NOTES

WHEN TORT FALLS SHORT: CRISIS, MALPRACTICE LIABILITY, AND WOMEN'S HEALTHCARE ACCESS

*Baldemar Gonzalez**

An approaching shortage of OBGYNs threatens the demands of a growing population of reproductive-age women. This threat is exacerbated by a shaky medical–legal structure that places a disproportionate burden on the OBGYN profession—a burden that patients are ultimately left to share. This Note explores the delicate interaction between medical malpractice litigation, the high-risk OBGYN profession, and patients' access to healthcare. It then examines the shortcomings of the current liability-based system in harmonizing these often dissonant pieces. Finally, this Note argues that the federal government should pick up where the states have fallen short and adopt comprehensive rather than stopgap solutions to an issue demanding more than a quick fix. A solution that stabilizes liability pressures for OBGYNs will preserve women's access to healthcare while better serving victims of medical malpractice.

INTRODUCTION

Current discourse on women's healthcare focuses far too often on the "what" of the services provided, neglecting the more important "who." A looming shortage of practicing obstetricians and gynecologists (OBGYNs) to meet the growing national demand threatens women's access to healthcare.[1] The threat is exacerbated by medical malpractice litigation, which, though necessary to achieve justice for the wronged, places an enormous

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1. For the purpose of this Note, "access to healthcare" primarily refers to access to obstetric services. This definition, in keeping with the sources cited, does not encompass men's access to obstetric services. Cf. Denise Grady, Responding to Critics, Gynecology Board Reverses Ban on Treating Male Patients, N.Y. Times (Jan. 30, 2014), https://www.nytimes.com/2014/01/31/health/responding-to-critics-gynecology-board-reverses-ban-on-treating-male-patients.html (on file with the *Columbia Law Review*) (discussing the controversy surrounding industry efforts to limit the scope of obstetric care only to that which is provided to women). Moreover, though this Note focuses only on the role of medical malpractice litigation in reducing women's access to healthcare, it acknowledges the potential impact of other barriers such as those created by disability, geography, poverty, race, ethnicity, cultural differences, sexual orientation, and gender identity.

burden on the OBGYN profession. Malpractice litigation not only distracts and demoralizes but also increases the cost of professional liability insurance, making it difficult for OBGYNs to maintain affordable liability coverage. OBGYNs may then pass on prohibitively high costs to consumers, refrain from providing costly procedures, or relocate or retire early—changes in clinical practice that ultimately limit women's access to OBGYN services. These changes commonly reflect the trickle-down effects of a medical malpractice crisis.

These effects underscore the need for tort reform in the realm of medical malpractice. With little movement on the federal level, states have attempted to address medical malpractice crises head-on: by reforming the medical–legal environment in order to alleviate high liability insurance costs, expecting relief from liability to not only benefit practitioners but also clear a potential barrier to women's healthcare access. Yet these reform efforts only chip away at the boundaries of the medical malpractice system, leaving the current structure largely in place. Indeed, these efforts have failed to assuage fears of medical malpractice crises; they are mere stopgap solutions to an issue demanding more than a quick fix.

This Note, in contrast, argues for a lasting and comprehensive approach to the liability insurance system for OBGYNs. More specifically, it proposes federal no-fault compensation for birth-related neurological injuries—typically the costliest and most frequent ground for suits against OBGYNs[2]—to stabilize and reduce liability insurance premiums for OBGYNs, thereby preserving women's access to healthcare while also providing more efficient compensation to victims of birth-related injuries.

Part I of this Note begins by describing the interaction between medical malpractice litigation, the OBGYN profession, and patient healthcare access. It then identifies conventional tort reforms enacted in response to previous medical malpractice crises. Part II details the shortcomings of the current liability-based system in meeting its goals, maintaining sustainable numbers of OBGYN practitioners, and assuaging continuing concerns about medical malpractice crises. It also examines the challenges of expanding no-fault compensation at the state level by considering constitutional objections raised against analogous reforms. Finally, in Part III, this Note argues for a national no-fault compensation program for birth-related neurological injuries as a means of preserving women's healthcare access.

I. AN OVERVIEW OF MEDICAL MALPRACTICE LAW AND LIABILITY

This Part explores medical malpractice law's far-reaching consequences for the U.S. healthcare system, particularly with respect to OBGYNs, and discusses traditional tort reforms attempting to curb its effects. Section I.A

2. See infra note 55 and accompanying text.

examines how medical malpractice litigation adversely affects patients and physicians alike. Section I.B reviews the history of medical malpractice crises and ensuing reforms, introduces no-fault compensation schemes, and discusses relevant federal reform efforts.

A. *Medical Malpractice Litigation and Its Trickle-Down Effects*

Medical malpractice falls under a subset of tort law dealing with negligence.[3] An injured patient may sue a healthcare provider for negligence in rendering care. To be successful, the patient must show that such negligence caused the injury.[4] After making this showing, the patient may recover damages from the provider; these damages can be economic (compensating for actual economic loss such as medical expenses or lost income), noneconomic (for emotional distress), or both.[5] To protect against malpractice suits, providers generally carry malpractice liability insurance, which shields them from liability.[6] This insurance covers the costs of defending and settling a malpractice suit, along with any damages a court awards a successful litigant.[7] As discussed below, this liability insurance is a critical piece in the broader discussion about medical malpractice crisis and reform.

1. *Threats to Obstetric Practices.* — The effects of medical malpractice litigation reach the far corners of the healthcare industry, adversely affecting patients and practitioners alike. Given the potential for severe injury to women and the possibility of lifelong injury to infants at birth, the obstetric field is deemed a high-risk specialty.[8] OBGYNs are more likely than colleagues in other medical specialties to be sued for malpractice.[9] The threat of litigation is real; by one measure, around

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3. See James Gibson, Doctrinal Feedback and (Un)Reasonable Care, 94 Va. L. Rev. 1641, 1654 (2008). Medical malpractice is defined as a healthcare provider's "failure to exercise the degree of care and skill that a physician of the same medical specialty would use under similar circumstances," causing injury or death to the patient. Malpractice, Black's Law Dictionary (10th ed. 2014).

4. B. Sonny Bal, An Introduction to Medical Malpractice in the United States, 467 Clinical Orthopaedics & Related Res. 339, 340 (2009). To prove negligence, a patient must establish (1) the existence of a legal duty owed to the patient; (2) a breach of this duty; (3) an injury caused by the breach; and (4) resulting damages. Id. at 342.

5. Id. at 340.

6. Id.; see also Understanding Medical Malpractice Insurance, Ins. Info. Inst., http://www.iii.org/article/understanding-medical-malpractice-insurance [https://perma.cc/MQ9K-D4ZN] (last visited Jan. 21, 2019).

7. See, e.g., Understanding Medical Malpractice Insurance, supra note 6.

8. See Sarah Domin, Comment, Where Have All the Baby-Doctors Gone? Women's Access to Healthcare in Jeopardy: Obstetrics and the Medical Malpractice Insurance Crisis, 53 Cath. U. L. Rev. 499, 506 (2004).

9. See Gibson, supra note 3, at 1673 (noting that OBGYNs "have historically been targets of lawsuits more often than any other physicians"); Elizabeth Kukura, Obstetric Violence, 106 Geo. L.J. 721, 771 (2018); Domin, supra note 8, at 505–06; OB/GYN Malpractice Insurance, Capson, https://www.capson.com/medical-malpractice-insurance-

three-quarters of OBGYNs are sued at least once and around half are sued three or more times.[10] Furthermore, OBGYNs bear adverse judgments that tend to be greater than those awarded in non-OBGYN malpractice suits.[11] A source estimates that OBGYN cases comprise "three-quarters of all malpractice insurance losses, with an average payment to plaintiffs of over $1.1 million."[12] Accordingly, the medical malpractice system uniquely affects OBGYNs because liability insurance companies decide to charge them correspondingly high premiums, refuse to insure them, or withdraw altogether from high-risk markets, thereby limiting the available choices for affordable coverage.[13]

Economics aside, malpractice litigation imposes emotional burdens on the obstetrical profession. Lawsuits are often traumatizing, and the

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by-specialty/ob-gyn [https://perma.cc/W48P-6CQ2] (last visited Jan. 14, 2019) (citing a fifteen-year study showing that more malpractice claims were brought against OBGYNs than any other specialists); see also Matray, Medscape Malpractice Report 2017 Finds the Majority of Physicians Sued, Med. Liab. Monitor (Nov. 15, 2017), http://medicalliabilitymonitor.com/news/2017/11/medscape-malpractice-report-2017-finds-the-majority-of-physicians-sued [https://perma.cc/B8LJ-FPXG] (finding that eighty-five percent of OBGYNs had been sued, compared with fifty-five percent of general physicians).

10. Kukura, supra note 9, at 771; see also Carol Peckham, Medscape Malpractice Report 2015: Why Ob/Gyns Get Sued, Medscape (Jan. 22, 2016), http://www.medscape.com/features/slideshow/malpractice-report-2015/obgyn (on file with the *Columbia Law Review*) (citing a survey showing that eighty-three percent of OBGYNs had been sued by the age of fifty-four).

11. See, e.g., Gibson, supra note 3, at 1673 (noting that "payments to plaintiffs trend much higher than the malpractice average"); Lindsay J. Stamm, Comment, The Current Medical Malpractice Crisis: The Need for Reform to Ensure a Tomorrow for Oregon's Obstetricians, 84 Or. L. Rev. 283, 287 (2005) ("Damage awards in obstetric-related cases tend to be higher than other malpractice claims . . . ."). OBGYNs are also more likely than physicians in other specialties to lose a medical malpractice trial. Gibson, supra note 3, at 1674.

12. Kukura, supra note 9, at 771; see also Thomas Allan Heller, An Overview of Medical Malpractice Law in the United States Including Legislative and the Health Care Industry's Responses to Increased Claims, 10 Med. L. & Soc'y 139, 147 (2017) (explaining that noneconomic damages awards can be substantial, in some cases "amounting to many millions of damages").

13. See R.W. Hale, Legal Issues Impacting Women's Access to Care in the United States—the Malpractice Insurance Crisis, 94 Int'l J. Gynecology & Obstetrics 382, 384 (2006) (recounting how one of the nation's largest insurers "notified all of their policyholders that they would no longer renew any medical professional liability insurance policies" for OBGYNs); Heller, supra note 12, at 144 (describing the consequences of the increases in medical malpractice claims and payouts); Kukura, supra note 9, at 771 (noting that current malpractice law subjects OBGYNs to comparatively high malpractice insurance premiums); see also Nat'l Conference of State Legislatures, Health Cost Containment and Efficiencies 1 (2011) [hereinafter NCSL], https://www.ncsl.org/portals/1/documents/health/MedicalMalReform-2011.pdf [https://perma.cc/Q336-T4WD] (noting that OBGYNs pay among the highest medical malpractice insurance rates—as much as $200,000 per year or more in some states); Stamm, supra note 11, at 287 ("The frequency and severity of malpractice liability for obstetricians has significantly impacted the practice.").

risk and fear of being sued may adversely shape clinical practices.[14] Fear of malpractice litigation, for example, could produce so-called defensive medicine, a practice in which OBGYNs seek to minimize their legal exposure by prescribing unneeded medication, recommending unnecessary tests and surgeries, or refusing to perform risky procedures or provide care for high-risk patients.[15] An increase in needless patient interventions—or refusals to intervene at all—can cause new injuries,[16] whereupon the bedrock of the patient–physician relationship begins to buckle beneath the pressures of liability.[17]

2. *Threats to Women's Access to Healthcare.* — Changes to OBGYN practices driven by increased liability costs and fear of litigation, in turn, threaten women's access to healthcare.[18] Faced with unsustainable

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14. See Nora Freeman Engstrom, A Dose of Reality for Specialized Courts: Lessons from the VICP, 163 U. Pa. L. Rev. 1631, 1645 (2015) (evaluating the emotional impacts of litigation—including "depression, anger, and frustration"—and noting that physicians "who have been sued are significantly more likely to consider an early retirement, advise their children not to practice medicine, and stop seeing the patients they perceive as more likely to sue going forward").

15. NCSL, supra note 13, at 1; Wendy Netter Epstein, The Health Insurer Nudge, 91 S. Cal. L. Rev. 593, 613 (2018); Allen Kachalia & Michelle M. Mello, New Directions in Medical Liability Reform, 364 New Eng. J. Med. 1564, 1565 (2011) ("An oppressive liability environment . . . can have the unintended effect of 'over-deterrence'—causing unwanted provider practices aimed primarily at avoiding liability." (footnote omitted)); Kukura, supra note 9, at 772; Steven E. Raper, Announcing Remedies for Medical Injury: A Proposal for Medical Liability Reform Based on the Patient Protection and Affordable Care Act, 16 J. Health Care L. & Pol'y 309, 319–25 (2013) (detailing two types of defensive-medicine behaviors—negative and positive—that can "negatively impact the patient"). But see Clarke T. Edwards, The Impact of a No-Fault Tort Reform on Physician Decision-Making: A Look at Virginia's Birth Injury Program, 80 Rev. Jurídica U. P.R. 285, 289, 307–08 (2011) (disputing the prevalence and magnitude of defensive medicine).

