# THE MEDICAL MALPRACTICE CRISIS: BANDAGING OREGON'S WOUNDED SYSTEM AND PROTECTING PHYSICIANS

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## I. INTRODUCTION

Since 1999, physicians have seen their premium rates for medical malpractice insurance increase considerably.[1] The consequences of such steep increases are dire, hitting hard both physicians and the communities in which they practice. Physicians serving rural communities are hardest hit; many are forced to move their practice to another state or into early retirement, leaving rural communities with little or no medical services.[2] States are left to pick up the pieces.

Currently, twenty states are identified by the American Medical Association as experiencing a medical malpractice liability crisis.[3] In response, states have made various attempts to address the medical

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1. UNITED STATES GENERAL ACCOUNTING OFFICE REPORT TO CONGRESSIONAL REQUESTERS, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE LED TO INCREASED PREMIUM RATES 1 (June 2003), *available at* http://www.gao.gov/new.items/d03702.pdf [hereinafter GAO REPORT] . "Premium rates for medical professional liability insurance in Oregon have increased [one hundred sixty] percent since 1999, with especially steep increases for high-risk specialties such as obstetrics." Press Release, Governor Ted Kulongoski, Governor's Plan Cuts Rural Doctors' Professional Liability Insurance Costs (Mar. 1, 2004), *available at* http://governor.oregon.gov/Gov/p2004/press_030104.shtml.

2. AMERICAN MEDICAL ASS'N, MEDICAL LIABILITY REFORM—NOW! 19-20 (July 19, 2006), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf. [hereinafter AMERICAN MEDICAL ASS'N].

3. *Id*. at 9. (Other states currently in crisis are: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, Nevada, West Virginia, and Wyoming.).

encouragement of increased doctor/patient communication.[4] California, perhaps the state most successful in alleviating the pressures of the medical malpractice liability crisis, enacted the Medical Injury Compensation Reform Act of 1975 (MIRCA).[5] California's "gold standard" of tort reform "largely eliminates the lottery aspect of medical liability litigation" by capping non-economic damages, resulting in less expensive litigation, rapid recovery to injured patients, and lower medical liability premium rates.[6] Many crisis states however, Oregon among them, have rejected non-economic caps on medical malpractice liability lawsuits.[7]

This paper examines the medical malpractice liability system and crisis, thoroughly exploring the problem in an effort to get at a workable solution. Part II discusses medical malpractice and the liability system in general. Next, Part III examines the medical malpractice crisis in depth, covering the history of the crisis and its causes. Part IV examines the physicians most affected by the crisis, focusing on differences in liability insurance policy types, specialty, and location. The relationship between the malpractice crisis and insurance companies is analyzed in Part V. Part VI discusses the crisis in Oregon, including the history of the crisis, the effort made to resolve it, and an assessment of current endeavors. Finally, Part VII looks at possible solutions to the crisis, examining the possibility of a physician's professional liability fund, a medical review and screening panel, and a reformation of Oregon's apology statute.

the system compensates the negligently injured patient; second, it deters negligent behavior. [9] Medical malpractice tort suits, by allowing individuals injured by the negligent act of a physician to seek compensation, theoretically deter physician negligence by forcing the doctor to bear the burden of the award.[10]

However, the link between malpractice incidents and the filing of malpractice claims is not as strong as one might expect.[11] In fact, most occurrences of malpractice fail to result in a malpractice claim.[12] In examining the relationship between injuries resulting from negligence and subsequent medical malpractice claims, one study reveals that a mere 1.53% of patients injured as a result of physician

America–all companies with medical malpractice specialties.[27] These insolvencies, along with St. Paul's announcement that it was exiting the sector, caused a damaging market dislocation that seriously affected the availability of coverage in previously served markets.[28]

These events resulted in considerable changes in the insurance marketplace.[29] Cost is one such change.[30] In 2001, medical malpractice insurance premiums topped twenty-one billion dollars, a cost more than double the amount ten years prior.[31]

### *B. Causes of the Medical Malpractice Crisis*

The medical malpractice crisis is the result of a variety of factors, including the increase in medical malpractice lawsuits, significant increases in tort claim recovery, the rising cost of medical procedures, physician anger, defensive medicine, considerable increases in insurance expenses, and increased claims loss.

