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A Tale of Two Initiatives: Where Propaganda Meets Fact in the Debate Over America's Health Care

Randolph I. Gordon¹ and Brook Assefa²

A THOUGHT EXPERIMENT

The Institute of Medicine reports that as many as 98,000 Americans die each year from preventable medical mistakes.³ According to one recent commentator, medical care is the third leading cause of death in the United States,⁴ accounting for 225,000 deaths annually. If the human cost of preventable medical mistakes were to be translated into airplane crashes, it would be the equivalent of a jumbo jet crashing somewhere in the country at least once a day, every day of the year, including weekends and holidays. Imagine that evidence showed that 5 percent of air traffic controllers were responsible for over 50 percent of these crashes (not true). Would you propose to fix the problem by cutting back on the rights of passengers? The truth is that 5 percent of physicians are responsible for over 50 percent of the preventable medical mistakes that result in death.⁵ Do these deaths delimitate a "crisis" worthy of our attention? If so, would your solution be to cut back on the rights of patients?

I-330 says yes. I-336 says no.

I. TWO CHOICES: ADDRESSING HEALTH CARE BY INITIATIVE

A. Washington State: Two Initiatives

In the Fall of 2004, over 600,000 signatures were collected in a period of three months on two state-wide initiatives to the Washington State Legislature, I-330⁶ and I-336.⁷ The right of initiative has special standing in

Washington, and is preserved in the Washington State Constitution: “The first power reserved by the people is the initiative.”⁸ Each initiative had its own website and ardent supporters.^{9,10} Each initiative purported to address a “crisis” in health care, but neither could agree on the nature or existence of the “crisis” as defined by the other. In its previous session, the Washington State Legislature failed in its effort to fashion its own third version. Since neither initiative was adopted by the Legislature, both made their way onto the November 2005 ballot as initiatives to the people. Thus, the stage was set for a titanic campaign of two initiatives, reflecting two completely different world views, and battling during an off-year election for the attention—and for the hearts and minds—of the electorate. When the dust settled and the smoke cleared, campaign expenditures set new records: over \$14 million was raised. This “obliterated the watermarks left by money gushing into past campaigns.”¹¹

B. The Text of the Initiatives: A Summary

The two initiatives are complex and not readily susceptible to abbreviation without doing violence to their meaning. For the sake of orienting the reader, however, each may be summarized thus: I-330 sought to limit liability of health care providers and limit patient claims and recovery under the name “health care liability reform.”¹² I-336 sought to prevent avoidable health care injuries and increase the transparency of the insurance rate-setting process by capping insurance premium increases, increasing transparency of settlements, and increasing consumer representation on the Medical Quality Assurance Commission, under the slogan “better, safer health care.”¹³

C. The Background of a Modern Tug-of-War

The current national and local movement to change the civil justice system has a long pedigree. During the last thirty years, there have been numerous state-based efforts in California, Florida, and Texas primarily

focused on limiting jury awards of damages with so-called “caps.”¹⁴ Since 2000, under the Bush administration, the national malpractice debate has increasingly focused upon proposals to change the civil justice system, particularly with respect to handling of liability for injuries arising from the provision of medical care.

President George W. Bush’s federal medical malpractice “reform”¹⁵ efforts have had a significant impact on the nature of recent state-based efforts. For example, I-330 expressly anticipates federal malpractice legislation as a fallback position “in the event that the Washington State Supreme Court . . . rules or affirms that section 2 of this act is unconstitutional.”¹⁶

Characterizing the issue as a struggle between health care providers and lawyers misses the impact on patients, patients’ relatives, and the rights of the citizenry. In fact, the caps on insurance rate increases proposed by I-336 would largely benefit doctors. The fact that the Washington State Nurses Association endorsed the “No on 330” campaign¹⁷ necessarily confutes such a simplistic dichotomy. Enactment of the initiatives would have broad impacts on the quality of medical care, the ability to get redress for damages, and such constitutional principles¹⁸ as due process, equal protection, the right to a jury trial, as well as altering the traditional balance of burdens and incentives within tort law.¹⁹

Furthermore, the oversimplified tale of doctors versus lawyers obscures the underlying tug-of-war between unorganized victims (patients) and organized defendants (business interests). The costs of accidents are allocated between plaintiff-victims and defendant-tortfeasors in judicial proceedings: “When judge and jury . . . choose damage-suit winners, they necessarily exercise discretionary government power.”²⁰ But in many areas where “courts expanded liability to unorganized victims . . . organized defendants persuade[d] legislatures to curtail it.”²¹ As such, both initiatives to the legislature are just one more attempt by organized parties to influence the legislature, and through legislation, the courts.

This article unfolds a tale of two initiatives in an historical context in which I-330 is not only embedded in the liability “reform” movement in particular, but also challenges the use of litigation as a vehicle of social change in general. The tale plays out in a political realm where the relationship between ends and means is particularly tortuous. While I-330 and I-336 both claim to improve the health care system for health care providers and for patients, each articulates incompatible world views. I-330 exaggerates the extent of litigation abuse afflicting good doctors and the extent to which liability payouts drive insurance rate increases, addressing both by punishing innocent patients victimized by bad doctors.²² I-336 defines a real problem with insurance gouging good doctors while bad doctors go unregulated, which it solves by stricter regulation of both insurers and offending doctors.²³ While both initiatives engage public interest by tapping into growing dissatisfaction with delivery of health care in America, neither initiative offers the sort of fundamental changes required to effect a cure as to what ails the system. In view of the conclusion by the authors that initiatives are a poor way of setting out complex changes to public policy, we suggest the public would be well-served by increased judicial vigilance and legislative guidance respecting the “one subject” limitation on ballot initiatives established under the Washington State Constitution.²⁴

The threshold question is which initiative does a better job at addressing health care availability, affordability, and quality without violating constitutional principles or long-standing tort remedies for civil wrongs? I-330, on its face, concerns itself with availability and affordability of medical care, both of which properly may be conflated into the shorthand term “access,” based upon what the authors believe to be a demonstrably false or unsupportable premise that access is adversely affected by liability suits. I-336 focuses primarily upon quality of medical care and directly addresses insurance rate spikes which I-330 misattributes to liability payouts.

The answer is that I-336 is better on both counts in that it begins the process of identifying and addressing real issues facing delivery of health care²⁵ without burdening innocent victims. I-330, on our review, encapsulates much that is wrong with the liability “reform” movement. The most troublesome aspects of I-330 appear to flow from a misdiagnosis of the problem and its prescription of a medicine inimical to civil justice, the sale of which inures to the benefit of the insurance industry.²⁶

A survey of the scope of that problem is examined below.

II. ASSAULT ON THE CIVIL JUSTICE SYSTEM MASQUERADING AS “REFORM”: HEALTH CARE, LAW, AND POLITICS

The malpractice “reform” debate ostensibly concerns what has been termed a health care “crisis.” Yet, in the public debate respecting I-330, surprisingly little was actually said about problems facing the provision of health care. Thus, we begin our discussion with a very brief review of one of the greatest challenges currently facing American society for, in words widely attributed to Martin Luther King, Jr.: “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

A. A Very Brief Summary of the State of Health Care in America

Approximately 45 million Americans, or 15.6 percent of the population, lacked health insurance coverage in 2003.²⁷ The data is specific: uninsured children in 2003 numbered 8.4 million (11.4 percent of all children); young adults, those eighteen- to twenty-four-years old, were least likely of any age group to have health insurance in 2003 (30.2 percent). Based on a three year average, people of Hispanic origin were the least likely to have health insurance, with an average of 32.8 percent lacking health insurance.²⁸

Lack of insurance compromises the health of the uninsured because they receive less preventive care, are diagnosed at more advanced disease stages, and, once diagnosed, tend to receive less therapeutic care and have higher

mortality rates than the insured.²⁹ About 20 percent of the uninsured, compared to 3 percent of those with coverage, say their usual source of care is the emergency room.³⁰

The United States spends nearly \$100 billion per year to provide uninsured residents with health services, often for preventable diseases or diseases that physicians could treat more efficiently with earlier diagnosis.³¹ The uninsured are 30 to 50 percent more likely to be hospitalized for an avoidable condition, with the average cost of an avoidable hospital stay estimated to be about \$3,300.³² The increasing reliance of the uninsured on the emergency department has serious economic implications, since the cost of treating patients is higher in the emergency department than in other outpatient clinics and medical practices.³³ The high proportion of uninsured in the United States contributes to health care costs because preventable conditions, or conditions which could have responded to inexpensive treatment at earlier stages, develop into health crises treated by more expensive emergency room care.³⁴ The human toll is enormous. Studies estimate that the number of excess deaths among uninsured adults age twenty-five to sixty-four is in the range of 18,000 a year.³⁵ The American College of Physicians-American Society of Internal Medicine stated that: "People without health insurance tend to live sicker and die younger than people with health insurance."³⁶

In 1998, the United States had the most expensive health care system in the world, costing \$4,178 per capita, which is twice the median expended by the twenty-nine nations of the Organization for Economic Cooperation and Development.³⁷ Yet, in 1996, the United States ranked twenty-sixth among industrialized countries for infant mortality rates.³⁸

B. The American Medical Association's Narrative

In the face of the gathering crises summarized above, it is no small source of wonder that the modern debate respecting health care reform so often devolves into arguments concerning medical liability and changes in

the civil justice system administering tort law. Yet, as its starting point in addressing issues respecting access to improved health care, the American Medical Association (“AMA”) adopts, advances, and adverts to a narrative perpetuated at the highest levels of government: “In his State of the Union Address last month, President Bush stressed that we all are threatened by a legal system that is out of control.”³⁹ This claim persists despite studies independently confirming that instances of substandard health care outstrip legal claims by between five and ten to one.⁴⁰ Judge Richard Posner cites the “incentive to sue [as] essential to the maintenance of the tort system as an effective, credible deterrent to negligence.”⁴¹ If, in fact, incidents of medical negligence outstrip legal claims, then weakening deterrence by burdening plaintiffs’ incentives and ability to sue would likely exacerbate the problems of medical quality. Plaintiffs’ incentive to sue is vitiated if the incentive does not apply to plaintiffs’ lawyers, as reducing the availability of counsel imposes additional challenges to plaintiffs’ prosecution of their claims. The entire framework of contingent fees is structured to align the incentives of lawyers with those of clients. Thus, when I-330 seeks to amend RCW 7.70.070 to limit attorneys’ fees irrespective of damages and the costs incurred to prove the claim,⁴² an essential component of the tort system—the incentive to sue—is being undermined with a concomitant weakening of the tort system’s capacity to deter negligence.

I-330’s attack on the incentive to sue is a direct assault on both historic tort notions of compensation and deterrence and the perceived power of the plaintiffs’ bar. As such, the tale of two initiatives occurs at the juncture of a number of historic trends: the ebb and flow of power between plaintiffs and defendants; the continual rebalancing of deterrence and compensation offered by the tort system; the instrumentalist notion that positive social change can be effected through litigation;⁴³ and the increased association of actors to the debate with opposing political parties. All these trends conjoin in a political landscape near one of its most intractable features, health care

reform. Clearly, “The stakes are higher: first medical malpractice, then product liability, and . . . the entire universe of tort law.”⁴⁴

C. Brown’s *Precedent of Litigation as a Vindication of Individual Rights*

Brown v. Board of Education and “[t]he civil rights movement is, in many ways, the crucible in which modern public interest law was forged.”⁴⁵ *Brown* revived the belief in law as a means of remedying social ills and effecting social change, advancing the general principle of “litigation as a path to the vindication of [individual] rights.”⁴⁶ This, in turn, led to a stronger, more vibrant, and increasingly specialized plaintiffs’ bar,⁴⁷ and to the rise of firms that “solicit[ed] clients who had suffered special kinds of harms”⁴⁸ such as medical negligence and toxic exposures. The demands of social justice in this modern age present new challenges and place new burdens upon those seeking recovery for injuries.

[T]he burden, however onerous, of establishing causation traditionally falls upon the plaintiff. For an injured worker, establishing a causal relationship between exposure to a novel chemical formulation and specific symptoms may constitute an insurmountable burden Poorly funded (often unemployed), sick, and desperate workers suffering an occupational disease resulting from exposure to toxic chemicals in the workplace often are asked to establish, by a preponderance of the evidence (or more), the toxicity of chemicals whose effects have yet to be explored by the combined resources of industry, employer, or government agency, or to be generally recognized by the medical community.⁴⁹

To be sure, some specializations looked more for “profitable practice rather than a new vision of social justice.”⁵⁰ Nonetheless, the success of the plaintiffs’ bar in cases advancing individual interests against corporate and governmental power and the resultant alignment of the plaintiffs’ bar with the Democratic Party,⁵¹ led inexorably to political attacks upon trial lawyers representing plaintiffs.⁵² On one side, Senator Jim Bunning (a Republican

from Kentucky) called for senators to “take a stand . . . [either with] the mothers and the children or with the personal injury lawyers.”⁵³ On the other side, Senator Patrick Leahy (a Democrat from Vermont) stated, “[i]nstead of looking at ways to reduce medical errors so that there would be fewer lawsuits, [they want] ‘to help these big insurance companies.’”⁵⁴

In this debate, Republican partisans can attack the civil justice system on both federal and state levels by appealing to a superficial populism critical both of unelected federal court judges and largely mythical runaway juries.⁵⁵ The political treasure trove to be won by successful advocacy for “tort reform” is plain: successful limitations on liability help insulate Republican Party loyalists and corporate supporters from liability while simultaneously attacking the financial wherewithal of one of the major contributors to the Democratic Party, members of the plaintiffs’ bar. At the least, initiatives like I-330 require a massive diversion of financial resources by plaintiffs’ lawyers to defense of their livelihood and away from advancing Democratic Party candidates and causes.

In a sense, *Brown* has defined both the legal and the political battlefield upon which I-330 and I-336 were fought. Pre-*Brown*, “[f]ew would have thought of the courts or civil litigation as an agent of social change.”⁵⁶ Post-*Brown*, both at the state and federal levels, injured patients, their families and their advocates in the plaintiffs’ bar are being challenged through initiatives and legislation sponsored by the insurance industry.

In this debate, it is worth acknowledging that the interests of doctors and lawyers in the ideal world are both aligned with those of the patient in the first instance. The doctor seeks to promote the patient’s health and the lawyer seeks to protect the patient’s rights. Once a medical malpractice action is filed as a result of a medical mistake, the lawyer’s and the patient’s interests are aligned while the doctor and the insurer assume an adversarial posture by virtue of their economic self-interest.

D. Unpacking “Reform”: Debunking Rationales Disconnected from Facts

The political alignments surrounding issues of malpractice “reform,” add more heat than light to the subject matter. The presentation of the subject as being a contest between doctors and lawyers further fuels the opportunity for ill will, as both sides perceive their professional livelihood as being at stake. With acknowledgment of the strength of convictions held, it is essential that one bring intellectual honesty and rigor to an analysis of public policy that too often springs from unstated axioms based upon urban legend.⁵⁷

The justifications for the “reforms” instantiated in I-330, address neither the actual causes of malpractice, nor the actual effects of malpractice litigation. Since a medical misdiagnosis⁵⁸ leads to a wrong prescription,⁵⁹ a high level overview of the major reasons for reform is warranted.

III. ANALYZING I-330: WHERE PROPAGANDA MEETS FACTS

A. Our National Narrative and the Attack on Civil Justice

On its face, the fact that medical errors account for 98,000 deaths per year⁶⁰ would seem to be the natural place to begin our national discourse on health care. The national narrative, as the term “malpractice reform” suggests, starts from litigation. In recent years, our national political debate on medical insurance and access to high quality health care has increasingly focused upon proposals to change the civil justice system, particularly with respect to the handling of liability for malpractice injuries. An attack on traditional notions of civil justice is at the core of the drive for malpractice “reform.”

President George W. Bush stated in his State of the Union Address on January 28, 2003:

To improve our health care system, we must address one of the prime causes of higher cost, the constant threat that physicians and hospitals will be unfairly sued. [Applause.] Because of excessive

litigation, everybody pays more for health care, and many parts of America are losing fine doctors. No one has ever been healed by a frivolous lawsuit. I urge the Congress to pass medical liability reform. [Applause.]⁶¹

In his 2004 State of the Union Address, the President stated: “To protect the doctor-patient relationship, and keep good doctors doing good work, we must eliminate wasteful and frivolous medical lawsuits. [Applause.]”⁶² In his 2005 State of the Union Address, the President again sought to advance “medical liability reform” with the promise that it “will reduce health care costs and make sure patients have the doctors and care they need. [Applause.]”⁶³

Other statements abound,⁶⁴ the thrust of which are to impute problems with the delivery of our health care to failings in the operation of our civil justice system. These national addresses to the American people and both houses of the Congress, however, are crafted, reviewed, and published in a manner that makes them among the most carefully scrutinized and least casual pronouncements of public policy. Accordingly, it is not unfair to regard them as examples of viewpoints with substantial following within the current debate. On the other hand, one ought not be surprised to find that the State of the Union Address is a rhetorical piece, rather than a detailed policy analysis. After all, its effectiveness is measured, in large part, upon its ability to appeal to, evoke, and shape a common understanding already held by the general public.

