

The Project on 
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**The Politics of Medical Malpractice in Pennsylvania,
1975-2005**

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Executive Summary

Since the initial modern malpractice crisis hit Pennsylvania and the nation in the mid-1970s, two successive episodes—including one in the present, which by autumn 2005 appeared to be abating—have rocked the Commonwealth’s liability insurers, medical providers, and health-care consumers. The state’s political establishment was swift to respond with reform legislation in both the first crisis and the present one; a malpractice bill also passed in 1996, in the wake of the 1980s troubles. But, in 1975 and 2002 alike, passage of a comprehensive reform measure did little to alleviate pressures for continued legislative relief. Political efforts to address soaring liability premiums and other systemic malpractice woes continued for years afterwards.

Pennsylvania’s malpractice politics has, over the past 30 years, developed into an *issue regime*: a distinctive constellation of political stakeholders, framing arguments, viable solutions, legislative outcomes, and responses to systemic shocks. Regimes often originate in response to a policy crisis; they thereafter harden into an established set of political practices that help to shape and constrain future policymaking. The specific features of Pennsylvania’s malpractice issue regime date to the mid-1970s, and may be described as follows:

- ***Familiar stakeholders.*** For three decades, a set of leading groups—most notably, the Pennsylvania Medical Society and other physicians’ representatives, trial lawyers, hospital officials, and insurance executives—have been central players in malpractice policy. All tend to advance arguments first honed in the mid-1970s,

employ consistent tactics to mobilize members, and adapt some positions in response to their opponents' views (a process referred to as "issue uptake")

- *Consistent policy options.* Malpractice debates in Pennsylvania have remained oriented around levels of patient (and attorney) compensation. Policies taken up by the state Assembly—and receiving the bulk of media coverage—are almost all first generation reforms, initially promoted during the 1970s.
- *Consistent style of legislating.* Rather than incremental policymaking, Pennsylvania leaders have periodically passed wide-ranging legislation designed to address the problem of high premiums and to alleviate fears of a malpractice "crisis." Reform packages include: Act 111 (1975), Act 135 (1996), and Act 13 (2002). These were only partly successful—laws changed, but not public perceptions—and did not result in the usual legislative pause after enactment of a relatively ambitious policy. Act 111, the nation's first comprehensive reform package, was followed by four amendment rounds between 1976-80; Act 13 was supplemented later in 2002 by two additional changes, and reformist pressure remained intense through 2004.

Issue regimes promote stability, but they are not iron-clad. Changes are evident in the Commonwealth's malpractice politics compared to the 1970s and 1980s. The current crisis exhibits at least two significant differences:

- *Wider context.* Malpractice in the 21st century has been molded by dramatic changes in U.S. health care since 1970s, yet the malpractice liability system itself is little altered. Notable technological advances in medicine have proven a double-

edged sword: once-miraculous cures are now routine, boosting expectations of success, but the costs of medical errors are far higher than during the first or second malpractice crises.

- *Novel players.* Political entrepreneurs, especially non-medical tort reform advocates and patient-safety groups, have gained prominence in Pennsylvania during the present crisis. In classic issue-regime fashion, however, they are usually absorbed into existing debates.

What of the future of malpractice politics, as the crisis abates in 2005? Issue regime analysis suggests more of the same. Commonwealth residents can expect continued laments about high malpractice premiums and renewed calls for damage caps, albeit at a reduced level of urgency. Experiments with second or third-generation reforms, though seen as widely desirable by many health-policy analysts, are unlikely to be promoted in Harrisburg. Thus Pennsylvania remains vulnerable, both politically and economically, to a fourth crisis of malpractice availability and/or affordability, and to a continuing disconnect between the liability system and the public policy goals of safe, accessible, cost-effective health care.

Introduction

Pennsylvania’s medical malpractice problems have been well chronicled in both journalistic and academic accounts.¹ This study takes up the specifically political features of the Commonwealth’s malpractice debates, which both resemble and depart from disputes in other state capitals and Washington, D.C. Pressed by a set of powerful and deeply engaged stakeholders, political leaders in Harrisburg were swift to respond with reform legislation both in the mid-1970s crisis and the present one. A malpractice bill also passed in 1996, in the wake of the 1980s crisis. These acts won national attention—President Bush has made more speeches on medical liability reform in Pennsylvania than in any other state—and seemingly continued Pennsylvania’s longstanding tradition of health-politics innovation. But, in 2002 and 1975 alike, passage of comprehensive reform measures did little to alleviate pressures for continued legislative relief. Efforts to address soaring liability premiums and other systemic malpractice woes continued for years afterwards.

