DePaul University
UNIVERSITY LIBRARIES

DePaul Law Review

Volume 63
Issue 2 *Winter 2014: Symposium - A Brave New World: The Changing Face of Litigation and Law Firm Finance*

Article 12

# Doulbe, Double, Toil and Trouble: Justice-Talk and the Future of Medical Malpractice Litigation

David A. Hyman

Charles Silver

Follow this and additional works at: https://via.library.depaul.edu/law-review

## Recommended Citation

David A. Hyman & Charles Silver, *Doulbe, Double, Toil and Trouble: Justice-Talk and the Future of Medical Malpractice Litigation*, 63 DePaul L. Rev. 547 (2014)
Available at: https://via.library.depaul.edu/law-review/vol63/iss2/12

This Article is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Law Review by an authorized editor of Via Sapientiae. For more information, please contact digitalservices@depaul.edu.

# DOUBLE, DOUBLE, TOIL AND TROUBLE: JUSTICE-TALK AND THE FUTURE OF MEDICAL MALPRACTICE LITIGATION

*David A. Hyman & Charles Silver**

I said there is no justice as they led me out the door
And the Judge said
"This isn't a court of justice, son.
This is a court of law."[1]

## INTRODUCTION

It's not easy being a lawyer. "Biglaw" may not be dead (yet), but major firms have dissolved, filed for bankruptcy, and shed partners and practice groups.[2] Small and mid-sized firms and solo practitioners are facing similar challenges. Some of these developments are attributable to the financial crisis and the Great Recession. Others are the result of structural and technological changes affecting the market for legal services—and those changes have revealed new weaknesses in the business forms through which lawyers have traditionally delivered legal services.

To most inhabitants of Biglaw, these changes and challenges are unprecedented, but to lawyers who do medical malpractice and personal injury litigation, market turbulence of this sort is old hat. Over the past three decades, there have been dramatic changes in the market (and demand) for such services. Some of these changes are clearly attributable to legislative action. For example, many states have made lawsuits less profitable for victims of malpractice and their lawyers by capping noneconomic or total damages. States have also made these lawsuits more expensive by putting procedural hurdles (including screening panels, certification requirements, and interlocutory appeals of expert witness reports) in the path that plaintiffs must follow to

* David A. Hyman is H. Ross & Helen Workman Chair in Law and Professor of Medicine, University of Illinois. Tel. 217-333-0061, e-mail: dhyman@illinois.edu. Charles Silver is McDonald Endowed Chair in Civil Procedure, University of Texas Law School. Tel. 512-232-1337, e-mail: csilver@law.utexas.edu.

1. BILLY BRAGG, *Rotting on Remand*, *on* WORKERS PLAYTIME (Elektra/Asylum Records 1988).

2. Larry E. Ribstein, *The Death of Big Law*, 2010 WIS. L. REV. 749, 751.

secure a recovery. The negative impact of these initiatives on litigation rates was predictable. But, even in states that have not taken such sweeping steps, there has been a long-term secular decline in the volume of medical malpractice litigation.

Apart from the highly visible public brawl over the merits of damage caps, these developments have attracted little attention. However, the dynamics are clear to those who wish to pay attention to them. In this Article, we explore these trends, highlight the ways in which they have interacted with one another, and then briefly discuss why it is not helpful to analyze these developments in terms of their impact on "access to justice." Part II identifies five developments that have affected the economics of plaintiff-side medical malpractice litigation—all in the direction of making such cases less remunerative. Part III explains why, despite routine practice to the contrary, we should stop talking about these developments in terms of their impact on "access to justice." Part IV concludes.

## II. Five Factors that Have Affected the Economics of Plaintiff-Side Medical Malpractice Litigation

### *A. Damage Caps*

Damage caps have been the most popular tort reform of the twentieth century (and, so far, the twenty-first century). As we have detailed elsewhere, roughly thirty states have adopted a diverse array of damage caps.[3] Some states cap only noneconomic damages. Some states cap total damages. Some states cap both. The severity of these caps varies, depending on the absolute dollar amount of the cap, whether it is adjusted for inflation (and if not, when the cap was enacted), and whether it varies by the number and type of defendants. Table 1 shows a breakdown of the caps that are in effect as of June 2013.