The address contains a number of factual assertions that are subject to testing. Before proceeding to do so, however, it is worth spending a moment to justify the undertaking and to consider briefly how public opinion is formed and how we reason from facts. This will be important so that a person can periodically check his or her internal resistance to various assertions made hereinafter and ask the question: What evidence have I relied upon in forming preconceived notions that make me resistant to this evidence?

B. Exposing a Malpractice Narrative Designed for Shaping Public Opinion Against the Civil Justice System

Public education and mobilization of public opinion are tools of governance in a democratic society. Where we encounter the systematic propagation of information reflecting the views and interests of those advocating a cause, we have by definition entered the realm of “propaganda.” Propaganda has a negative connotation in that it implies the manipulation of public opinion by dishonest means, usually by perpetuation and repetition of falsehoods.⁶⁵ The distinction between that which is termed “propaganda” and that which is termed “public information” necessarily arises from an assessment by a hypothetical neutral of the veracity of the statements made and the ulterior motives of those disseminating the propositions at issue.

The preeminent Scottish philosopher, David Hume, recognized the significance of public opinion as the sole support of government:

NOTHING appears more surprizing to those, who consider human affairs with a philosophical eye, than the easiness with which the many are governed by the few; and the implicit submission, with which men resign their own sentiments and passions to those of their rulers. When we enquire by what means this wonder is effected, we shall find, that, as FORCE is always on the side of the governed, the governors have nothing to support them but opinion. It is therefore, on opinion only that government is founded; and this maxim extends to the most despotic and most military governments, as well as to the most free and most popular.⁶⁶

Noam Chomsky concluded in his 1984 essay, “The Manufacture of Consent”: “Propaganda is to democracy what violence is to totalitarianism.”⁶⁷ The reason tartly stated by Chomsky: “A despotic state can control its domestic enemy by force, but as the state loses this weapon, other devices are required to prevent the ignorant masses from interfering with public affairs, which are none of their business.”⁶⁸ It has recently come to be in vogue to speak of “framing” the issues, because members of

the public approach each issue with a neurologically instantiated frame of reference which makes them more or less likely to be receptive to the data presented.⁶⁹

Hume wrestled with the problem of inductive reasoning,⁷⁰ by which we reach general conclusions about the future based on a series of observations about the past, noting that someone who insisted on sound deductive justifications for everything would starve to death. When we are less receptive to certain data due to preconceived notions, any inductive processes will necessarily display a bias. Hence, propaganda functions not only as a tool of persuasion for the proposition presented, but as a pervasive influence tending to make us less receptive to contrary data by helping to shape our preconceptions or belief systems. It becomes all the more important, then, to remain aware of urban legends perpetuated respecting the operation of the civil justice system, legends which often demean the jury system by suggesting irresponsible verdicts.⁷¹

C. Testing Urban Legends Underlying Proposals for Medical Liability "Reform"

It is time to consider the propositions repeatedly put forward by President George W. Bush in his State of the Union addresses. In doing so, we must keep in mind that the mere fact that these remarks meet with public acclamation may only mean that they are resonating with some pre-existing belief system or even that their repetition has created its own resonance. Since that belief system may have been fortified or even created by propaganda, the veracity of the propositions cannot be judged by "common sense."

The following propositions were put forward by or may be inferred from the State of the Union Addresses cited above:

1. Health care litigation is unfair, excessive, and frivolous.
2. One of the prime causes of higher health care costs is litigation.
3. Many parts of America are losing doctors due to litigation.

4. Medical liability “reform” will significantly reduce health care costs and make sure patients have the doctors and care they need.⁷²

1. Is Health Care Litigation Unfair, Excessive, and Frivolous?

a. Is Health Care Litigation Unfair?

Our current civil justice system provides for compensation for victims for the civil wrongs known as torts. Such compensation is awarded based upon the injured party establishing that the defendant is “at fault.”⁷³ In Washington State, claims for injuries arising from the provision of health care are governed by statute and the statute defines the elements of proof required.⁷⁴

The burden, both legal and practical, upon the injured party is greater in medical malpractice litigation than in, say, litigation arising from a car accident in a number of ways. First, in medical malpractice cases, the statute of limitations runs even though a plaintiff is under eighteen; in the ordinary tort action, the statute of limitation is tolled during the injured party’s minority.⁷⁵ Second, except in rare cases where the evidence of injury is observable by lay persons and able to be described without medical training, the breach of the standard of care must be established by a medical practitioner in the same field or specialty.⁷⁶ Third, some collateral sources such as payments from other sources than the injured party or his or her immediate family may be considered as a way of offsetting damages due from the defendant; this is something not generally available in other tort claims.⁷⁷ Fourth, the burden of proof rests with the injured party who must establish all of the elements of the claim by a preponderance of the evidence.⁷⁸ And lastly, no punitive damages are available in Washington on tort claims.⁷⁹

For the purposes of our discussion, let us envision the case of a child who has suffered hypoxic injury at time of birth due to a breach of the standard of care on the part of the doctor or nurse. This injury, let us suppose, will

result in some form of brain damage and, as a consequence, moderate to severe impairment of speech, motor, and cognitive function, requiring assistance for the balance of the injured child's life. The traditional economic rationale for the tort system is that holding the negligent actor liable will both compensate the victim and provide incentives for improved safety. The injured party, through his or her parents or guardian or personal representative,⁸⁰ has the burden of establishing the liability of the physician by a preponderance of the evidence⁸¹ based upon a breach by the physician of the standard of care expected of a reasonably prudent medical practitioner in Washington in the same field acting in the same or similar circumstances at the time of the care in question,⁸² as supported by expert witnesses deemed qualified by the court.⁸³ Under Washington law, for civil trials with a jury of twelve, ten of the twelve jurors must concur on each element necessary to the verdict.⁸⁴

The unfortunate reality is that the plaintiffs in such a case approach litigation having already experienced a personally devastating experience and, more often than not, have suffered economic devastation as well. It is now their task to seek compensation from a malpractice insurance company, a professional litigant with relatively unlimited resources. In the absence of any cost-shifting based upon a juror determination of fault, the victim would presumably be left on their own with the entire burden being borne by the victim's family—and the public. No deterrence against carelessness or incentives for greater safety would be present in such a system. In a system of absolute liability, all health care injuries would be covered by insurance, again with the cost spread among the general public, but no specific disincentive against future negligence by the at-fault party would necessarily inhere in such a system. One is hard put to discern any unfairness to the defendant unique to health care litigation that justifies substantial change to our civil justice system so as to tilt the balance against the plaintiff and in favor of the defendant.⁸⁵

b. Is Health Care Litigation Excessive?

The assertion that there is “excessive” litigation appears untenable in the face of studies suggesting, to the contrary, that the vast majority of patients who sustain injuries from substandard medical care pursue no legal action whatsoever.⁸⁶ In Florida, hospital reporting of injuries resulting from “adverse incidents,” “event[s] over which health care personnel could exercise control,” is required by statute.⁸⁷ Florida hospitals reported over six times as many adverse incidents as medical malpractice claims during the period 1996-99.⁸⁸ Instances of substandard care outstrip claims in Utah (ratio of 5.1 to 1), Colorado (ratio of 6.7 to 1), New York (ratio of 7.6 to 1) and California (ratio of 10.0 to 1).⁸⁹

Taken together, the data . . . suggest that the dysfunctional characteristics of the medical malpractice system--most notably, its adequacy and its accuracy--have a resilience over time and across jurisdictions... [O]ur findings certainly lend plausibility to the argument that the findings from Utah, Colorado, New York, and California are a reasonably [sic] reflection of the situation in other states.⁹⁰

To the extent that civil liability for avoidable medical mistakes promotes safety by requiring negligent providers to compensate victims, it cannot be concluded that the number of lawsuits is “excessive” given that between 80 and 90 percent of injury claims are never filed.⁹¹ Moreover, recent studies report that while roughly 12 percent⁹² of those injured file a claim, “the number of medical malpractice cases being filed per capita has dropped over the last ten years.”⁹³ For example, “[a]djusting for population growth, the number of payments per 100,000 people has fallen from 5.85 in 2001 to 4.91 in 2004, a decline of 16.1 percent.”⁹⁴

Is litigation “excessive,” perhaps, in the indirect sense that fear of liability on the part of physicians encourages unnecessary medical tests and procedures referred to as “defensive medicine?” Even in this attenuated sense, apparently not. The United States General Accounting Office, relying

upon a 2003 study of the Congressional Budget Office (CBO), was unable to find “savings” from a reduction in “defensive medicine” stating: “[P]reliminary findings from a 2003 study [by CBO] . . . failed to find any impact of state tort laws on medical spending.”⁹⁵

Furthermore, in connection with the enactment by the House of Representatives of a bill seeking to limit patients’ recovery of damages, the CBO was requested to calculate savings from reduced spending on “defensive medicine.” The CBO stated:

CBO’s estimate does not include savings from reductions in the practice of defensive medicine—services and procedures that are provided largely or entirely to avoid potential liability. Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians’ responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending. . . . CBO could find no statistically significant difference in per capita health care spending between states with and without malpractice tort limits. These findings are preliminary, however, and CBO continues to explore this issue.⁹⁶

Lastly, litigation is also not “excessive” in terms of malpractice payouts to resolve claims. On the contrary, the rate of increase in malpractice payouts has been miniscule for over a decade. Adjusted for inflation, between 1991 and 2004, such payouts had a negligible rise: from \$2.1 to \$2.3 billion or only 0.8 percent per annum.⁹⁷ Over the same period, the inflation-adjusted median payment from jury verdicts rose only 1.2 percent per annum⁹⁸ while verdicts for more than \$1 million declined by 31 percent during the period 2001-04.⁹⁹ The percentage of paid claims over \$1 million

declined from 1.8 percent to 1.6 percent from FY 1996–2000 when compared to FY 2001–2005.¹⁰⁰

It is worth noting at this point that in Washington, while the population has grown at a rate of 1.7 percent a year from 1994 to 2002, the number of malpractice suits filed has only grown at .4 percent per year during that same period.¹⁰¹ Moreover, when inflation is taken into account, the average amount of a malpractice payout per doctor in 2001 declined 32.3 percent from 1997 to 2001, from \$4,525 per doctor to \$3,065.¹⁰² It may be concluded that whatever urgency is driving the current initiatives to change the civil justice system, it is neither an increase in the number of lawsuits or the amounts paid out, both of which have been trending lower in recent years.¹⁰³

c. Is Health Care Litigation Frivolous?

To conclude our review of the triad of criticisms leveled by President Bush (unfair, excessive, frivolous), we must consider whether the current system of liability for medical malpractice encourages frivolous litigation. At the outset, it should be noted that lawyers representing plaintiffs injured as a consequence of medical malpractice are generally compensated on a contingent fee basis, with legal fees being paid as a percentage of the recovery, if any. Defense lawyers, representing the malpractice defendant, are generally compensated on an hourly basis by the insurance company for the defendant health care provider. One would not expect plaintiffs' attorneys, who only receive a fee if there is a settlement or verdict in favor of their injured client, to pursue cases lacking merit. Plaintiffs' attorneys, as a rule, must incur substantial expenses obtaining copies of a patient's medical records, paying for record review by medically trained individuals, and retaining expert witnesses (customarily out-of-state) to render opinions respecting the standard of care.¹⁰⁴ In addition, such cases involve the expense of compensating the defense experts for their time during deposition. Finally, there is the lost opportunity cost associated with the

pursuit of a frivolous case, when other meritorious cases are not pursued. There is nothing in the economics of attorney compensation through a contingent fee that militates in favor of the commencement of non-meritorious claims or the prolongation of litigation.¹⁰⁵

One Ohio State University study concludes that: “It appears that malpractice defendants—rather than plaintiffs—may be somewhat too inclined to resist settlement and push cases to trial.”¹⁰⁶ Comparing the outcomes of trials following settlement negotiations in both medical malpractice and product liability cases, the study found that defense attorneys in product liability cases correctly rejected plaintiff demands that exceeded the eventual jury verdict twelve out of fourteen times; on the other hand, defense lawyers in medical malpractice cases only made the correct settlement decision in eight out of seventeen cases, more often than not going to trial despite the fact that the jury ultimately awarded more in damages than plaintiffs had been willing to accept in settlement.¹⁰⁷ This data tends to refute the notion of litigious plaintiffs’ lawyers eager to play the civil jury “lottery.” It does support the notion that physician-defendants, driven by an emotional desire to defend their reputation in a medical malpractice suit, may not be best situated to enter into the sorts of negotiations reasonably calculated to lead to rational compromise settlements.

Moreover, malpractice lawsuits are anything but “jackpot justice.”¹⁰⁸ First, the inflation-adjusted median size of judgments has changed little: it grew from \$125,000 to \$146,100 at an average per annum increase of just 1.2 percent.¹⁰⁹ In Washington, for example, the dollar value of malpractice payouts decreased 25.7 percent¹¹⁰ between 1997 and 2001—hardly an indicator of our state’s “jackpot justice.” Second, “the proportion of payments of \$1 million or more, adjusted for inflation, is down 56 percent . . . from 2.25 percent of all payments to just 1 percent of all payments.”¹¹¹ Lastly, and most importantly, between 2001 and 2004, the annual number of malpractice payments has fallen 13.6 percent from 16,682 to 14,441—a

number “only 5.5 percent higher than the 13,687 payments recorded for 1991.”¹¹² In summary, the data shows that malpractice suits are not a territory for frivolous lawsuits to begin with, and in more recent years, are increasingly favoring defendants over plaintiffs.¹¹³

Beyond the rhetorical charge against trial lawyers (which presupposes the ineffectiveness of the ethical and procedural safeguards of the Rules of Professional Conduct and Civil Rules), the “frivolousness” argument strikes at the heart of the rationality of the jury system. Jury decisions, however, if biased at all, are biased in favor of medical doctors.¹¹⁴ “Defendants with an M.D. degree appeared to win medical malpractice trials more often than health care workers who lacked that degree, even when . . . controlled for injury severity and type of alleged malpractice.”¹¹⁵ Merritt & Barry report that their “findings are consistent with a plethora of other studies concluding that civil juries are conscientious in their work and reach rational decisions.”¹¹⁶ The evidence supports the contention that juries are more conservative than judges, physicians, or lawyers in their assessments of personal injury cases.¹¹⁷

Against this factual background, the polemics of health care litigation as unfair, excessive, and frivolous appear unfounded. Rather, “In the face of this evidence, exaggerated anecdotes and wild stories no longer have a place in responsible review of the tort process.”¹¹⁸

2. Is Litigation One of the Prime Causes of Higher Health Care Costs?

Proponents of medical liability “reform” contend that a prime cause of rising health costs is medical malpractice litigation. One could think this to be true as “[m]any medical errors are occurring.”¹¹⁹ The 2000 Institute of Medicine report found that preventable medical errors are the cause of up to 98,000 deaths per year in the nation’s hospitals.¹²⁰ Additionally, a 2002 Commonwealth Fund report confirmed these statistics and “estimated that 22.8 million people have experienced a major medical error, either personally or through at least one family member, at an annual cost of USD

\$17 to \$29 billion.”¹²¹ “The United States Agency for Health care Research and Quality (AHRQ) estimates that medical errors are the eighth [sic] leading cause of death, which is higher than . . . cancer.”¹²² If we include some 106,000 deaths from adverse effects of medications (in the absence of negligent prescription and administration), deaths related to health care total some 225,000 Americans annually, making it the third leading cause of death.¹²³

Surprising as it may seem, medical errors do not drive malpractice premiums. “[M]alpractice premiums are not really experience rated, i.e., they are not based on past malpractice claims. As a result, negligent and non-negligent physicians pay similar premiums.”¹²⁴ Therefore, whether the insurance crisis is due to medical errors, “the level of damages themselves, or alternatively, some aspect of the insurance system”¹²⁵ is an open question. Ironically, I-336, opposed by the Washington State Medical Association, proposed a fix that would support non-negligent physicians: a rating plan mandating consideration of past loss experience of facilities or individual physicians.¹²⁶

In 2005, the AMA “reported that twenty states are experiencing a ‘full-blown medical liability crisis’ due to sharply increasing medical malpractice insurance premiums.”¹²⁷ “Many physicians have experienced exorbitant medical malpractice liability insurance premium increases, oftentimes as high as 100 percent or even 200 percent over the previous year.”¹²⁸ A 2003 AMA study reported “92.4 percent of high-risk specialists said that liability pressures were important in their decision to stop providing certain services.”¹²⁹ In short, according to the AMA, the liability insurance rate crisis has reached epic proportions.