As in other states, most malpractice policies proposed and/or passed in Pennsylvania during all three crises have been “first generation” efforts to boost insurance availability and reduce provider liability via tort reforms aimed at limiting malpractice damage awards and also by streamlining claims resolution through case screening tribunals, restrictive statutes of limitation, and other mechanisms. Receiving far less political attention have been

¹ See, e.g., Bovbjerg and Bartow, 2003; Guadagnino 2004; U.S. House Subcommittee on Oversight & Investigations 2003; Wysocki 2003; GAO 2003, esp. 64.

“second generation” proposals such as alternative dispute resolution, no-fault insurance plans, and enterprise liability, or “third generation” ideas such as state-based demonstration projects or organizing malpractice through the Medicare program. On the other hand, the current crisis has featured more efforts to enact patient-safety reforms, inspired by the Institute of Medicine’s influential 1999 report on medical errors.

This distinctive Pennsylvania malpractice politics had, well before the present crisis, hardened into what political scientists term an *issue regime*.² These typically feature:

- Standard arguments by legislators and their interest-group allies over how to frame a policy problem and the best solutions
- Mobilization of supporters in tried-and-true ways; and
- A particular style of legislative response to systemic shocks.

Over time, as an issue regime becomes institutionalized, novel reforms are less likely to win attention or enactment. Issue regimes are an important key to political stability, both nationally and within a state or local polity, but also can deter innovative reforms.

As the current malpractice crisis subsides, it is possible to take stock of the Commonwealth’s political response. This study first summarizes the history of malpractice politics in Pennsylvania in the context of both the state’s distinctive health policy culture and concurrent national health care debates. State officials’ response to the first two malpractice crises, originating in the mid-1970s and mid-1980s, is described in detail, as is the ambitious legislative attempt in 1996 to stave off future malpractice crises. Soon thereafter, a cascade of malpractice-insurer failures and rising premium levels breached all

² “Policy regime” is a synonymous term. See Orren and Skowronek 2004, 90, 191-94.

protective barriers. This third crisis occasioned an especially intense round of malpractice politicking, which reverberates still through Harrisburg and across the state.

Pennsylvania’s political response to the current malpractice crisis has been shaped in important ways by the reaction of state leaders and key stakeholders to the first crisis, three decades before. After describing the issue regime that has developed in Pennsylvania, a comparison is drawn with other states’ malpractice policymaking. This report concludes with a summary of indicators that suggest the latest malpractice crisis is subsiding, and briefly considers reforms that could help stave off the next one.

I. Health Politics in Pennsylvania: A History

Pennsylvania’s history of medical “firsts” extends well beyond the colonial period, which saw the founding of the nation’s first modern hospital, psychiatric treatment facility, and medical school, all in Philadelphia. State innovations in the nineteenth century included the first American-trained professional nurses, the first women’s medical college, and the first statewide public health organization. Eventually other locales would challenge the state’s standing as the “medical center of North America,” but Pennsylvania’s pioneering health care legacy continued.³ In a nationally watched 1991 special U.S. Senate election following the death of John Heinz, lesser-known Harris Wofford bested popular former governor Richard Thornburgh. Wofford’s emphasis on health care reform was adopted by then-President Bush as well as Arkansas governor Bill Clinton, whose surprising

³ Shryock 1941, 6-8, 15-22; Burkhardt 1990, 4 and *passim.*; Richman 1968, 72-75, 82-83.

presidential victory the following year was built in significant part around a promise to reform health care “like they’re doing in Pennsylvania.”⁴

Pennsylvania’s longstanding position as health-policy innovator has also held true for medical malpractice, if sporadically. During the early U.S. republic, when malpractice suits were still quite rare, a celebrated Pennsylvania case resulted in the state’s supreme court becoming the first in the nation to overturn a malpractice judgment on appeal.⁵ When an initial wave of malpractice claims in the 1840s aroused widespread alarm and dismay among physicians; the few prominent voices in the medical establishment to acknowledge malpractice as a means of “driving charlatans and amateur hacks from the field” included Dr. R.E. Griffith, a “giant of early medical education” who spent his career at the University of Pennsylvania’s medical school. Griffith’s hope that professionally trained doctors and lawyers could make common cause in improving American health care through judicious use of legal remedies was never realized; by the 1850s, a painful and permanent rift opened around malpractice between physicians and lawyers.⁶

