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Jaden Cowdin
jaden.cowdin@gmail.com

Tyler Lindley
tyler.b.lindley@gmail.com

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A NEW MEDICAL MALPRACTICE TORT SYSTEM: IT'S TIME TO PRIORITIZE THE PATIENT

Jaden Cowdin¹ and Tyler Lindley²

Just over three years ago, the author married his beautiful wife Lindsay. Unfortunately, disaster struck a few months after their wedding. Lindsay fell incredibly ill and was hospitalized. Her condition worsened to the point that the author feared she would never recover. To make matters worse, Lindsey was left in the care of a seemingly negligent doctor. Without performing any of the standard tests, he diagnosed her with a condition called SMA syndrome. The diagnosis required a nasal feeding tube—which goes past the stomach deep into the intestines—to be inserted. Both the procedure to insert the tube and its maintenance were unpleasant. This doctor unsuccessfully treated Lindsay for four months before they obtained a second opinion. Upon receiving a second opinion, the new doctor performed the obvious test and

1 Jaden Cowdin is a senior at Brigham Young University studying sociology with an emphasis in medical sociology. He plans on attending law school in fall 2019. He wishes to thank the generous efforts of Jaden Cowley for his impeccable editing and insights for the paper. He also wishes to thank his co-author Tyler Lindley for all his efforts to help capture the vision of this paper. Furthermore, special thanks are given to the editing board and Kris Tina Carlston for their work on this review.

2 Tyler Lindley is a senior at Brigham Young University finishing his degree in economics with a minor in legal studies. He will enroll in law school in the fall of 2018. He wishes to thank his co-author Jaden Cowdin for allowing him to share a passion for this wonderful idea and contribute to the development of this paper and this proposal. He would also like to thank Jaden Cowley, the review board—especially Kendall Orton—and Kris Tina Carlston. Lastly, he would like to thank his wife Katrina for all of her patience and support.

immediately gave Lindsay a different diagnosis. The feeding tube was subsequently removed, but those four months of mistreatment have caused issues with which Lindsay still struggles today.

The author's frustrations with the offending doctor caused him to research possible legal action. After researching the topic, he realized that his desire to sue this practitioner was misguided. Although malpractice lawsuits may help the victimized patient, they exacerbate problems, such as increased health care costs and the increased practice of defensive medicine.³ How can we properly compensate victimized patients while minimizing the negative effect of malpractice suits on health care costs and defensive medicine? Current attempts at tort reform are aimed at capping rewards for non-economic damages and contingency fees in malpractice cases.⁴ These attempts have proved ineffective and have been met with negative treatment by patients and patient-advocacy groups.⁵ Despite the prevalence of unsuccessful attempts, we propose that such a resolution does exist and has already been proposed by state legislatures. This resolution includes a replacement of the current tort system in favor of a malpractice review board, together with a demerit system that reports negligent physicians without additional financial strain. This review board and demerit system would effectually replace litigation within medical malpractice. Adopting this solution will slow down increasing insurance premiums and decrease the prevalence of defensive medicine,

3 Daniel Kessler and Mark McClellan, *Do Doctors Practice Defensive Medicine?* 111 *THE QUARTERLY JOURNAL OF ECONOMICS* 353 (1996) (presenting evidence that defensive medicine is prevalent and can be reduced to a degree from tort reform). See also M. Sonal Sekhar and N. Vyas, *Defensive Medicine: A Bane to Healthcare*, 3(2) *ANN. MED. HEALTH SCI. RES.* 295 (2013) (discussing defensive medicine and its effect on healthcare prices generally).

4 Richard E. Anderson, M.D., *Case Study: Effective Legal Reform and the Malpractice Insurance Crisis*. 5 *YALE J. HEALTH POL'Y L. & ETHICS* 341 (2005) (summarizing many of the popular reform among states).

5 Valerie Witmer, *Third Annual Health Law Colloquium: A Patient Perspective: Focusing on Compensating Harm*. 13 *ANN. HEALTH L.* 589 (2004).

while still providing the benefits of the current tort system.