Significantly, a causal relationship between litigation payouts and insurance rate increases has not been firmly established. To the contrary, studies by the CBO, the Government Accountability Office (“GAO”) and other leading analysts show neither medical errors nor litigation costs to be the dominant drivers of malpractice premiums. The GAO noted at least

three factors affecting malpractice premiums including: “(1) decreases in investment income as interest rate from bonds decreased; (2) competition for market shares . . . ; and (3) [increases in] reinsurance rates.”¹³⁰ The CBO also cited, *inter alia*, (1) increased cost of malpractice claims; (2) reduced investment income; (3) reinsurance costs; (4) short term adjustments in reserve levels; as well as, (5) reductions in the supply of malpractice insurance carriers.¹³¹ Commentators and analysts agree that the six significant factors include: “(1) medical cost inflation; (2) the cyclical nature of the insurance market; (3) the need to shore up reserves for policies in force; (4) a decline in investment income; (5) overall financial safety considerations; and (6) the supply and demand of coverage.”¹³²

An aggregation of the above factors would find market forces (factors 1, 2, 4, and 6) and insurance business decisions (factors 3, 4, and 5) to be the progenitors of the liability insurance crisis. According to its analysis of the business cycle as it relates to insurance premiums, Weiss Ratings, Inc.¹³³ concludes: “The property and casualty industry suffered a twelve-year “soft” period through 1999, during which marketing goals often superseded prudent underwriting practices and decision-makers typically relied too heavily on high investment income to make up for losing operations. In an attempt to catch up, insurers have tightened underwriting standards and raised premiums.”¹³⁴ In short, insurers raised premiums to cover losses in the stock market, not because of runaway litigation.

Medical malpractice premiums are a minute part of overall health care costs, and it appears an open secret that litigation settlements and awards amount to less than 1 percent of the costs of health care. In January 2004, the National Health Statistics Group’s Office of the Actuary for the Centers for Medicare and Medicaid Services released its report showing a 9.3 percent increase in health care expenditures in 2002 to \$1.6 trillion.¹³⁵ Malpractice payouts by physicians and their insurers were a mere \$4.5 billion in 2001—less than 1 percent of the country’s overall health care costs that year of about \$1.4 trillion.¹³⁶

The CBO came to a similar conclusion that malpractice costs account for less than 2 percent of health care spending—private or governmental.¹³⁷ Therefore, even if malpractice “reform” lowered payouts by an estimated “average of 25 percent to 30 percent from the levels likely to occur under current law”, it would “lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health care insurance premiums would be comparably small.”¹³⁸

For example, GE Medical Protective, the nation’s largest medical malpractice insurer, sought a premium rate increase of 19 percent a mere six months after Texas lawmakers enacted caps on non-economic damages in medical malpractice awards. In a regulatory filing with the Texas Department of Insurance, seeking to justify the rate increase in the face of a recent cap on damages, GE Medical Protective admitted that capping non-economic damages would show loss savings of only 1.0 percent.¹³⁹ In Washington State, Physicians Insurance, the largest writer of medical malpractice insurance for physicians and surgeons in Washington, was required by the Washington State Insurance Commissioner to refund more than \$1.3 million in premiums to Washington physicians associated with unfiled and unjustified rate hikes.¹⁴⁰ In view of the reduced number of claims per capita and lower payouts already noted, it would appear that insurance premium increases do not correlate with malpractice awards, and therefore, cannot be linked to malpractice litigation costs.

On the contrary, if any of the cost is attributed to litigation, it is likely that some of it is due to the strategies employed by defense attorneys and insurance firms. Consider, for example, The Doctors Company, a physician-owned insurance company. It markets its coverage on-line based upon aggressive defense of its insured doctor’s reputations stating:

Over and over, our approach has not only saved millions of dollars in potential settlements, but has also preserved the well-earned good reputations of countless doctors.

*Millions for defense. Not a penny in tribute.*¹⁴¹

No malpractice claim is settled without your written permission.¹⁴²
America's Doctors are Under Assault.¹⁴³

It is hardly surprising to discover that costs of litigation go up when the settlement decision is turned over to a party who has been informed that accountability for avoidable medical mistakes is a matter of personal honor and reputation. According to The Doctors Company, although the average medical malpractice insurer spends thirty-two cents of every premium dollar on defense costs, it markets itself with the claim that it spends 49 percent of its premiums on defense costs.¹⁴⁴ If either of The Doctors' Company claims is true, they bode ill for the industry, as well as the company itself.

In the State of Washington Office of Insurance Commissioner Medical Malpractice Closed Claim Study released in October 2005, Commissioner Kreidler updated and compared his findings from the previous report published the previous February.¹⁴⁵ What clearly emerges is a relatively stable history of malpractice litigation in which increases in Defense and Cost Containment (DCC) expenses significantly outstrip the indemnity paid to plaintiffs. This is highly significant, not least of all, because DCC costs (including defense attorneys' fees above deductibles) are borne directly by the insurance companies while plaintiffs' attorneys' fees are generally paid on a contingent basis from the compensation awarded to the plaintiff.

Key Findings	Ten Years Ending 6/30/04	Ten Years Ending 6/30/05
Total # Closed Claims	10,073	10,212
% Increase Average Paid Indemnity	4.1% per year	3.2% per year
% Increase # of Paid Claims	4.9% per year	3.5% per year
% Increase Average DCC	6.4% per year	7.0% per year
% Increase # of Claims with DCC	5.3% per year	3.5% per year
% Claims Paid Indemnity > \$1million	1.6%	1.7%
% Claims Closed with \$0 Paid	66.6%	67.1%
Type of Settlement (% Claims):		
Negotiations	74.8%	72.9%
Mediation, Arbitration, Private Trial	16.3%	17.6%
Plaintiff's Verdict	1.8%	1.6%

We see in these figures more justification for limiting defense attorneys' fees than for limiting plaintiffs' lawyers' fees. Plaintiffs' lawyers, usually paid on a contingent fee as a percentage of the award or settlement, would only have seen their fees rise at the rate that the indemnity awards rose, by any measure at a rate of increase substantially less than the rate of DCC cost increase and under half the rate of increase for DCC for the ten year period ending June 30, 2005. Moreover, the increases in paid indemnity to plaintiffs are modest: 3.5 percent without consideration of either the rate of population growth (1.7 percent annually)[*see* text accompanying footnote 157-159 *infra*] or inflation, both of which would create a structural increase in apparent payouts. Moreover, inflationary increases tending to increase the dollar amount (but not the value) of paid indemnity to plaintiffs are offset by correspondingly higher investment returns earned by insurance companies on premium dollars collected.

Ironically, it is higher health care costs that tend to drive medical malpractice payouts higher—not the reverse—since one of the principal elements of damages in any award for seriously injured individuals is the cost of ongoing or anticipated medical care. In the cases of individuals in a persistent vegetative state or with quadriplegia, the expense of past and ongoing health care needs can constitute the largest share of damages.

Lastly, it is worth repeating that only a relatively small percentage of claims filed ultimately go to trial.¹⁴⁶ In Washington “[o]f the 10,212 closed claims [over a period of the preceding ten years], forty-five claims—or less than one percent—were decided by a jury and resulted in a payment to a plaintiff.”¹⁴⁷

Of the claims that do proceed to trial, those that result in a defense verdict are not necessarily wholly lacking in merit. Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly selected medical negligence claims and found that the pairs agreed in 62 percent of the cases and disagreed in 38 percent of the cases respecting the appropriateness of care. They concluded: “These

observations indicate that neutral experts . . . commonly disagree in their assessment when using the accepted standard of reasonable and prudent care.”¹⁴⁸

3. Are Many Parts of America Losing Doctors Due to Litigation?

Is America losing doctors due to litigation? The simple answer is no. It is axiomatic that the supply and demand of doctors is not regulated by litigation but by personal and economic factors. For instance, “[rural areas] often have difficulty attracting or retaining other professionals.”¹⁴⁹ Even the Council on Graduate Medical Education has stated, “The relative shortage of health professionals in rural areas of the United States is one of the few constants in any description of the United States medical care system.”¹⁵⁰ Moreover, this problem predates the so-called litigation crisis. “Rural health care shortages occur throughout the world, including places where . . . nothing like the U.S. civil justice system [is] in place.”¹⁵¹

Furthermore, the GAO investigated allegations that five states, Florida, Mississippi, Nevada, Pennsylvania, and West Virginia, faced a “crisis” in medical care. Supposedly, rising medical malpractice insurance premiums were driving doctors out of practice or out of the state resulting in a critical shortage of doctors affecting consumer access to health care.¹⁵² However, the GAO concluded:

In the five states with reported problems . . . we determined that many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care. For example, some reports of physicians relocating to other states, retiring, or closing practices were not accurate or involved relatively few physicians.¹⁵³

In Florida, for instance, the GAO investigators noted:

[Reports of physicians departing the practice] were anecdotal, not extensive and in some cases . . . inaccurate.¹⁵⁴ For example, state medical society officials told us that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however,

we found at least five neurosurgeons currently practicing in each county as of April 2003. . . . [O]ver the past two years the number of new medical licenses issued has increased and physicians per capita has remained unchanged.¹⁵⁵

Here in Washington, an investigation by the *Seattle Times* revealed that, contrary to various advertising campaigns, no medical clinics had been “mothballed” and that doctors were flowing into the state faster than they were departing:

Full-page newspaper ads say that high malpractice jury awards . . . have driven hundreds of doctors from the state, thousands from “states like Washington.” “As a sad result,” the ads say, emergency rooms are “mothballed,” trauma centers “shuttered,” maternity wards “shut down,” and neighborhood clinics closed

. . . No emergency rooms or trauma centers in Washington state have been ‘shuttered’ or ‘mothballed,’” said Cassie Sauer, spokeswoman for the Washington State Hospital Association. . . .

Doctors are leaving the state, but others are coming in. Tom Curry, executive director of the state medical association, the source for a Doctors for Medical Liability Reform claim that 500 doctors have left Washington since 1998, said the association doesn’t know how many doctors had come into the state during that period, or how that figure compares to doctor drain in previous five-year periods.

According to a 2003 U.S. General Accounting Office report, “Physician Workforce,” there were more doctors per capita in 2001 than there were in 1991 in all of Washington’s metropolitan areas and in the aggregate of rural areas as well” Kemp, of Doctors for Medical Liability Reform, said the ad refers to specialists. The GAO report said the number of specialists also increased per capita in both metro and rural areas.”¹⁵⁶

Lastly, Public Citizen also stated “far from an exodus of doctors—Washington continues to experience a steady and significant increase in the

number of doctors.”¹⁵⁷ According to Public Citizen, based on private communications with the Washington Medical Quality Assurance Commission, “the number of in-state practicing doctors in Washington has jumped 3,720 [physicians] over the last decade, from 15,533 in 1993 to 19,253 in 2003[,] [which] is an overall increase of 23.9 percent or 2.4 percent a year.”¹⁵⁸ In the same period, “Washington’s overall population experienced an annual average increase of 1.7 percent from 1993 to 2002. This means the number of doctors increased at a rate 37.3 percent faster than the rate of population increase during this period.”¹⁵⁹ The bottom line is that a shortage of doctors, to the extent that it exists, is getting better and not worse.

4. Will Medical Liability “Reform” Significantly Reduce Health Care Costs and Make Sure Patients Have the Doctors and Care They Need?

a. General Response: Proposed “Reform” Will Have a Negligible Impact

While this question has been previously addressed from a number of facets previously, we will only recap the essential points: liability payouts for medical malpractice are a relatively small contributor to health care costs and are not a primary factor in the availability of health care. Since its contribution to the purported problem is small, it follows that the impact of any “reform” is small. The sensitivity of total health care costs to changes in malpractice liability is negligible.¹⁶⁰ This is confirmed by the 2004 CBO report which stated that “restrictions on malpractice liability . . . do not affect economic efficiency: they modify the distribution of gains and losses to individuals and groups but do not create benefits or costs for society as a whole.”¹⁶¹ The report concludes:

In short, the evidence available to date does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency. Thus, choices about specific proposals *may hinge more on their implications for equity*—in particular, on their effects on health care providers, patients injured

through malpractice, and users of the health care system in general.¹⁶² (Emphasis added.)

What the CBO suggests in the phrase “implications for equity” is the dark matter that is unseen but curves the legal landscape.¹⁶³ Just as black holes bend space, changes to the tort law bend justice. Changing longstanding equitable principles not only affects people’s legal rights, but blunts, often for generations, societal expectations for justice—and even the sense of injustice. Proposals for medical liability “reform” typically include a number of technical features designed to tilt the legal landscape in favor of defendants and against plaintiffs. I-330 contained all the typical provisions, together with some additional features: reduction in the statute of limitations period for both adults and minors; relaxed rules for the admission of collateral source evidence (such as payments received by injured plaintiffs from disability insurance carriers for which they have paid premiums); a cap on non-economic damages; restrictions on the access to a trial by jury; limitations on contingent attorneys’ fees for plaintiffs; elimination of apparent agency liability for hospitals; requirement of structured settlements (stream of payments) for awards above \$50,000; reversion of unpaid portion of the structure to the insurer/defendant in the event of the death of the judgment creditor (plaintiff). All of these proposals are designed to deter the prosecution of cases, to limit parties from being held liable, or to reduce the number and size of awards or payouts to injured plaintiffs.

b. Ineffectiveness of Capping Jury Awards in Arresting Malpractice Insurance Premium Increases

(i) Overview

What has been described as an insurance “crisis” or litigation “crisis” has, in the former case, been misattributed to a growth in malpractice payouts in civil trials and, in the latter case, simply does not exist as a prime factor in rate increases. It would be surprising, therefore, if we were to

learn that limitations or “caps” on jury awards, a “cure” based upon the verity of the unsubstantiated propositions just debunked, actually worked. We are not surprised. The evidence suggests that caps have little or no effect on malpractice premium rates.

Efforts to limit or “cap” jury awards in several states, such as California, Florida, Maryland, and Ohio, which date as far back as the 1970s, have resulted in varied success in the courts and little success in the medical malpractice insurance business. It is helpful to review the record of the last three decades.

(ii). Thirty Years of Failed Results in Arresting Insurance Rates

The nearly three-decade-old experience of states is quite telling. In California, for example, “Conventional wisdom holds that . . . the [1975] MICRA¹⁶⁴ cap is systematically reducing compensation and substantially reducing the damages paid by culpable defendants.”¹⁶⁵ However, California and several other states that modeled their damage caps after MICRA have not seen a reduction in their rate of increases. In the thirteen years after the MICRA \$250,000 non-economic damage cap was enacted, “doctors’ malpractice insurance premiums rose by 450 percent.”¹⁶⁶ Maryland, which enacted a \$350,000 cap in 1986, saw premiums rise “by more than 70 percent” in 2003-04.¹⁶⁷ Doctors in Missouri, where a \$350,000 cap was enacted in 1986, also saw their premiums rise by 121 percent in 2000-03.

Recent experience with newly enacted caps is not different. Oklahoma, which passed a cap in 2003, saw a 105 percent increase in 2004.¹⁶⁸ The 2003 caps imposed by Texas’ Proposition 12¹⁶⁹ also failed to limit rate increases. In fact, “Right after the referendum passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.”¹⁷⁰ To be sure, the GAO Report “could not determine the extent to which differences in premium rates and claim payments across states were attributed only to damage caps.”¹⁷¹ In short, “whether damage caps slow, or otherwise affect, [rate] increases remains unclear.”¹⁷²

Moreover, there is no conclusive proof that the absence of damage caps is associated with increases in premiums. Minnesota, for example, “has the lowest premiums and the mildest increases in premiums, but it has neither damages caps nor crisis.”¹⁷³ Comparing Minnesota (a state without damage caps) with Florida (a state with damage caps), we see that between 1998 and 2002, the Minnesota insurer increased its base premium rate by about 2 percent in contrast to the Florida insurer that increased its base premium rate by about 98 percent.¹⁷⁴

Oddly enough, the evidence that caps and premiums are not strongly linked is not news to insurance companies. In 2004, one insurance company reported to the Texas Department of Insurance that the state’s non-economic damage cap would be responsible for no more than a 1 percent drop in losses.¹⁷⁵ As recently as June 2005, an insurance executive was quoted stating “tort reform had little effect on medical malpractice premium rates.”¹⁷⁶

(iii) Crossover Effects of Non-Economic Caps and Other Confounding Factors

The simplistic proposition that non-economic caps lower premiums is dubious based on the evidence. It must be noted, however, that rigorous analysis is an undertaking that meets with many challenges, not the least of which is a sort of legal Heisenberg Uncertainty Principle, whereby the observer effects the events observed.¹⁷⁷ For instance, the very existence of caps may affect plaintiffs or their counsel with respect to the types of cases they will choose to pursue, litigation or settlement. Second, it is unknown whether caps, when known to jurors, serve as a “floor” for severe injuries or death or as a “ceiling” for less severe injuries. For example, a 2004 Rand Corporation study on California’s MICRA concluded: “It is not clear whether jurors, when [aware of caps], would be more likely to ‘self-limit’ their original awards to just \$250,000 for non-economic damages or to inflate their awards . . . to make a public statement about their feelings.”¹⁷⁸ And finally, the crossover effect of caps, i.e., “where non-economic

damages are capped . . . some portion . . . might spill over into . . . unlimited economic damages,”¹⁷⁹ is not fully understood. In a nutshell, in considering the total compensation scheme, the flexibility inherent in calculation of non-economic damages in response to caps is a complex phenomenon that requires further analysis before any conclusions can be drawn.