Given this history of blending politics and health innovations, Pennsylvania’s political response to malpractice alarms in the modern era is intriguing. Pennsylvania was among the first states to pass wide-ranging legislative reform in response to the 1970s malpractice “crisis.” Today, despite profound changes in the U.S. health care system generally, the arguments, tactics, players, and policies at the forefront of the malpractice debate 30 years ago still dominate. To understand the origins and nature of this issue

⁴ Tokarski 1992.

⁵ De Ville 1990, 8.

⁶ Mohr 2000, 1732-33.

regime, we turn now to the recent history of malpractice politics in Pennsylvania, beginning with a brief general overview of the subject.

Three Modern Crises: An Overview

Americans' malpractice concerns stretch back to colonial times. In 1757 the New York historian William Smith remarked "to our Shame be it remembered, we have no Law to protect the Lives of the King's Subjects, from the malpractice of Pretenders....No candidates are either examined or licensed."⁷ It would take almost a century before malpractice became a regular feature of the U.S. medical landscape, beginning with a spate of cases in New York, Pennsylvania, and Ohio in the mid-1840s. For more than another century, however, malpractice was barely mentioned by public officials. Like much of the U.S. health care system, it remained off-limits to political intervention.⁸

Political inattention to malpractice began to change in the 1960s, a trend accelerated by the first modern liability crisis in the mid-1970s. This and two successive episodes, in the mid-1980s and 2001-05, firmly established malpractice on the map of national and state political concerns. Pennsylvania's political establishment responded earlier than most to the warning signs of declining liability insurance availability and rising premiums. Indeed, the Commonwealth's insurance commissioner was one of the first state officials to label the situation a "crisis," in March 1969.⁹ Four separate malpractice reform bills were enacted

⁷ Smith 1757, 212.

⁸ Kersh forthcoming; on the private nature of many health-policy issues prior to the 1960s-70s, see Kersh and Morone 2005.

⁹ Insurance Commissioner David Maxwell, quoted in (Connellsville) Daily Courier, March 19, 1969.

between 1975 and 1980, beginning with Act 111. State lawmakers were slower to respond to the second crisis, but eventually passed a substantial measure in 1996 (Act 135). Six years later, with malpractice again making headlines, Harrisburg was among the earliest state capitals to address the issue. The Assembly enacted a sweeping set of changes in 2002 (MCARE, or Act 13), added two more important liability reform measures later the same year, and has debated further malpractice policies almost constantly since then.

Thirty years of Pennsylvania malpractice politics has yielded a wide and sometimes contradictory array of statutory changes to the Commonwealth's malpractice system. In each of three reform episodes, state lawmakers (prodded by affected groups) advanced very similar arguments and proposals for change. During the current crisis, almost no stakeholders have expressed satisfaction with the result. How did such a combination of official activity and public/private displeasure come about—especially considering Pennsylvania's swift and broad-gauged legislative response in 2002? And do positions and policy solutions first advanced decades ago still apply in the 21st century?

First Crisis: mid-1970s

Malpractice first attracted national government attention during the late 1960s, when a White House commission and a U.S. Senate subcommittee each completed lengthy reports on the system's problems and prospects for reform. But the subject truly burst onto the U.S. political agenda during the first modern malpractice crisis of 1974-76. Battered by the oil-shock recession, a number of malpractice insurers abruptly ceased offering coverage, driving premiums to new heights. Pennsylvania's then-largest malpractice insurer,

Argonaut, threatened to stop writing policies altogether and, in 1975, sought a premium rate increase of over 200 percent for some specialties.