In this paper, we will explore this proposal in greater detail and explain why it would be effective and realistic. In section I, we will give background information regarding the current malpractice tort system and its history. Section II gives an in-depth analysis on the current problems within the system and futile attempts at its reform. Following this analysis, Section III details our proposed replacement and demonstrates its support and practical nature. A few states have already begun to debate similar ideas in their legislatures; each will be evaluated in detail. Section IV will conclude the paper and contains a call to action for all members of state legislatures to examine the current malpractice climate in their respective states and propose and vote for bills aligned with the proposals presented in this paper.

I. A GLANCE AT THE CURRENT MALPRACTICE TORT SYSTEM

Malpractice law falls under tort—or personal-injury—law. An effective medical malpractice law and its accompanying tort system is supposed provide relief to victims of malpractice, deter negligent behavior by physicians, and improve the overall quality of health care delivery.⁶ To succeed in a medical lawsuit, the plaintiff must satisfy the following established criteria:

- 1) The plaintiff must show that the defendant owed a duty of care to the plaintiff.
- 2) The plaintiff must prove that the defendant breached this duty of care.
- 3) The plaintiff must demonstrate that the defendant breached this duty by failing to adhere to the standard of care expected.
- 4) The plaintiff must show that this breach of duty caused injury to the plaintiff.⁷

6 David Studdert, Michelle Mello, Troyen A. Brennan, *Medical malpractice*. 23 THE NEW ENG. J. OF MED: 283. (2004).

7 *Id.*

The standard of care referred to is defined by the state where the alleged incident occurred. The attorney for the plaintiff serves as the system's gatekeeper because claims rarely move forward without counsel.⁸ Once an attorney determines that the patient has a case against a physician, the attorney becomes the pivotal player in determining the amount to be awarded for damages.⁹

In theory, the malpractice system functions as follows: the courts serve as a general deterrence and provide a method of reparation in cases where self-regulation of physicians has failed to provide the adequate standard of care.¹⁰ Plaintiffs' attorneys facilitate this process by separating valid claims from illegitimate ones, and liability insurance for physicians protects health care providers from bankruptcy.¹¹ However, the current application of the system is more complicated and less efficient.¹² Unnecessary spending is prevalent as doctors practice defensive medicine, by ordering tests and procedures out of fear of getting sued, rather than concern for the patient.¹³ The patient pays the additional costs from these tests and procedures; furthermore, physicians face increased malpractice insurance premiums which are passed onto the consumer.¹⁴

Numerous attempts at reform have occurred on the state and national levels to return to a simpler, more efficient system. In 2000, the Bush administration proposed a national \$250,000 cap on non-economic damages in medical malpractice awards.¹⁵ At the state level,

8 *Id.*

9 *Id.*

10 *Id.*

11 *Id.*

12 *Id.*

13 Kessler, *supra* footnote 3.

14 Adriaan Ten Kate and Gunnar Niels, *To What Extent are Cost Saving Passed on to Consumers? And Oligopoly Approach* 20 EUROPEAN J. OF L. AND ECON. 323, (2005) (a brief discussion on how costs are passed on to consumers regardless of the assumed market structure).

15 Michelle Diaz, *The Real Emergency: Will Florida Follow Georgia in Medical Malpractice Reform*, 40 NOVA L. REV. 185 (2015).

Georgia has changed the standard of evidence for proving malpractice from a preponderance of the evidence to a higher and more convincing standard of proof, but “only when a practitioner has shown a standard of gross negligence.”¹⁶ States like Utah, Arizona, and North Carolina have followed Georgia, but exclude “only when a practitioner has shown a standard of gross negligence.”¹⁷ Other states, like Florida, have attempted to institute caps on non-economic damages that vary based on the specialty of the provider being sued.¹⁸ These reforms seek to mitigate the rising costs of liability insurance—and, therefore, health insurance premiums—and limit defensive medicine.