Professor Catherine M. Sharkey’s paper, discussing the unintended consequences of medical malpractice damages, posits that “economic compensatory damages in medical malpractice cases might be much more malleable than its conventional depiction and might therefore be subject to inflation via a crossover function.”¹⁸⁰ In other words, in the pursuit of justice, jurors may blur “what the law often treats as hermetically sealed categories of economic and non-economic damages.”¹⁸¹

In *Carter v. United States*,¹⁸² Judge Richard Posner wrote, “[t]here might be harm . . . if for example a plaintiff had some leeway in classifying damages as economic rather than non-economic, or if knowledge that non-economic damages were unavailable would have induced her to devote less effort to proving up such damages and more to proving her economic damages.” Therefore, there seems to be some level of judicial recognition, if not acceptance, of the crossover effect.

c. Table Summarizing Impact of Proposed Changes

None of the proposed changes provide any incentive for safer medical care by negligent physicians, as the table below demonstrates:

Proposed Change	Impact on Injured Party	Increased Safety Incentive
Statute of Limitations (Minor) (I-330, §6)	Minor patients under six or their custodians must file within three years or by age eight; limitations period not tolled during minority. Cuts off claims without regard to merit; hard on minors and disempowered populations.	No. At fault party not held accountable based upon passage of time, not upon the merits. Incentive for safety reduced.
Statute of Limitations (I-330, §6)	Patients or their custodians must file within one year of the time they discovered or reasonably should have discovered negligence; cuts off claims without regard to merit; hard on minors and disempowered populations.	No. At fault party not held accountable based upon passage of time, not upon the merits. Incentive for safety reduced.
Requirement of Structured Payout (I-330, §10)	Mandates time payments on jury awards in excess of \$50,000, possibly over decades; delays receipt of funds and investment opportunities.	No. At fault party may have reduced expense related to purchase of structured payments. Incentive for safety may be reduced.

Proposed Change	Impact on Injured Party	Increased Safety Incentive
<p>Limit on Contingent Fee for Plaintiff (I-330, §4)</p>	<p>Reduces incentive for plaintiffs' attorneys to undertake the representation on the contingent fee basis and may result in some cases not being pursued because not cost-effective to do so. Limit on contingent fees will nearly always impair the ability of the injured party alone to obtain counsel as defendants' counsel generally paid on hourly basis.</p>	<p>No. At fault party may escape liability because plaintiff is unable to obtain counsel or counsel has less incentive for vigorous prosecution of claim. Reduced incentive for safety.</p>
<p>Ninety-Day Notice Period (I-330, §5)</p>	<p>Creates new procedural hurdle; possible trap for the unwary; may create in some cases an opportunity for spoliation of evidence.</p>	<p>No. At fault party may escape liability on procedural technicality. May create opportunity for spoliation (destruction, concealment, or alteration) of evidence. Reduced incentive to prevent negligence.</p>

Proposed Change	Impact on Injured Party	Increased Safety Incentive
Abolition of Apparent Authority (I-330, §11)	Eliminates vicarious liability of hospital for wrongdoing by physicians and overturns existing Washington law under <i>Adamski v. Tacoma General Hospital</i> . ¹⁸³ Reduces chance that patients will receive compensation.	No. Hospitals that traditionally would have been held accountable for malpractice occurring on their premises immunized. Reduced incentive to prevent negligence.
Collateral source (I-330, §7)	Injured party pays for part of damages caused by wrongdoer through injured party's premiums.	No. At fault party is not held accountable for full damages caused; plaintiff covers self with medical/disability plan.
Cap on damages (I-330, §1, §2)	Reduces available compensation for non-economic damages; may make obtaining counsel harder for injured persons without economic losses such as lost income; hurts most seriously injured most. Seeks to reverse <i>Sofie v. Fibreboard Corp.</i> ¹⁸⁴	No. At fault party not fully accountable for damages sustained by injured party. Reduced financial exposure for injuries to women, minorities, minors, and traditionally under employed groups. Possible meritorious cases may not be pursued.

Proposed Change	Impact on Injured Party	Increased Safety Incentive
Reduced jury access (I-330, §8)	Deprivation of constitutional right; deprives injured party of hearing before peers; may affect liability and damages	No. Possible decreased incentive for safe conduct on the part of the at-fault party by eliminating public trial. Risk of secret settlements.

Some of these features build upon previous alterations to tort law. For instance, in most personal injury cases—but not in medical malpractice—the limitations period is tolled during periods of minority: the injured individual is not time-barred from pursuing a legal action until some period of time after he or she reaches adulthood. But RCW 4.16.350¹⁸⁵ provides, in pertinent part:

For purposes of this section, notwithstanding RCW 4.16.190, the knowledge of a custodial parent or guardian shall be imputed to a person under the age of eighteen years, and such imputed knowledge shall operate to bar the claim of such minor to the same extent that the claim of an adult would be barred under this section. Any action not commenced in accordance with this section shall be barred.

For purposes of this section, with respect to care provided after June 25, 1976, and before August 1, 1986, the knowledge of a custodial parent or guardian shall be imputed as of April 29, 1987, to persons under the age of eighteen years.

Since all of the foregoing features, tend to reduce compensation to victims without creating any incentive for better, safer health care, they are only going to address “the problem.”

The history of RCW 4.16.190 shows a multi-generational effort to disfavor plaintiffs in medical malpractice claims by alteration of the applicable limitations period and by elimination of tolling for minorities. I-330 continues the trend by reducing the statute of limitations to one year for children seven and older, in addition to the imputation of knowledge to their custodial parent or guardian earlier enacted. The imputation rules necessarily mean that households disadvantaged in terms of access to justice and financial wherewithal directly limit the rights of children in such households, visiting inequities upon later generations. All the while, it is important to keep in mind that “the statute of limitations, although not an unconscionable defense, is not such a meritorious defense that either the law or the facts should be strained in aid of it.”¹⁸⁶

D. Constitutional Infirmities of Malpractice “Reform” Present in I-330

1. Basic Principles of Constitutional Review

Marbury v. Madison established the principle that when a law conflicts with the Constitution, the judiciary determines “what the law is.”¹⁸⁷ Otherwise, if the legislature is free to change the constitution by legislative acts, the constitution would become nothing more than “form without substance.”¹⁸⁸ The *Marbury* opinion also had a prescient formulation of substantive due process that shines bright today: in *Marbury*, Chief Justice John Marshall wrote, quoting Blackstone, that “every right, when withheld, must have a remedy, and every injury, its proper redress.”¹⁸⁹ While an in-depth constitutional analysis is beyond the scope of this article, even a cursory review¹⁹⁰ of I-330 demonstrates that enactment would implicate a number of state constitutional issues including separation of powers,¹⁹¹ due process,¹⁹² equal protection,¹⁹³ the right to a jury trial,¹⁹⁴ the attempt to reinstate caps on damages which the Washington State Supreme Court had already held to be unconstitutional,¹⁹⁵ and constraints on the power of judges to declare the law when charging juries.¹⁹⁶

2. Separation of Powers Issues Implicated

The practice of law in Washington State is administered by the Washington State Bar Association: “That association is responsible to the Supreme Court, not the legislature or an agency of the executive branch, for the delineation of its responsibilities in the admission, discipline and enrollment of lawyers.”¹⁹⁷ “It is a well established principle that one of the inherent powers of the judiciary is the power to regulate the practice of law.”¹⁹⁸ Even under the least jealous assertion of judicial power, it is unlikely that regulation of legal fees, as provided in I-330’s limit on contingent fees in Section 4, would permit an initiative such as I-330 to be embodied into legislation as contemplated by its proponents.¹⁹⁹

3. The Challenge to Substantive Due Process

“[I]t has been emphasized that the purpose of the due process clause is to protect individuals from the arbitrary exercise of government power.”²⁰⁰ If adopted, I-330’s limits on damages and attorneys’ fees would constitute such an unconstitutional exercise. Fortunately, the Washington Constitution offers protection for Washingtonians’ due process rights.²⁰¹ As the Washington State Supreme Court noted:

Washington is one of many states that rely on their own constitutions to protect civil liberties. Since the recent retrenchment of the United States Supreme Court in this area, the appellate courts of a majority of the states have interpreted their state constitutions to provide greater protection for individual rights than does the United States Constitution.²⁰²

In general, although, “the Washington Supreme Court has followed the federal judiciary in interpreting constitutional due process language,”²⁰³ Washington’s “[d]ue process has evolved . . . to a somewhat broader notion of fairness”²⁰⁴ described as “the substantive due process test of reasonableness.”²⁰⁵ The Court articulated its three-prong test as follows: “1) there must be a public problem or ‘evil,’ 2) the regulation must tend to

solve this problem, and 3) the regulation must not be ‘unduly oppressive’ upon the person being regulated.’²⁰⁶

Applying the three-prong test to I-330, we see that the initiative stumbles at the threshold of our review: it is not even clear that there is a public problem in terms of malpractice litigation, which I-330 purports to address. In Washington, the number of malpractice suits has remained steady, the dollar value of malpractice payouts has declined, and the number of practicing doctors has increased.²⁰⁷ In short, there is no evil being addressed by the initiative.

Assuming *arguendo* that the first prong was met, the experience of other states makes abundantly clear that the proposed regulation, prominently featuring a “cap” on damages, does not tend to solve the problem. Post “damage caps” premium increases in California (450 percent), Maryland (70 percent), Missouri (121 percent), Oklahoma (105 percent) and Texas (35 percent) demonstrate the failure of such “caps” to arrest such increases. Minnesota, a state that has no cap on damages, has the lowest rate of premium increases at 2 percent.²⁰⁸ The initiative fails to meet the second prong of the due process test.

Lastly, in denying the injured the “proper redress” by arbitrarily imposing damage caps, the regulation is “unduly oppressive.” One need only consider that the individuals subject to the damage caps on non-economic recovery are those adjudged by a jury to be the most seriously injured victims of medical malpractice warranting compensation for loss at the highest levels.

4. A Violation of Equal Protection: Special Immunity to the Health Care Industry; Special Hardship on a Class of Victims

Washington’s Constitution prohibits laws granting special immunities and privileges.²⁰⁹ “Our constitutional guarantees to equal protection mean that ‘all persons similarly situated should be treated alike.’”²¹⁰ The Washington Supreme Court ruled this section “requires an independent

constitutional analysis from the equal protection clause of the United States Constitution.”²¹¹ “Enacted after the Fourteenth Amendment, state privileges and immunities clauses were intended to prevent people from seeking certain privileges or benefits to the disadvantage of others. The concern was prevention of favoritism and special treatment for a few, rather than prevention of discrimination against disfavored individuals or groups.”²¹² Moreover, “Washington’s addition of the reference to *corporations* demonstrates that our framers were concerned with undue political influence exercised by those with large concentrations of wealth, which they feared more than they feared oppression by the majority.”²¹³

a. The “Cap” on Non-economic Damages

I-330 states:

[I]n an action or arbitration for injury or death occurring as a result of health care or related services, or the arranging for health care or related services . . . the total combined limit for civil liability for non-economic damages for all health care institutions . . . shall not exceed seven hundred thousand dollars for each claimant, regardless of the number of health care institutions.²¹⁴

The plain language of the text provides an unprecedented special immunity to health care corporations without regard for the magnitude of the harm or their ability to remedy the harm.²¹⁵ There is no rational limit to the immunity: injury by ten health care institutions to a single patient is bound by the same limit as injury by a single provider, irrespective of the severity of the injury sustained by the patient or the extent to which such injury goes uncompensated above the arbitrary “cap” established. The Washington Supreme Court has held that:

Under the minimum [rational basis] scrutiny approach, the reviewing court must determine (1) whether the legislation applies alike to all members within the designated class; (2) whether there are reasonable grounds to distinguish between those within and

those without the class; and (3) whether the classification has a rational relationship to the purpose of the legislation.²¹⁶

I-330 fails this test.

Whether such legislation applies to all members within the designated class may be affected by changes in the law only dimly visible at present.²¹⁷ I-330's grant of special immunity permeates the entire health care industry. The law holds all health care institutions, no matter how large or small, no matter the line of service including sperm banks, adult family homes, clinics, Health Management Organizations (HMOs), or surgical facilities, to the same \$700,000 cap. The language, on its face, promotes creation of a multiplicity of health care entities for provision of care to each patient, promoting loss-spreading for negligent entities and their insurers.

When it comes to the impact visited upon victims, however, limitations on non-economic recovery will almost certainly have a disproportionate impact on disempowered and disadvantaged members of society whose economic damages are smallest. "Anatole France satirized formal legal equality by stating the poor 'must labour in the face of the majestic equality of the law, which forbids rich and poor alike to sleep under the bridges, to beg in the streets, and to steal their bread.'"²¹⁸

While one's earning capacity is one aspect of value to society, a system that fully compensates loss of income as an "economic damage," but denies full compensation for "non-economic damage," necessarily insures that individuals with the highest wages will gain the largest recoveries. Women, seniors, and other members of groups suffering some degree of relative economic disadvantage, will necessarily receive smaller verdicts. The limitation on non-economic damages diminishes the relative size of any jury verdict allocable to the injury to plaintiffs as human beings, as opposed to that portion allocable to plaintiffs as engines of economic production. The crossover effect, by which some portion of non-economic damages is re-characterized by a jury as economic loss to achieve its perception of

overall fair compensation, is least effective in cases concerning those plaintiffs who were least well off pre-injury.

Likewise, I-330 stumbles under the second prong of the equal protection test: “a rational basis for treating those within and without the class.”²¹⁹ There is no rational basis for treating victims of medical negligence differently than victims of negligence in automobile accidents, product liability, or other kinds of injury victims under a regime of deterrence established by tort law. There is no rational basis for granting special immunity to members of the health care industry for their negligent acts while members of other industries lack this immunity. More to the point, compensation of innocent victims of negligence is a cost primarily allocated by society in three ways: (i) by allocating all risk and burden to the victim and his or her family support group, eliminating the productive potential of the afflicted individual and support group as they experience hardship unmitigated by compensation from wrongdoers; (ii) by allocation of the burden to the general public to the extent traditional social values mandate that it insure and support those members of the public who are disabled; (iii) by allocation of the burden to those whose negligent conduct gave rise to the injury and whose conduct can be prospectively deterred by a system of tort liability. There is no rational basis, from a societal view, for eliminating victim compensation or tortfeasor deterrence²²⁰ simply because one is victimized by a certain flavor of negligence.

Lastly, I-330 fails the third prong of the equal protection analysis: “a rational relationship to the purpose of the legislation.”²²¹ As amply demonstrated, the proposed initiative fails to establish any cause-and-effect, let alone rational, relationship between the means sought to be enacted and the ends sought to be achieved.

b. The Limit on Contingent Fees of Plaintiffs’ Counsel

I-330’s limits on attorneys’ fees are equally suspect under equal protection analysis.²²² Contingent fees are long established means of

facilitating access to those otherwise unable to afford representation: “The most important justification for the contingent fee is that it opens up the legal system to those who could not otherwise afford it.”²²³ Contingent fees are well established in Washington law and court rules in particular and American jurisprudence in general.²²⁴ Therefore, our constitutional analysis “requires us to consider the degree of protection that Washington has historically given to similar situations.”²²⁵

Here, the initiative would have the effect of *severely limiting* plaintiffs’ attorneys’ fees while allowing *unlimited* spending on defendants’ attorneys’ fees. This undermines the very increased access to justice that the contingent fee affords members of the public; in short, it burdens the ability of injury victims to pursue compensation. This reduces both incentive to sue and deterrence in an area where the available evidence suggests substandard care outstrips claims by between five and ten to one.²²⁶ There is an unjustified difference in the treatment of the class of lawyers handling medical negligence claims. We note that attorneys who specialize in medical negligence claims are no different from attorneys who practice other forms of tort law including personal injury, product liability, professional liability, and toxic tort litigation.