3. David A. Hyman, Bernard Black, Charles Silver & William M. Sage, *Estimating the Effect of Damage Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. Legal Analysis 355, 356 (2009).

TABLE 1: STATUTORY DAMAGE CAPS[4]

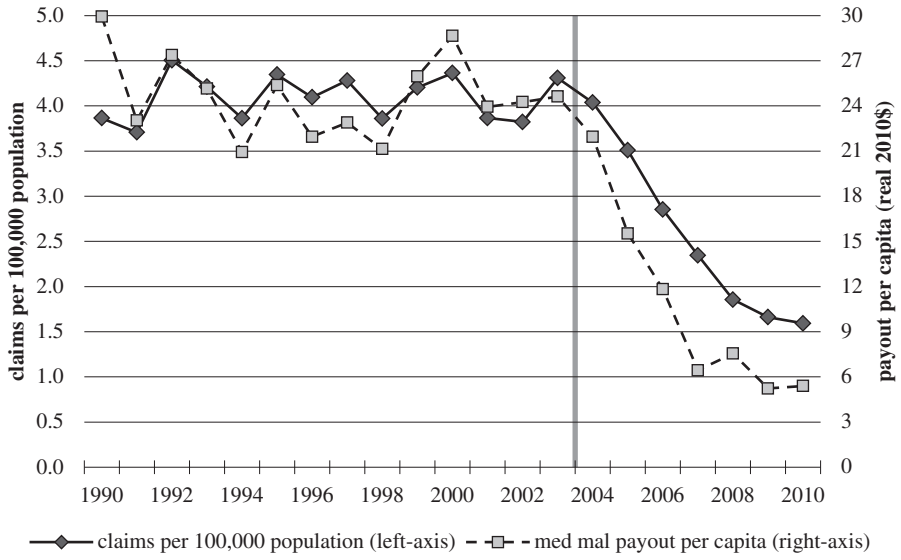
| **State** ***(*inflation adjusted*)*** | **Cap Type** | **Cap Level** |
|---|---|---|
| Louisiana | Total | $500k plus future medical expenses |
| New Mexico | Total | $600k plus future medical expenses |
| Colorado | Total<br>Noneconomic | $1M total; $300k noneconomic |
| Indiana | Total | $1.25M |
| Massachusetts | Total (hospitals),<br>Noneconomic (all) | $20k total (nonprofit hospitals); $500k noneconomic (all defendants) |
| Nebraska | Total | $1.75M |
| *Virginia** | Total | $1.95M |
| California<br>*Idaho**<br>Kansas<br>Montana | Noneconomic | $250k |
| *Oklahoma** | Noneconomic | $300k |
| *West Virginia** | Noneconomic | $250k, except $500k in death cases |
| Missouri | Noneconomic | $330k |
| Texas | Noneconomic | $250k–$750k, depending on number and type of defendants |
| Nevada | Noneconomic | $350k |
| Ohio | Noneconomic | Greater of $250k or (3x economic damages, up to $500k) |
| Hawaii | Noneconomic | $375k |
| Alaska | Noneconomic | $400k |
| *Utah** | Noneconomic | $409k |
| *Michigan** | Noneconomic | $641k |
| Georgia<br>South Carolina | Noneconomic | $350k–$1.05M, depending on number and type of defendants |
| Mississippi<br>North Dakota<br>South Dakota | Noneconomic | $500k |
| *Maryland** | Noneconomic | $650k |
| Florida | Noneconomic | $500k ($1M in death and other serious injury cases) |
| Wisconsin | Noneconomic | $750k |

Do these damage caps matter? If so, how much do they matter? Do they simply reduce payouts per claim, or do they also affect claim volume by making small-value claims less remunerative? Figure 1, drawn from other work we have done using Texas closed claims data, shows

4. *Id.* at 393–94 tbl. 11.

the impact of Texas's moderately strict 2003 cap on noneconomic damages.[5]