#### *1. Increase in Medical Malpractice Lawsuits*

There are many reasons for the rise in medical malpractice litigation over the past fifty years.[32] Following World War II, Americans came to regard the increasing regularity of lawsuits against physicians as a "source of medical cost inflation," and the cost of malpractice insurance coverage escalated.[33]

When the federal government took on the financial aspects of American health care via the Medicaid and Medicare programs in the 1960s, medical malpractice became a national concern as Americans questioned health care quality and expense.[34] By the following decade, the importance of malpractice had become evident, as evidenced by the fact that "80% of the malpractice suits filed between 1935 and 1975 were filed in the last five years of that forty year

27. *Id.*

28. *Id.* (St. Paul was the largest writer of medical malpractice in the United States.).

29. *Id.*

30. *Id.*

31. JOINT ECONOMIC COMMITTEE STUDY, *supra* note 9, at 1.

32. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST & ROBERT L. SCHWARTZ, HEALTH LAW 344 (2d ed. 2000) [hereinafter FURROW ET AL. 2000].

33. *Id.*

34. *Id.*

period."[35] And as the Medicaid and Medicare programs increased access to the health care system, the amount of negligent injuries increased.

Progress in medical technology has also caused an expanding number of malpractice lawsuits.[36] The increased power to treat and diagnose illness caused medicine to become more complex, adding considerations of possible side-effects resulting from the use of new drugs and instrumentalities to already intricate procedures and treatments.[37] New drugs and instrumentalities also carry with them a "learning curve—the rate of maloccurrence will be higher early in the introduction of a new medical device, drug, or technology."[38] In fact, according to a report issued by the Institute of Medicine, "one of the largest classes of errors involved the utilization of prescription drugs."[39]

In addition to increased risk to patients, there exists the unrealistic belief that all ailments are successfully treatable.[40] Patients, encouraged by new medical developments, may find extreme disappointment and bring suit when faced with an unanticipated outcome.[41] As William Sage wrote:

> Foremost, improvements in the clinical capabilities of medicine increase expectations of success, redefine success upwards, and foster the belief that failure is the result of negligence rather than misfortune. The first wave of medical malpractice suits in the late 19th century involving nonunion of limb fractures, arose only

monetary award for the plaintiff, there exist a only few instances in which a jury conferred an enormous award. This encourages other lawyers and their plaintiffs, who hope to share in the "litigation lottery," and influences all subsequent settlement negotiations.[51] Further, these "mega-verdicts" have rapidly increased,[52] a fact all the more disconcerting considering the negligible connection between malpractice litigation and physician negligence.[53] According to one study, the only factor indicating a strong correlation with the outcome of malpractice litigation is the degree of patient injury, suggesting "that our system of medical-legal jurisprudence does not identify 'bad' physicians and fails to contribute to attaining the ideal of improved medical outcomes."[54]

*3. Rising Cost of Medical Procedures*

Raiding the wallet of every American are the litigation and malpractice insurance problems, because "[m]oney spent on malpractice premiums (and the litigation costs that largely determine premiums) raises health care costs."[55] However, increases in health care spending contribute to the growth of the average value of a medical malpractice claim,[56] thus creating a vicious cycle and exacerbating the malpractice crisis. On a per-person basis, the co8c0.4(lpractice cris1.52ie3(d)4.(cle

*4. Physician Anger*

Physician anger may also play a role in the medical malpractice crisis, or at least the perception that a crisis exists.[59] According to Barry R. Furrow, "[p]hysicians are angry because malpractice litigation focuses on the errors of specific individual providers. This personalization of liability produces anger and anxiety in physicians. The legal system has become the lightning rod for changes physicians find unwelcome."[60] In addition, there also exists an increase in jury disapproval of physicians perceived negligent, which may further drive up a malpractice verdict and thus contribute to the malpractice crisis.[61] Lack of sympathy is especially pronounced for those physicians practicing in groups due to a patient perception that less time spent with the physician equates to lower quality care.[62]