There is no rational relationship between the problem sought to be addressed and the solution. By and large, the one rational relationship that *has* been established is the one between the insurance business cycle and malpractice insurance rates.²²⁷ There is no rational relationship between decreasing access to justice and increasing access and availability of quality health care in Washington.

5. I-330’s Twin Challenges to the Mandate under the Washington State Constitution that the Right to a Jury Trial be Held Inviolable

In I-330, we find twin challenges to the right to a jury trial held to be inviolate under the Washington State Constitution:²²⁸ an attempt to impose a cap on non-economic damages so as to change the outcome of a jury

determination; and an effort to permit contractual waiver by patients of the right to a jury trial.

a. A Second Attempt to Impose Caps on Non-Economic Damages

Over fifteen years before I-330 was presented to the voters, the unconstitutionality of a cap on non-economic damages had already been determined in *Sofie v. Fibreboard Corp.*²²⁹ In a fashion similar to I-330, “[t]he statute [in *Sofie*] operate[d] by taking a jury’s finding of fact and altering it to conform to a predetermined formula.”²³⁰ The Washington Supreme Court found that the function of the jury included determination of damages, holding: “To the jury is consigned under the [Washington] constitution the ultimate power to weigh the evidence and determine the facts – and the amount of damages in a particular case is an ultimate fact.”²³¹ The application of community standards and values inherent in a verdict determining non-economic losses (in contradistinction to economic losses) experienced by plaintiffs is uniquely suitable for determination by a jury of their peers: “The jury’s role in determining non-economic damages is perhaps even more essential.”²³² The *Sofie* court concluded, “We find the non-economic damages limit unconstitutional on adequate and independent state [constitutional] grounds.”²³³

Sofie was not the first time the constitutional guarantee to a jury trial had been upheld. In 1889, the Washington Supreme Court invalidated “a scheme for determining the value of train-killed animals by appraisers [as] unconstitutional because it denied the right to a jury trial.”²³⁴ In a sense, I-330 is an attempt to proffer special immunities to the health care industry that were held unconstitutional to powerful railroad companies in their heyday in the 1880s.

Simply put, I-330’s legislative act “may not preempt a jury’s findings on a factual issue which has properly been submitted to the jury.”²³⁵

b. An Attempt to “Negotiate” Away the Inviolable Right to a Jury Trial

I-330, § 8 authorizes inclusion of contractual language in a form suggesting a *quid pro quo* trade between parties of the right to a jury trial for mandatory arbitration. The circumstance under which such a trade would often occur—an individual seeking medical care, even emergency care, for themselves or a loved one—has all the hallmarks of a contract of adhesion. Such contractual “trades” operate under the pretext that classical contract bargaining is occurring when, to the contrary, the facts of the modern world suggest that such language simply becomes part of the legal “boilerplate” of a contract which modern consumers have neither the time, training or motivation to negotiate—even were the receptionist in the clinic or the nurse in the emergency room in a position to negotiate the provisions. I-330, § 8 states, in pertinent part:

A contract for health care services . . . *must* have the provision as the first article of contract and the provision *must* be expressed in the following language:

It is understood that any dispute as to medical malpractice . . . will be determined by *submission to arbitration* . . . and not by lawsuit or resort to court process Both parties to this contract . . . are *giving up their constitutional right* to have such a dispute decided in the court of law before a jury (Emphasis added.)

Given the evident constitutional infirmities in I-330, the motivation of its proponents remains unclear. Why would its advocates invest millions of dollars and expend tens of thousands of hours to promote an initiative so plainly destined for judicial review and probable reversal? The current political alignment of the proponents and opponents of I-330 suggests one possible explanation: the initiative was intended to serve as part of a war of attrition, testing and draining the resources of its opponents, or as a feint requiring initiative opponents to commit resources otherwise available to advance (or oppose) other items on the local or national political agenda.

6. Other Constitutional Infirmities: Judges Shall Declare the Law.

Article IV, Section 16 of the Washington Constitution declares that judges shall declare the law.²³⁶ “[A]n instruction which does no more than accurately state the law pertaining to an issue does not constitute an impermissible comment on the evidence by the trial judge.”²³⁷ I-330 expressly prohibits the trial judge from instructing the jury with respect to the statute’s limitations on non-economic damages: “the jury shall not be informed of the limitations on non-economic damages.”²³⁸ What then is the effect of a legislative enactment that instructs the judiciary to hide the law from the jury? “Since this is a rule of law, it is appropriate that the jury be informed of this by the instructions of the court.”²³⁹ The gag order violates Art. IV, Sec. 16 by prohibiting trial judges from performing their constitutionally mandated duties, and by extension, violates Art. I, Sec. 21 by impermissibly intruding in the ability of the jury to award just compensation and the separation of legislative from judicial powers.

Whatever the merits of the foregoing constitutional interpretation, it only takes one plaintiff’s attorney requesting a jury instruction on the limitation on non-economic damages and one trial court judge to accede to the request for an appellate court to have before it the question of whether violation of the “gag order” constitutes “harmless error.”

IV. EPILOGUE: THE CAMPAIGN AND BEYOND

On November 8, 2005, Washington voters rejected both I-330 and I-336.²⁴⁰

Measure	Votes For		Votes Against	
	Vote	Vote %	Vote	Vote %
Initiative Measure 330 - Negligent Health care	783435	43.2705%	1027117	56.7295%
Initiative Measure 336 - Medical Malpractice	711443	39.7818%	1076918	60.2182%

Both initiatives were rejected by a decisive margin, but when the smoke cleared and the dust settled, it was clear that the coalition of forces who joined together on the “No on I-330” campaign were exultant. Outspent nearly two to one, the raft of labor, consumer, nurse, patient, bar association, community, Democratic, church and trial lawyer advocacy groups had chosen a bold tactic: they had abandoned support for I-336 and focused on opposition to I-330 about which there was a stronger consensus. By contrast, the proponents of I-330 (largely insurance, physician and pharmaceutical interests) had divided their message and campaign resources between advocating for I-330 and opposing I-336.

With an initial lead in early campaign polling, the public response to I-330 increasingly shifted to skepticism. Urged by the “No on I-330” campaign to “Read the Fine Print”²⁴¹ and supported by a robust yard sign campaign featuring the now familiar logo of a magnifying glass over the “o” in “No on I-330” signs, it appears that the public did so. The absence of any cap on insurance rate increases while capping non-economic damage awards from juries, the provisions waiving the right to jury in contracts for medical services, the reversion of the unpaid portion of structure settlements to insurers/defendants in the event of the death of the plaintiff, and the generally negative tone of the campaign soured the public’s appetite for the flavor of “reform” being advocated. It was not apparent how capping damage awards and having structured settlement payments revert to the insurance company or defendant would advance the promise made by I-330 proponents on their website to “get more money to injured patients.”²⁴² Increasingly, the public questioned the appropriateness of having complex matters resolved by initiative at all.²⁴³

In the end, proponents of I-330 appeared to devolve into lawyer bashing and name calling, urging members of the public to “Help bring the lying lawyers to justice” and to “Follow the liars’ money.”²⁴⁴

In some respects, this tale of two initiatives has primarily been the tale of I-330. As a local manifestation of a national phenomenon, I-330 sought to alter the civil justice system in favor of organized defendants and against the unorganized public, which in its midst includes the yet unknown prospective victims of medical negligence. Our examination of I-330 confirms the open secret that spikes in medical liability insurance premiums appear to be related to insurance business cycles, not to jury verdicts. It follows that efforts to burden plaintiffs’ access to justice, to remove incentives from representation of injured people, and to limit recovery by innocent victims will prove ineffective as a means of regulating insurance premiums.

I-336, with its forthright cap on insurance rate increases and proposals for increasing transparency of rate setting, holds out hope for Washington physicians that I-330 did not. Increasing the vigilance of the Medical Quality Assurance Commission, mandating experience based rating for physicians' insurance, and increasing the transparency of medical malpractice settlements holds out a promise of better, safer health care for patients in Washington.

One cannot help but be mindful of the fact that our tale of two initiatives is necessarily a tale of the initiative process itself. Recent experience suggests that initiative campaigns suffer from the same frailties as other political campaigns: enormous costs incurred in an effort to get the attention of a public preoccupied with the concerns of daily living, a public education challenge of the first magnitude. Indeed, where campaigns ask the public to make important policy decisions, it is important that voices of reason be recognized and heard above the mind-bending din of special interest advocacy and attack advertising. The power of special interests to lobby elected representatives of the people has long been regarded as problematic.²⁴⁵ Most citizens lack the time, financial wherewithal, organization, and motivation to lobby for their own general interests. An initiative directly from the people might appear to present an antidote to the unrestrained lobbying of the people's representatives in the legislature. This promise, however, can go unrealized where massive resources of interested groups expend millions of dollars lobbying the people directly through disinformation campaigns. The task of promoting and funding public education generally and civics education specifically is an appropriate challenge for any democracy and one foreseen by our Founders.²⁴⁶

Our initiatives also subsist in a context where access to medical care of quality is in crisis. Both initiatives were able to galvanize a public eager for solutions with the promise of improvements, but neither initiative addressed the basic, underlying, unmet challenge of providing high quality medical

care to our people. It is likely that there is a broad consensus in the public as to what is desired respecting medical care: accessibility, affordability, portability, transferability, security, quality, and universality, all to the end that no person's health need depend on his or her wealth. It will take bold leadership to gain public acceptance of the choices and sacrifices necessary to fulfill such desires.

What would have been a damaging blow to civil justice has been averted by the defeat of I-330. As Chief Justice Marshall wrote in *Marbury v. Madison*: "The very essence of civil liberty, certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury. One of the first duties of government is to afford that protection."²⁴⁷ I-330 is but the latest challenge to traditional constitutional protections. It remains to be seen whether the exhaustion of the financial resources of the opponents of I-330 engendered by the initiative campaigns will, in the final analysis, prove to be a victory for I-330 proponents in battles to come.

Fulfillment of a vision of social justice calls for true reform that takes on the challenges of campaign reform for our democracy, civics education for our electorate, and health care for our people.

This is the lesson of the tale of two initiatives.

POST-SCRIPT

In post-election negotiations, Governor Christine Gregoire convened a series of meetings with representatives of the Washington State Trial Lawyers Association, Washington State Medical Association, Washington State Hospital Association and Physicians Insurance who agreed upon a compromise bill addressing health care liability reform, Second Substitute House Bill 2292 ("2 SHB 2292"), which passed the State House with the amendments of the State Senate on February 28, 2006.²⁴⁸ Widely hailed as a good first step, 2 SHB 2292 is as significant for what it does not include, as for what it addresses.²⁴⁹ Whether the accord ushers in an era of peace or

is simply a cease fire in an ongoing clash of opposing interests remains to be seen.

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³ INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et. al. eds., 2000), available at <http://www.nap.edu/openbook/0309068371>.

⁴ Includes 106,000 deaths due to "nonerror adverse effects of medications." Barbara Starfield, M.D., M.P.H., *Is US Health Really the Best in the World?*, 284 JAMA 483, 484 (2000).

⁵ PUBLIC CITIZEN, MEDICAL MALPRACTICE BRIEFING BOOK: CHALLENGING THE MISLEADING CLAIMS OF THE DOCTORS' LOBBY 41 (2004), available at <http://www.citizen.org/documents/MedMalBriefingBook08-09-04.pdf>. [hereinafter PUBLIC CITIZEN, MEDICAL MALPRACTICE]. "Just 5.4 percent of doctors have been responsible for 56.2 percent of all malpractice payouts to patients, according to NPDB [National Practitioner Data Bank] data from September 1990 through 2003. Each of these doctors has made at least two payouts. Even more surprising, just 2 percent of doctors, each of whom has made three or more malpractice payouts, were responsible for 31.1 percent of all payouts." *Id.*

This parallels the experience in Washington State where, "[a]ccording to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, just 3.5 percent of Washington's doctors have been responsible for 42.6 percent of all malpractice payouts to patients." PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON: CHALLENGING THE MEDICAL MALPRACTICE CLAIMS OF THE DOCTORS' LOBBY 18 (2003), available at http://www.citizen.org/documents/WA_State.pdf [hereinafter PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON].

⁶ Initiative Measure No. 330 [hereinafter Text of I-330]. The text, as certified by Secretary of State Sam Reed, is available at http://www.leg.wa.gov/pub/billinfo/2003-04/initiatives/325-349/initiative_330_07122004.txt.

⁷ Initiative Measure No. 336 [hereinafter Text of I-336]. The text, as certified by Secretary of State Sam Reed, is available at <http://www.secstate.wa.gov/elections/initiatives/text/i336.pdf> (last visited Feb. 19, 2006).

⁸ WASH. CONST. art. II, § 1; *see also*, *Washam v. Sonntag*, 874 P.2d 188, 193 (1994) (holding that referendum provisions in the Washington State Constitution are to be liberally construed to facilitate the referendum rights of the citizenry).

⁹ Doctors, Nurses & Patients for a Healthy Washington, <http://www.yesoni330.org/> (last visited Feb. 19, 2006).

¹⁰ Citizens for Better, Safer Healthcare, <http://www.bettersafecare.org/> (last visited Feb. 19, 2006).

¹¹ Brad Shannon, *A Record Year for Political Money: Spending Spirals Upward for Initiatives*, THE OLYMPIAN, Nov. 3, 2005, at 1.

¹² See generally Text of I-330, *supra* note 6.

¹³ See generally Text of I-336, *supra* note 7.

¹⁴ For a recent update on the reform efforts of the fifty states, see Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417, 431-58 (2004).

¹⁵ See, e.g., George W. Bush, President of the United States, State of the Union Address (Jan. 28, 2003), available at <http://www.whitehouse.gov/news/release19.html> (last visited Feb. 19, 2006).

It is a central premise of this article, which will be explored further, *infra* in Sections II and III, that one ought not to presuppose that everything labeled “reform” actually partakes of the positive connotations of “improvement” or “correction.”

¹⁶ Text of I-330, *supra* note 6, at § 15 provides: “In the event that the Washington state supreme court or other court of competent jurisdiction rules or affirms that section 2 of this act is unconstitutional, then the prescribed limitations on noneconomic damages set forth in section 2 of this act take effect upon the ratification of a state constitutional amendment that empowers the legislature to enact limits on the amount of noneconomic damages recoverable in any or all civil causes of action or upon the enactment by the United States congress of a law permitting such limitations on noneconomic damages, whichever occurs first.” (Emphasis added.)

¹⁷ Press Release, Washington State Nurses Association, *Nursing Organizations and Elected Officials Speak Out Against Medical Malpractice Initiatives* (Oct. 18, 2005), available at <http://www.wsna.org/snas/wa/library/2005.malpractice/default.asp>.

¹⁸ Our constitutional analysis is primarily based on the Washington Constitution and its clauses regarding due process (WASH. CONST. art. I, § 3), equal protection (WASH. CONST. art. I, § 12), and jury trials (WASH. CONST. art. I, § 21).

¹⁹ See generally RICHARD A. POSNER, ECONOMIC ANALYSIS OF THE LAW § 6 (6th Ed. 2003) and the discussion therein on tort law. The continued vitality of Washington’s tort law and the integrity of this system for redress of civil wrongs is one issue at the threshold of our tale of two initiatives. Judge Learned Hand first articulated the economic underpinnings of tort law with his now famous formula, “The Learned Hand” Formula [$B < P \times L \rightarrow N$], in *United States v. Carroll Towing Co.*, 159 F.2d 169 (2nd Cir. 1947). This formula acts as a bridge between traditional tort analysis of negligence and economic “utility” analysis. Negligence (“N”) results whenever the burden (“B”) of avoiding an injury to another is “less than” (“<”) the probability of the loss (“P”) multiplied by the magnitude loss (“L”). Professor and Judge Richard Posner writes, “Maintaining the credibility of the tort system requires that if a defendant is found liable, he must pay at least as great as L in the Hand Formula. Damages equal to L are compensatory damages.” POSNER, *supra*, at 192. I-330, to the extent that it reduces the recovery of victims, is reducing the “L” by not allowing full compensation for the loss for

reasons other than the merits. The grant of special immunity to one species of tortfeasor necessarily leaves uncompensated one species of innocent victim. In our current consideration of I-330, we dare not leave unstated the fundamental truth that measures that insulate health care providers from liability or tend to limit their liability necessarily shift to victims and to society at large the uncompensated costs and consequences of injuries adjudged to be the product of negligence and reduce disincentives for negligent care.

²⁰ Kenneth Vinson, *Constitutional Stumbling Blocks to Legislative Tort Reform*, 15 FLA. ST. U. L. REV. 31, 31 (1987).

²¹ Richard L. Abel, *Questioning the Counter-Majoritarian Thesis: The Case of Torts*, 49 DEPAUL L. REV. 533, 540 (1999).

²² Consider that caps on damages awarded by jury verdicts only serve to limit compensation to the most seriously injured plaintiffs whom a jury has adjudged to be entitled to compensation from negligent defendants.