FIGURE 1[6] TIME TRENDS IN TEXAS MED MAL CLAIMS AND PAYOUTS, 1990–2010




As Figure 1 reflects, we observe a 61% decline in paid claims, and a 45% decline in payouts per capita during the post-reform period (i.e., comparing 2009 with 2003). Since plaintiffs' lawyers generally charge a contingency fee of one-third of the amount recovered, the combined effect is a 75% reduction in the amount of money received by plaintiffs—and a comparable reduction in the fees received by their lawyers. Other work has similarly shown that damage caps have a substantial impact on claiming and payouts, although the evidence is less clear for studies that do not account for tort reform's phase-in effects.[7]

---

5. *See* David A. Hyman, Charles Silver, Bernard S. Black & Myungho Paik, *Does Tort Reform Affect Physician Supply? Evidence from Texas* 7 fig. 1 (Univ. of Ill. Coll. of Law, Law, Behavior, and Social Science Research Papers Series, Research Paper No. LBSS12-12, 2012), *available at* http://ssrn.com/abstract=2047433.

6. Claims per 100,000 population by year for all claimants (left-axis), and payouts per capita (right-axis), for 14,995 non-duplicate, non-nursing-home, medical malpractice cases closed from 1990–2009 with payout > $25,000 in 1988 dollars. Texas tort reform in 2003 is depicted by the vertical line. Amounts are in 2008 dollars.

7. *See* Myungho Paik, Bernard Black & David A. Hyman, *The Receding Tide of Medical Malpractice Litigation: Part 2—Effect of Damage Caps*, 10 J. EMPIRICAL LEGAL STUD. 639 (2013).

### B. Caps on Attorney Fees

Caps on attorney fees have attracted far less attention than damage caps, but sixteen states have adopted them. Cap design varies, but most provide that lawyers can only charge a declining contingency fee as the size of the recovery increases. Table 2 provides a brief summary of the fee caps in each state and for claims brought pursuant to the Federal Tort Claims Act (FTCA).

TABLE 2: STATUTORY CAPS ON CONTINGENCY FEES[8]

| State | Fee-Limit Rule |
|---|---|
| California | Sliding scale, not to exceed 40% of first $50,000; 1/3 of next $50,000; 25% of next $500,000; and 15% of damages exceeding $600,000 |
| Connecticut | Sliding scale, not to exceed 1/3 of first $300,000; 25% of next $300,000; 20% of next $300,000; 15% of next $300,000; and 10% of damages exceeding $1.2 million |
| Delaware | Sliding scale, not to exceed 35% of the first $100,000 recovered; 25% of the next $100,000; and 10% of the balance |
| Florida | Sliding scale, not to exceed 30% of first $250,000; 10% of any award over $250,000 |
| Illinois | 1/3 of amount recovered (in effect since 2013). Previously, sliding scale on medical malpractice cases, not to exceed 1/3 of first $150,000; 25% of $150,000 to $1 million; 20% of damages over $1 million |
| Indiana | No limit on first $250,000; no more than 15% on amounts above $250,000 |
| Maine | Sliding scale, not to exceed 1/3 of first $100,000; 25% of next $100,000; and 20% of damages exceeding $200,000 |
| Massachusetts | Sliding scale, not to exceed 40% of first $150,000; 1/3 of next $150,000; 30% of next $200,000; and 25% of award over $500,000 |
| Michigan | 1/3 of amount recovered |
| Nevada | Sliding scale, not to exceed 40% of first $50,000; 1/3 of next $50,000; 25% of next $500,000; 15% of any amount over $600,000 |
| New Jersey | Sliding scale, not to exceed 1/3 of first $500,000; 30% of next $500,000; 25% of third $500,000; and 20% of fourth $500,000 |
| New York | Sliding scale, not to exceed 30% of first $250,000; 25% of second $250,000; 20% of next $500,000; 15% of next $250,000; 10% over $1.25 million |
| Oklahoma | 50% of net judgment |
| Tennessee | 1/3 of award |
| Utah | 1/3 of award |
| Wisconsin | Sliding scale, not to exceed 1/3 of first $1 million; 20% of any amount exceeding $1 million |
| FTCA | 20% of administrative settlements, and 25% of a judgment or compromise after suit is filed |

8. David A. Hyman, Bernard Black & Charles Silver, *The Economics of Plaintiff-Side Personal Injury Practice* 10 tbl. 2 (Univ. of Ill. Coll. of Law, Law, Behavior, and Social Science Research Papers Series, Research Paper No. LBSS13-28, 2013), *available at* http://ssrn.com/abstract=1441487.