II. ISSUES CAUSED BY THE CURRENT MALPRACTICE TORT SYSTEM

A. Health Insurance Premiums on the Rise

The average annual cost of health insurance premiums for employer-sponsored family coverage reached \$16,029 in 2013.¹⁹ This is a 73 percent increase from the average cost in 2003 of \$9,249.²⁰ During that same time period, premiums for single coverage also increased from \$3,481 to \$5,571 per year, a 60 percent increase.²¹ Additionally, insurance premium increases outpaced income growth during this period: while the average family premiums have risen 73 percent, median family income has risen merely 16 percent over the same period.²² In 2013, annual family premiums constituted 23 percent of the median family’s income, up from 15 percent in 2003 and

16 *Id.*

17 *Id.*

18 David Studdert, Michelle Mello & Troyen A. Brennan, *Medical Malpractice*. 23 THE NEW ENG. J. OF MED. 283 (2004).

19 Sara R. Collins, David C. Radley, Cathy Schoen &, Sophie Beutel, 32 *National Trends in the Cost of Employer Health Insurance Coverage, 2003-2013*. ISSUE BRIEF. NEW YORK, NY: THE COMMONWEALTH FUND (2014).

20 *Id.*

21 *Id.*

22 *Id.*

21 percent in 2010.²³ Apart from premiums, deductibles have more than doubled from 2003 to 2013, up from an average of \$1,575 to \$3,761 annually for family plans.²⁴ This data reveals stark increases in health insurance costs without a corresponding increase in coverage. Unfortunately, medical malpractice plays a role in this increase.

Medical malpractice represents a respectable portion of all health care expenditures. The medical malpractice system costs the country approximately \$55.6 billion a year according to a study by the Harvard School of Public Health.²⁵ Given this large amount and the fact that the vast majority of malpractice payouts are paid by physicians themselves, some have suggested it directly affects the patient's health care costs. An article from the *American Journal of Medical Research* discusses the idea that the prevailing growth in malpractice premiums contributes to the growth in health care costs.²⁶

The connection between medical malpractice and health insurance premiums is supported by economic theory.²⁷ When malpractice insurance premiums increase from the number of lawsuits and payouts, state regulations, or other factors, doctors are left to

23 *Id.*

24 *Id.*

25 Michelle M. Mello, Amitabh Chandra, Atul A. Gawande and David M. Studdert, *National Costs of the Medical Liability System* 29(9) HEALTH AFF. (MILLWOOD) 1569 (2010).

26 Gheorghe H. Popescu, *Increased Medical Malpractice Expenditures as a Main Determinant of Growth in Health Care Spending*, 2(1) AM. J. MED. RES. 80-86 (2015) (“The expansion of medical malpractice liability expenditures may impact the distribution of health care in the U.S. The predicted payouts experienced by insurers tend to have a first-order consequence on malpractice premiums. Rises in malpractice premiums increase the expenditures of doing business for physicians and hospitals... The medical malpractice procedure is a time-consuming and costly approach for recompensing individuals who are injured as a consequence of (not) receiving treatment. The increased expenses of medical malpractice insurance premiums are a sign that the medical malpractice system is imperfect. Medical malpractice is an element of second-order significance among drivers of rises in health care expenditure and of reductions in patient access to care.”).

27 Kate, *supra* footnote 14.

absorb the higher costs. As a result, many of these costs are passed on to consumers as physicians charge more for medical services and health insurance companies are forced to cover the additional charges. In turn, health insurance companies raise premiums and deductibles to balance the increased cost of providing coverage. Patients, largely unaware of the effects, continue to move forward with lawsuits—both frivolous and non-frivolous—relying on a settlement paid for by malpractice insurance and not considering the consequences of such actions. This cycle continues due to a lack of an immediate individual incentive to stop—a modern-day prisoner’s dilemma.²⁸