²³ I-336's approach seeks to create a regulatory regime with a greater range of medical liability insurance options, creating a supplemental malpractice insurance program (§ 105 *et seq.*), providing for expanded malpractice incidents reporting requirements and public access to malpractice information (§ 126 *et seq.*); mandating greater transparency respecting insurance rate setting (§§ 102, 103), and enhancing physician oversight by, *inter alia*, adding two patient advocates to the Medical Quality Assurance Commission (§ 201). See Text of I-336, *supra* note 7.

²⁴ WASH. CONST. art. II, § 19. "No bill shall embrace more than one subject, and that shall be expressed in the title." *Id.* This provision applies to initiatives to the people. *Washington Fed'n of State Employees v. Washington*, 901 P.2d 1028, 1030 (Wash. 1995).

²⁵ I-336's approach is three-pronged with efforts (i) to increase regulatory oversight of malpractice rate setting and increased reporting requirements (*see, e.g.*, Text of I-336, *supra* note 7, at §§ 102, 103, 105, 126) (insurance reform); (ii) creating a presumptive limit of two on the number of expert witnesses and requiring the filing of a certificate of merit confirming consultation with a qualified expert respecting the basis for recovery (*id.* at §§ 301, 302) (court reform); and (iii) enhancing review and discipline of repeat offender doctors (*id.* at § 201) (medical review reform). In this last category, it is worth noting that Washington ranks forty-first out of fifty states respecting the frequency with which it takes significant disciplinary action for serious ethical and professional misconduct or malfeasance, such as incompetence, sexual misconduct, misprescribing drugs, and criminal convictions. PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON, *supra* note 5, at 22. In 2002, the Washington State Medical Quality Review Commission only levied serious discipline on 36 of its 16,154 physicians. *Id.* at 3. Unlike I-330's measures, the measures of I-336 do not generally impact the rights of citizens to pursue compensation for injury and, accordingly, do not impair the traditional disincentives to preventable error advanced by the tort system. Nonetheless, the authors do not advocate the use of initiatives as the preferred method of legislating or rulemaking.

²⁶ One provision of I-330 which most clearly shows insurance industry interests as the beneficiary of initiative provisions is contained at § 10 ¶¶ 4, 5, which provides that

unexpended structured payments (payments over time) to the plaintiff allocable to non-economic damages will, post-judgment, in the event of the plaintiff's death, revert to the insurance company rather than descend to the spouse, children, or heirs of the plaintiff. This post-judgment diminution of the insurance company obligations is not counterbalanced by an increase in potential liability to address, say, post-judgment increases in medical expenses experienced by the plaintiff. Text of I-330, *supra* note 6. This provision proved, in the experience of one of us [Gordon], to be one of the least popular provisions made known to the voters.

²⁷ CARMEN DENAVAS-WALT, ET. AL, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2003 14 (2004).

²⁸ *Id.* at 15-16.

²⁹ INSTITUTE OF MEDICINE, CARE WITHOUT COVERAGE—TOO LITTLE, TOO LATE 102-03 (2002).

³⁰ NATIONAL COALITION ON HEALTH CARE, HEALTH INSURANCE COVERAGE (2004), <http://www.nchc.org/facts/coverage.shtml>.

³¹ INSTITUTE OF MEDICINE, HIDDEN COSTS, VALUES LOST: UNINSURANCE IN AMERICA 10 (2003).

³² *Id.*

³³ *See id.* at 89-91.

³⁴ *See generally* AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE (ACP—ASIM), STATEMENT FOR THE RECORD OF THE WAYS AND MEANS HEALTH SUBCOMMITTEE HEARING ON THE NATION'S UNINSURED (Apr. 4, 2001), available at http://www.acponline.org/hpp/ways_means.htm.

³⁵ INSTITUTE OF MEDICINE, INSURING AMERICA'S HEALTH—PRINCIPLES AND RECOMMENDATIONS 46 (2004).

³⁶ AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE (ACP—ASIM), *supra* note 34, at [3]. The ACP-ASIM also stated, "More than 80 percent of the uninsured are in working families, but 60 percent are not offered employer-based health insurance coverage. These families must choose between a doctor's appointment and feeding their families, buying medicine or paying the rent." *Id.* at [2].

³⁷ Bureau of Labor Education, University of Maine, *The U.S. Health Care System: Best in the World, or Just the Most Expensive?* 2 (2001), available at <http://dll.umaine.edu/ble/U.S.%20HCweb.pdf>.

³⁸ *Id.* at 5. "The most recent complete comparative data analysis for infant mortality rates are from 1996, according to both the National Center for Health Statistics and the U.S. Department for Health and Human Services (U.S. Department of Health and Human Services, 'Preventing Infant Mortality,' HHS Fact Sheet, (Apr. 18, 2001))." *Id.* at 5 n.17.

³⁹ Donald J. Palmisano, M.D., J.D., *Statement of the American Medical Association to the Committee on the Judiciary, U.S. House of Representatives, Re: Legislative Hearing on H.R. 5, to Improve Patient Access to Health Care Services and Provide Improved Medical Care by Reducing the Excessive Burden the Liability System Places on the Health Care Delivery System* (Feb. 28, 2003), available at <http://www.ama-assn.org/ama/pub/category/12991.html>.

⁴⁰ *See infra* notes 100-01 and accompanying text.

⁴¹ POSNER, *supra* note 19, at 192.

⁴² See Text of I-330, *supra* note 6, at § 4(2)(a)-(c), which would amend WASH. REV. CODE § 7.70.070 (2006). For example, under I-330, a \$600,000 plaintiff judgment would result in attorneys fees of a maximum of \$161,000, i.e., less than 27 percent. But a damage award of \$6 million would result in attorneys fees of \$971,000, i.e., less than 17 percent. Reduced incentives adversely affect the willingness of counsel to take on prolonged, expensive, and novel cases. In a curious reversal, those who espouse traditional capitalist values see no contradiction in reducing incentives to pursue tobacco-related illness, asbestos, and products liability claims, which have greatly inured to the benefit of the public.

⁴³ For an interesting exposition, see Stephen C. Yeazell, *Brown, the Civil Rights Movement, and the Silent Litigation Revolution*, 57 VAND. L. REV. 1975, 1983 (2004).

⁴⁴ Abel, *supra* note 21, at 546.

⁴⁵ Yeazell, *supra* note 43 (quoting NAN ARON, LIBERTY AND JUSTICE FOR ALL: PUBLIC INTEREST LAW IN THE 1980S AND BEYOND 8 (1989)).

⁴⁶ *Id.* at 1997. Ironically, the resistance to *Brown* “constituted an important step in the restructuring of the U.S. bar.” *Id.* In one of *Brown*’s progeny, NAACP v. Button, 371 U.S. 415 (1963), the NAACP challenged Virginia’s newly enacted schemes for regulating civil rights lawyers, which were aimed at cutting off the NAACP from potential litigants. Yeazell, *supra* note 43, at 1986. The U.S. Supreme Court invalidated Virginia’s laws as violative of the First Amendment right of expression and association, noting that they were “part of the program of ‘massive resistance’ against *Brown*.” *Button*, 371 U.S. at 446. *Button*’s offspring, *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977), also struck on First Amendment grounds “state limitations on attorney advertising.” See JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW 1249 (2004).

⁴⁷ Yeazell, *supra* note 43, at 1991.

⁴⁸ *Id.* at 1995.

⁴⁹ Randolph I. Gordon, *No Balm in Gilead: Why Workers’ Compensation Fails Workers in a Toxic Age*, in DEFINING MULTIPLE CHEMICAL SENSITIVITY 85 (Bonnye L. Matthews ed., 1998).

⁵⁰ Yeazell, *supra* note 43, at 1997.

⁵¹ *Id.* at 2002-2003.

⁵² *Id.* at 1976.

⁵³ *Id.* at 2002.

⁵⁴ *Id.*

⁵⁵ There is a deep populist thread in American politics which, from the days of the Founding Fathers, has distrusted elitism and government power. Popular disparagement of the jury, the ultimate populist institution, however, is a disturbing trend suggesting a merger between anti-authoritarian traditions and a sort of lawless “Know-Nothingism.” Public education, respecting the importance of juries as a counterbalance to government excesses, is essential.

⁵⁶ *Id.* at 1978.

⁵⁷ In our analysis, we shall see the oft-asserted linkage between (i) allegedly unjustified verdicts by runaway juries on frivolous claims to (ii) increased insurance payouts to (iii) increased premiums to (iv) doctor flight to (v) unavailability of medical care, to be untrue

and unsubstantiated at virtually every link in the chain. See, e.g., PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON, *supra* note 5, at 1-6.

⁵⁸ *Id.*

⁵⁹ Abel, *supra* note 21, at 553.

⁶⁰ See INSTITUTE OF MEDICINE, TO ERR IS HUMAN, *supra* note 3.

⁶¹ Bush, *supra* note 15.

⁶² George W. Bush, President of the United States, State of the Union Address, (Jan. 20, 2004), available at <http://www.whitehouse.gov/news/releases/2004/01/20040120-7.html>.

⁶³ George W. Bush, President of the United States, State of the Union Address (Feb. 2, 2005), available at <http://www.whitehouse.gov/news/releases/2005/02/20050202-11.html>.

⁶⁴ See, e.g., George W. Bush, President of the United States, Address at University of Scranton: President Calls for Medical Liability Reform (Jan. 16, 2003) (transcript available at: <http://www.whitehouse.gov/news/releases/2003/01/20030116-1.html>).

⁶⁵ NOAM CHOMSKY, DETERRING DEMOCRACY 357 (1992).

⁶⁶ DAVID HUME, ESSAYS: MORAL, POLITICAL, AND LITERARY (Eugene F. Miller ed., 1987), available at <http://www.econlib.org/library/LFBooks/Hume/hmMPL4.html> (last visited Feb. 19, 2006).

⁶⁷ Noam Chomsky, *The Manufacture of Consent*, in THE CHOMSKY READER 121-36 (1987).

⁶⁸ NOAM CHOMSKY, DETERRING DEMOCRACY 357 (1992).

⁶⁹ See, e.g., GEORGE LAKOFF, DON'T THINK OF AN ELEPHANT: KNOW YOUR VALUES AND FRAME THE DEBATE—THE ESSENTIAL GUIDE FOR PROGRESSIVES (2004).

⁷⁰ DAVID HUME, A TREATISE OF HUMAN NATURE (Oxford Press 2d ed. 1978) (1888); DAVID HUME, ENQUIRIES CONCERNING THE HUMAN UNDERSTANDING AND CONCERNING THE PRINCIPLES OF MORALS (Oxford Press 2d ed. 1970) (1777). Faced with a classic problem of inductive reasoning, public policy makers must reach general conclusions based on a series of observations and are well advised to adopt some species of practical skepticism. If the number of observations and associations are too few, we may rightly discount such evidence as anecdotal. Chalmers notes that the number of data points sufficient to justify a sound conclusion is highly fact-sensitive: the number of observations sufficient to establish when we may conclude inductively that "All swans are white" may not be the same as are required to conclude that "Nuclear weapons have great destructive capability." See A.F. CHALMERS, WHAT IS THIS THING CALLED SCIENCE? 47 (Open University Press 3d ed. 1999) (1978).

⁷¹ See, e.g., Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093 (1996); Michael J. Saks, *Malpractice Misconceptions and Other Lessons about the Litigation System*, 16 JUST. SYS. J. 7 (1993).

⁷² Throughout this article, the term "reform" appears in quotation marks to suggest to the reader that the term "reform," which denotes betterment or improvement, is itself a non-neutral descriptor of the changes proposed that assumes the merit of the very proposals under review. Amongst opponents to proposed changes to the tort system, the term tort "deform" is often employed, suggesting that the proposals, to the contrary, seek to distort

in an undesirable fashion the existing laws. The course proposed by the author is an examination of the evidence.

⁷³ Alternatives exist. For instance, the exclusive remedy Washington workers have against their employers for personal injuries in the workplace resulting from employer negligence arises under the Industrial Insurance Act. WASH. REV. CODE § 51.04.010 *et seq.* (2006). Washington courts have no original jurisdiction over such actions: “The state of Washington, therefore, exercising herein its police and sovereign power, declares that all phases of the premises are withdrawn from private controversy, . . . and to that end all civil actions and civil causes of action for such personal injuries and all jurisdiction of the courts of the state over such causes are hereby abolished, except as in this title provided.” *Id.* at § 51.04.010. In the first instance, worker compensation is determined by a State agency, the Department of Labor & Industries, with hearings conducted by administrative judges without a jury, and appeals considered by a three judge panel at the Board of Industrial Insurance Appeals. *See, e.g., id.* at § 51.28 *et seq.; id.* at § 51.52.010 (2006). Awards are based upon a schedule of damages widely regarded as less generous than those available in the civil justice system, but without having to prove “fault.” *Id.* at § 51.32.010. For instance, complete loss of hearing in both ears and loss of one eye by enucleation are compensable as permanent partial disabilities for \$43,200 and \$21,600, respectively, plus adjustments per the Consumer Price Index (CPI). *Id.* at § 51.32.080. Workers, however, may recover damages over and above scheduled workers compensation benefits if they can establish that the injury was a consequence of the “deliberate intention of his or her employer to produce such injury.” *Id.* at § 51.24.020.

⁷⁴ *Id.* at § 7.70 *et seq.*

⁷⁵ *Id.* at § 4.16.350; *cf. id.* at § 4.16.190. Specifically, the knowledge of a custodial parent or guardian is imputed to a person under the age of eighteen years in actions for injuries arising from health care or related services; otherwise actions are generally tolled during the minority of the injured party.

⁷⁶ *See, e.g., Shellenbarger v. Brigman*, 3 P.3d 211, 215 (Wash. App. 2000).

⁷⁷ WASH. REV. CODE § 7.70.080.

⁷⁸ The “preponderance of the evidence” is defined in the Washington Pattern Jury Instructions as follows: “more probably true than not true.” *Washington Pattern Jury Instructions—Civil*, in 6 WASHINGTON PRACTICE SERIES, 5TH EDITION, WPI 21.01, at 221 (2005).

⁷⁹ “It has long been established that recovery of punitive damages is contrary to the public policy of the State and will not be allowed unless expressly authorized by statute.” *Kennewick Educ. Ass’n, v. Kennewick Sch. Dist. No. 17*, 666 P.2d 928, 930 (Wash. App. 1983); *see also: Barr v. Interbay Citizens Bank*, 649 P.2d 827 (Wash. 1982); *Steele v. Johnson*, 458 P.2d 889, 890 (Wash. 1969); *Spokane Truck & Dray Co. v. Hoefer*, 25 P. 1072 (Wash. 1891).

⁸⁰ In Washington, WASH. REV. CODE § 4.20.010 *et seq.* (2006), authorizes the personal representative of the estate of a decedent to pursue claims for wrongful death on behalf of certain statutory beneficiaries: the spouse and child or children of the decedent (if any); the parents and siblings of the decedent (if no spouse or child exists), if dependent upon the decedent and residing in the United States.

⁸¹ See, e.g., *Attwood v. Albertson's Food Centers, Inc.*, 966 P.2d 351, 353 (Wash. App. 1998); *Washington Pattern Jury Instructions—Civil*, in 6 WASHINGTON PRACTICE SERIES, *supra* note 78.

⁸² See, e.g., *McKee v. American Home Prods. Corp.*, 782 P.2d 1045, 1048 (Wash. 1989) (Arizona physician affidavit could not establish standard of care for Washington pharmacist); *Young v. Key Pharm., Inc.*, 770 P.2d 182 (Wash. 1989) (Pharmacist not competent to opine on physician's standard of care for treatment using medications); *Washington Pattern Jury Instructions—Civil*, in 6 WASHINGTON PRACTICE, *supra* note 78, at 559.

⁸³ Washington Rules of Evidence, ER 702 (2006), provides that “[i]f scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.”

⁸⁴ WASH. REV. CODE § 4.44.380 (2006), provides that ten jurors must agree before there is a verdict of a jury of twelve; Washington Pattern Jury Instructions so provide: *Washington Pattern Jury Instructions—Civil*, in 6 WASHINGTON PRACTICE, *supra* note 78, at 34. See also Washington Superior Court Civil Rules (CR) 49(l), providing that the same ten jurors need not agree on every question contained within a special verdict.

⁸⁵ It should be noted that current proposals for medical liability “reform” do not seek to create a no-fault system analogous to workers compensation (with all of its strengths and weaknesses), but simply seek to make it more difficult for injured plaintiffs to prevail. The consequence of such proposals, for example, shortening the statute of limitations for health care claims, would be to lift the burden of future costs of health care from negligent defendants and place it upon the general public. A no-fault system might well be subject to all of the criticisms of the current workers compensation scheme; such criticisms go well beyond the scope of this article but would undoubtedly include: loss of the right to a jury trial in the first instance; administrative costs and delays; burdens of premiums upon employers; challenges to the setting of such premiums; reduced compensation to the victim and, as a consequence, reduction in the incentive for safety on the part of the liable party.