*5. Defensive Medicine*

As Judge Learned Hand pointed out in *United States v. Carroll Towing*, there is no general rule setting forth the socially optimal level of precaution against accidental injury, as any liability determination will vary according to the surrounding circumstances.[63] Instead, one's duty to protect against injury is a function of three variables: the probability of harm, the gravity of the resulting injury if the harm occurs, and the burden of adequate precautions.[64] Thus, as physicians encounter a variety of patients having various ailments, the duty to each patient will necessarily differ; a physician's duty to order expensive tests will be greater toward a seriously ill patient whose diagnosis is undetermined than toward a teenaged patient exhibiting the non-deadly symptoms of the flu in January.

The existing medical malpractice liability system encourages physicians to operate at the optimal level of precaution; i.e., to practice defensive medicine.[65] Defensive medicine refers to the

59. FURROW ET AL. 2000, *supra* note 32, at 345.

60. *Id.*

61. *Id.*

62. *Id*. at 345, n.11.

63. U.S. v. Carroll Towing, Co., 159 F.2d 169, 173 (2d Cir. 1947). *See also* Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS. 81, No. 1, 82 (1997).

64. *Carroll Towing*, 159 F.2d at 173.

65. Kessler & McClellan, *supra* note 63, at 83.

practice of ordering excessive tests and procedures for a patient in an attempt to prevent any feasible oversight in diagnosis and treatment.[66] Physicians practicing defensive medicine take every precaution available to protect the patient, even when the benefits of doing so are extremely small.[67] Practicing defensive medicine helps protect against the threat of liability—especially when neither the doctor nor the patient will bear a substantial share of the cost; i.e., when the patient's health insurance provider is picking up the tab.[68]

In addition to reaping some benefit for the patient, albeit small, defensive medicine also has its drawbacks. One such drawback is the effect on quality of care, which suffers as the total amount of resources dwindles proportionate to the amount of defensive medicine practiced, leaving some doctors struggling to provide adequate care.[69] In fact, according to one survey, malpractice litigation has left over 76% of physicians concerned about their ability to provide quality patient care.[70] "Every test and every treatment poses a risk to the patient, and takes away funds that could better be used to provide health care to those who need it."[71]

Secondly, defensive medicine leads to higher health care and insurance expenses as insurers pass the added cost on to consumers.[72] As medical malpractice awards take into account health care costs incurred by the patient, damages awarded against a doctor may rise due to the increased cost of attempting to prevent malpractice. Finally, as malpractice becomes more expensive, "accessibility becomes an issue when escalating costs of malpractice liability

66. MARCIA MOBILIA BOUMIL, CLIFFORD E. ELIAS, & DIANE BISSONETTE MOES, MEDICAL LIABILITY IN A NUTSHELL 250 (2d ed., West 2003).

67. U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 45, at 4-5 (citing HARRIS INTERACTIVE, COMMON GOOD, FEAR OF LITIGATION STUDY: THE IMPACT ON MEDICINE, FINAL REPORT, Apr. 11, 2002 *available at* http://cgood.org/assets/attachments/68.pdf).

> Due to fear of a malpractice lawsuit, 79% of physicians ordered more tests than they would otherwise have and 91% have noticed others doctors doing the same; 74% have referred patients to specialists more often than necessary; 51% have suggested invasive procedures to confirm a diagnosis when they believed it unnecessary; and 41% reported prescribing more medications and antibiotics than believed required; 73% report other doctors doing the same. *Id.*

68. Kessler & McClellan, *supra* note 63, at 82.

69. BOUMIL ET AL., *supra* note 66, at 259.

70. U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 45, at 4.

71. *Id*. at 5.