B. Medical Malpractice as a Cause of Defensive Medicine

By definition, defensive medicine is the performance of unnecessary procedures due to fear of malpractice suits.²⁹ When a doctor orders too many tests or prescribes treatment out of fear of being sued for failing to meet the perceived standard of care, regard for the patient decreases and the market becomes inefficient. Of the \$55.6 billion spent on medical malpractice in 2008, defensive medicine cost \$45.6 billion; roughly 80 percent of all malpractice spending. Defensive medicine creates unnecessary expenses for the consumer receiving medical care. We understand the doctor’s situation; however, a doctor should not be performing medical tests out of fear of lawsuit rather than a regard for the patient. Senator Orrin Hatch said the following in a prominent medical journal regarding his discussions with physicians about defensive medicine: Hatch said the following in a prominent medical journal regarding his discussions with physicians about defensive medicine:

The constant threat of litigation leads physicians to perform extraneous and often inappropriate procedures, the costs of which they have no choice but to pass on to

28 WILLIAM POUNDSTONE, PRISONER’S DILEMMA: JOHN VON NEUMANN, GAME THEORY AND THE PUZZLE OF THE BOMB. (Reprint Ed., 1993).

29 Sekhar, *supra* footnote 3.

their patients. To stay in business, physicians must do everything they can to avoid being sued and to keep the costs of their malpractice insurance premiums from going through the roof.³⁰

Since over 90 percent of Americans are covered by some form of health insurance, these cost shifts are seen in increased health insurance premiums, adding further evidence to earlier discussion about the connection between medical malpractice and health insurance premiums.³¹

C. Attempts at Tort Reform

Caps on non-economic damages are popular among current proponents of reform, but this attempt at reform is inherently flawed. The scarcity of high-stakes malpractice cases affected by such caps minimizes any effect this policy might have.³² Caps on non-economic damages also do not fully address rising costs of medical malpractice insurance or defensive medicine. If doctors are still being sued at a high rate, malpractice insurance will continue to rise and defensive medicine will remain prevalent in physicians' typical practice. Other opponents to damage caps claim that this effort to improve efficiency unfairly burdens victims of true malpractice.³³ In fact, the constitutionality

30 Sen. Orrin G. Hatch, *Invited Commentary—It Is Time to Address the Costs of Defensive Medicine: Comment on “Physicians’ Views on Defensive Medicine: A National Survey,”* 170(12) ARCH. INTERN. MED. 1081 (2010) doi:10.1001/archinternmed.2010.155.1.

31 *Health Insurance Coverage*, CENTER FOR DISEASE CONTROL AND PROTECTION, <https://www.cdc.gov/nchs/fastats/health-insurance.htm> (last visited November 2017).

32 Neil Vidmar, *Juries and Medical Malpractice Claims: Empirical Facts versus Myths*. 467 CLINICAL ORTHOPAEDICS AND RELATED RESEARCH 367, (2008).

33 Zenon Zabinski and Bernard S. Black, *The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform*. NW. LAW & ECON. RES. PAPER No. 13-09 (2015).

of such bans has been recently called into question at a state level.³⁴

Other reform proposals have included raising the standard of proof to a higher and more convincing standard of proof.³⁵ Raising the standard may deter a small number of malpractice lawsuits that are inherently trivial, but the decrease does not seem to be getting at the root of the problem. Additionally, physicians have an incentive to avoid litigation and instead settle. Although the reform may increase the fraction of lawsuits that fail to meet the standard, it will not change the physician's incentive to settle even frivolous suits out of court.

It is becoming increasingly evident that tort reform at the state or any level is relatively ineffective. State legislatures should begin to look at potential replacements to the current tort system despite its more extensive nature. Replacement is rational for any state legislation attempting to make the malpractice system more cost efficient and properly incentivize physicians.

III. PROPOSED ALTERNATIVE TO THE CURRENT MALPRACTICE TORT SYSTEM

A. *Analogous Alternatives to Litigation*

Our proposed replacement of the current malpractice tort system is not entirely unprecedented. Other fields of law have similar features and help us understand why alternatives to litigation can be in the best interest of opposing parties. In family law, mediation in a number of states is often required before the parties can proceed in the courts. For example, the state of Utah requires that the parties attempt mediation before litigation can commence.³⁶ This structure is conscious of the costs associated with legal processes; in fact, extensive and often unnecessary litigation costs can be avoided if the parties come to voluntary agreements.