⁸⁶ See generally David M. Studdert et. al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643 (2000); Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990), as quoted by PUBLIC CITIZEN, MEDICAL MALPRACTICE BRIEFING BOOK, *supra* note 5, at 14-15: “found that only one in 7.6 instances of medical negligence committed in hospitals results in a malpractice claim.”

⁸⁷ FLA. STAT. ANN. § 395.0197 (4)(e), (5) (2006).

⁸⁸ The Agency for Health Care Administration, Division of Health Quality Assurance, Reported Malpractice Claims by District Compared to Reported Adverse Incidents 1996, 1997, 1998, 1999, http://www.fdhc.state.fl.us/MCHQ/Health_Facility-Regulation/Risk/statistics.shtml (last visited Feb. 19, 2006).

⁸⁹ Studdert, et. al, *supra* note 86, at 1664.

⁹⁰ *Id.* at 1664-65.

⁹¹ *Id.* at 1664, Table 3 (New York (13.1 percent filed; 86.9 percent unfiled); Florida (15.97 percent filed; 84.03 percent unfiled); Colorado (14.9 percent filed; 85.1 percent unfiled); Utah (19.6 percent filed; 80.4 percent unfiled)).

⁹² Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 357, 358 (2005).

⁹³ *Id.*

⁹⁴ PUBLIC CITIZEN, MEDICAL MALPRACTICE PAYOUT TRENDS 1991–2004: EVIDENCE SHOWS LAWSUITS HAVEN'T CAUSED DOCTORS' INSURANCE WOES 2 (2005), available at http://www.citizen.org/documents/Malpracticeanalysis_final.pdf.

⁹⁵ UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 29 (2003), available at <http://www.gao.gov/new.items/d03836.pdf>.

⁹⁶ CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE FOR H.R. 5, HEALTH ACT OF 2003 5, (Mar. 5, 2003) (ordered by the House Committee on the Judiciary), available at <http://www.cbo.gov/showdoc.cfm?index=4091&sequence=0>.

⁹⁷ PUBLIC CITIZEN, MEDICAL MALPRACTICE PAYOUT TRENDS, *supra* note 94, at 3.

⁹⁸ *Id.* at 4.

⁹⁹ *Id.* at 5.

¹⁰⁰ STATE OF WASHINGTON OFFICE OF INSURANCE COMMISSIONER, MEDICAL MALPRACTICE CLOSED CLAIM STUDY 7/1/95-6/30/2005 17 (2005), available at <http://www.insurance.wa.gov/special/wic/MedMalDataCall.pdf>.

¹⁰¹ PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON, *supra* note 5, at 12.

¹⁰² *Id.* at 11, based upon the Washington Quality Assurance Commission and the National Practitioner Data Bank, Sept. 1, 1990 – Sept. 30, 2002.

¹⁰³ STATE OF WASHINGTON OFFICE OF INSURANCE COMMISSIONER, MEDICAL MALPRACTICE CLOSED CLAIM STUDY, *supra* note 100, at 16.

¹⁰⁴ The author [Gordon] is personally familiar with the challenge of asking local physicians to testify against their colleagues, even under factual circumstances that they themselves regard as establishing clear liability. Within days of an affidavit being filed, one local physician witness reported that he was addressed as "Doctor" by colleagues with whom he had been on a first name basis for years. Resolving a crisis in conscience in favor of collegiality in the workplace, the physician withdrew as a testimonial witness, but professed relief when an out-of-state expert supporting his opinion was found. It is now standard practice among the medical malpractice plaintiffs' bar to retain expert witnesses out of the jurisdiction in which the case is brought. Academic institutions routinely discourage physicians holding academic positions from participating as expert witnesses in litigation. The perceived "closing of ranks" and lack of ready cooperation from physicians respecting provision of expert testimony against other physicians is sometimes referred to as "the white wall."

¹⁰⁵ Defense lawyers, customarily paid on an hourly basis, may have a modest financial incentive to assert defenses tending to prolong litigation. Even Washington's *Rules of Professional Conduct* (RPC) 3.2 acknowledges this much where it states, "[a] lawyer shall make reasonable efforts to expedite litigation *consistent with the interests of the client*" (emphasis added). There are, of course, procedural constraints upon both plaintiffs' and defendants' lawyers under *Civil Rules for Superior Court* (CR) 11(a),

which provides that pleadings, motions, and briefs are not “interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.” Nonetheless, financial incentives do exist arising from being paid on an hourly fee which, if unconstrained by ethical duty could, in the case of an unscrupulous attorney, result in prolongation of litigation for personal financial advantage to the detriment of the client. While payment on a contingent fee does encourage a plaintiffs’ lawyer to maximize compensation for the client (and therefore for the lawyer), there is no incentive for prolongation of litigation for its own sake that inheres in payment based upon a percentage of the recovery. To the extent the costs of litigation, including attorneys’ fees, are cited as a source of wasteful expenditure, it is the defense attorneys’ fees alone that add to the overall costs since the plaintiffs’ attorneys’ fees are subsumed within the payout to the injured plaintiff. Attempts to audit defense counsel so as to better control defense litigation costs proved “too disruptive to their relationship with outside counsel” and have been abandoned. Krysten Crawford, *When Good Ideas Go Bad*, LEGAL TIMES, Apr. 19, 2004, at 21.

¹⁰⁶ Deborah Jones Merritt & Kathryn Ann Barry, *Is the Tort System in Crisis? New Empirical Evidence*, 60 OHIO ST. L. J. 315, 373 (1999).

¹⁰⁷ *Id.*

¹⁰⁸ PUBLIC CITIZEN, MEDICAL MALPRACTICE PAYOUT TRENDS, *supra* note 94, at 1.

¹⁰⁹ *Id.* at 4.

¹¹⁰ PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON, *supra* note 5, at 2.

¹¹¹ PUBLIC CITIZEN, MEDICAL MALPRACTICE PAYOUT TRENDS, *supra* note 94, at 5.

¹¹² *Id.* at 2.

¹¹³ This is consistent with other data on federal and state tort claims. For example, “median jury awards for personal injury plaintiffs declined from \$65,000 in 1990 to \$55,660 in 1996.” Merritt, *supra* note 106, at 395. Nationwide studies on “filings, trials, win rates, and recoveries are either steady or declining in medical malpractice and product liability actions.” *Id.*

¹¹⁴ *Id.* at 392.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 393.

¹¹⁸ *Id.* at 398.

¹¹⁹ Alec Shelby Bayer, Comment and Notes, Looking Beyond the Easy Fix and Delving into the Roots of the Real Medical Malpractice Crisis, 5 HOUS. J. HEALTH L. & POL’Y 111, 112 (2005).

¹²⁰ *Id.* at 113. See also INSTITUTE OF MEDICINE, TO ERR IS HUMAN, *supra* note 3.

¹²¹ James H. Nichols, *Reducing Medical Errors at the Point of Care*, 36 LABORATORY MEDICINE 275, 275 (May 2005).

¹²² Finding that cancer killed 42,297. *Id.* (quoting AHRQ, MEDICAL ERRORS: THE SCOPE OF THE PROBLEM, *Fact Sheet Publication No. AHRQ 00-P037*, available at <http://www.ahrq.gov/qual/errback.html>).

¹²³ Starfield, *supra* note 4, at 484.

¹²⁴ Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Cap*, 80 N.Y.U. L. REV. 391, 410 (2005) (footnotes omitted).

¹²⁵ *Id.*

¹²⁶ I-336 § 121(1)(a), specifically provides for a rating plan that “must consider the past loss and loss adjustment expense experience of a facility or an individual provider.” Text of I-336, *supra* note 7.

¹²⁷ Sharkey, *supra* note 124, at 406.

¹²⁸ Glassman, *supra* note 14, at 417 (footnotes omitted).

¹²⁹ *Id.* at 419.

¹³⁰ *Id.* at 430 n. 53.

¹³¹ CONGRESSIONAL BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE (JAN. 8, 2004), available at www.cbo.gov/showdoc.cfm?index=4968&sequence=0.

¹³² Glassman, *supra* note 14, at 463 (citing Weiss Ratings, Inc., *Medical Malpractice Caps Fail to Prevent Premium Increases, According to Weiss Ratings Study*, available at http://www.weissratings.com/News/Ins_General/20030602pc.htm); PUBLIC CITIZEN, MEDICAL MALPRACTICE BRIEFING BOOK, *supra* note 5, at 26.

¹³³ Weiss Ratings, *supra* note 132: “Weiss Ratings issues safety ratings on more than 15,000 financial institutions, including HMOs, life and health insurers, Blue Cross Blue Shield plans, property and casualty insurers, banks, and brokers. Weiss also rates the risk-adjusted performance of more than 12,000 mutual funds and more than 7,000 stocks. Weiss Ratings is the only major rating agency that receives no compensation from the companies it rates. Revenues are derived strictly from sales of its products to consumers, businesses, and libraries.”

¹³⁴ Weiss Ratings, *supra* note 132.

¹³⁵ Katharine Levit et al., *Health Spending Rebound Continues in 2002*, 23 HEALTH AFFAIRS 147 (2004).

¹³⁶ Lorraine Woellert, *Commentary: A Second Opinion about the Malpractice Plague*, BUS. WEEK ONLINE, Mar. 3, 2003, at Legal Affairs, available at http://www.businessweek.com/magazine/contents/03_09/b3822079.htm. See also Public Citizen, Congress Watch: Quick Facts on Medical Malpractice Issues, <http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=9125> (citing Woellert, *supra*).

¹³⁷ CONGRESSIONAL BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE, *supra* note 131, at 6.

¹³⁸ *Id.*

¹³⁹ *GE: Malpractice Caps Don't Work*, CONSUMERAFFAIRS.COM, Oct. 27, 2004, http://www.consumeraffairs.com/news04/malpractice_ge.html.

¹⁴⁰ News Release, Washington State Office of Insurance Commissioner, Largest Medical Malpractice Insurer Ordered to Refund \$1.3 Million (Mar. 2, 2005), available at <http://www.insurance.wa.gov/news/dynamic/newsreleasedetail.asp?offset=30&rcdNum=438>.

¹⁴¹ The Doctors Company, History of Success, <http://www.thedoctors.com/whychoose/history/successhistory.asp> (last visited Feb. 7, 2004).

¹⁴² The Doctors Company, Coverage Benefits, <http://www.thedoctors.com/howwecover.asp> (last visited Feb. 7, 2004).

¹⁴³ THE DOCTORS COMPANY, 2003 ANNUAL REPORT: PROTECT ACCESS TO CARE: THE CASE FOR MEDICAL-LIABILITY REFORM 8 (2003), available at <https://secure.thedoctors.com/sourcebook/tdc2003annualreport.pdf> (last visited Feb. 7, 2006).

¹⁴⁴ PUBLIC CITIZEN, MEDICAL MALPRACTICE BRIEFING BOOK, *supra* note 5, at ii-iii.

¹⁴⁵ STATE OF WASHINGTON OFFICE OF INSURANCE COMMISSIONER, MEDICAL MALPRACTICE CLOSED CLAIM STUDY, *supra* note 100, at 7.

¹⁴⁶ See PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON, *supra* note 5, at 12.

¹⁴⁷ News Release, Washington State Office of the Insurance Commissioner, Second Annual Medical Malpractice Insurance Report (Oct. 4, 2005), available at <http://www.insurance.wa.gov/news/dynamic/newsreleasedetail.asp?offset=0&rcdNum=470>; *But see* STATE OF WASHINGTON OFFICE OF INSURANCE COMMISSIONER, *supra* note 100, at 6 (72.9 percent claims settled, constituting 64.9 percent of paid indemnity; 17.6 percent resolved by mediation, settlement conference or alternate dispute resolution, constituting 27.8 percent of indemnity; 1.6 percent resolved by plaintiff's verdict, constituting 5.3 percent of indemnity; and 8 percent resolved after the court ruled against plaintiff, plaintiff did not pursue the action, or other miscellaneous grounds, constituting 2 percent of indemnity paid. The statistics reflect a very small minority of cases being disposed of by jury verdict—far too few to constitute a major share of the total indemnity paid out).

¹⁴⁸ Karen L. Posner & R. A. Caplan, *The Expert Witness: Insights from the Closed Claims Project*, 61 ASA NEWSLETTER 9, 9-10 (1997).

¹⁴⁹ Boehm, *supra* note 92, at 361.

¹⁵⁰ *Id.*

¹⁵¹ *Id.* at 361-62.

¹⁵² UNITED STATES GENERAL ACCOUNTING OFFICE, *supra* note 95, at 3.

¹⁵³ *Id.* at 5.

¹⁵⁴ *Id.* at 17.

¹⁵⁵ *Id.* at 17-18.

¹⁵⁶ Carol M. Ostrom, *Contrary to Ads, Doctors Replaced, Clinics Still Open*, SEATTLE TIMES, Feb. 23, 2004, at B1.

¹⁵⁷ PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON, *supra* note 5, at 17.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* Email from Public Citizen from the Medical Quality Assurance Commission, Department of Health, Washington State (Apr. 18, 2003). Population growth figures for Washington State were obtained from the U.S. Census Bureau, *State Population Estimates: April 1, 2000-July 1, 2002*, available at <http://www.census.gov/Press-Release/www/releases/archives/statepop05table.xls>, and *State Population Estimates: Annual Time Series, July 1, 1999*, available at <http://www.census.gov/population/estimates/state/st-99-3.txt>.

¹⁶⁰ A number of proposed changes (e.g., capping non-economic damage awards by juries; requiring structured payouts for jury awards over \$50,000; etc.) can only directly affect the limited number of cases which actually proceed to a civil jury verdict, fewer than one-half of 1 percent (45 of 10,212 over a decade). See PUBLIC CITIZEN, MEDICAL MISDIAGNOSIS IN WASHINGTON, *supra* note 5, at 17, and accompanying text. While jury

verdicts certainly affect settlement negotiations by setting expectations and, therefore, influence the far larger number of cases resolved short of a jury verdict, the evidence suggests that plaintiffs' counsel are relatively risk-averse when resolving claims in that, for the individual client, a trial on both mode and median averages is a defense verdict in which plaintiff receives no compensation whatsoever. An informal survey by the Washington State Trial Lawyers, in which one of the authors participated [Gordon], suggests that requests for trial by jury in malpractice cases were overwhelmingly made by defense counsel rather than counsel for plaintiff, on the order of nine out of ten cases or more.

¹⁶¹ CONGRESSIONAL BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE, *supra* note 131, at 5.

¹⁶² *Id.* at 7.

¹⁶³ See Laurence H. Tribe, *The Curvature of Constitutional Space: What Lawyers Can Learn from Modern Physics*, 103 HARV. L. REV. 1, 7 (1989).

¹⁶⁴ Medical Injury Compensation Reform Act (MICRA), CAL. CIV. CODE § 3333.2(b) (West 1975) (limits non-economic damages to \$250,000).

¹⁶⁵ Sharkey, *supra* note 124, at 394.

¹⁶⁶ Center for Justice and Democracy, *Mythbuster: "Caps" Don't Work* (2005), available at http://www.centerjd.org/free/mythbusters-free/MB_CapsDontWork.htm (last visited Feb. 7, 2006).

¹⁶⁷ *Id.* at 1.

¹⁶⁸ *Id.*

¹⁶⁹ "A joint resolution proposing a constitutional amendment concerning civil lawsuits against doctors and health care providers, and other actions, authorizing the legislature to determine limitations on non-economic damages." H.J.R 3, 78th Reg. Sess. (Tex. 2003), available at <http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=78&SESS=R&CHAMBER=H&BILLTYPE=JR&BILLSUFFIX=00003&VERSION=5&TYPE=B>: (last visited Feb. 24, 2006).

¹⁷⁰ Center for Justice and Democracy, *supra* note 166, at 3.

¹⁷¹ UNITED STATES GENERAL ACCOUNTING OFFICE, *supra* note 95, at 37.

¹⁷² Sharkey, *supra* note 124, at 408.

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ In quantum physics, the Heisenberg Uncertainty principle represents the notion that simultaneous knowledge of both position and momentum (mass x velocity) of subatomic particles is unattainable because the act of observing the particles alters what is being observed.

¹⁷⁸ Sharkey, *supra* note 124, at 425.

¹⁷⁹ *Id.* at 429.

¹⁸⁰ *Id.*

¹⁸¹ *Id.* at 431.

¹⁸² *Carter v. United States*, 333 F.3d 791, 796 (7th Cir. 2003).