We have been unable to locate any empirical research quantifying the impact of these fee caps. In other work, using a dataset comprised of plaintiff-side personal injury firms located in diverse states, we found that the probable impact of these fee caps would vary greatly, depending on both the details of cap design and the portfolio of cases handled by the firm.[9] Table 3 summarizes the "haircut" that the three of the firms in our dataset (located in Illinois, Texas, and an undisclosed third state) would take if the caps imposed by three states (California, Florida, and pre-2013 Illinois) had been applied to all of their cases.

TABLE 3: IMPACT OF FEE CAPS ON FIRM REVENUE[10]

| Firm | Fee Cap | | |
|---|---|---|---|
| | California | Florida | Illinois (pre-2013) |
| Illinois Firm | 27% | 45% | 18% |
| Texas Firm | 26% | 40% | 19% |
| Firm in Undisclosed State | 7% | 17% | 5% |

As Table 3 makes clear, a fee cap can have dramatically different effects when it is applied to firms with different case portfolios. California's fee cap reduces the third firm's fees by only 7%, but it reduces the fees for the Illinois and Texas firms by 27% and 26%, respectively—meaning there is more than a four-fold difference in the haircut on fees imposed on these firms by the same fee cap. Similarly, different fee caps can have dramatically different impacts when they are applied to the same firm. For example, the Texas firm would see a 19% haircut on its fees from the Illinois cap, but a 40% haircut from the Florida cap.

To be sure, Table 3 oversimplifies matters. The fee caps only apply to medical malpractice cases. But the firms we studied handled diverse types of cases, some of which did not involve medical malpractice. Because we applied the cap to all cases alike, our results overstate the likely impact of the fee caps. We also assume that fee caps do not affect case volume or case mix (i.e., we assume that firms continue to represent the same clients and seek the same damages) but that assumption is obviously unrealistic. By making cases less remunerative, fee caps discourage lawyers from taking some (or many) cases they would have otherwise accepted. The assumption of "no impact on case selection" biases our results downward. We think it

9. *See id.* at 3, 25–26.
10. *Id.* at 23 tbl. 10.

likely that the volume or case selection effect is larger than the non-medical malpractice case cap effect. If so, Table 3 underestimates the impact of fee caps on firm revenue.

Fee caps and damage caps are designed to bite hard only in the largest cases—and such cases typically constitute only a small fraction of plaintiffs' firms' dockets. So, why do fee caps and damage caps have such a large impact? The business model for plaintiffs' firms provides an obvious answer. For the law firms we have studied, and for firms studied by others, a minority of very large cases accounts for an enormous fraction of total revenues. The top 10% of cases handled by a plaintiff's firm (based on the amount of the recovery) can account for 50% or more of the firm's entire revenue. Policies that make these cases significantly less remunerative destabilize the basic economics of these firms and, more generally, of plaintiff-side practice.

### *C. Secular Decline*

Apart from the developments mentioned above, in other research we found a long-term secular decline in the frequency of medical malpractice litigation, even in states that have not adopted caps on damages or fees.[11] Between 2001 and 2012, we found a 50% decline in claim frequency (paid claims per 1000 physicians) in states that did not have a cap in effect during this period, compared to a 62% decline in states that adopted caps during the 1990s, and a 47% decline in states that adopted caps during the 1970s and 1980s.[12] Thus, for reasons that have nothing to do with tort reform, we are seeing fewer paid medical malpractice claims, even as health care spending and treatment intensity rise inexorably.