34 Jim Saunders, *Malpractice Damage Caps struck down by Florida Supreme Court*. ORLANDO SENTINEL, 2017.

35 See *supra* Section I.

36 UTAH ADMIN CODE R. 30-3-39 (2008).

Another example of an alternative is insurance company review boards for insurance claims regarding issues like personal injury. Rather than immediately suing an insurance company for damages, the insurance company reviews the patient claim and proposes a compensation package in the form of an arbitration clause that satisfies the complainant and prevents further legal action. This can be beneficial to both parties; the insurance company is not required to engage in a legal battle rife with substantial monetary losses and reputational risks, and the injured party receives compensation much faster and does not share awards with an attorney. Additionally, many state-funded profession boards, such as the state bar, are authorized to hold hearings to determine whether an attorney can practice law and other sanctions.³⁷

B. *Vermont's Proposed Alternative*

Similar to the methods in other areas of law, an alternative approach to malpractice may prove more cost-efficient and reduce defensive medicine practices while still requiring the high standard of care that current medical malpractice law seeks to uphold. We propose that the alternative should originate with the adoption of an independent medical review board established by the state. As previously mentioned, this proposal is not entirely unprecedented.

In 2013, the Vermont state legislature proposed a no-fault compensation program for medical injury claims brought against primary care physicians in Vermont. Their proposal attempted to “streamline remedies for injured patients, free medical providers to participate in health care rather than time-consuming lawsuits, and dramatically scale back the time and expense of litigation.”³⁸ They further hypothesized that this system would cost the state less than the current litigation system and more effectively provide timely compensation to a greater number of patients.³⁹ Additionally, they

37 *Ohralik v. Ohio State Bar Association*, 436 US 447 (1798).

38 H.B. 35, 2013 Leg., (Vt. 2013).

39 *Id.*

claimed the proposal will “preserve the doctor’s role as the patient’s advocate, as opposed to the litigation-based system in which the doctor and patient become adversaries.”⁴⁰ The review board would be controlled by the state commissioner of financial regulation and would consist of five members: (1) one primary care physician licensed to practice in Vermont, (2) one attorney licensed to practice in Vermont who has experience with medical malpractice, (3) one person employed by a health insurer, and (4) two public members.⁴¹

The members of the board would have the authority to review claims submitted by complainants requesting compensation for medical injury at the hand of a primary care physician.⁴² They would meet at least monthly to review petitions and grant awards at their discretion.⁴³ Interestingly, primary care physicians would pay an annual fee into a fund to reimburse the review board’s expenses and pay for successful claims, replacing malpractice insurance premiums.⁴⁴ The “no-fault” part of the proposal essentially means that a particular physician’s annual payment will not increase if an award is granted from his negligence. Eliminating litigation and the need for malpractice insurance combined with the “no-fault” annual fee should mitigate the excessive fear being sued and make malpractice law more efficient.

Although the bill is intriguing, it has not yet gained enough traction to be passed into law.⁴⁵ This is likely the result of clear demerits to the proposal. Mainly, the scope is limited to primary care physicians. It does not reach far enough to totally replacement to the current tort system. Only 5.2 percent of family-care physicians have

40 *Id.*

41 *Id.*

42 *Id.*

43 *Id.*

44 *Id.*

45 *Bill Status H.35*, VERMONT GENERAL ASSEMBLY, <https://legislature.vermont.gov/bill/status/2014/H.35> (last visited March 19, 2018).

claims brought against them, the third lowest of all specialties.⁴⁶ I argue that this alternative method must be applicable to all practicing physicians to be sufficiently effective. This is because most claims of malpractice are brought against specialty physicians such as neurosurgeons or cardiovascular surgeons.⁴⁷ Second, the Vermont proposal fails to address how it will effectively punish primary care physicians who are repeatedly, grossly, or willfully negligent. Although such instances are rare, failure to include such provisions are inexcusable and quite alarming given the potential consequences. Two other concerns are conflicts of interest and the appeals process. These issues make Vermont's bill fragmented and incomplete and make its denial justifiable. Despite its weakness and ultimate failure, the proposal of an alternative malpractice system should not go unnoticed. Given the right provisions, such a system could survive and be more effective than the current structure.