16. See Gibson, supra note 3, at 1674 (noting that defensive measures, like increasing the number of cesarean sections performed, "correlate[] positively with . . . [the] number of claims per physician"); Kukura, supra note 9, at 754, 771 ("Medically unnecessary interventions, especially surgeries like cesareans and episiotomies, increase the risk of childbirth complications for women.").

17. See AMA, Code of Medical Ethics § 1.1.1 (2017) ("The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest . . . ."); see also Kukura, supra note 9, at 772–73 (noting how current practices undercut the once-held belief that "defensive medicine would lower rates of malpractice because physicians were being more cautious").

18. See William F. Rayburn, Am. Cong. of Obstetricians & Gynecologists, The Obstetrician–Gynecologist Workforce in the United States: Facts, Figures, and Implications 6–7 (2017) [hereinafter ACOG, OBGYN Workforce] (finding that OBGYNs were likely to change their practices "because of the affordability of insurance, availability of insurance, or both"); Domin, supra note 8, at 507 ("[O]bstetricians are caught in an ironic trap: they can practice only if they have insurance, but insurance is so expensive that the cost prohibits them from practicing."); see also Randall R. Bovbjerg & Frank A. Sloan, No-Fault for Medical Injury: Theory and Evidence, 67 U. Cin. L. Rev. 53, 105 (1998) (finding that physicians who quit obstetrics "often reported that they did so because of the threat of liability claims"); Matthew K. Richards, Comment, The Utah Medical No-Fault Proposal: A

premiums, OBGYNs may retire early,[19] relocate to a different state,[20] or reduce the number of patients they accept, creating shortfalls of available practitioners in some localities.[21] OBGYNs may also offset premium increases in what they charge their patients, making obstetric care prohibitively expensive, especially for low-income women.[22]

The landscape is further complicated by an approaching shortage of OBGYNs to meet the demands of a growing population of reproductive-age women.[23] Costly premiums and fear of litigation coupled with an aging obstetric workforce and insufficient numbers of practitioners entering the field exacerbate the problem.[24] Women also represent an increasing

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Problem-Fraught Rejection of the Current Tort System, 1996 BYU L. Rev. 103, 106–07 (finding that malpractice costs are usually borne by prospective patients because physicians pass premium rates onto patient bills).

19. See Barry Werth, Damages: One Family's Legal Struggles in the World of Medicine 108 (Berkley ed. 1999) (explaining how OBGYNs in malpractice crises were "forced to move, quit, or work for somebody else because they couldn't afford to insure themselves and stay in private practice"); Chandler Gregg, Comment, The Medical Malpractice Crisis: A Problem with No Answer?, 70 Mo. L. Rev. 307, 315 (2005) (finding that costly premiums are "driving some doctors out of their professions" (footnote omitted)).

20. Frank A. Sloan & Lindsey M. Chepke, Medical Malpractice 56 (2008) (stating that "physicians may migrate to areas with relatively smaller premium increases," which increases patient healthcare costs "as the number of physicians in an area decreases"); Imam M. Xierali et al., Relocation of Obstetrician-Gynecologists in the United States, 2005–2015, 129 Obstetrics & Gynecology 543, 546–47 (2017) (finding that "[a]pproximately one in every three ob-gyns moved at least once between 2006 and 2015," and that of over 24,000 relocations during this period, nearly forty-two percent occurred interstate). But see Sloan & Chepke, supra, at 67 (questioning the prevalence of relocation, since "moving to another state for reasons of medical malpractice is a risky undertaking"). Traditionally, the individual states have been the arbiters of medical malpractice law, leading to variance in premium rates by state. See, e.g., Greg Roslund, The Medical Malpractice Rundown: A State-by-State Report Card, Emergency Physicians Monthly (July 21, 2014), http://epmonthly.com/article/the-medical-malpractice-rundown-a-state-by-state-report-card [https://perma.cc/DU76-W6YD] ("Depending on your state, your liability and premiums might be sky high or totally unreasonable."). Physicians may thus elect to move their practices to states offering more affordable premiums.

21. See Jody Stonehocker et al., Is There a Shortage of Obstetrician-Gynecologists?, 44 Obstetrics & Gynecology Clinics N. Am. 121, 127 (2017); Richard E. Anderson, Opinion, OB-GYN Shortage Is Going to Get Worse, Live Sci. (June 27, 2013), http://www.livescience.com/37824-obgyn-shortage-looming.html [https://perma.cc/AX3Y-JPWN].

22. See Domin, supra note 8, at 537–38.

23. See Doximity, 2018 OB-GYN Workforce Study 2 (2018) (projecting a pronounced "shortage of up to 8,800 [OBGYNs] by 2020, and a shortfall of up to 22,000 by 2050"); ACOG, OBGYN Workforce, supra note 18, at 1–8, 12 (finding that "current supply and demand suggest a . . . shortage of ob-gyns that will increase in the future if past standards continue," which may "lead to a diminution of obstetric services"); Timothy M. Dall et al., Estimated Demand for Women's Health Services by 2020, 22 J. Women's Health 643, 645 (2013) (concluding that national demand for services is projected to increase at a six percent rate within the next decade, while the number of practicing OBGYNs is projected to decrease relative to the female reproductive-age population).

24. See IHS Markit, The Complexities of Physician Supply and Demand: Projections from 2015 to 2030, at 39 (2017) (finding that "over one-third of all currently active

proportion of the OBGYN workforce and are more likely than their male colleagues to retire early.[25] As a result, finding and maintaining obstetric services has become increasingly difficult for a growing number of patients.[26]

In short, the fragility of the liability insurance market takes a heavy toll on both patient and physician. The costs of the malpractice system—the looming OBGYN workforce shortage, elevated premiums, and fear of litigation—seriously threaten women's access to healthcare. But these costs are merely manifestations of a flawed tort system that asks high-risk medical specialists, like OBGYNs, to carry a disproportionate burden.

B. *A Pattern of Change and Conservation*

Before considering possible solutions to the foregoing issues, it is instructive to assess how they have previously been addressed. Section I.B.1 examines the measures—collectively referred to as "tort reform"—that states have taken in response to medical malpractice crises. Sections I.B.2 and I.B.3 examine more sweeping reforms—administrative compensation programs for victims of medical injuries.

1. *Waves of Crisis and Ensuing Reform.* — The normalization of medical malpractice suits in tort law is a fairly recent phenomenon. These suits were not commonplace until the 1970s, when the first of three "medical malpractice crises" took place.[27] A medical malpractice crisis is typically characterized by rapidly escalating professional liability insurance premiums, stoking fears that practitioners will be "unable to afford the cost of practicing" and thus "shutter their . . . clinics and either relocate to a less expensive jurisdiction or stop practicing altogether."[28] Indeed, the wave in the 1970s featured withdrawal of liability insurers

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physicians will be 65 or older within the next decade"); ACOG, OBGYN Workforce, supra note 18, at 1–8 (finding a minimal increase in the number of residency positions relative to the female population); Sloan & Chepke, supra note 20, at 56 (acknowledging that "younger physicians may be less prone to enter practice in locations with high premiums"); Kukura, supra note 9, at 771 (noting that "residency programs saw interest in obstetrics decline significantly"); Mattie Quinn, Brace Yourself for an Ob/Gyn Shortage by 2020, Self (Sept. 8, 2017), http://www.self.com/story/brace-yourself-for-an-obgyn-shortage-by-2020 [https://perma.cc/4LKL-U7D9] (explaining that high premiums make it harder to "recruit more medical students into the profession").

25. ACOG, OBGYN Workforce, supra note 18, at 3, 7–8 (finding an increasing number of women surveyed who reported a "likelihood of planning to reduce their clinical work hours or eventually leaving their current practices"). This pattern is particularly troubling, since women are projected to make up around sixty-six percent of the OBGYN workforce in the next ten years. Id.

26. Ellen Neuborne, Is There an Ob-Gyn Crisis?, Parents, https://www.parents.com/pregnancy/giving-birth/labor-support/is-there-an-ob-gyn-crisis [https://perma.cc/F3TZ-KGN2] (last visited Jan. 17, 2019).

27. See Bovbjerg & Sloan, supra note 18, at 61; Gregg, supra note 19, at 312–13.

28. Lydia Nussbaum, Trial and Error: Legislating ADR for Medical Malpractice Reform, 76 Md. L. Rev. 247, 263 (2017); see also Kristie Tappan, Note, Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform?, 46 B.C. L. Rev. 1095, 1096 (2005) (observing that amid crises, "liability insurance [was] less available and less affordable, forcing some physicians to leave the profession").

from the market, which left practitioners with few liability coverage options.[29] The second wave, in the 1980s, gave rise to dramatic spikes in liability insurance costs.[30] And the third, in the 2000s, saw traces of the first two, with insurer withdrawal from the market and soaring liability insurance costs making liability coverage increasingly unavailable or unaffordable.[31]

During these crises, states attempted to moderate the harsh medical–legal environment by adopting various tort reforms so that practitioners would not be driven from their profession.[32] Notwithstanding ongoing debate about the causes of costly malpractice premiums,[33] general consensus recognizes dual sources: large malpractice payouts (through either settlements or court judgments) and excessive frivolous suits.[34] Accordingly, reforms principally sought to lower liability premiums by reducing both the average payout size and the volume of suits filed.[35] This relief from liability was intended to benefit not only practitioners by lowering premiums but also patients by clearing a potential barrier to healthcare access.[36] State measures often took the form of noneconomic damages caps, which limit what a successful plaintiff can recover for subjective

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29. See Bovbjerg & Sloan, supra note 18, at 61; see also Gregg, supra note 19, at 313; Melissa Patterson, Note, The Medical Malpractice Crisis: The Product of Insurance Companies and a Threat to Women's Health, 8 Quinnipiac Health L.J. 109, 113, 119 (2004).

30. See, e.g., Bovbjerg & Sloan, supra note 18, at 61–62; Jill Horwitz & Troyen A. Brennan, No-Fault Compensation for Medical Injury: A Case Study, Health Aff., Winter 1995, at 164, 166 ("Between 1980 and 1986 premiums for Florida OB/GYNs rose 395 percent.").

31. See Gregg, supra note 19, at 314–15 (explaining that some of the nation's largest malpractice carriers withdrew from the medical liability insurance market and that, for some doctors, annual premiums rocketed from $40,000 to $200,000).

32. See NCSL, supra note 13, at 1–3; Bal, supra note 4, at 344–45; Gregg, supra note 19, at 319.

33. One line of thinking suggests that insurance premiums are tied to the natural fluctuations in the economy, with no correlation between premium rates and payments in medical malpractice suits. See, e.g., Nussbaum, supra note 28, at 264 (pointing to a confluence of economic factors as possible drivers behind cyclical increases in liability insurance costs); Patterson, supra note 29, at 130–34 (positing that "insurance companies have been the true cause of their own market losses by making poor investments and by trying to undercut their competitors' premium rates in spite of falling profits"); Carrie Lynn Vine, Comment, Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps, 26 N. Ill. U. L. Rev. 413, 421 (2006) (discussing studies showing that "the timing and severity of [medical malpractice] crises is better explained by fluctuations in the bond market"). However, this view fails to explain why market fluctuations do not similarly affect other insurance industries, like automobile insurance or workers' compensation, suggesting there are other relevant external factors in determining the causes of medical malpractice crises. See Vine, supra, at 422.

34. See Gregg, supra note 19, at 318–19; Horwitz & Brennan, supra note 30, at 166.

35. See NCSL, supra note 13, at 1.

36. See id.

damages, such as pain and suffering.[37] Unlike economic damages, the subjectivity in quantifying mental anguish makes calculating noneconomic damages a tougher endeavor, often leading to more unpredictable and costly payouts.[38] Naturally, reform to noneconomic damages was low-hanging fruit for state legislatures.