### *D. Subrogation*

Subrogation has had an increasingly significant impact on the economics of plaintiff-side litigation. Subrogation allows a plaintiff's health insurer (including Medicare, Medicaid, and workers' compensation insurers) to recoup the amounts they paid to (or on behalf of) the injured plaintiff from funds received in settlement of the plaintiff's tort claim. The logic of subrogation is straightforward. Health insurers advance funds to pay for the cost of treating patients injured by negligence. When patients sue for medical malpractice, the damages

11. Myungho Paik, Bernard Black & David A. Hyman, *The Receding Tide of Medical Malpractice Litigation: Part 1—National Trends*, 10 J. EMPIRICAL LEGAL STUD. 612 (2013).

12. *Id.* at 618 tbl. 1. States that adopted caps in the 1970s, 1980s, and 1990s are starting from a lower baseline; the percentage decline is relative to that lower baseline.

they recover reflect (in whole or in part) the cost of the additional medical services they required because of the malpractice. If patients kept all the money, they would be reimbursed for costs that were actually borne by someone else—namely, their first-party health care insurer. This would be inequitable and would also make first-party coverage more expensive than it would be if payers were reimbursed. Consequently, first-party insurers use their contracts to step into the shoes of injured patients and recover their losses.

This description of insurer subrogation seems simple and intuitively obvious, but it masks a dynamic that makes litigation progressively less remunerative for injured patients and their lawyers. Throughout the United States and over many decades, health care costs have risen dramatically. By contrast, the amount of liability insurance health care providers carry to cover malpractice claims has not kept pace.[13] In real dollars, malpractice coverage has declined, and it continues to be eroded by inflation. Because medical malpractice cases rarely settle for amounts that exceed providers' primary policy limits, rising medical costs and diminishing policy limits whipsaw injured patients, who find less and less money left over after reimbursing their first-party insurers.

This development has predictable effects. First, plaintiffs with large subrogated damages are less likely to pursue litigation, since they will be left with little to show for their lawsuit after their lawyer and the subrogated insurer are paid. Second, plaintiffs' lawyers will become reluctant to take cases with large subrogated damages. This is due, in part, to the costs and uncertainties of dealing with subrogated insurers who have no preexisting contractual obligation to pay the lawyer for securing the funds they receive. Plaintiffs' attorneys' norms also cut against taking such cases. Plaintiffs' attorneys see their mission as recovering compensation for injured people. They do not see themselves as subrogation lawyers for insurers, and they are reluctant to take cases when they know there is little they can do to help their clients.

### *E. Attacking the Expert*

Medical malpractice litigation relies on expert testimony. Steps that reduce the supply of physicians who are willing and able to serve as experts or that otherwise increase the cost of those experts' services

13. *See* Kathryn Zeiler, Charles Silver, Bernard Black, David A. Hyman & William M. Sage, *Physicians' Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims, 1990–2003*, 36 J. LEGAL STUD. (SPECIAL ISSUE) S9, S10 (2007).

will affect the costs and feasibility of litigating the underlying malpractice cases. Three strategies have been used to attack the expert: statutory restrictions on who can serve as an expert, interlocutory appeals when an expert is accepted by the trial court but the defendant wants to challenge that decision, and professional discipline against those with the temerity to offer testimony on behalf of injured plaintiffs. We address each of these strategies in turn.

*1. Limitations on Who Can Be an Expert*

Who can testify as an expert? In Alabama, the expert must be licensed in the same specialty as the defendant.[14] In Tennessee, the expert has to come from Tennessee or an adjoining state.[15] In West Virginia, experts must devote at least 60% of their time to clinical practice or teaching at an accredited university.[16] Such restrictions, over and above the generic requirement that one "has to know enough about the subject area to qualify as an expert," reduce the supply of those able to serve as experts. In the limiting case, it may be impossible for a plaintiffs' attorney to find a doctor who is ready, willing, and able to testify as an expert. Short of that, legislative measures that reduce supply enable physicians who qualify as experts under the more restrictive criteria to charge higher fees. This increases plaintiffs' attorneys' out-of-pocket costs, making plaintiff-side litigation riskier and less profitable.