C. Georgia's Proposed Alternative

Also in 2013, members of the Georgia legislature proposed a similar bill that sought to replace their malpractice tort system.⁴⁸ The alternative includes all physicians in the state of Georgia regardless of specialty. Many of the numerous reasons cited for the proposal were parallel to Vermont's. These included pertinent issues like defensive medicine, significant delays in compensation to injured patients, and attorneys only taking "high-stakes" cases at the expense of the other patients who have legitimate claims. The creators of the bill said the proposal "intended to significantly reduce the practice of defensive medicine, thereby reducing health care costs, increasing the number of physicians practicing in this state, and providing patients fair and timely

46 Anupam B. Jena, Seth Seabury, Darius Lakdawalla and Amitabh Chandra. *Malpractice Risk According to Physician Specialty*. 365 N ENG J. MED 629 (2011).

47 Anupam Jena, Seth Seabury, Darius Lakdawalla, Amitabh Chandra, *Malpractice Risk According to Physician Speciality*, 365 N Eng. J. Med. 629, 629 (2011).

48 Patient Injury Act, S.B. 141, 152nd Gen. Assemb., Reg. Sess. (Ga. 2013).

compensation without the expense and delay of the court system.”⁴⁹

The bill creates the Patient Compensation System which shall be governed by the Patient Compensation Board. The members of the board shall serve four-year terms and shall elect a chair of the board annually. This board would be composed of eleven members:

- Five members shall be appointed by the governor:
 - An actively practicing physician in the state,
 - A business executive in the community,
 - A hospital administrator,
 - A certified public accountant who actively practices in the state,
 - And an actively practicing attorney.
- Three members shall be appointed by the lieutenant governor:
 - A practicing physician in the state,
 - A patient advocate,
 - And one who does not need to meet any specific criteria.
- Three members shall be appointed by the Speaker of the House of Representatives subject to the same stipulations as the Lieutenant Governor.⁵⁰

This board, like the Vermont board, would oversee the review and compensation of malpractice claims in the state of Georgia. If a potential conflict of interest with a board member exists, the board member must detail in writing this conflict of interest and recuse himself or herself from the case. Similar to Vermont, compensation by the Patient Compensation System shall be funded by the physicians of the state. The amount would be determined on an annual basis by the board. Another key provision included is an appellate process. An administrative judge shall be appointed to review all appeals, solely deciding whether the review board took the appropriate and necessary steps to determine compensation for the patient. If the

49 *Id.*, p. 4.

50 *Id.*, p. 5.

judge determines the board failed in its duty, the case is remanded to the board for a second, more thorough review. If the review board justly handled the claim, the judge confirms the original decision.⁵¹

Following an analysis of the two proposals, one can see the Georgia proposal's greater desirability in comparison to Vermont's bill. Many of the gaps in Vermont's bill were addressed and properly resolved. Disappointingly, this bill has not yet been passed into law.⁵² Though improved, the proposal still failed to address the major concern of punishing physicians who are repeatedly, grossly, and/or willfully negligent. This must be a part of any recommended replacement of malpractice tort law.

D. *Our Proposed Alternative*

To reiterate, we do not believe it damning that neither of these bills has passed. Rather, they serve as stepping stones to passing a law that replaces the current malpractice tort system. A sound proposal must incorporate sound aspects from the previous proposals while addressing physician accountability in a way that incentivizes a high standard of care instead of defensive medicine. Georgia's legislation accomplished much of the legwork in establishing a comprehensive and plausible alternative, lacking only a provision to hold physicians accountable. For this reason, we would advocate adopting Georgia's approach and to simply add a system to hold physicians to the appropriate standard of care. This can be accomplished by requiring clinics and hospitals to publicize instances in which compensation was awarded to injured patients for malpractice, including the name of the involved physician. If requiring hospitals to do this proves difficult, the state could utilize to the National Practitioner's Data Bank, which contains all lawsuits and adverse actions brought against

51 *Id.*, p. 8-9.