California, for instance, enacted the Medical Injury Compensation Reform Act (MICRA) in 1975, which capped noneconomic damages at $250,000.[39] The Act helped stabilize premium costs; insurance rates rose in substantially smaller increments than those in the rest of the country.[40] Some states, encouraged by MICRA's apparent success, implemented similar caps,[41] while others turned to alternatives like pretrial screening panels,[42] limits on attorneys' fees,[43] certificate-of-merit requirements,[44] collateral-source rule reform,[45] joint and several liability

37. See Tappan, supra note 28, at 1097; Vine, supra note 33, at 414. Twenty-five states currently impose caps on noneconomic damages in medical malpractice cases. See Alaska Stat. § 09.17.010 (2018); Cal. Civ. Code § 3333.2 (2018); Colo. Rev. Stat. § 13-64-302 (2018); Haw. Rev. Stat. § 663-8.7 (2018); Idaho Code § 6-1603 (2018); Iowa Code § 147.136A (2019); Kan. Stat. Ann. § 60-19a02 (West 2018); Md. Code Ann., Cts. & Jud. Proc. § 3-2A-09 (West 2018); Mass. Gen. Laws Ann. ch. 231, § 60H (West 2018); Mich. Comp. Laws Ann. § 600.1483 (West 2018); Miss. Code Ann. § 11-1-60 (2018); Mo. Ann. Stat. § 538.210 (West 2018); Mont. Code Ann. § 25-9-411 (West 2018); Nev. Rev. Stat. § 41A.035 (2018); N.C. Gen. Stat. § 90-21.19 (2018); N.D. Cent. Code § 32-42-02 (2018); Ohio Rev. Code Ann. § 2323.43 (2018); Okla. Stat. tit. 23, § 61.2 (2018); Or. Rev. Stat. § 31.710 (2017); S.C. Code Ann. § 15-32-220 (2018); S.D. Codified Laws § 21-3-11 (2018); Tenn. Code Ann. § 29-39-102 (2018); Tex. Civ. Prac. & Rem. Code § 74.301 (2017); Utah Code § 78B-3-410 (2018); W. Va. Code Ann. § 55-7B-8 (LexisNexis 2018). Six states currently impose caps on total damages (both economic and noneconomic) in medical malpractice cases. See Colo. Rev. Stat. § 13-64-302; Ind. Code § 34-18-14-3 (2018); La. Stat. Ann. § 40:1231.2 (2018); Neb. Rev. Stat. § 44-2825 (2018); N.M. Stat. Ann. § 41-5-6 (West 2018); Va. Code § 8.01-581.15 (2018).

38. See Heller, supra note 12, at 143; Carly N. Kelly & Michelle M. Mello, Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation, 33 J.L. Med. & Ethics 515, 516–17 (2005) (contending that "unfairly large awards" may be "influenced by juror emotion"); Frank A. Sloan et al., The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ, Law & Contemp. Probs., Spring 1997, at 35, 65 ("Non-economic loss is real, but difficult to quantify with any degree of accuracy . . . .").

39. See ch. 1, § 24.6, 1975 Cal. Stat. 3949, 3969 (codified at Cal. Civ. Code § 3333.2).

40. See Patterson, supra note 29, at 119.

41. See, e.g., id. at 116.

42. See Kachalia & Mello, supra note 15, at 1567 tbl.2 (explaining that pretrial screening panels "review malpractice cases at an early stage and provide opinions about whether claims have sufficient merit to proceed").

43. See id. (providing that limitations "placed on the amount that a plaintiff's attorney may take as a contingency fee" discourage attorneys from accepting nonmeritorious cases).

44. See id. ("The plaintiff must present, at the time of filing . . . an affidavit certifying that a qualified medical expert believes that there is reasonable and meritorious cause for the suit.").

45. See id. (eliminating the traditional rule that "even if an injured plaintiff has received compensation from other sources (e.g., health insurance), the amount of that compensation should not be deducted from the amount that a defendant who is found liable must pay").

reform,[46] alternative dispute resolution,[47] apology laws,[48] and the shortening of statutes of limitations.[49] Still other states, like Virginia and Florida, experimented with more progressive reform.

2. *No-Fault Compensation for Birth-Related Injuries.* — To address skyrocketing OBGYN premiums and threats to women's healthcare access during the medical malpractice crisis of the 1980s, Virginia and Florida created administrative no-fault compensation programs.[50] These programs differ from traditional tort suits in fundamental ways. Under no-fault, for example, individuals pursue their claims in an administrative proceeding where compensation depends not on whether the physician acted negligently (hence "no fault") but on whether the physician caused the injury.[51] Although eliminating tort's negligence, in theory, could result in a greater number of compensated victims—that is, a greater number of claims paid out—"[a]ny increase in compensation costs is supposed to be offset

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46. See id. (explaining that in cases with multiple defendants, joint and several liability reform "limits the financial liability of each defendant to the percentage of fault that the jury allocates to that defendant").

47. Nussbaum, supra note 28, at 250–51, 282–301 (discussing Oregon's adoption of alternative dispute resolution (ADR) for medical malpractice claims and advocating for reconsidering newer-generation ADR programs, despite the shortcomings of early ADR efforts to address medical malpractice liability); see also Joseph S. Kass & Rachel V. Rose, Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs, 18 AMA J. Ethics 299, 303 (2016) (discussing how ADR encourages open communication and transparency with injured patients and facilitates restitution for injured parties through its various forms, which include arbitration, mediation, and communication and resolution programs).

48. See Heather Morton, Medical Professional Apologies Statutes, Nat'l Conference of State Legislatures (Dec. 11, 2018), http://www.ncsl.org/research/financial-services-and-commerce/medical-professional-apologies-statutes.aspx [https://perma.cc/G3X8-GUFU] (explaining that "apology laws" prevent expressions of sympathy and admissions of fault from being admitted into evidence in a lawsuit, allowing patients and physicians to address misunderstandings and emotions that lead to litigation); cf. Benjamin J. McMichael et al., "Sorry" Is Never Enough: How State Apology Laws Fail to Reduce Medical Malpractice Liability Risk, 71 Stan. L. Rev. 341, 378 (2019) (casting doubt on the efficacy of apology statutes in achieving their goals).

49. See Michelle M. Mello et al., Policy Experimentation with Administrative Compensation for Medical Injury: Issues Under State Constitutional Law, 45 Harv. J. on Legis. 59, 60 (2008) [hereinafter Mello et al., Policy Experimentation].

50. See Domin, supra note 8, at 508–14 (contending that the absence of such reforms would have left "nearly one-fourth of all Virginia obstetricians without coverage"); Sloan et al., supra note 38, at 37 (detailing the programs' enactment "in response to increased frequency and severity of tort claims, skyrocketing insurance premiums, and insurers' withdrawal from the coverage market, resulting in the prospect of unavailability of medical malpractice insurance coverage"); see also Edwards, supra note 15, at 293 (describing how "mounting losses and uncertain risk" led the three largest national insurance carriers to either leave the Virginia market or place moratoriums on new policies). The Virginia Birth-Related Neurological Injury Compensation Act became law in 1987, Va. Code §§ 38.2-5000–5021 (2019), and the Florida Birth-Related Neurological Injury Compensation Act in 1988. Fla. Stat. §§ 766.301–.316 (2018).

51. Fla. Stat. § 766.301; Va. Code § 38.2-5008–5009.

by lower administrative costs of the no-fault system compared with traditional tort litigation."[52] Claimants who choose to pursue their claims through no-fault are generally precluded from relitigating such claims in court but not from appealing no-fault determinations to a state court.[53] No-fault programs also tend to narrow the class of injuries eligible for compensation, since broadening the compensable class to all medical injuries is considered politically unfeasible and financially untenable.[54] The Virginia and Florida programs, for instance, cover only birth-related neurological injuries—typically among the most costly in malpractice payouts and the most prevalent sources of malpractice suits.[55] This Note focuses particularly on the Florida program (NICA[56]), which is larger and has demonstrated greater potential for continued success[57] and should thus guide future policy and federal reform efforts.

NICA's basic operation warrants further elaboration. To establish a compensable claim under the program, a claimant must have sustained a birth-related neurological injury while in the care of a NICA-participating OBGYN during the birthing process.[58] Once a claim has been deemed compensable by an administrative law judge, NICA pays the lifetime costs of the infant's necessary and reasonable care, noneconomic damages for the infant's parents not to exceed $100,000, and reasonable attorneys' fees.[59] NICA is financed primarily by nonpublic hospitals, which pay $50 per live delivery; all licensed physicians in the state, who pay $250 annually; and participating OBGYNs, who pay $5,000 annually.[60]

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52. Horwitz & Brennan, supra note 30, at 165.

53. See Fla. Stat. §§ 766.303, 766.311; Va. Code §§ 38.2-5002, 38.2-5011.

54. See, e.g., Gil Siegal et al., Adjudicating Severe Birth Injury Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation, 34 Am. J.L. & Med. 493, 519 (2008).

55. See Horwitz & Brennan, supra note 30, at 167–68; see also Fla. Obstetric & Gynecological Soc'y, NICA Update 2007, at 2 (2007) [hereinafter NICA Update] (finding such injuries to have been the costliest and most frequent from the mid-1980s to early 2000s); Domin, supra note 8, at 503 (noting that such injuries account for thirty percent of all cases against obstetricians, with the average payout totaling around $1 million in the early 2000s).

56. The Florida Birth-Related Neurological Injury Compensation Plan and Florida Birth-Related Neurological Injury Compensation Association—the administrating body—are often collectively known as NICA. This Note, however, uses NICA to refer only to the program.

57. See Horwitz & Brennan, supra note 30, at 165.

58. See Fla. Stat. § 766.309. NICA defines a birth-related neurological injury as an "injury to the brain or spinal cord of a live infant . . . caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation . . . which renders the infant permanently and substantially mentally and physically impaired." Id. § 766.302(2).

59. See id. § 766.31. For a broader description of NICA's benefits, see NICA, Benefit Handbook 5–13 (2015).

60. See Fla. Stat. § 766.314. Additionally, Florida appropriated up to $20 million to cover the program in the event of a fundraising shortfall. Id. Although data are limited, most eligible Florida OBGYNs appear to participate in the program. Fla. Office of Ins.

In addition to offering relief to victims on a no-fault basis, NICA aims to stabilize the costs of malpractice insurance for OBGYNs, encourage physicians to practice obstetrics, and make OBGYN services more readily available to patients.[61] NICA attains its premium-stabilization goals by covering most of the truly catastrophic claims, thereby reducing OBGYNs' exposure to liability and tort's typically steep payouts.[62] And because insurance spreads risk, not only participating OBGYNs but *all* state physicians benefit under NICA through reductions in premiums that appreciably exceed their respective annual contributions.[63] Granting participating OBGYNs immunity from lawsuits in certain situations is also thought to encourage physicians to begin—and continue—practicing obstetrics and discourage defensive medicine, making obstetric services safer and more accessible.[64]

Somewhat surprising is that, except for Virginia and Florida, no state offers no-fault compensation for birth injuries. This might be due in part to skepticism about the willingness of state judiciaries to uphold these legislative efforts when challenged in court.[65] Although medical malpractice law has traditionally been governed by the individual states,[66] the federal government itself has at times mobilized in response to crisis.[67]

Regulation, Florida Birth-Related Neurological Injury Compensation Association 1 (2018) ("[A] very high percentage of physicians that are eligible to participate in NICA do so.").

61. See Fla. Stat. § 766.301; Anne-Maree Farrell et al., No-Fault Compensation Schemes for Medical Injury: A Review 58 (2010), https://ssrn.com/abstract=2221836 (on file with the *Columbia Law Review*); What Is NICA?, Fla. Birth-Related Neurological Injury Comp. Ass'n, http://www.nica.com/what-is-nica.html [https://perma.cc/Y2SF-2DPC] [hereinafter What Is NICA?] (last visited Jan. 23, 2019).

62. See NICA Update, supra note 55, at 4.

63. See Other Physicians, Fla. Birth-Related Neurological Injury Comp. Ass'n, https://www.nica.com/other_physicians/index.html [https://perma.cc/TUT9-NDSB] [hereinafter Other Physicians] (last visited Jan. 17, 2019). Recent figures, for example, show the net effect is an estimated annual reduction in malpractice premiums of between $62,000 and $88,000 for participating OBGYNs and between $1,200 and $1,800 for all nonparticipating physicians. See Fla. Office of Ins. Regulation, Closed Claims Data Report 5 (2017) [hereinafter FLOIR Report 2017]; see also NICA Update, supra note 55, at 4 (finding annual savings of between $49,000 and $85,000 for participating OBGYNs and around $1,477 for nonparticipating physicians). Annual premiums for Florida OBGYNs can reach up to $200,000, depending on locality. See Florida Medical Malpractice Insurance, Cunningham Grp., https://www.cunninghamgroupins.com/historic-medical-malpractice-insurance-rates/florida [https://perma.cc/V47E-QJ5Q] (last visited Jan. 18, 2019).

64. See, e.g., NICA Update, supra note 55, at 1–2 (noting that because "physicians were increasingly finding it difficult to provide obstetric services to expectant mothers," the Florida legislature enacted NICA, which sought to encourage "physicians to practice obstetrics and provide obstetrical services").

65. See infra section II.B.

66. See Bal, supra note 4, at 340.

67. See Abigail R. Moncrieff, Federalization Snowballs: The Need for National Action in Medical Malpractice Reform, 109 Colum. L. Rev. 844, 857–58 (2009) (finding that while states have led the way in enacting reform, the federal government has actively participated in the debate as evidenced by congressional hearings on medical malpractice

3. *Federal Reform Efforts.* — While states' experiences with no-fault provide a useful backdrop for considering medical malpractice reform, legislators might also draw insight from a related, federal no-fault scheme: the Vaccine Injury Compensation Program (VICP).[68] In the 1980s, public fear about the dangers of vaccines led to increased litigation against vaccine manufacturers, which burdened them with crushing liability and forced them to either raise their prices sharply or cease vaccine production altogether.[69] Amid concerns of vaccine shortages and a potential epidemic, Congress established VICP to protect vaccine manufacturers from liability by redirecting vaccine suits from the traditional tort system into an administrative court designed to deal precisely with these suits.[70] This court, much like NICA, replaced negligence liability with no-fault liability.[71] Over time, VICP successfully shielded manufacturers from liability, stabilized vaccine prices, and fortified the vaccine marketplace.[72] Its success in providing quick and consistent compensation to victims, however, is less apparent.[73] But despite a mixed track record, VICP offers precedent for no-fault compensation for medical injury on a national scale and intimates that the federal government may be amenable to a no-fault regime under the right circumstances.