*2. Interlocutory Appeals*

Texas requires the submission of an expert report within 120 days of the initiation of a malpractice suit—and since 2007, has allowed defendants to file an interlocutory appeal challenging the validity of the expert report.[17] If the trial court accepts the expert report, defendants are allowed to file an immediate appeal, to argue that the proffered expert does not actually qualify to offer expert testimony, or to argue that the proffered report does not otherwise satisfy the statutory requirements.

In general, interlocutory appeals are strongly disfavored, since they increase costs without much in the way of commensurate benefits. Unless we believe the costs of a false positive (i.e., allowing a malpractice case to go forward when it should not have) are comparable to the costs of erroneously certifying a class action, it is hard to conclude that

14. ALA. CODE § 6-5-548(e) (2004).
15. TENN. CODE ANN. § 29-26-115(b) (2012).
16. W. VA. CODE § 55-7B-7(a) (1994).
17. TEX. CIV. PRAC. & REM. CODE ANN. § 74.351 (West 2012).

routine interlocutory appeals add much value in this setting. But they do increase costs and risks for plaintiffs' lawyers—which was probably the point.

### *3. Professional Discipline*

Physicians have also used professional discipline to attack those willing to testify on behalf of plaintiffs.[18] The American Association of Neurological Surgeons (AANS) is a voluntary organization. One of its members (Donald C. Austin) testified in a malpractice case against another member, who then complained to the AANS. After an investigation and hearing, the AANS suspended Austin for six months, reasoning that he had offered irresponsible testimony and thereby breached his professional obligations as a neurosurgeon. Discovery in the resulting lawsuit revealed that the AANS had disciplined other physicians who had testified on behalf of plaintiffs, but had never disciplined a physician who testified on behalf of a defendant. In his usual nonchalant fashion, Judge Richard Posner dismissed this highly salient fact and upheld summary judgment for the defendants, reasoning that the only complaints that had been made to AANS had involved neurosurgeons who had testified for plaintiffs, so it was unsurprising that AANS had only disciplined those who testified for plaintiffs.[19]

## *F. Cumulative Impact of These Factors*

Each of these developments affects the larger economics of plaintiff-side practice in this area. Some reduce the potential rewards directly (e.g., capping damages and fees), while others do so indirectly (e.g., subrogation and attacking the expert). Some are both cause and effect of larger dynamics in the litigation environment (e.g., the secular trend toward less malpractice litigation). Even those provisions that are facially neutral seem likely to disparately impact plaintiffs.[20] In combination, the effect is to change the risk–return tradeoff of many malpractice cases. Professor Joanna Shepherd sketched out the basic dynamic:

---

18. We do not address the parallel use of professional discipline to attack physicians who serve as medical directors for managed care organizations. *See, e.g.*, Murphy v. Bd. of Med. Exam'rs, 949 P.2d 530, 532, 537–38 (Ariz. Ct. App. 1997); Morris v. D.C. Bd. of Med., 701 A.2d 364, 365 (D.C. 1997).

19. Austin v. Am. Ass'n of Neurological Surgeons, 253 F.3d 967, 971–72 (7th Cir. 2001).

20. Of course, limitations on who can serve as an expert are facially neutral, but defendants are more likely to be able to find a willing expert, even in the shrunken pool.

> As one attorney interviewed for my study noted: "med-mal litigation is the 'sport of kings' from an expense standpoint . . . the liability/damages mix must present sufficient strength in both measures to make economic sense." Another attorney that participated in my survey explained that "the cake has to be worth the candle . . . I know if expenses will be high, I won't take the case without the likelihood of a large recovery."[21]

Eventually, plaintiffs' attorneys get the message, and they find other things to do with their time. When they leave, so do defense attorneys. "Starve the beast" may not actually work to constrain the growth of government,[22] but it is certainly an effective strategy for reducing or eliminating capacity in the market for legal services.

## III. JUST SAY NO TO JUSTICE-TALK

For many years, the American Bar Association and other worthies have framed campaigns to improve access to the legal system in terms of "access to justice." Numerous studies have been done on unmet "legal needs." Panels and symposia have been held. Law professors and titans of the bar have held forth on the subject. Lawyers have tried, without much success, to establish a "civil Gideon" right to counsel in certain types of civil cases.