¹⁸³ *Adamski v. Tacoma General Hospital*, 579 P.2d 970 (Wash. App. 1978) (holding that hospitals may be held liable for a physician’s acts or omissions under “apparent authority” or “ostensible authority”). I-330 would reverse *Adamski* and only impose liability on hospitals if the health care provider is an actual agent or employee of the hospital. See Text of I-330, *supra* note 6.

¹⁸⁴ 771 P.2d 711 (Wash. 1989) (holding non-economic damage caps of WASH. REV. CODE 4.56.250 unconstitutional because they violated the right to a jury trial under WASH. CONST. art. I, § 21).

¹⁸⁵ Health Care Limitations, ch. 212, § 1401, 1987 Wash. Laws (1987). In the second paragraph, the legislature inserted “and such imputed knowledge shall operate to bar the claim of such minor to the same extent that the claim of an adult would be barred under this section,” and added the third paragraph, relating to the effective date for imputing the knowledge of a custodial parent or guardian. In *DeYoung v. Providence Medical Center*, 960 P.2d 919, 923 n.2 (Wash. 1998):

“The discovery rule was adopted for medical malpractice actions in *Ruth v. Dight*, 75 Wn.2d 660, 665, 453 P.2d 631[, 634-635] (1969), where the court reasoned that ‘fundamental fairness’ and ‘the common law’s purpose to provide a remedy for every genuine wrong’ are not served when a statute of limitations passes before the injured party ‘would not in the usual course of events know he had been injured until long after the statute of limitations had cut off his legal remedies[.]’ *Ruth* construed former [WASH. REV. CODE] § 4.16.010 and [WASH. REV. CODE] § 4.16.080(2), which then provided a three year accrual-based statute of limitations for medical malpractice actions, as providing that a medical malpractice action might accrue upon discovery. In response to *Ruth*, the Legislature enacted [WASH. REV. CODE] 4.16.350 in 1971, and provided for a one-year discovery rule.”

¹⁸⁶ *Rochester v. Tulp*, 337 P.2d 1062, 1064 (Wash. 1959); *Wickwire v. Reard*, 226 P.2d 192 (Wash. 1951).

¹⁸⁷ 5 U.S. 137, 177 (1803).

¹⁸⁸ *Id.* at 174.

¹⁸⁹ *Id.* at 163.

¹⁹⁰ As this is a “sketch” of an argument, we will not do an analysis under *State v. Gunwall*, 720 P.2d 808, 811 (Wash. 1986): “The following nonexclusive neutral criteria are relevant in determining whether, in a given situation, the Washington State Constitution should be considered as extending broader rights to its citizens than the United States Constitution: (1) the textual language; (2) differences in the texts; (3) constitutional history; (4) preexisting state law; (5) structural differences; and (6) matters of particular state or local concern.”

¹⁹¹ Text of I-330, *supra* note 6, at § 4 directly limits contingent fee percentages, a matter under the exclusive jurisdiction of the Washington State Supreme Court. The justification of limiting plaintiffs’ attorneys’ fees as a means of reducing insurance payouts evaporates once one realizes that plaintiffs’ attorneys’ contingent fees are paid by plaintiffs or their personal representatives from the compensation awarded for injury or death—it is the unregulated costs of legal defense that increase payout.

¹⁹² WASH. CONST. art. I, § 3: “No person shall be deprived of life, liberty, or property, without due process of law.”

¹⁹³ WASH. CONST. art. I, § 12: “No law shall be passed granting to any citizen, class of citizens, or corporation other than municipal, privileges or immunities which upon the same terms shall not equally belong to all citizens, or corporations.”

¹⁹⁴ See Text of I-330, *supra* note 6, at § 8 (mandatory arbitration of claims under contract); WASH. CONST. art. I, § 21: “The right of trial by jury shall remain inviolate, but the legislature may provide for a jury of any number less than twelve in courts not of record, and for verdict by nine or more jurors in civil cases in any court of record, and for waiving of the jury in civil cases where the consent of the parties interested is given thereto.” Gordon served on the Board of Governors of the Washington State Bar Association as Governor (8th Congressional District) when a position on I-330 was presented to that body. Pursuant to General Rule (GR) 12(c), which defines its authority, the Washington State Bar Association undertook a review of I-330 and found it implicated the “administration of justice” and was within the purview of the State Bar’s decision-making functions. The impairment of the right to a jury trial was one of the two constitutional grounds leading the Board of Governors of the Washington State Bar Association to oppose the enactment of I-330. The Board of Governors took no position on I-336, it being determined that I-336 did not substantially implicate the “administration of justice.”

¹⁹⁵ See, e.g., *Sofie*, 771 P.2d at 722 (holding non-economic damage caps of WASH. REV. CODE § 4.56.250 unconstitutional because they violated the right to a jury trial under WASH. CONST. art. I, § 21).

¹⁹⁶ WASH. CONST. art. IV, § 16: “Judges shall not charge juries with respect to matters of fact, nor comment thereon, but shall declare the law.”

¹⁹⁷ *In re Wash. State Bar Ass’n*, 548 P.2d 310, 313 (Wash. 1976); See *In re Bruen*, 172 P. 1152 (Wash. 1918); *In re Schatz*, 497 P.2d 153 (Wash. 1972).

¹⁹⁸ *Bennion, Van Camp, Hagen & Ruhl v. Kassler Escrow, Inc.*, 635 P.2d 730, 735 (Wash. 1981). See also *Bruen*, 172 P. 1152; *In re Wash. State Bar. Ass’n*, 548 P.2d 310 (Wash. 1976); *State v. Cook*, 525 P.2d 761 (Wash. 1974); *Schatz*, 497 P.2d 153; *State ex rel. Laughlin v. Wash. State Bar Ass’n*, 176 P.2d 301 (Wash. 1947); *In re Levy*, 161 P.2d 651 (Wash. 1945). See also *Short v. Demopolis*, 691 P.2d 163, 177 (Wash. 1984) (Rosselini, J., dissenting):

“Const. art. 4, § 1, provides: ‘The judicial power of the state shall be vested in a supreme court’. Inherent in this constitutionally granted power is this court’s inviolate authority to regulate the practice of law. *Seattle v. Ratliff*, 667 P.2d 630 (Wash. 1983). This power to regulate the practice of law is solely within the province of the judiciary. *Hagan & Van Camp, P.S. v. Kassler Escrow, Inc.*, 635 P.2d 730 (1981).”

¹⁹⁹ Such was the sense of the Board of Governors of the Washington State Bar Association during discussions on June 2, 2005, in Bellevue, Washington when consideration of “separation of powers” issues raised by I-330 led to a 12-0-0 vote in favor of taking a position respecting the initiative. See Lindsay Thompson, *The Board’s Work*, WASHINGTON STATE BAR NEWS (Sept. 2005), available at <http://www.wsba.org/media/publications/barnews/2005/board.htm>.

In its July 30, 2005 meeting in Bellingham, Washington, the Board of Governors concluded on a vote of 10-4, that its GR [General Rule] 12 analysis, did not warrant taking a position on I-336 which did not clearly implicate “the practice of law” or the

“administration of justice.” Thompson, *supra*, available at

<http://www.wsba.org/media/publications/barnews/boardwork905.htm>.

²⁰⁰ *State v. McCullough*, 784 P.2d 566, 568 (Wash. App. 1990), citing *State v. Cater’s Motor Freight Sys. Inc.*, 179 P.2d 496 (Wash. 1947).

²⁰¹ WASH. CONST. art. I, § 3: “No person shall be deprived of life, liberty, or property, without due process of law.”

²⁰² *Gunwall*, 720 P.2d at 811 (citing Robert F. Utter, *Freedom and Diversity in a Federal System: Perspectives on State Constitutions and the Washington Declaration of Rights*, 7 U. PUGET SOUND L. REV. 491, 499 (1984)).

²⁰³ ROBERT F. UTTER & HUGH D. SPITZER, *THE WASHINGTON STATE CONSTITUTION: A REFERENCE GUIDE* 18 (2002).

²⁰⁴ *Id.* at 17.

²⁰⁵ *Rivett v. City of Tacoma*, 870 P.2d 299, 303 (Wash. 1994).

²⁰⁶ *Id.*, quoting *Presbytery of Seattle v. King County*, 787 P.2d 907 (1990).

²⁰⁷ See *supra* notes 72-187 and accompanying text.

²⁰⁸ See Sharkey, *supra* note 124, at 408.

²⁰⁹ WASH. CONST. art. I, § 12 states, “No law shall be passed granting to any citizen, class of citizens, or corporation other than municipal, privileges and immunities which upon the same terms shall not equally belong to all citizens, or corporations.”

²¹⁰ *O’Hartigan v. Dep’t of Personnel*, 821 P.2d 44, 50 (Wash. 1991), quoting *Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432 (1985).

²¹¹ *Grant County Fire Protection Dist. No. 5 v. City of Moses Lake*, 83 P.3d 419, 425 (Wash. 2004).

²¹² *Id.* at 427 (quoting *State v. Smith*, 814 P.2d 652 (Wash. 1991) (Utter, J., concurring)).

²¹³ *Id.* at 426 (citing Brian Snure, *A Frequent Recurrence to Fundamental Principles: Individuals Rights, Free Government, and the Washington State Constitution*, 67 WASH L. REV. 669, 671-72 (1992)) (emphasis added).

²¹⁴ Text of I-330, *supra* note 6, at § 2(3).

²¹⁵ To put it in context, for a large health care corporation, a damage cap of \$700,000 may be roughly the cost of one MRI machine.

²¹⁶ *Paulson v. County of Pierce*, 664 P.2d 1202, 1207 (Wash. 1983).

²¹⁷ I-330 may not apply to all members within the designated class, if that class is apprehended to include all living beings. While our current state of jurisprudence is developing in the area of animal rights—the Washington State Bar Association has only within the last several years approved creation of an Animal Rights Section—it is worthy of note that the broad range of health care facilities subject to I-330 does not include veterinarians and veterinary hospitals. Malpractice insurance for veterinarians has been the topic of at least one law review article. Gregg A. Scoggins, *Legislation without Representation: How Veterinary Medicine Has Slipped through the Cracks of Tort Reform*, 1990 U. ILL. L. Rev. 953 (1990). There is no small irony in a world where animal rights find little jurisprudential protection, that a post-I-330 legal landscape would result in greater right to redress in “an injury or death as a result of health care services” affecting one’s pet than one’s person. Text of I-330, *supra* note 6, at § 2(3).

²¹⁸ Wash. State Republican Party v. Wash. State Public Disclosure Comm’n, 4 P.3d 808, 838 n.3 (Wash. 2000), quoting ANATOLE FRANCE, *THE RED LILY*, 75 (1917 ed.) (1894).

²¹⁹ *Paulson*, 664 P.2d. at 1207.

²²⁰ The deterrence arising from tort liability is most effective respecting prospective defendants who can take measures to assure that the standard of care is met in advance; the deterrence effect on prospective plaintiffs, even if they were sufficiently prescient to see themselves as future victims, would presumably be maximized by the natural, human desire to avoid pain, injury, and disability and alterations in tort liability would be unlikely to give rise to significant additional motivation for injury-avoidance.

²²¹ *See Paulson*, 664 P.2d at 1207.

²²² It is difficult not to suspect political motivations underlying this measure, which seeks to limit the liability of a traditionally Republican insurance industry while attacking the earnings of a traditionally Democratic plaintiff trial lawyers' bar and burdening plaintiffs in their ability to secure counsel.

²²³ *Allard v. First Interstate Bank of Washington, N.A.*, 768 P.2d 998, 1005 (Wash. 1989).

²²⁴ *Id.* at 1006: "It should be noted at the outset that the contingent fee is the dominant system in the United States by which legal services are financed by those seeking to assert a claim."

²²⁵ *Grant County Fire Protection District No. 5*, 83 P.3d at 427.

²²⁶ *See Snure*, *supra* note 213.

²²⁷ *See Studdert*, *supra* note 86.

²²⁸ WASH. CONST. art. I, § 21: "The right of trial by jury shall remain inviolate, but the legislature may provide for a jury of any number less than twelve in courts not of record, and for verdict by nine or more judges in civil cases in any court of record, and for waiving of the jury in civil cases where the consent of the parties interested is given thereto."

²²⁹ *Sofie*, 771 P.2d at 724.

²³⁰ *Id.* at 720.

²³¹ *Id.* at 716-17 (quoting *James v. Robeck*, 490 P.2d 878 (1971)).

²³² *Id.*

²³³ *Id.* at 718.

²³⁴ *Id.* at 717 (citing *Dacres v. Oregon Ry. & Nav. Co.*, 20 P. 601 (1889)).

²³⁵ *Id.* at 722.

²³⁶ *See supra* note 196.

²³⁷ *Hamilton v. Dep't of Labor & Indus.*, 761 P.2d 618, 571 (Wash. 1988).

²³⁸ Text of I-330, *supra* note 6, at § 2, ¶ 6.

²³⁹ *Hamilton*, 761 P.2d at 572.

²⁴⁰ Washington State Secretary of State, 2005 General Election: Official Vote Count, *available at*

<http://vote.wa.gov/election/2005/general/measures.aspx>.

²⁴¹ Washington Network for Civil Justice and Accountability, <http://www.no330.org/no330/index.html> (last visited Feb. 24, 2006).

²⁴² Washington State Medical Association, Yes On I-330, *available at* <http://www.yesoni330.org/> (last visited Feb. 7, 2006).

²⁴³ Revised Code of Washington provisions amended by I-330 are WASH. REV. CODE §§ 4.16.250, 4.22.070, 4.22.015, 4.56.250, 7.70.020, 7.70.070, 7.70.080, 7.70.100, and

74.34.200. I-330 also adds new sections to WASH. REV. CODE §§ 4.56, 7.04, and 7.70. Provisions amended by I-336 are WASH. REV. CODE §§ 18.71.015, 18.71.0195, 7.70.050, and 70.02.101. I-336 also adds new sections to WASH. REV. CODE §§ 18.130, 18.71, 7.70, 70.02, as well as a new chapter to Title 48.

²⁴⁴ Doctors, Nurses & Patients for a Healthy Washington, Their Lips Are Moving, <http://theirlipsaremoving.com/> (last visited Feb. 24, 2006).

²⁴⁵ See, e.g., THEODORE J. LOWI, *THE END OF LIBERALISM: THE SECOND REPUBLIC OF THE UNITED STATES* (1979). In his prescient classic, Lowi argues that national policymaking has become the province of organized lobbies, which worked to the detriment of the overall public interest.

²⁴⁶ The challenges to our republic created by the ubiquity of lobbyists goes beyond the scope of this article to address. For our purposes it suffices to note that our founding fathers were prescient when they advocated public education as the foundation of citizenship. Thomas Jefferson, in his April 24, 1816 letter to P. S. Dupont de Nemours, held “the diffusion of knowledge among the people” to be the instrument by which the human condition would be improved and stated: “Enlighten the people generally, and tyranny and oppressions of body and mind will vanish like evil spirits at the dawn of day.” THOMAS JEFFERSON, *WRITINGS*, 1387-1388 (1984).

²⁴⁷ *Marbury*, 5 U.S. at 177.

²⁴⁸ The State Senate passed the legislation 48-0, with one excused; the State House passed the amended legislation 82-15, with one excused. S.S.H.B. 2292 (2006), *LEGISLATIVE HISTORY*, <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2292&year=2006>. (last visited Mar. 25, 2006).

²⁴⁹ Proponents of the legislation cite significant reforms in patient safety, provider discipline, insurance and civil justice reform without the incorporation of many of the measures in I-330 which impaired the rights of injured patients. 2 SHB 2292 does not cap economic or non-economic damages for injured individuals; limit their ability to hire a lawyer; abolish agency, ostensible agency or joint and several liability; allow defendants to make periodic payment of judgments; make future collateral source offsets admissible; or change the burden of proof from preponderance of the evidence to clear, cogent and convincing evidence in medical negligence lawsuits. In its fifty-six sections and sixty-two pages, 2 SHB 2292 requires increased reporting and investigation by the Department of Health; mandates that prescriptions be hand printed, typewritten or generated electronically; renders inadmissible a health care provider’s statements of apology or regret within thirty days of discovery of an adverse event; increases public membership of the Medical Quality Assurance Commission by two additional members; immunizes health care professionals who, in good faith, report another’s unprofessional conduct; alters existing insurance regulations to require “prior approval” of policies and prior notice and explanation for non-renewal; prohibits adverse action against an insured solely on the basis of notification of potential claims or claims closed with no payment; requires filing of a certificate of merit from a health care provider before suit as well as attorney certification that claims are not frivolous; requires a ninety day pre-filing notice of a pending claim; and allows introduction of collateral source information respecting any benefits received by the plaintiff up until the time of trial. S.S.H.B. 2292, 59th Legislature (2006), *available at*,

<http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bills/House%20Passed%20Legislature/2292-S2.PL.pdf>.