Other federal efforts have typically focused on limiting patient recovery through traditional means like damages caps.[74] For instance, legislators have advanced numerous proposals that would set a national cap of $250,000 on noneconomic damages in medical malpractice suits, but none has yet successfully passed both houses of Congress.[75] In the most recent iteration of such a proposal, the House of Representatives passed the Protecting Access to Care Act of 2017 (PACA), which would federalize various tort reforms already adopted by several states.[76] The

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in the 1960s and President Nixon's commissioning of a study of the matter in the 1970s); see also Bal, supra note 4, at 340.

68. See 42 U.S.C. §§ 300aa-10–34 (2012).

69. See Paul J. Barringer et al., Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again, 33 J. Health Pol. Pol'y & L. 725, 735–36 (2008).

70. See id.

71. See Engstrom, supra note 14, at 1660, 1663, 1670–71.

72. See id. at 1715; see also Sloan & Chepke, supra note 20, at 288.

73. See Engstrom, supra note 14, at 1675, 1685–86. These issues, however, may be unique to VICP and should not be readily ascribed to other potential no-fault proposals. See id. at 1688 (acknowledging that VICP has twice seen a barrage of unanticipated filings, which created a backlog and delayed adjudications).

74. See Kelly & Mello, supra note 38, at 518; Gregg, supra note 19, at 322.

75. As of this Note's writing, legislators have in the last three years alone introduced six bills that would cap noneconomic damages nationally in medical malpractice cases. See H.R. 1704, 115th Cong. § 4(b) (2017); H.R. 1215, 115th Cong. § 3(b) (2017); S. 3291, 114th Cong. § 403(b) (2016); H.R. 4771, 114th Cong. § 4(b) (2016); H.R. 4589, 114th Cong. § 204(b) (2016); H.R. 3682, 114th Cong. § 713(b) (2015).

76. See H.R. 1215, 115th Cong. (2017). In a close vote and facing considerable opposition, the House passed H.R. 1215. See 163 Cong. Rec. H5286–87 (daily ed.

proposal, however, ultimately languished in the Senate.[77] Nonetheless, these considerations help guide federal approaches to medical malpractice reform.

II. SHORTCOMINGS AND CHALLENGES OF THE STATUS QUO

Fears of medical malpractice crises persist despite various statutory attempts to address them. Conventional reforms largely leave the structure of medical malpractice law in place while tinkering with its outer boundaries, and none of the measures alone may adequately address the approaching OBGYN workforce shortage.

Part II discusses the shortcomings of the current liability-based system in meeting its goals. Section II.A compares no-fault with the current system, discussing the effects of each on patients and physicians alike. Section II.B then explores the feasibility of expanding no-fault reform at the state level by examining some of the constitutional challenges raised against analogous reforms.

A. *Status Quo: Faulty or Faultless?*

The tort system is often touted for its efficiency in meeting the goals of compensation, deterrence, and corrective justice.[78] However, as discussed below, the status quo should not so readily be commended for meeting these goals in the realm of medical malpractice.[79]

1. *A Patient-Centric Lens: Compensation, Deterrence, and Corrective Justice.* — One major contention against no-fault schemes is that they deny victims

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June 28, 2017) (218-210 vote); see also Robert Lowes, House Passes Bill to Cap Malpractice Noneconomic Damages, Medscape (June 28, 2017), http://www.medscape.com/viewarticle/882263 (on file with the *Columbia Law Review*). Eighty organizations opposing the bill sent a letter to House leaders expressing concerns that the bill would weaken physician incentives to act safely. See Letter from National Groups to Paul Ryan, Speaker, U.S. House of Representatives, and Nancy Pelosi, Minority Leader, U.S. House of Representatives 1 (June 12, 2017) (on file with the *Columbia Law Review*).

77. That said, similar legislation has been introduced before and will almost certainly be introduced again. Indeed, the 2019 U.S. budget designates reform to medical liability as an objective. OMB, Major Savings and Reforms: Budget of the United States Government, Fiscal Year 2019, at 116 (2018). Specifically, the Budget suggests curbing excessive payouts, capping noneconomic damages, and notably, creating "administrative health care tribunals to review medical liability cases." Id.

78. See Bovbjerg & Sloan, supra note 18, at 57 ("The system compensates meritorious claims of negligent injury in order to deter potential tortfeasors from causing such injuries and to provide justice by administering a socially sanctioned dispute resolution process meant to satisfy individual participants and create social accountability."); Stamm, supra note 11, at 293.

79. See, e.g., Kukura, supra note 9, at 781–90 (identifying obstacles that women face in bringing successful tort claims for childbirth-related injuries); Gregg, supra note 19, at 316 ("The law neither deters negligent conduct by doctors nor appropriately compensates those who have been injured by doctors' negligent care." (footnotes omitted)); Stamm, supra note 11, at 296 ("[T]he tort litigation system fails to encourage reporting of mistakes and does not promote improved healthcare services.").

adequate compensation for their injuries.[80] This concern, however, might be overestimated.[81] First, although no-fault programs do typically cap the upper limits of noneconomic recovery, their raison d'être is to provide compensation to a greater number of victims at the expense of reducing the amount of recovery for a few.[82] Nevertheless, that more claimants overall could qualify for compensation than under negligence liability is likely to be of little concern and consolation to the patient whose noneconomic damages have been substantially reduced by caps. One must keep in mind, however, that most states already cap recovery on noneconomic or total damages in malpractice cases,[83] so the group of individuals purported to be affected would be limited to those in states that cap recovery at a higher threshold or that have no caps at all. Significantly, despite capping noneconomic recovery, comparable no-fault and negligence-liability cases appear to pay successful litigants similar amounts.[84]

Moreover, in contrast to the processes of the status quo, which too often lead to lengthy court-resolution delays and excessive litigation costs,[85] no-fault's informal processes are considerably more efficient at streamlining claimant compensation and lowering attorneys' fees.[86] Although one might worry that decreasing attorneys' fees could result in lower-quality representation,[87] findings have shown no significant difference

80. See Stamm, supra note 11, at 306.

81. See, e.g., Bovbjerg & Sloan, supra note 18, at 72 ("Damages under no-fault should be more accurately measured and less variable than under fault."); Stamm, supra note 11, at 306 ("[C]laimants are more likely to get an award reflecting the severity of their injury."). But cf. Bovbjerg & Sloan, supra note 18, at 72–73 (acknowledging that no-fault could prevent patients from getting payment for nonpecuniary losses).

82. Cf. Tappan, supra note 28, at 1114 (citing a 1997 study that tested the economic feasibility of no-fault medical compensation in Utah and Colorado and found that "two to three times the number of patients would be compensated in Utah and Colorado respectively" compared with the system currently in place).

83. See supra note 37 and accompanying text.

84. See Bovbjerg & Sloan, supra note 18, at 107; Horwitz & Brennan, supra note 30, at 171–72 (finding that victim recovery "under the two systems would be quite similar").

85. See, e.g., Bovbjerg & Sloan, supra note 18, at 58 (noting the perspective that the tort system is "too costly" and "also slow, unpleasant, and insufficiently protects those with serious and permanent injuries"); Engstrom, supra note 14, at 1645; Stamm, supra note 11, at 296; cf. Sloan et al., supra note 38, at 65 ("Proving negligence comes at a cost.").

86. See Bovbjerg & Sloan, supra note 18, at 103, 108, 113 (finding that no-fault resolved claims at a faster rate than suits filed in tort and substantially decreased legal expenses); Domin, supra note 8, at 531–32 (explaining that "the true benefits of . . . no-fault plans are found in their efficiency—namely their speed of resolution and lower administrative costs"); Sloan et al., supra note 38, at 64 ("No-fault is an effective compensation method . . . because it provides fast compensation without an assessment of blame.").

87. Cf. Bovbjerg & Sloan, supra note 18, at 73 ("No-fault may also provide for lower attorneys' fees than are customary in tort and hence may result in a lower quality or quantity of representation.").

in access to quality legal representation under either system.[88] Overall, no-fault appears to facilitate—rather than obstruct—a victim's path to legal recourse and recovery.

Defenders of the status quo also praise its deterrent value, arguing that fear of tort liability deters medical malpractice by stigmatizing negligent physicians and incentivizing careful practice.[89] There is, however, little evidence that attributes any meaningful deterrent effect on individual practitioners to the current system.[90] First, "doctors and hospitals lack a full incentive to invest in cost-justified safety measures that would reduce probabilities of injury" because most patients ultimately choose not to sue for their injuries.[91] Second, because liability insurance rates are not experience rated—that is, not predicated on a policyholder's past claim or payout history[92]—litigation costs are mostly externalized by liability insurance companies rather than borne by the individual physician with a high-claim history.[93] And it is unlikely that a no-fault scheme would affect the profession's existing moral, ethical, and reputational incentives to minimize mistakes.[94] What no-fault might diminish is not so much deterrence as much as defensive medicine by mitigating the fear of legal liability.[95] In short,

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88. See, e.g., Sloan et al., supra note 38, at 54 ("Overall, there appear to be few barriers to obtaining legal representation, either for no-fault or tort.").

89. See Bovbjerg & Sloan, supra note 18, at 73; see also Edwards, supra note 15, at 289 ("Some legal scholars argue that the tort system is necessary to deter negligent practice by physicians . . . ."); Horwitz & Brennan, supra note 30, at 167 ("In theory, the threat of economic loss . . . deters physicians from negligence . . . .").

90. See Michelle M. Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Tex. L. Rev. 1595, 1634 (2002). Indeed, as some scholars put it: "[I]t is unlikely that we can do much worse than the status quo with respect to individual deterrence." Id.

91. Moncrieff, supra note 67, at 854.

92. Vine, supra note 33, at 427.

93. See Mello & Brennan, supra note 90, at 1621 ("[U]nlike motorists who fear getting into an accident because it is virtually certain to mean higher insurance premiums for years to come, health care providers do not feel the full economic consequences of their mistakes."); Nussbaum, supra note 28, at 259–61 (providing that "liability insurance frequently shields [practitioners] from paying injured patients out of their own pockets"); Gregg, supra note 19, at 330 (explaining that insurance rates are tied to the national economy, not individual physician performance).

94. Tappan, supra note 28, at 1118. One such deterrent, for example, is the requirement that physician-made payments in connection with a medical malpractice claim or judgment be reported to the National Practitioner Data Bank (NPDB), a federal repository of information on medical malpractice payments and adverse actions. See 42 U.S.C. §§ 11101–11152 (2012) (establishing the NPDB). Physicians are reluctant to have these payouts listed on their professional record because this information resurfaces when applying for state licensing and certification or renewing liability insurance. See Engstrom, supra note 14, at 1672 n.179.

95. See NCSL, supra note 13, at 1; Tappan, supra note 28, at 1119 (claiming that the "less fear physicians have of malpractice claims, the less likely they are to prescribe unnecessary care simply to shield themselves from liability").

there is little support for the assertion that no-fault diminishes the quality of patient care.[96]

Another concern is that by shielding physicians against personal liability, no-fault deprives victims of corrective justice—the notion that individuals, not third parties, should pay for harm they wrongly cause others.[97] This concern, however, might rest on a questionable view of traditional tort law as an effective vehicle for doling out corrective justice.[98] In practice, victims are not usually paid directly by the wrongdoers but rather by third parties (insurance companies, for example).[99] The focal point should be not on quibbling about debatable notions of tort law and corrective justice but on making victims whole through compensation.

2. *A Physician-Centric Lens: Liability Insurance Stability.* — The recurrence of medical malpractice crises demonstrates the status quo's inability to achieve long-term stability in the liability insurance market. In contrast, the appeal of no-fault rests in part in its ability to stabilize professional insurance costs.[100] The Florida and Virginia programs have shed insight into the efficiency of no-fault programs in addressing costly liability insurance premiums. First, the programs have decreased the number of tort claims filed for birth-related injuries, which could assist in reducing frivolous suits.[101] Moreover, the programs have succeeded in stabilizing insurance premiums for OBGYNs,[102] with substantial annual

96. See Sloan et al., supra note 38, at 52–53, 64 (citing a study in which the "quality of care was worse for the sample of tort claimants than for no-fault claimants"); see also Stamm, supra note 11, at 296 (explaining that the "tort litigation system fails to encourage reporting of mistakes and does not promote improved healthcare services").

97. See Mello & Brennan, supra note 90, at 1635.

98. For a comprehensive discussion of corrective justice in tort litigation, see generally Tom Baker, Blood Money, New Money, and the Moral Economy of Tort Law in Action, 35 Law & Soc'y Rev. 275, 316 (2001) ("[T]ort law in practice has only a tenuous link with the corrective justice theories propounded by legal theorists." (citations omitted)). Interestingly, Baker also notes the existence of an unwritten moral code in tort litigation to pursue insurance companies, not individual defendants, in ordinary negligence cases. Id. at 281–95.