What do we have to show for all this "justice-talk"? Victims of medical malpractice cannot obtain compensation unless they hire an attorney, or can credibly threaten to do so.[23] Damage caps make many cases non-starters, and disproportionately reduce recoveries in the largest cases, where victims' injuries are likely to be the most severe.[24] And under-compensation and non-compensation was the rule, even before damage caps were added to the mix.

---

21. Joanna Shepherd, *Uncovering the Silent Victims of the American Medical Liability System*, 67 VAND. L. REV. (forthcoming 2014) (manuscript at 15) (alterations in original), *available at* http://ssrn.com/abstract=2147915.

22. *See, e.g.*, William Niskanen, *Limiting Government: The Failure of "Starve the Beast,"* 26 CATO J. 553 (2006); Jonathan Rauch, *Stoking the Beast*, ATLANTIC MONTHLY, June 2006, at 27, 28.

23. We quantified the frequency with which pro se plaintiffs successfully used the tort system to obtain compensation in Texas. In all five lines of commercial insurance in our dataset, cases waged by pro se plaintiffs comprise less than 1% of all paid claims. *See* Charles Silver & David A. Hyman, *Access to Justice in a World Without Lawyers: Evidence from Texas Bodily Injury Claims*, 37 FORDHAM URB. L.J. 357, 364 (2010).

24. Of course, matters are a bit more complicated. Large economic damages, which are increasingly common among those who suffer permanent injuries requiring expensive lifetime medical treatments, are not subject to a cap on noneconomic damages. This increases the value of such cases, relative to those in which noneconomic damages predominate. And noneconomic damages predominate among non-working women, children, and the elderly.

In sum, all of this justice-talk has had no apparent impact on access to legal services for victims of medical malpractice. There is no evidence to suggest more of the same will change that. In part, this is because bar leaders refuse to admit that some of the causes lie close to home—in the restrictions imposed by state bars on the manner and means by which legal services can be delivered, including harsh penalties for the unlicensed practice of law.[25] But even those lucky enough to find a lawyer quickly find that the legal system is slow, expensive, prone to error, and fundamentally inhumane. To add insult to injury (and to the baseline of non-compensation and under-compensation of those suffering injury), the legal system also does a spectacularly mediocre job of deterring medical error.

To repeat, it seems unlikely that more justice-talk will remedy any of these ills. We know of no state that is considering a wholesale rollback of its tort reforms, and we know of many that seem inclined to pile more lawsuit restrictions on top of those already in place. In pro-reform states like Texas, it is arguably worse to maintain the fiction that medical malpractice victims can obtain justice through the tort system than it would be to concede the reality that they often cannot.

Rather than more justice-talk, we should find a new way to talk about these issues, and a different strategy for addressing the underlying problems. For example, tort reform advocates often assert that liability is an inefficient substitute for first-party insurance coverage of accident-related losses. Perhaps it is time to take them at their word and explore the possibility of making new forms of first-party coverage available for tort-related injuries. Alternatively, maybe it is time to "make a deal," swapping federal tort reform (which would cover the nineteen states that do not currently have a cap on noneconomic or total damages, and could standardize the varying caps in the other thirty-one states) in exchange for physician acceptance of payment reform, public accountability for performance, and practice reorganization.[26]

## IV. CONCLUSION

Each of the developments highlighted in this Article has affected the basic economics of plaintiff-side medical malpractice litigation. In

25. *See* Gillian K. Hadfield, *The Cost of Law: Promoting Access to Justice Through the Corporate Practice of Law* (Univ. of S. Cal. Gould Sch. of Law, Center in Law, Economics, and Organization Research Papers Series, No. C12-16, 2012), *available at* http://ssrn.com/abstract=2183978.

26. William M. Sage & David A. Hyman, *Let's Make A Deal: Trading Malpractice Reform for Health Reform*, HEALTH AFF. (forthcoming 2013) (on file with authors).

combination their effect has been devastating. To the extent we have relied on medical malpractice to compensate negligently injured patients and deter negligent treatment, the developments highlighted in this Article indicate it is long past time to look elsewhere.