52 *SB 141 2013-2014 Regular Session*, GEORGIA GENERAL ASSEMBLY, <http://www.legis.ga.gov/Legislation/en-US/display/20132014/SB/141> (last visited March 19, 2018).

a physician.⁵³ Traditionally, this database is only available to hospitals, federal and state health agencies, and other qualifying entities, but its application here seems logical.⁵⁴ The increased accountability will hold doctors to a high standard without imposing an increased fear of losing funds, thus lowering the prevalence of defensive medicine. This requirement has already been proposed by the state of New York.⁵⁵ It effectually deters physicians from being careless in their methods of practice and ensures they keep the patient's best interest at heart without incentivizing defensive medicine. careless in their methods of practice and ensures they keep the patient's best interest at heart without incentivizing defensive medicine.

A "black mark" on a physician's public record need not be permanent. In fact, depending on the severity, this should not be the case. If the black mark were perpetual, physicians may continue to practice defensive medicine and our system would become obsolete. Physicians should have the opportunity to take ethics courses prescribed and provided by the medical review board. Upon completion, the board may permit the omission of such marks. Details should be determined by the established medical review board, but theoretically, this simple addition should prove effective in removing the incentive for defensive medicine. Like having a driver's license, practicing medicine is a privilege with consequences for improper use. Physicians should be given the chance to clear their record, granted no additional successful claims are brought forward and the appropriate courses are taken and passed. In more severe cases that privilege may not be granted; we would defer to the greater judgment of the established medical review board to make such distinctions. Also noteworthy is the fact that all criminal charges regarding physicians should and will not be affected by this proposal. The current system already makes this distinction, and

53 *About Us*, NATIONAL PRACTITIONER DATA BANK, <https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp> (last visited March 16, 2018).

54 *What is the NPDB?*, National Practioner Data Bank, <https://www.npdb.hrsa.gov/resources/whatIsTheNPDB.jsp> (Last visited March 16, 2018).

55 A.B. 4764, 2013 Leg., (N.Y. 2013).

after criminal acts, physicians are subject to criminal proceedings.

We are conscious that this replacement may or may not decrease overall health care spending by the state, but it will make a more cost-efficient system that deters unnecessary spending on litigation and defensive medicine. Furthermore, it will allow the focus to be centered back to the patient, which is the original intent of the malpractice system.

IV. CONCLUSION

The billions spent annually on a broken tort system, the prevalence of defensive medicine, and failed attempts at reforming the system all make a replacement of the current malpractice tort system necessary. Patients are suffering medically and financially at the hand of a system failing to live up to its aspirations of patient-first care. Health care insurance premiums continue to rise due to increased health care costs, partially fueled by the increase of defensive medicine and the increasing cost of liability insurance. More important, patients rarely benefit from defensive medicine and even face severe negative consequences from such practices. Yet, it is hard to blame clinicians for practicing defensive medicine when they are involved in the current malpractice system. It would be unrealistic to expect a physician who fears a lawsuit and a severe increase in malpractice premiums to refrain from practicing defensive medicine.

We are certainly not the first to see such concerns in the health care environment as legislation from many states have attempted reform. As outlined in this paper, these attempts do not resolve the core issue found within the tort system itself. As long as medical lawsuits are prominent, malpractice insurance and defensive medicine will continue to rise at the expense of the physician and, consequently, the patient. The best resolution is a replacement of the current system. This undertaking may seem daunting, but examining the successes and failures of previous replacement attempts makes this task feasible. Using the proposed legislation in states such as Vermont, New York, and Georgia, we have proposed a novel—yet practical—solution that maintains the accepted standard of care without incentivizing physicians to practice defensive medicine.

We admit that our resolutions constitute only a basic framework for such a replacement, and we defer the details of implementation to the expertise of state officials. Therefore, we call upon legislatures from each state to assess the malpractice climate within their own region and implement a replacement using the framework outlined in our paper.