99. See Ronen Perry, The Role of Retributive Justice in the Common Law of Torts: A Descriptive Theory, 73 Tenn. L. Rev. 177, 191 (2006) ("Very often, liability insurance removes the burden of liability from the actual wrongdoer."); see also Baker, supra note 98, at 289–90 (recognizing that in the few instances when the wrongdoer is required to pay, the wrongdoer may be judgment proof and unable to fully compensate the victim out of pocket).

100. See Farrell et al., supra note 61, at 60–61.

101. See Sloan et al., supra note 38, at 63. While no-fault opponents argue that by decreasing the number of tort claims filed, no-fault deprives deserving patients a chance at compensation, there appears to be a missing nexus between "patients who actually suffer negligent injuries and those who ultimately file malpractice claims." Nussbaum, supra note 28, at 257.

102. See Am. Cong. of Obstetricians & Gynecologists District XII Fla., NICA Update 2015, at 1–2 (2015) [hereinafter ACOG, NICA Report] (finding the NICA program to be "largely fulfilling its mission of reducing malpractice costs for Florida's obstetricians"); Bovbjerg & Sloan, supra note 18, at 99–100 ("By directly affecting a small number of cases of relatively high severity and high volatility, a much larger objective of insurance market

premium reductions for participating OBGYNs.[103] These findings suggest that no-fault is more successful than the status quo in lowering premiums, not only for participating OBGYNs but also for all physicians regardless of participation or specialty.[104]

B. *Challenging the Status Quo at the State Level*

Although states are the traditional arbiters of medical malpractice law, state legislatures rarely stray far from the confines of familiar reforms. This may be due in part to skepticism about the willingness of state judiciaries to uphold certain legislative efforts when challenged in court—a skepticism heightened when more progressive reforms, like no-fault schemes, are in play. Because so few no-fault compensation schemes exist, legal challenges to the no-fault liability structure are infrequent.[105] In contrast, case law on the constitutionality of damages caps is quite common. And because no-fault structures generally feature some form of damages caps,[106] understanding state constitutional jurisprudence as applied to damages caps is relevant in pinpointing potential barriers to comprehensive federal malpractice reform.

1. *Damages Caps and the Murky Waters of State Jurisprudence.* — Opponents of noneconomic damages caps have frequently brought legal challenges on equal protection grounds.[107] Like its federal counterpart,

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stability was achieved."); Siegal et al., supra note 54, at 504 ("[These programs] have resulted in lower malpractice insurance premiums for obstetrician-gynecologists, even those who do not participate in the programs."); Stamm, supra note 11, at 312 (explaining that OBGYN liability costs in Virginia "declined remarkably more rapidly after the adoption of no-fault"). Notably, Florida still maintains high annual physician premium rates. See Roslund, supra note 20. Yet Florida is also one of the most litigious states, establishing a culture of litigation that may respond slowly to reform efforts. See Heller, supra note 12, at 155 (acknowledging that "overall culture in any given state plays a role" in tort reform); Sloan et al., supra note 38, at 64 ("Floridians tend to be more litigious."). Another possible explanation is that NICA's class of compensable, eligible injuries may be so narrow that many of the larger-payout claims are falling outside the scope of the program and are being litigated in tort instead.

103. See, e.g., ACOG, NICA Report, supra note 102, at 2–3 (finding that the average annual reductions in medical malpractice premiums led to savings of over $57,000 for NICA-participating OBGYNs); FLOIR Report 2017, supra note 63, at 5 (estimating annual reductions in medical malpractice premiums of $62,000 to $88,000 for participating OBGYNs).

104. See ACOG, NICA Report, supra note 102, at 2–3 (finding that nonparticipating physicians enjoyed premium reductions that amounted to approximately $1,040); FLOIR Report 2017, supra note 63, at 5 (finding savings of $1,200 to $1,800 for all nonparticipating physicians); Raper, supra note 15, at 318; Siegal et al., supra note 54, at 504; Other Physicians, supra note 63 ("Because insurance spreads risk, all physicians have benefited from NICA.").

105. But see infra section III.B.3 (discussing equal protection challenges to NICA).

106. See, e.g., Fla. Stat. § 766.31(b) (2018); Va. Code § 38.2-5009.1(A) (2019).

107. See Mello et al., Policy Experimentation, supra note 49, at 84, 85 tbl.2. Recent cases, though, have also struck down damages caps on other constitutional grounds. See, e.g., Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt, 691 S.E.2d 218, 222–24 (Ga. 2010)

state equal protection law prohibits disparate treatment of similarly situated individuals or classes of individuals.[108] Because state courts have generally not found that statutory noneconomic damages caps implicate a suspect class or fundamental right protected by the state constitution,[109] they have used rational basis review to examine whether the caps bear a rational relationship to a legitimate state objective and whether the means used have been arbitrarily or capriciously imposed.[110] Purported state objectives include alleviating the medical malpractice crisis by reducing high liability insurance premiums,[111] ensuring the availability of OBGYN services by limiting interstate physician migration,[112] or preventing defensive medicine.[113] Challengers, in general, have alleged that the caps arbitrarily discriminate on the basis of unfair classifications (1) among medical malpractice victims depending on the number of claimants[114] or (2) between fully compensated medical malpractice victims and partially compensated victims.[115] Recent decisions illustrate this framework.

In *Estate of McCall v. United States*, the Florida Supreme Court struck down noneconomic damages caps in wrongful death medical injury cases

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(holding that noneconomic damages caps violated the constitutional right to a jury trial because the caps would nullify the jury's findings of fact regarding damages and undermine the jury's basic function); Lebron v. Gottlieb Mem'l Hosp., 930 N.E.2d 895, 908 (Ill. 2010) (finding that noneconomic caps violated the separation of powers clause of the state constitution on the grounds that damages caps acted as a sort of legislative remittitur, which would infringe on the judiciary's responsibility to determine whether jury damages awards are excessive). Still other constitutional objections may involve violations of due process and access to the courts. See Kelly & Mello, supra note 38, at 518.

108. See Kelly & Mello, supra note 38, at 522 ("Most state courts follow the federal framework when evaluating equal protection challenges that are brought under their state constitution."); Mello et al., Policy Experimentation, supra note 49, at 63, 67 ("Equal protection and due process protections . . . tend to be similarly formulated and interpreted at state and federal levels."); see also, e.g., Fla. Const. art. I, § 2 ("All natural persons . . . are equal before the law and have inalienable rights . . . . No person shall be deprived of any right because of race, religion, national origin, or physical disability.").

109. See, e.g., N. Broward Hosp. Dist. v. Kalitan, 219 So. 3d 49, 56 (Fla. 2017).

110. See, e.g., id. at 58–59 ("Although we conclude the arbitrary caps are not rationally related to alleviating the purported medical malpractice crisis, we nonetheless consider the legitimacy of the asserted state objective."); Estate of McCall v. United States, 134 So. 3d 894, 913 (Fla. 2014) ("Conditions can change, which remove or negate the justification for a law, transforming what may have once been reasonable into an arbitrary and irrational legislation. . . . [N]o rational basis exists to justify continued application of the noneconomic damages cap . . . .").

111. See, e.g., *N. Broward*, 219 So. 3d at 58–59; *McCall*, 134 So. 3d at 906; Mayo v. Wis. Injured Patients & Families Comp. Fund, 901 N.W.2d 782, 790 (Wis. Ct. App. 2017).

112. See *Mayo*, 901 N.W.2d at 789.

113. See id.

114. See *McCall*, 134 So. 3d at 901–02 (reasoning that multiple claimants seeking a $500,000 award would individually receive less than a single claimant seeking the same award).

115. See *N. Broward*, 219 So. 3d at 57–58 (delineating the distinction between litigants who had their awards reduced by the statutory caps and those who did not).

on equal protection grounds.[116] In *McCall*, the decedent's estate challenged the constitutionality of the state damages cap after their awards had been substantially reduced pursuant to the cap.[117] Applying the state equal protection framework, the court first held that the damages statute arbitrarily limited recovery when it was applied without regard to the number of claimants entitled to compensation.[118] Because the cap limited the recoverable noneconomic damages in a given medical malpractice case, the greater the number of claimants that sought recovery, the less each would be entitled to receive.[119] In contrast, a single claimant in another case would recover the full award. Thus, malpractice claimants were not afforded equal rights to full compensation.

The court then held that the cap on noneconomic damages did not bear a rational relationship to its purposed objective: alleviating the medical malpractice crisis.[120] After exhaustively examining the state legislature's conclusions as to the existence of a crisis and the viability of a cap as a solution, the court rejected the legislative findings as being insufficiently "supported by available data."[121] Finally, the court found that even if a crisis existed when the cap was enacted, changing conditions could "negate the justification for a law," and legislation that "may have once been reasonable" could become "arbitrary and irrational."[122]

Just a few years later, in *North Broward Hospital District v. Kalitan*, the same court held that noneconomic damages caps violate the state's equal protection clause—not only in wrongful death cases but in *all* medical injury cases.[123] In so holding, the court first determined that the caps arbitrarily distinguished between classes of medical malpractice victims by reducing damages for the most severely injured patients while

116. See 134 So. 3d at 916.

117. Id. at 899. In *McCall*, the patient delivered a healthy baby but lost massive quantities of blood during the birth. Id. at 898–99. After medical providers failed to check on her, she went into shock and cardiac arrest. Id. at 899. She never regained consciousness and was eventually removed from life support. Id.

118. See id. at 901–03.

119. See id. at 901–02.

120. Id. at 909.

121. Id. at 906–15 ("While courts may defer to legislative statements of policy and fact, courts may do so only when those statements are based on actual findings of fact, and even then courts must conduct their own inquiry . . . ." (emphasis omitted) (quoting N. Fla. Women's Health & Counseling Servs., Inc. v. State, 866 So. 2d 612, 627 (Fla. 2003))); see also id. at 906 (noting that legislative findings are not entitled a "presumption of correctness if they are nothing more than recitations amounting only to conclusions and they are always subject to judicial inquiry" (emphasis omitted) (citation omitted)).

122. Id. at 913 ("[A] law depending upon the existence of an emergency or other certain state of facts to uphold it may cease to operate if the emergency ceases or the facts change even though valid when passed." (internal quotation marks omitted) (quoting Chastleton Corp. v. Sinclair, 264 U.S. 543, 547–48 (1924))).

123. See 219 So. 3d 49, 50 (Fla. 2017). In *North Broward*, the patient went into surgery for carpal tunnel syndrome and ended up with a perforated esophagus from the tubes inserted into her mouth and esophagus during the anesthesia process. Id. at 51.

allowing full recovery to those who suffered less severe harms (and whose potential recovery did not exceed the cap).[124] Relying heavily on its decision in *McCall*, the court then held that the state could not legitimately address the purported medical malpractice crisis through the imposition of statutory caps because no evidence of a continuing crisis existed.[125] The caps were thus deemed unconstitutional because the arbitrary reduction of compensation without regard to the severity of the injury did not bear a rational relationship to the legislature's stated interest in addressing the medical malpractice crisis.

These cases are significant in understanding potential barriers to comprehensive federal no-fault reform. Because no-fault programs generally limit the upper boundaries of noneconomic recovery,[126] such a program could expect to face similar constitutional challenges as those raised against damages caps. While NICA has yet to encounter a direct challenge to its constitutionality, courts *have* considered and upheld certain provisions of the program.[127] Lowering the limit on noneconomic recovery—leaving victims with a lower maximum recovery—could draw greater scrutiny, thus making it more difficult for these programs to survive judicial review.

Moreover, these cases evince state judiciaries' willingess to engage in independent fact-finding to challenge legislative conclusions and overturn legislative policy.[128] Indeed, *North Broward* and *McCall* appear to employ a more exacting level of scrutiny that is difficult to reconcile with traditional rational basis review.[129] These courts used the rational basis framework not

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124. Id. at 57–58. The court, for example, compared the severity of an injury leading to amputation of a hand with one leading to a permanent vegetative state. Id.

125. See id. at 58–59.

126. Indeed, both the Florida and Virginia programs feature a $100,000 "award," interpreted as a ceiling on noneconomic damages. See Fla. Stat. § 766.31(b)(1) (2018) (noting that payments to the parents of an injured infant "shall not exceed $100,000"); Va. Code § 38.2-5009.1(A)–(B) (2019) (noting that the award aims to compensate for the "sorrow, mental anguish, solace, [and] grief associated with the death of the infant").

127. See, e.g., Fla. Birth-Related Neurological Injury Comp. Ass'n v. Fla. Div. of Admin. Hearings, 948 So. 2d 705, 717 (Fla. 2007) (holding that administrative law judges have jurisdiction to determine whether a healthcare provider has complied with the statutory requirement that notice of participation in the injury-compensation plan be provided to patients); Coy v. Fla. Birth-Related Neurological Injury Comp. Plan, 595 So. 2d 943, 944–45 (Fla. 1992) (upholding NICA's annual assessment on nonparticipating physicians against an equal protection challenge).