72. BOUMIL ET AL., *supra* note 66, at 259.

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expected costs, incurred losses are the primary determinant of premium rates.[95]

Looking at the recent history of the medical malpractice insurance market, specifically the trend toward larger damage awards,[96] the cost of medical malpractice insurance will likely continue to rise as insurers project higher incurred losses in an attempt to avoid unanticipated losses in the future. The increases in cost are already reflected in the cost of liability insurance coverage as premiums for all specialties are rising.[97]

at the outset than claims-made policies.[102]

Claims-made policies, on the other hand, protect the policyholder against claims that occur and are reported while the policy is in force.[103] Due to the fact that there is often a delay of several years between the alleged negligent treatment and the filing of a claim, premiums are less expensive at the beginning of the policy.[104] However, as the policy matures, the premium increases; at the policy's fifth birthday, it is considered mature and the premium becomes equivalent to that of an occurrence policy.[105]

### *B. Specialty Differences*

Differences in the amount a physician will pay for liability insurance also depend on the specialty the physician practices and will generally increase in proportion to surgical complexity.[106] This affects what specialty a physician chooses, according to a 2002 survey, which found that one-third of physicians "shied away from going into a particular specialty because they feared it would subject them to greater liability exposure."[107]

According to the Insurance Division, based on rates filed as of May 1, 200y]TJoifm.7( 1n5 T)(surv747es6)-5.864 an 1e Division, base -1.2188.$4 an 1e Divim p

claims-made policy by Continental Casualty Company and Northwest Physicians Mutual Insurance Company with limits of $1 million / $3 million.[109] Credits or surcharges reflected on a physician's premium, based on his or her specifi

> of claims. Second, use of historical statistics to predict future losses is based on the law of large numbers–as the number of insured physicians and hospitals increases, actual losses will approach expected losses. The medical malpractice insurance market is small, making the statistical base for making estimates of future losses relatively small. As a result, it is difficult to set accurate premium prices. The "long tail" of malpractice insurance (the length of time that may elapse after an injury occurs before a claim is filed and settled) is a further complicating factor because the data base used for estimating future losses may not reflect current actual losses. Many claims are filed in the second, third, or later year after treatment.[117]

Recent trends have reduced revenues and increased costs, causing medical malpractice to become one of the most unprofitable insurance lines.[118] In 2001, an insurance company in the medical malpractice sector paid out $1.34 in claims and costs for every $1.00

insurance carriers do not exit a market due to short-term cycles—they do so only when "the long-term outlook is so bleak as to make continued business operation untenable."[123] Additionally, if the crisis were indeed "nothing more than the natural 'insurance cycle,'" all states would be experiencing a crisis.[124] Further, insurers are not leaving other insurance markets—only the medical malpractice liability sector is experiencing the phenomenon of fleeing insurers.[125]

Another claim made against insurance companies blames the crisis on the lack of state regulation.[126] However, according to the American Association of Health Plans, "all state insurance departments and other state governmental agencies heavily regulate and monitor the solvency of medical malpractice carriers . . . and require extensive reporting."[127]

Under Oregon law, the Insurance Division of the Oregon Department of Consumer and Business Services is responsible for reviewing any rate changes made by insurers admitted in Oregon.[128] Any changes submitted by an insurer in Oregon must comply with all state statutes, rules, and Insurance Division bulletins.[129]

Among these rules exists the requirement that any professional liability rate change of more than fifteen percent be subject to the approval of the Insurance Division before the insurer may implement the new rate.[130] Further, regardless of what percentage of change the insurer proposes, it must demonstrate that "its rates are appropriate given how much it expects to pay in claims and administrative costs, how much it expects to earn in investment income, and what if any profit it should reasonably expect to make."[131] In addition, each

123. *Id.*

124. AMERICAN MEDICAL ASS'N, *supra* note 2, at 47 (citing Raghu Ramachandran, *A Note on Investment Income of Medical Malpractice Companies*, Feb. 4, 2003, *available at* http://salsa.bbh.com/news/Articles/medmal2.html).

