Use of Administrative Review Board and Compensation Fund

This fault-based system would do away with the tort system, or could be a hybrid where an expert review panel would determine technical issues and submit them to the jury during trial. The review system would require that claims be filed before a board comprised of local medical and legal experts. Appointment of these board members would be for a limited number of years to ensure non-biased participation, thus avoiding the inherent conflicts presented by electoral systems. This board would review the claims and determine physician negligence/fault (if any), whether the injury was avoidable, whether the cause of injury is determinable, and/or whether there was a parental role in injury (genetic, accident or parental negligence/failure to follow physician orders). This board could also determine the expected economic losses and award the family a sum (either payable by the physician and the hospital or from a compensation fund) based on economic and a schedule of non-economic losses.

The need for uniformity of outcome would support creation of this system through legislative enactment, as opposed to creation of this committee by private contract. Additionally, to ensure uniformity, the board should be trained and educated as a group and determine claims independently of individual hospital influence. Such a system would require uniform awards across the region or state, otherwise similar injuries in different regions would receive disparate compensation. This system would provide the deterrence of the tort system as it maintains the fault-based analysis, but would reduce the amount recoverable by placing limits on non-economic awards, thereby removing the subjectivity of laymen analyzing medical procedures and providing some degree of certainty for insurance carriers as to liability and risk. The system

187 *See id.* at 193.
188 *See* Stoeltje, *supra* note 181, at 1.
189 *See id.*

could be coordinated with review for physician competence by licensing agencies, either through mandatory review by claim, or on recommendation by the board, thus ensuring quality of care.[190] To maintain Constitutional requirements, families could waive their right to review by the board and take their chances in a court system. Hopefully, people would prefer to use the administrative system, because recovery of economic losses would be more likely, and resolution of claims would be faster than in the court system. Furthermore, those physicians brought into court would be willing to litigate liability issues, because malpractice rates — over the long term — would have been reduced by the administrative system.

A compensation fund could be established in a variety of ways. A fixed rate system is the most even-handed to all contributors. This would require each contributor to pay a fixed fee per year, ensuring that the amount is high enough to fund adequately all injuries each year, but not so high as to present a hardship to smaller practices or not-for-profit clinics. Dissimilarly, a system based on a proportional or fee per delivery system might induce physicians, hospitals, or insurance companies to reduce services in order to reduce their contribution. Mandatory participation would ensure coverage and compensation to all, without discrimination. Mandatory financial participation may also encourage physicians, hospitals and clinics to utilize the system for resolution of claims against them as their economic contribution will not benefit them if, instead, they rely on the court system.

Insurance companies would only be required to reimburse physicians for those damages based on non-economic losses calculated on a scale which takes into consideration the degree of physician fault, the type of injury and parental contribution to injury (if any). Premiums would go down because the subjectivity of a jury's valuation would be eliminated. Accordingly, the amount of awards would be reduced as well. If a particular physician was consistently paying non-economic damages, that insurance carrier could raise its premiums accordingly, thereby deterring physician error. As noted, patterns of negligence would be addressed quickly by a licensing board or other designated quality of care reviewing agency.

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190 In fact, "[t]he AMA-Specialty Society, comprised of the [AMA] and 31 national medical specialty societies, including the American College of Obstetricians and Gynecologists, . . . have proposed that a state administrative agency have power both to resolve medical liability disputes and to discipline doctors." Mary A. Cavanaugh, Note, *Bad Cures For Bad Babies: Policy Challenges to the Statutory Removal of the Common Law Claims for Birth-Related Neurological Injuries*, 43 CASE W. L. REV. 1299, 1323-24 (1993).

Peer review would also be provided by this system. Since the reviewing committee would be made up of local professionals, physicians would be deterred from acting negligently for fear of damage to their community reputation. Additionally, since the committee would be comprised in part by medical professionals, dialogue as to treatment approaches could be incorporated into the system. The reviewing committee could submit non-binding written reports to the hospital and physician as to what they believed a proper or alternative course of treatment would have been. If a mandatory review process is established — where local physicians, hospitals and clinics submit all cases involving suspected birth-related injuries — there would be automatic quality-of-care review, and access to the review process would be ensured for those who might otherwise not have the resources to file a claim. Alternatively, the system could be based solely on a claimant-based filing system. Finally, if the administrative system is established solely for obstetric injury, not only can the system be implemented at lower cost but the process of alleviating the crisis will be accelerated as the workload for the system should not be unmanageable. Swift resolution of claims will relieve the crisis faster than a system that is overburdened by a heavy caseload involving a variety of malpractice injuries in a variety of medical disciplines.

CONCLUSION

The aforementioned problems are interrelated. The interdependency of issues concerning physician and patient attitudes and relationships and medical/technological approaches in providing obstetrical care has created a tautology system of treatment necessitating a gestalt approach to reform. Once-promising defensive practices are now exacerbating the problem. If we are to see an overall improvement in the system, the primary question of reform must focus on mechanisms and methods in order to reduce malpractice claims, insurance premiums, *and* defensive practices and ensure access to care. No approach designed to solve only one aspect of the problem will be effective in alleviating this crisis because of the interdependency of the issues.