128. See, e.g., Membreno v. City of Hialeah, 188 So. 3d 13, 30 (Fla. Dist. Ct. App. 2016) (describing the *McCall* court's reasoning as "reminiscent of the manner in which . . . *Lochner* era [cases] set aside legislature findings because they were only 'mildly persuasive'" (quoting Adkins v. Children's Hosp., 261 U.S. 525, 560 (1923))).

129. See *N. Broward*, 219 So. 3d at 58–59 (finding that while a crisis may have existed during the caps' implementation, there was no evidence of a continuing crisis and thus no longer a legitimate state objective to which the caps could rationally and reasonably relate); Estate of McCall v. United States, 134 So. 3d 894, 913 (Fla. 2014) (explaining that while the court may defer to legislative findings of policy and fact, it is not required to accept these findings at face value and must conduct its own inquiry). *McCall* raised the question whether Florida had adopted a more rigorous equal protection analysis, which,

only in determining whether the means states use are rationally related to the state interest in alleviating medical malpractice crises but also in examining whether the means actually succeeded in furthering the legislature's ends. Consequently, state legislation's vulnerability to attack from the judiciary creates an unpredictable landscape averse to lasting solutions, making federal tort reform a more sensible option in tackling medical malpractice crises in the long run.

III. REVISITING FEDERAL NO-FAULT

Despite states' attempts to address medical malpractice litigation beginning with the first crisis in the 1970s, fears of medical malpractice crises persist, revealing the shortcomings of the status quo in achieving durable reform.[130] And none of the traditional reforms alone will effectively address the approaching OBGYN workforce shortage.[131] Accordingly, a comprehensive federal solution might be the most pragmatic. But federal legislation altering state malpractice systems will not come without its share of legal, political, social, and economic challenges.

Section III.A begins by proposing an operational framework for a federal no-fault program for birth-related injuries. Section III.B examines the constitutional grounds on which such a program may be challenged and upheld in federal court. Finally, section III.C explores the political, social, and economic challenges of broader no-fault implementation and how these challenges could guide future policy and federal reform efforts.

A. *Operation of a Federal No-Fault Compensation Program for Birth-Related Injuries*

Of the existing no-fault compensation programs for medical injuries, Florida's NICA has demonstrated the greatest promise and should be the guiding model in crafting federal no-fault legislation. The program should be limited in scope to birth-related neurological injuries since these claims tend to produce the highest payouts, are a frequent source of malpractice suits, and appear to have the greatest effect on OBGYN

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pre-*McCall*, had mirrored its federal equivalent. Subsequent cases have answered in the negative. See, e.g., *Membreno*, 188 So. 3d at 28 ("[A]lthough courts should not act as rubber stamps when analyzing a law under the rational basis test, neither should the courts presume to second guess the legislature by . . . conduct[ing] a courtroom-style evidentiary hearing . . . that is really more of a value judgment than a historical fact.").

130. See Engstrom, supra note 14, at 1648 (opining that "limiting damages doled out by juries or capping the fees lawyers can earn does not fix the system, it merely offers 'less of the same'" (emphasis omitted) (quoting Lawrence R. Tancredi & Randall R. Bovbjerg, Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, a Malpractice and Quality Reform Ripe for a Test, Law & Contemp. Probs., Spring 1991, at 147, 148)); Gregg, supra note 19, at 319 (noting the persisting concern about medical malpractice crises despite various legislative changes over the years).

131. See, e.g., Vine, supra note 33, at 424 (asserting that "damage caps have no impact on nearly ninety-nine percent of cases filed," because so few medical malpractice cases result in a plaintiff's award, and many of those are below the established statutory caps).

liability costs.[132] Expanding the class of eligible injuries beyond birth-related injuries might prove too costly, impractical, and politically unfeasible.[133] While some types of injuries might be ineligible for compensation, lower litigation costs and the removal of tort's negligence standard should facilitate recovery for a greater number of individuals.[134] And victims whose injuries fall outside the program's scope would still be able to litigate their claims under traditional negligence liability in an Article III court.

No-fault coverage should also be made available to OBGYNs on a voluntary basis.[135] Mandated OBGYN participation would render the program the exclusive legal remedy for all victims of eligible birth-related claims. Eliminating victims' ability to pursue their claims in an Article III court would expose the program to legal challenges for violations of the right to a jury trial and access to the courts.[136] The program should also compensate claimants for reasonable attorneys' fees on a lodestar basis, in which attorneys are paid based on the hours worked rather than a set percentage of the plaintiff's award.[137] Although this might financially discourage some attorneys from taking a case, it would, in theory, give a greater part of the award to the victim than would the standard contingent fee arrangement, in which attorneys charge a percentage of the award upon settling or prevailing at trial.[138] Moreover, like NICA, the program should require annual assessments from all physicians, regardless of specialty or participation.[139] While one cannot easily predict how this financing scheme would function on a national scale, it has worked well at the state level, providing adequate compensation for victims while

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132. See Bovbjerg & Sloan, supra note 18, at 83; Domin, supra note 8, at 503; Horwitz & Brennan, supra note 30, at 168.

133. See Tappan, supra note 28, at 1109 (calling models that would allow recovery for all injuries "expensive and impractical"); see also Bovbjerg & Sloan, supra note 18, at 98 ("A larger program would almost certainly draw more attacks from the trial bar and more judicial scrutiny, if only because it would be a larger threat to the status quo."); Siegal et al., supra note 54, at 519 ("The budgetary uncertainties introduced by any change in the eligible pool would . . . be unwelcome.").

134. See supra text accompanying note 52.

135. See Bovbjerg & Sloan, supra note 18, at 100 (explaining that although participation in the Florida and Virginia no-fault programs is optional, upwards of ninety percent of OBGYNs in both states participate); Siegal et al., supra note 54, at 514 (noting the voluntariness of the Florida and Virginia programs).

136. See Bovbjerg & Sloan, supra note 18, at 98 (noting that the voluntary NICA program has avoided potential constitutional challenges because it remains relatively easy to continue to bring cases in tort, providing "a 'safety valve' for dissatisfaction with no-fault"); Engstrom, supra note 14, at 1664 (explaining that VICP retains an opt-out provision which allows dissatisfied claimants to litigate their suits in court).

137. See, e.g., Raymo v. Sec'y of Health & Human Servs., 129 Fed. Cl. 691, 696–97 (2016) (employing the lodestar approach in calculating reasonable attorneys' fees under VICP).

138. See Heller, supra note 12, at 148 (explaining that the contingent fee percentage can be substantial, typically ranging from thirty-three to forty percent).

139. A sensible starting point would mirror the state annual-payment structure, with participating OBGYNs contributing $5,000 and nonparticipating physicians contributing $250.

maintaining program actuarial soundness.[140] Finally, the financial solvency of such a program would also require it to cap noneconomic damages at some predetermined threshold.[141]

B. *Constitutional Barriers to Federal No-Fault*

Medical malpractice law in the United States has historically been governed by the individual states.[142] Any federal legislation that substantially infringes on this domain would require a constitutional basis for doing so.[143] This section argues that the federal government wields such authority under the Commerce Clause, Taxing Power, and Equal Protection Clause. Because of sparse experience with national administrative compensation schemes, this section references VICP, Florida's NICA, and Virginia's Birth-Injury Program (BIP) to consider overcoming possible challenges to the implementation of a federal no-fault program.

1. *The Commerce Clause.* — Courts may uphold a federal no-fault program through Congress's authority to regulate interstate commerce under the Commerce Clause.[144] Early Commerce Clause jurisprudence

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140. See ACOG, NICA Report, supra note 102, at 3 (noting that NICA "typically accrues approximately $23 million per year in funding, has never paid out that amount annually, [and therefore] continues to operate with a positive margin"); see also Horwitz & Brennan, supra note 30, at 172 ("One measure of NICA's success, especially given the predictions of legislators and observers, is that it still exists."). But see Siegal et al., supra note 54, at 500 (noting concern about the financial soundness of the Virginia program).

141. This Note takes no side with regard to what this threshold should be. For a glimpse into the ongoing discussion surrounding these thresholds, see, for example, Seth A. Seabury et al., Medical Malpractice Reform: Noneconomic Damages Caps Reduced Payments 15 Percent, with Varied Effects by Specialty, 33 Health Aff. 2048, 2048–52 (2014) (concluding that "[a] more restrictive $250,000 cap reduced average payments by $59,331 (20 percent), and a less restrictive $500,000 cap had no significant effect, compared to no cap at all," and finding restrictive noneconomic damages caps to be "associated . . . with particularly large [premium] reductions" for OBGYNs). For more about the effectiveness of damages caps in general, see, for example, Ronen Avraham, An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments, 36 J. Legal Stud. S183, S221–23 (2007); Seabury et al., supra; see also Eric Helland & Seth A. Seabury, Tort Reform and Physician Labor Supply: A Review of the Evidence, 42 Int'l Rev. L. & Econ. 192, 193, 201 (2015); Michael F. Pesko et al., The Effects of Malpractice Non-Economic Damage Caps on the Supply of Physician Labor: Heterogeneity by Physician Age and Risk, 50 Int'l Rev. L. & Econ. 7, 13 (2017) (concluding that noneconomic damages caps may be an effective way for states to increase their supply of high-risk physicians).

142. See supra notes 20, 66 and accompanying text.

143. See E. Donald Elliott et al., Administrative "Health Courts" for Medical Injury Claims: The Federal Constitutional Issues, 33 J. Health Pol. Pol'y & L. 761, 768 (2008) (stating that in "federalizing tort actions traditionally reserved to the states, Congress must show that it has constitutional authority to do so" (internal quotation marks omitted) (quoting Michael I. Krauss, Tort Reform, *in* Cato Handbook for Congress: Policy Recommendations for the 107th Congress 357, 359 (2001))); see also Fernandez v. Wiener, 326 U.S. 340, 362 (1945) ("The Tenth Amendment does not operate as a limitation upon the powers, express or implied, delegated to the national government.").

144. U.S. Const. art. I, § 8, cl. 3.

recognized plenary congressional power to regulate an activity as long as the activity might have some effect on interstate commerce.[145] However, the Court constrained its deference to Congress's plenary commerce authority in the landmark case *United States v. Lopez*, in which it held that while Congress has broad lawmaking authority under the Commerce Clause, the power is limited and does not extend so far as to authorize the regulation of an activity that has no clear effect on the economy on a massive scale.[146] Thus, modern Commerce Clause doctrine holds that Congress's power to regulate an economic activity traditionally regulated by the states will pass judicial muster only if the activity sought to be regulated has a substantial effect on interstate commerce and a legitimate federal purpose exists.[147] The federal government must establish a rational basis for believing this substantial effect exists.[148]

Medical malpractice litigation is an economic activity that has a substantial effect on interstate commerce and thus falls within Congress's regulatory purview under the Commerce Clause. Not only does medical malpractice litigation cumulatively affect the national supply and demand of OBGYNs,[149] it is also a multibillion-dollar business with incidental effects that

145. See, e.g., Wickard v. Filburn, 317 U.S. 111, 128–29 (1942) (holding that Congress could regulate an individual's wheat production, though it had only a negligible impact on interstate commerce, because its cumulative production could substantially affect interstate commerce); NLRB v. Jones & Laughlin Steel Corp., 301 U.S. 1, 37 (1937) (finding intrastate activities that have a "close and substantial relation to interstate commerce" to be regulatable); Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 19–20 (1824) (adopting an expansive view of the congressional commerce power); see also Erwin Chemerinsky, Constitutional Law: Principles and Policies 234 (3d ed. 2006) (noting that "from 1937 until 1995, not a single federal law was declared unconstitutional as exceeding the scope of Congress's commerce power").

146. 514 U.S. 549, 558–63 (1995) (holding also that legislative findings, while not required, may be persuasive in determining whether the substantial-effect requirement is met); see also Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 552–54 (2012) (declining to extend congressional commerce power to inactivity because doing so would compel commerce rather than regulate it); United States v. Morrison, 529 U.S. 598, 613 (2000) (narrowing Congress's ability to regulate noneconomic activity based only on findings of that conduct's aggregated and substantial effect on interstate commerce); cf. Gonzales v. Raich, 545 U.S. 1, 21 (2005) (noting that the Court has "never required Congress to make particularized findings in order to legislate").

147. See *Lopez*, 514 U.S. at 558–63; Elliott et al., supra note 143, at 772 (explaining that Congress must prove that "the effect on commerce argument is not a mere ruse being used to take over a traditional area of state concern").

148. See, e.g., *Raich*, 545 U.S. at 19 (holding that Congress had a "rational basis for concluding that leaving home-consumed marijuana outside federal control would similarly affect price and market conditions"); see also Hodel v. Va. Surface Mining & Reclamation Ass'n, 452 U.S. 264, 276–77 (1981) (finding that "when Congress has determined that an activity affects interstate commerce, the courts need inquire only whether the finding is rational").