125. AMERICAN MEDICAL ASS'N, *supra* note 2, at 47.

126. *Id.*

127. *Id.* (citing AMERICAN ASS'N OF HEALTH PLANS, "LAWSUIT LOTTERY" CAUSES MEDICAL. MALPRACTICE CRISIS—SUGGESTIONS THAT POOR INVESTMENTS LED TO CRISIS DON'T PASS SMELL TEST 1, *available at* http://www.americanbenefitscouncil.org/documents/refutingstockmarketargument.pdf (last visited Mar. 11, 2006).

128. OREGON FACT SHEET, *supra* note 100, at 2.

129. *Id.*

130. *Id.* (Rate changes of less than fifteen percent do not require Insurance Division approval before the insurance company can use the rate.).

131. *Id.*

profitability of medical liability insurers has been on the decline and was lower than that of other property casualty insurers. Underwriting profitability is measured by the combined ratio after policyholders' dividends. A ratio less than 100 indicates that an insurer is earning an underwriting profit. The lower the ratio, the higher the profit rate. In 2004 the combined ratio of medical liability insurers was 112.3. This means that for every $1 insurers received in premiums in 2004 they paid out $1.12. In comparison,

### *A. Oregon's History*

Oregon has been laboring under the pressure of a medical malpractice crisis for years. In 1987, as part of the "Tort Reform Act," the Oregon State Legislature enacted Oregon Revised Statute (ORS) 18.560,[150] limiting noneconomic damages to $500,000.[151] The purpose of imposing the half-million dollar damages cap was to "stabilize insurance premiums and to decrease the costs associated with tort litigation."[152]

Twelve years later, *Lakin v. Senco Products, Inc.* questioned the constitutionality of ORS 18.560.[153] On July 15, 1999, the Oregon Supreme Court invalidated the statute, finding it to be in violation of

coverage in the regular, admitted market. *Id.*

149. *Id.* According to the Insurance Division of the Oregon Department of Consumer and Business Services, professional liability insurance is not mandatory. *Id.*

150. Oregon Revised Statute 18.560 provided in full:

> (1) Except for claims subject to ORS 30.260 and ORS chapter 656, in any civil action seeking damages arising out of bodily injury, including emotional injury or distress, death or property damage of any one person including claims for loss of care, comfort, companionship and society and loss of consortium, the amount awarded for noneconomic damages shall not exceed $500,000.
>
> (2) As used in this section:
>
> a."Economic damages" means objectively verifiable monetary losses including but not limited to reasonable charges necessarily incurred for medical, hospital, nursing and rehabilitative services and other health care services, burial and memorial expenses, loss of income and past future impairment of earning capacity, reasonable and necessary expenses incurred for substitute domestic services,

Article I, section 17,[154] of the Oregon Constitution[155] because "[the]

rural Oregon residents had only 104 physicians per 100,000 residents.[164] Adding to the problem of physician availability in rural parts of Oregon is the presence of older physicians who may soon retire and the reduction of incoming physicians to the area.[165] To illustrate, as of September 28, 2003, an internist position at the Pioneer Memorial Hospital located in Prineville, Oregon, had been vacant for more than one year and "fourteen hospitals, four clinics and two health departments in rural areas are short a total of seventy physicians."[166]

Oregon is also experiencing a shortage in "several specialties, including rheumatology, nephrology, gastroenterology, cardiology, allergy-immunology and pediatrics . . . ."[167] This shortage is likely to continue worsening. The Oregon Medical Association reported in April 2003 that "43% of Oregon neurosurgeons, 27.1% of orthopedic surgeons, and 23.5% of obstetrician-gynecologists reported they have already stopped providing certain services or would do so."[168] Dr. Katherine Merrill, an obstetrician in Astoria, stopped delivering babies altogether in August of 2003, in part because of the rapidly rising costs of medical liability

patients are put in the current system.[171]

Physicians and surgeons wishing to take part in the Reinsurance Plan must be "certified as eligible under ORS 442.563, licensed under ORS chapter 677, . . . engaged in the practice of medicine, and [have] a rural practice that amounts to [sixty] percent of the individual's practice."[180]

The Insurance Division of the Oregon Department of Consumer and Business Services reports that, as of October 1, 2004, 1,063 rural physicians were participating in the Reimbursement Program, distributing over three million dollars to offset the high cost of insurance premiums.[181] Of these physicians, fifty-seven were obstetricians, receiving $669,880, and sixty-eight were family practice physicians that also offer obstetrical services, receiving $424,135.[182]

### *C. Criticism: Why Oregon's Effort Will Not Be Enough*

Generally, malpractice tort reforms attempt to affect the system by "1) reducing the frequency of claims, 2) lowering the amounts recoverable, and 3) curbing the costs of the legal process."[183]

Oregon's attempt to aid rural practitioners in the payment of medical malpractice liability insurance merely addresses a symptom of Oregon's medical malpractice crisis, not its cause. The aid simply cushions the blow of insurance payments and does not solve the overall problem. Oregon's effort is akin to the prescription of pain medication to a patient suffering from cancer; while helpful in reducing pain and complaints, it does nothing to solve the underlying problem.

An effort toward creating effective reform will lead to the significant reduction of malpractice premiums and go a long way toward quelling the crisis.[184] Effective reforms must address the "crux of malpractice litigation."[185] California's MICRA statutes provide a prime example of effective reforms by reducing malpractice

180. OR. REV. STAT. ANN. § 315.613(1) (West 2006).

181. OREGON FACT SHEET, *supra* note 100, at 5.

182. *Id.*

183. Stephen Zuckerman, Randall R. Bovbjerg, & Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167, 170-71 (1990).

184. Anderson, *supra* note 53, at 1176.

185. *Id.*

premiums by forty percent since 1975; premiums now rise at a rate

Common reforms include shortening the statute of limitations, limiting the plaintiff's award, and altering the plaintiff's burden of proof.[193] However, given that Oregon's statute of limitations is already only two years,[194] the unfairness of altering the plaintiff's burden of proof (i.e., creating a heavier burden for the plaintiff to

striking similarities between the current situation faced by physicians and the situation as it existed in 1977 for attorneys. According to the Committee on Professional Liability Insurance in August 1977, implementation of a Lawyer's Professional Liability Fund was the result of years of consideration resulting from "substantial premium increases by private insurers and the withdrawal of several insurers from the state."[199]

The anticipated benefits upon operation of a professional liability fund for Oregon lawyers practicing in the late 1970s are also comparable to the desired benefits of physicians currently practicing in Oregon. In August 1977, the Oregon State Bar Bulletin wrote of three expected benefits: "[G]reater protection to the clients and the public; greater protection to the lawyer; and continued availability of professional liability protection at a reduced cost."[200] Replace "clients" with "patients" and "lawyer" with "physician" and what remains are goals that, if realized, would do wonders for Oregon physicians feeling the pinch of the current malpractice crisis.

As was true for the Lawyer's Professional Liability Fund, a Physician's Professional Liability Fund would be a national first.[201] However, despite being innovative for the medical field, the process of organizing a professional liability fund would not be without guidance—Oregon's Professional Liability Fund for lawyers provides TT2

company from the pockets of physicians, allowing physicians to spend extra monies on supplies, equipment, or even a salary increase for themselves. Second, physicians may find a professional liability fund fair simply due to the impression that it is better than the alternative.

### *B. Medical Review & Screening Panel*

Currently, Oregon has a mandatory dispute resolution statute, requiring all parties to an action brought against a health practitioner and their attorneys to participate "in some form of dispute resolution within 270 days after the action is filed unless: [t]he action is settled or otherwise resolved within 270 days after the action is filed; [o]r all parties to the action agree in writing to waive dispute resolution under this section."[202] Parties may comply with this statute by taking part in either arbitration, mediation, or a judicial settlement conference.[203] Further, the failure of any party to comply and/or act in good faith may result in court imposed sanctions.[204]

This statute, while encouraging pretrial settlement and the conservation of money otherwise spent on litigation, does not provide any incentive to settle. Rather, it seems that with the rise in "mega-verdicts,"[205] the incentive is to take the case to the jury or to use the threat of a potential mega-verdict to bully the defendant into agreeing to a settlement that unfairly favors the plaintiff, relying more on a risk assessment attitude of the defendant and his insurance company than what will make the injured patient whole.