149. See *Sebelius*, 567 U.S. at 549 ("Congress's power . . . is not limited to regulation of an activity that by itself substantially affects interstate commerce, but also extends to activities that do so only when aggregated with similar activities of others."); *Raich*, 545 U.S. at 19; Paul Taylor, The *Federalist Papers*, the Commerce Clause, and Federal Tort

radiate throughout the economy.[150] Medical malpractice litigation also accounts for roughly two percent of national healthcare spending, which amounts to upwards of $55 billion annually—and this does not account for the indirect costs of medical malpractice litigation.[151] Moreover, NICA has demonstrated that no-fault programs can achieve their purpose of lowering overall healthcare costs, stabilizing OBGYN insurance premiums, and protecting women's access to obstetric services.[152] The government could reasonably expect a federal no-fault program modeled after these state schemes to achieve similar outcomes. Therefore, such a program would likely withstand legal challenges under Congress's commerce power.[153]

2. *The Taxing Power.* — One contentious aspect of a national no-fault program would be determining who should bear the financial burden of maintaining it. Congress has the constitutional authority to levy taxes.[154] The Court has recognized Congress's broad authority to impose taxes for the nation's general welfare, thus granting Congress significant influence even in areas in which it cannot directly regulate.[155] While Congress may influence conduct through taxation, however, it may not do so through

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Reform, 45 Suffolk U. L. Rev. 357, 383–84 (2012) (citing studies showing an influx of doctors to states that enacted medical malpractice litigation reform); supra section I.A.

150. See Elliott et al., supra note 143, at 769, 774 (acknowledging that much of medical malpractice litigation is conducted on an interstate level, with specialized attorneys, expert witnesses, and liability insurance carriers conducting business in multiple states, in addition to frequent interstate patient movement to seek medical care).

151. See Michelle M. Mello et al., National Costs of the Medical Liability System, 29 Health Aff. 1569, 1572–74 (2010) (noting that the estimated annual $45 billion cost of defensive medicine does not include the potentially large financial losses stemming from the emotional and reputational toll on practitioners, since these figures are difficult if not impossible to quantify); Moncrieff, supra note 67, at 852–54 & n.24 (explaining that these figures do not include the healthcare costs of malpractice-related injuries that do not result in a lawsuit). The Congressional Budget Office (CBO) projected that the 2017 PACA bill would reduce the national deficit by roughly $50 billion from 2017 to 2027. CBO, H.R. 1215 Protecting Access to Care Act of 2017, at 1 (2017). That tort reform can lead to such substantial savings evinces the burden medical malpractice litigation places on the national economy.

152. See supra section II.A.

153. Indeed, Congress acted pursuant to the Commerce Clause in passing the Protection of Lawful Commerce in Arms Act, which prohibits lawsuits against firearm manufacturers and dealers for damages resulting from the unlawful use of firearms by others. See Protection of Lawful Commerce in Arms Act of 2005, Pub L. No. 109-92, 119 Stat. 2095 (codified at 15 U.S.C. §§ 7901–7903 (2012)); see also City of New York v. Beretta U.S.A. Corp., 524 F.3d 384, 395 (2d Cir. 2008) (upholding Congress's power to pass the firearms legislation pursuant to its Commerce Clause power). Further, Congress has justified its authority to pass a national cap on noneconomic damages under the Commerce Clause on the basis of medical malpractice litigation's high costs and effects on insurance premiums. See H.R. 1704, 115th Cong. (2017); S. 3291, 114th Cong. (2016); H.R. 4771, 114th Cong. (2016); H.R. 4589, 114th Cong. (2016).

154. U.S. Const. art. I, § 8, cl. 1.

155. See, e.g., Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 537 (2012) (explaining that Congress "may enact a tax on an activity that it cannot authorize, forbid, or otherwise control").

the imposition of penalties, though the line distinguishing taxes and penalties is not always clear.[156] Indeed, in *National Federation of Independent Business v. Sebelius*, the Court examined the Patient Protection and Affordable Care Act's (ACA) shared responsibility payment to determine whether it imposed an exceedingly heavy financial burden and thus amounted to a penalty rather than a tax for constitutional purposes.[157]

If a federal no-fault program were structured like NICA, a court would likely not find the program's annual assessment imposed on nonparticipating physicians to be unduly burdensome. In fact, a cost-benefit analysis indicates that the annual fee for nonparticipating physicians is a small price to pay for the various benefits conferred.[158] Although only participating OBGYNs would have direct coverage, all physicians would likely benefit from premium reductions due to the removal of some of the costliest suits from the tort system.[159] Further, federal no-fault legislation could avoid unfair overinclusivity were it to include exemptions from paying into the program for certain classes of physicians, including resident physicians and retired physicians who maintain an active license—comparable to the exemptions currently provided by NICA.[160] Ultimately, lawmakers should articulate

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156. See id. at 573 (declining to determine "the precise point at which an exaction becomes so punitive that the taxing power does not authorize it"); see also Bailey v. Drexel Furniture Co., 259 U.S. 20, 38 (1922) ("But there comes a time in the extension of the penalizing features of the so-called tax when it loses its character as such and becomes a mere penalty with the characteristics of regulation and punishment.").

157. See *Sebelius*, 567 U.S at 522 (finding that "[t]he payment is not so high that there is really no choice but to buy health insurance"). As the law on *Sebelius* continues to evolve, the Court may come to take up the issue of these payments once again. See Texas v. United States, 340 F. Supp. 3d 579, 597–602 (N.D. Tex. 2018) (holding that the ACA's individual mandate, as amended by the Tax Cuts and Jobs Act of 2017, could not be fairly read as an exercise of Congress's constitutional tax power).

158. See Sonzinsky v. United States, 300 U.S. 506, 513 (1937) (explaining that a tax is no less a tax simply for imposing some pecuniary burden on the taxpayer); Coy v. Fla. Birth-Related Neurological Injury Comp. Plan, 595 So. 2d 943, 945 (Fla. 1992) (finding that the $250 NICA assessment burdened nonparticipating physicians to some degree but helped to support a government enterprise—"a state-created system for compensating certain individuals for certain types of birth-related injuries"); supra section II.A. Moreover, the annual fee is a nominal figure when compared with the national average physician salary. See Sarah Grisham, Medscape Physician Compensation Report 2017, Medscape (Apr. 5, 2017), http://www.medscape.com/slideshow/compensation-2017-overview-6008547#1 (on file with the *Columbia Law Review*).

In *Sonzinsky*, the Court upheld a $200 annual license fee on firearm dealers as a tax rather than a penalty. 300 U.S. at 513. When adjusted for inflation, the fee in *Sonzinsky* would exceed $3,000 today—significantly more than the proposed no-fault annual fee for nonparticipating physicians. Inflation Calculator, US Inflation Calculator, https://www.usinflationcalculator.com [https://perma.cc/W9YY-69HK] (last visited Jan. 23, 2019) (enter "1937" as the starting year; then enter "200" as the dollar amount and "2019" as the ending year; then click "calculate").

159. See supra notes 62–63 and accompanying text.

160. For a complete list of NICA exemptions, see Fla. Stat. § 766.314(5)(a) (2018).

the importance of a national no-fault compensation program for birth-related injuries in providing for the general welfare, carefully drafting the legislation to fulfill the conditions of a tax rather than a penalty.

3. *The Equal Protection Clause.* — A federal no-fault birth-injury compensation program would likely survive challenges based on equal protection.[161] There are various equal protection objections litigants could make, including that no-fault programs arbitrarily discriminate on the basis of unfair classifications against (1) claimants by limiting the aggregate recovery of all claimants with respect to a single incident or the individual recovery of each claimant;[162] (2) single- and multiple-gestation infants by utilizing different minimum-weight thresholds as a basis for determining compensability;[163] or (3) nonparticipating physicians who are required to contribute to the program,[164] and that such classifications bear no rational relationship to a legitimate government purpose.

But courts have not sustained such challenges. Instead, they have held that although no-fault programs might impose some undue burden on certain plaintiffs, their classifications bear a rational relationship to a legitimate government interest, which may include maintaining the actuarial soundness of the programs,[165] alleviating the medical malpractice

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161. Like the state framework discussed in section II.B, the Equal Protection Clause prohibits disparate treatment of individuals or classes of individuals in like circumstances. See, e.g., City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 439 (1985). And unless a suspect class or fundamental right protected by the Constitution is implicated, courts use rational basis review to determine whether a challenged statute bears a rational relationship to a legitimate government purpose. See, e.g., Romer v. Evans, 517 U.S. 620, 631 (1996); U.S. Dep't of Agric. v. Moreno, 413 U.S. 528, 533 (1973).

162. See Samples v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 114 So. 3d 912, 917 (Fla. 2013) (challenging NICA's parental-award provision, which provides for a noneconomic award of $100,000, because parents who applied for the award alone could receive twice the amount awarded to parents who shared or split the award).

163. See Putnam Cmty. Med. Ctr. v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 204 So. 3d 598, 599 (Fla. Dist. Ct. App. 2016) (challenging NICA's definition of "birth-related neurological injury").

164. See Coy v. Fla. Birth-Related Neurological Injury Comp. Plan, 595 So. 2d 943, 944–45 (Fla. 1992) (challenging NICA's annual assessment, claiming nonparticipating physicians derived no benefit from the program greater than the nonpaying general public and that the link between the annual assessment and "its benefits was too tenuous to meet constitutional standards"); King v. Va. Birth-Related Neurological Injury Comp. Program, 410 S.E.2d 656, 660 (Va. 1991) (challenging the requirement that nonparticipating physicians pay an annual assessment to fund the Virginia Birth-Injury Program when they would purportedly receive no benefit from it).

165. See *Samples*, 114 So. 3d at 917–18 (concluding that any discrimination caused by the parental-award provision was "'minimal, unintentional and not arbitrary,'" and that limiting the "award to $100,000 per claim—as opposed to per parent—is rationally related to maintaining the actuarial soundness of the Plan" (quoting Samples v. Fla. Birth-Related Neurological, 40 So. 3d 18, 27 (Fla. Dist. Ct. App. 2010))); *Putnam Cmty.*, 204 So. 3d at 602–04 (finding that NICA's weight distinctions withstand constitutional scrutiny because they "further the legitimate governmental interest of preserving the availability of exclusive benefits on a no-fault basis for a limited class of catastrophic injuries").

crisis by reducing premiums, ensuring the availability of OBGYN services, and providing for the care of children who suffer birth-related neurological injuries.[166] In so concluding, courts have afforded deference to legislative findings and investigations.[167] Notably, courts have employed a more deferential review of limitations to noneconomic recovery under a no-fault system than under tort litigation, seemingly acknowledging no-fault programs' various additional benefits.[168]

These cases provide insight into how a federal no-fault program for birth-related injuries might fare against potential equal protection challenges. Given the strong body of evidence demonstrating a no-fault scheme's advantages to patients and physicians alike, courts could reasonably be expected to give deference to Congress in assessing the program's relationship to the broader objective of supporting public health, safety, and welfare. Unlike recent state-level equal protection jurisprudence that suggests a judicial willingness to challenge legislative fact-finding and investigation,[169] federal equal protection jurisprudence remains fairly deferential to the legislative will, especially on social and economic matters.[170] Moreover, both state and federal cases demonstrate

166. See *Coy*, 595 So. 2d at 945–47 (upholding NICA's annual assessment because all physicians benefit from the program, regardless of participation, and the program also seeks to ensure the availability of OBGYN services and provide for the care of injured infants); *King*, 410 S.E.2d at 660–61 (finding it "reasonably conceivable" that removing birth-injury claims from the tort system "would decrease the cost of medical malpractice insurance premiums for all physicians and, thus, make medical malpractice insurance available to all physicians practicing in Virginia").

167. See *Samples*, 114 So. 3d at 917 (finding it not within the judiciary's purview "to determine whether the legislation achieves its intended goal in the best manner possible, but only whether the goal is legitimate and the means to achieve it are rationally related to the goal" (internal quotation marks omitted) (quoting Loxahatchee River Envtl. Control Dist. v. Sch. Bd. of Palm Beach Cty., 496 So. 2d 930, 938 (Fla. Dist. Ct. App. 1986))); *Putnam Cmty.*, 204 So. 3d at 603 (noting that the legislature conducted an adequate investigation into the possible reduction of NICA's weight requirements before deciding against it, finding that it would substantially increase OBGYN premiums and that these increases would undermine the program's purpose of providing compensation to injured infants by making the financial costs untenable).

168. See *Samples*, 114 So. 3d at 919 ("Limitations on damages that raise equal protection concerns under a fault-based system are dissimilar and appropriately viewed differently than limitations on compensation under a system where eligible claimants are assured of a recovery without regard to fault.").