Medical review and screening panels, on the other hand, attempt to "weed out nonmeritorious cases and encourage prompt settlement before parties incur the costs of a trial"[206] (thus lowering malpractice insurance costs as projected future costs would decrease). A typical panel is comprised of a physician or other professional health care worker, a legal professional, and a lay member.[207] The panel members craft findings regarding fault and sometimes damages on the basis of testimony and other evidence presented by the parties, using

202. OR. REV. STAT. § 31.250 (2005).
203. *Id.*
204. *Id.*
205. U.S. DEPT. OF HEALTH & HUMAN SERVICES, *supra* note 45, at 9.
206. Zuckerman et al, *supra* note 183, at 171.
207. *Id.*

evidential rules more flexible than those used in formal court proceedings.[208] Review of a panel decision is typically mandatory and conclusions reached are often admissible in a subsequent trial, should one be necessary.[209]

Oregon should consider the institution of a medical review and screening panel as a method to address the current malpractice crisis plaguing Oregon's citizens and physicians. The evidence suggests

### *C. Giving Teeth to the Apology Statute*

Oregon, along with twenty other states,[216] has enacted a statute explicitly proclaiming that an apology or similar expression of sympathy offered by a physician to a patient following an adverse medical event may not be used as an admission of liability in a civil action.[217] These "apology statutes" are a sign that the perspective regarding the impact of physician apologies are changing; it used to v nc0.0to

Still, due to either feelings of embarrassment, disgrace, or Soq0o4 Tm0 T(v805 Tc17

Contrary to the above proclamations, this purportedly positive attitude seems to undergo a sort of Dr. Jekyll and Mr. Hyde transformation following the reporting of an adverse incident. Subsequent to being advised of an incident involving a patient, Northwest Physicians Mutual Insurance Company sends a letter to the insured physician with instructions "NOT [to] engage in office conferences, letter writing or phone conversations with the patient, family or their attorney" and to "[n]ever make admissions of guilt, fault or liability about your acts or the acts of another."[231]

large."[234]

The malpractice crisis being experienced in Oregon qualifies as a public policy issue because malpractice lawsuits against physicians result in significant expenditures by their insurers.[235] Insurers are forced to pass this cost along to policyholders, which in turn raises the cost of practicing medicine and often results in either higher fees to the patient or a decision to cease practice or move it out of state. Because this threatens both the availability and reasonable cost of medical care, this issue is of "fundamental concern to the state and the whole of society" because it "tend[s] to injure the public at large."[236] A public policy amendment to the "apology statute" would impose a penalty on those seeking to restrain a physician from expressing regret or apology to a patient following an adverse medical outcome, thus allowing a doctor to offer an apology free from fear that the expression will be used as an admission of liability or as a basis for terminating her insurance policy. An example of such an amendment to the "apology statute" is as follows:

> (3) The ability of a person who is licensed by the Board of Medical Examiners to offer an expression of regret or apology, and the ability of any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Board of Medical Examiners, shall not be interfered with.
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> (4) The court shall fine any person or entity determined, by a preponderance of the evidence, to have interfered with the ability to offer an expression of regret or apology, as provided in Sections (1)-(3) above, not more than $20,000 for each violation, which shall be entered as a judgment and paid to the Oregon Health Plan. Each violation is a separate offense. In the case of continuing violations, the maximum penalty shall not exceed $200,000.
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> (5) The court may award reasonable attorney fees to one licensed by the Board of Medical Examiners if he or she prevails in an action under this section.