169. See supra section II.B.1.

170. See, e.g., City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 440 (1985) ("When social or economic legislation is at issue, the Equal Protection Clause allows the States wide latitude . . . ."); Minnesota v. Clover Leaf Creamery Co., 449 U.S. 456, 464 (1981) ("States are not required to convince the courts of the correctness of their legislative judgments. Rather, 'those challenging the legislative judgment must convince the court that the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the governmental decisionmaker.'" (quoting Vance v. Bradley, 440 U.S. 93, 111 (1979))); Ferguson v. Skrupa, 372 U.S. 726, 729–30 (1963) ("[I]t is up to legislatures, not courts, to decide on the wisdom and utility of legislation. . . . We have returned to the [pre-*Lochner*] proposition that courts do not

that the individual provisions of the program may be defended on the basis of actuarial soundness, which has been upheld as a legitimate government interest by several courts faced with equal protection claims.[171]

C. *Political, Social, and Economic Barriers to Federal No-Fault*

Given the relative successes of no-fault schemes and widespread public dissatisfaction with the status quo, why have no-fault programs for medical injuries failed to catch on? And how can they overcome potential barriers to implementation? Examining the environment underlying these programs' implementation provides a useful backdrop against which to consider these questions in the federal context. While section III.B focused on the potential legal barriers to no-fault implementation, section III.C overviews the political, social, and economic challenges to no-fault enactment and considers how these challenges could guide future policy and federal reform efforts.

1. *Dissonance in Problem, Politics, and Perception.* — One of the greatest challenges to no-fault implementation lies in mobilizing public support barring a full-blown health crisis. Generally, social mobilization presupposes widespread awareness of a visible problem or crisis—one that riles up public support and its political-will corollary.[172] Absent any real sense of crisis, policymakers have little appetite to bet on politically risky proposals.[173] Though some prior legislative attempts at no-fault stalled, others succeeded. Yet these successes were infrequent and were borne only from periods marked by widespread stakeholder recognition of the trouble facing practitioners and patients alike.[174]

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substitute their social and economic beliefs for the judgment of legislative bodies, who are elected to pass laws.").

171. See, e.g., Day v. Mem'l Hosp. of Guymon, 844 F.2d 728, 731 (10th Cir. 1988) (recognizing the legitimate state interest in the "maintenance of fiscal stability" of government entities, which promotes the general welfare); Osick v. Pub. Emp. Ret. Sys. of Idaho, 835 P.2d 1268, 1274 (Idaho 1992) (acknowledging the legitimate state interest of keeping the retirement system actuarially sound); Wrzesien v. State, 380 P.3d 805, 809 (Mont. 2016) (same).

172. See Barringer et al., supra note 69, at 729 (noting that the lack of "concerns about or perceptions of a crisis in medical liability insurance" helps explain the lack of reform); Tappan, supra note 28, at 1127 ("Without strong political momentum, it is difficult to imagine an extensive reform like no-fault being enacted.").

173. See Barringer et al., supra note 69, at 742 ("Insurance was widely available and premiums were relatively stable, creating little demand for far-reaching reform."). Contrast this with the Florida movement of the 1980s, in which "[l]egislators, targeted by well-organized and effective physician lobbying, feared that women in labor would be turned away from delivery rooms" and "[w]idespread media and constituent attention to large and increasing jury verdicts fueled the perception of a crisis." Horwitz & Brennan, supra note 30, at 166–67.

174. For instance, Florida and Virginia enacted their no-fault birth-injury programs after public outcry at diminished access to OBGYN services following dramatic surges in OBGYN liability insurance premiums. See Barringer et al., supra note 69, at 738 (citing a 1987 survey that indicated that around forty percent of Virginia's "obstetricians planned to

These experiences intimate the need for widespread perception of a severe crisis to spur legislative movement. Indeed, history indicates that reform discourse usually occurs in the midst of medical malpractice crises.[175] But of course, the lack of a publicly perceived crisis does not always correspond with the actual absence of one[176] and should not diminish the urgency to adopt proactive measures, especially when dealing with an issue threatening women's access to healthcare.[177] On the contrary, a "period of calm in liability insurance markets" may be the best time to proceed with comprehensive reform rather than maintaining the reactive status quo approach of patiently awaiting the next big crisis.[178]

Ironically, continually passing piecemeal medical malpractice reform at the state level may prolong the failure to pass comprehensive reform at the federal level. The uneven success of traditional state reforms in alleviating medical malpractice crises has perhaps prevented crises from reaching the severity of prior decades. This has in turn minimized the perception of serious crises and inhibited the galvanization of stakeholder support for more progressive reforms.[179] Although well-intentioned and perhaps temporarily beneficial, traditional reforms are merely stopgap measures to an issue requiring a long-term solution.

2. *Stakeholder Discord and Quid Pro Quo.* — No-fault proposals are inhibited by an absence both of consensus that moving to a no-fault system would be mutually beneficial and of interest groups to champion such a system.[180] It may not be enough for no-fault compensation

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stop delivering babies"); Tappan, supra note 28, at 1102 ("[T]he stories of doctors being forced out of practice by prohibitively high costs of medical-malpractice-liability insurance has potent political force."); Email from Kenney Shipley, Exec. Dir., NICA, to author (Oct. 31, 2017) (on file with the *Columbia Law Review*) ("It was a time of malpractice crisis in Florida that allowed hospitals, physicians, insurers[,] trial lawyers and other powerful interests to work together and agree on the need for [NICA].").

175. See supra section I.B.1.

176. One need not look further than the most recent financial crisis. See, e.g., Alan Greenspan, Never Saw It Coming: Why the Financial Crisis Took Economists by Surprise, Foreign Aff., Nov.–Dec. 2013, at 88, 89.

177. See Michelle M. Mello et al., Medical Liability—Prospects for Federal Reform, 376 New Eng. J. Med. 1806, 1808 (2017) [hereinafter Mello et al., Prospects] ("Many observers may find this an odd time for Congress to be considering malpractice reform. Malpractice environments are currently stable . . . and many physicians pay less for liability insurance than they did a decade ago." (footnote omitted)).

178. See id. at 1808.

179. See Kachalia & Mello, supra note 15, at 1567.

180. See Sloan & Chepke, supra note 20, at 294–95 (stating that while "various stakeholders supported implementing workers' compensation . . . supportive constituencies for medical no-fault are lacking"); Tappan, supra note 28, at 1126 ("[A] no-fault system may not have an organized interest group to champion it."); Email from Kenney Shipley, Exec. Dir., NICA, to author (Nov. 1, 2017) (on file with the *Columbia Law Review*) ("The economic interests are conflicting, and until everyone is affected in some way the more powerful interests rule."); see also Bovbjerg & Sloan, supra note 18, at 118 ("For a more comprehensive type of reform to be enacted, it will be necessary to build a constituency for change.").

programs to greatly benefit patients and physicians if other stakeholders are not also better off.[181] Unlike other no-fault compensation movements, medical malpractice no-fault schemes have failed to command consensus from the various relevant stakeholders about both the magnitude of the problem and its viability as a solution.[182]

Despite general dissatisfaction with the current malpractice system, some stakeholders have "vested interests in the status quo and could be expected to resist any initiative of this kind," while others may be more receptive.[183] Plaintiffs' attorneys stand to lose profits under a no-fault scheme that requires fewer hours of preparation than a typical tort case and limits the upper boundaries of plaintiff recovery.[184] Patients may more readily support a no-fault program if they are adequately informed about the various benefits such a program can offer.[185] Hospitals would be understandably cautious about such sweeping reform but have good business reasons for supporting such programs, as their customers (patients and physicians) are the stakeholders that would most benefit from and support the programs.[186] OBGYNs have good reasons to advocate for such programs, because replacing the existing malpractice structure with

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181. See Thomas R. Phillips, The Constitutional Right to a Remedy, 78 N.Y.U. L. Rev. 1309, 1335 (2003) (noting that jurisprudence is mixed on this matter at the state level, with some states holding "that the substitute need only benefit society as a whole, while others require that it benefit the individual plaintiff" (footnote omitted)).

182. For example, workers' compensation provided injured employees access to quick, guaranteed compensation by waiving their tort suits, while employers benefitted from a decline in enormous payouts. See Mello et al., Policy Experimentation, supra note 49, at 77 ("Employers . . . gained broad immunities from full-blown litigation at a time when historical barriers to workers' recovery, such as fellow servant and assumption of risk doctrines, were beginning to be eroded by the courts."). Similarly, no-fault automobile insurance featured the tradeoff of forfeiting the right to sue in court in exchange for guaranteed coverage in the event of an accident. See id. at 78–79. Stakeholders of a no-fault program for birth-related injuries may include patients, physicians, hospitals, liability insurance companies, and plaintiffs' attorneys, among others. See, e.g., Barringer et al., supra note 69, at 743.

183. See Mello et al., Policy Experimentation, supra note 49, at 62.

184. See Sloan & Chepke, supra note 20, at 171; Tappan, supra note 28, at 1126–27 ("Attorneys who bring medical-malpractice claims probably stand to lose the most if a no-fault system were implemented.").

185. See ACOG, NICA Report, supra note 102, at 4 ("[F]amilies who face a decision as to whether they should apply for NICA benefits, often seem unclear as to the risks they undertake by foregoing [sic] NICA compensation."). Recent Maryland efforts have shown that campaigns to explain the various benefits of no-fault may boost public support. See Letter from Steve Raabe, President, OpinionWorks, to Md. Maternity Access Coal. 1–2 (Jan. 19, 2016) (on file with the *Columbia Law Review*). A statewide poll of Maryland voters found an overwhelming preference for the creation of a birth-injury fund over compensating families through the courts upon learning about no-fault compensation. See id. at 1 (finding that "71% of voters support[] the creation of a birth injury fund, and only 16% oppose[]").

186. See Mello & Brennan, supra note 90, at 1629 ("A health center could market itself as a responsible institution, committed to providing compensation for avoidable injuries that is prompt, fair, and integrated with a physician reporting system.").

a no-fault system would likely ease the burden of costly liability insurance coverage and abolish the social and emotional consequences of malpractice litigation.[187] Liability insurance companies would probably support reform that places limits on noneconomic recovery, but given their desire for predictability,[188] they might also hesitate to fully embrace an untested, national no-fault program.[189] Ultimately, active stakeholder consensus and quid pro quo will prove instrumental in enacting comprehensive medical malpractice reform. So how do we coalesce stakeholder consensus?

3. *Refocusing the Narrative to Patient Benefit.* — Early public discourse about no-fault compensation programs featured a central focus on the victims,[190] but current tort reform conversations too often seem to cloud this focus, in turn minimizing the perception of a crisis. Talk of patient care frequently bows to discussions about helping physicians burdened with high liability insurance costs, failing to emphasize that lowering physician insurance costs ultimately addresses the needs of patients.[191] Therefore, recalibrating the no-fault narrative demands that legislative efforts tout the benefits of such a system not only to physicians but also to patients—namely, that it clears a potential barrier limiting women's access to OBGYN services, ensures affordable and quality patient healthcare, and provides efficient compensation to victims of medical malpractice.[192] Broadcasting the risky proposition of maintaining the status quo[193] and the benefits to patients of a no-fault compensation program *in addition* to highlighting what other stakeholders stand to gain would help bolster support for comprehensive reform.[194] It is this patient–physician narrative that distinguishes no-fault programs from traditional reform measures. Indeed, the objectives of addressing physician insurance

187. See supra section II.A.2; see also Bovbjerg & Sloan, supra note 18, at 109, 114 (contending that practitioners "report general satisfaction with no-fault").

188. See Heller, supra note 12, at 147.

189. See Mello et al., Policy Experimentation, supra note 49, at 63.

190. See Barringer et al., supra note 69, at 729–31 (explaining that workers' compensation and no-fault automobile insurance were, in part, products of serious public concerns about failure to adequately compensate victims for their injuries).

191. See Sloan & Chepke, supra note 20, at 287 (noting that BIP and NICA were established with a focus that was "overwhelmingly on medical malpractice cost containment, not on the unmet needs of injury victims"); Kachalia & Mello, supra note 15, at 1566 ("[E]valuations of traditional tort reforms have remained heavily focused on metrics related to liability costs, with most care-related measures receiving relatively short shrift.").

192. See supra section II.A.1.

193. See Casey Quinlan, Our Country Is Facing a Serious OB-GYN Shortage, ThinkProgress (July 20, 2017), http://thinkprogress.org/obgyn-shortage-a5bc9110d6f2 [https://perma.cc/WED8-PR8D] (warning that the lack of adequate medical care "could prove deadly").

194. Workers' compensation and automobile insurance programs effectively focused on both victim benefits and comparable benefits to other stakeholders. See Barringer et al., supra note 69, at 729–32.

premiums and preserving patient access to healthcare need not be mutually exclusive.

CONCLUSION

The ripple effects of medical malpractice litigation reach the far corners of the healthcare industry, adversely affecting patients and healthcare providers. These consequences could culminate in a serious shortage of OBGYNs to meet the growing national demand for services, threatening women's access to essential healthcare. Despite state legislative attempts to address medical malpractice litigation following prior crises, the tort liability system falls short of its goals, and fears of medical malpractice crises persist. Existing reforms largely leave in place the current compensation structure for medical mistakes while tinkering with the margins of medical malpractice law. Unfortunately, none of the proposals alone may be enough to address the approaching OBGYN workforce shortage. This highlights the need for comprehensive and long-term—rather than piecemeal and short-sighted—change to the status quo. Given the looming threats, the time is ripe for revisiting a federal approach to tort reform. When dealing with a matter affecting women's access to essential services, the system should be proactive in enacting change, rather than maintaining the reactive policy of waiting for the next tide of medical malpractice crisis.