Officials in Pennsylvania and other states actively sought policy change, transforming medical malpractice from a private matter into one for public regulation. The “first-generation” state remedies adopted in the 1970s fell into two primary categories: reforms designed to *increase malpractice insurance availability* through joint underwriting associations, guaranty funds, reinsurance plans, or state-run patient compensation funds; and attempts to *reduce provider liability* through tort reforms that reduced the size or frequency of claims such as shortened statutes of limitations, screening panels for frivolous claims, caps on damages, and offsetting awards when other sources of payment were available.¹⁰

Prominent among state tort-reform approaches was California’s Medical Injury Compensation Reform Act (MICRA), enacted in September 1975, less than a month before Pennsylvania’s Act 111 was signed into law. MICRA featured a \$250,000 cap on non-economic damages that was adopted in varying forms by several other states. Congress was more hesitant than state legislatures to act during this first crisis; no malpractice reform measures were seriously considered by any federal legislative committee.¹¹

A cap on non-economic damages, urged by the 13,000-member Pennsylvania Medical Society (PMS), was a major feature of the 1974-75 Pennsylvania debate. But the

¹⁰ On the 1970s crisis, and state remedies, see Feagles et. al. 1975; Bovbjerg 1989; Sloan 1985; Robinson 1986. “First” and “second” generation malpractice reforms are described in detail in Kinney 1995.

¹¹ Federal policymakers’ reform proposals in the mid-1970s featured first-generation plans like regulation of lawyers’ contingency fees, and also such innovative policies as no-fault malpractice insurance, stricter hospital regulation to prevent accidents, and more stringent physician licensing laws. None received much attention in Congress. DHEW 1973; Pope 1971.

Health Care Services Malpractice Act (Act 111 of 1975) did not include such a measure. Then-governor Milton Shapp, along with House Speaker Herbert Fineman, opposed damage caps—in part because any such change would require an amendment to Pennsylvania’s constitution.¹² Instead, a number of other first-generation reforms were adopted. These included creation of one of the U.S.’s first public patient-compensation funds, the Medical Professional Liability Catastrophic Loss (CAT) Fund (renamed the MCARE Fund in 2002). The CAT Fund was designed to help health providers secure high-dollar medical liability coverage that was unavailable on the private market.¹³ Act 111 also mandated basic insurance coverage requirements for physicians, hospitals, and other providers; approved a set of self-insurance mechanisms, such as risk retention groups; created the state’s ‘insurer of last resort,’ the Joint Underwriting Association; limited attorneys’ contingency fees; mandated arbitration panels in certain malpractice cases; and established a partial ‘collateral source offset’ rule.¹⁴ The latter three provisions—limits on attorney fees, mandatory arbitration, and collateral source—were subsequently overturned on state constitutional grounds by Pennsylvania’s supreme court.

These first modern malpractice debates featured arguments and lobbying techniques that would remain familiar 30 years later. Commonwealth physicians sought “a bill that performs radical surgery on the right to sue for pain and suffering” (caps on non-economic damages), staged work slowdowns across the state to publicize their plight, and threatened a

¹² Article III, Sec. 18 of Pennsylvania Constitution: forbids General Assembly to enact any limit on damage amounts in personal injury lawsuits (except workers’ compensation). On Shapp and Fineman’s opposition, see Ferrick 1975.

¹³ On Pennsylvania’s and other state patient compensation funds, see Sloan, Mathers, Conover, and Sage 2005.

¹⁴ Health Services Malpractice Act (HB 1367), enacted Oct. 15, 1975.

mass walkout. Full-page advertisements in Pennsylvania newspapers warned of physicians retiring early, young doctors avoiding the Commonwealth, wasteful spending on “defensive medicine,” and declining availability of “critical specialties” such as neurosurgery and orthopedics. Lawyers responded, with equally alarmist rhetoric, that basic principles of fairness to injured patients were at stake. The state legislature, urged to work swiftly, engaged in marathon sessions (the House debate on one malpractice bill featured over 150 amendments), while warning that no “miracle cure” was available—including damage caps. In a display of unity initially kept out of the public eye, lawyers’ and physicians’ representatives joined forces to “talk things out,” and achieved consensus on the final bill that became the Health Services Malpractice Act (Act 111).¹⁵

Concerns about insurance availability and affordability were little diminished following the Act’s passage, however. A November 1976 account of a special legislative hearing on the impact of Act 111 reported that “the crisis is alive as ever, according to testimony [by insurance and physicians’ representatives].”¹⁶ More than a dozen amendments to Act 111 were adopted in 1976, 1978, and 1980. After these changes, Pennsylvania’s legislature stood alongside California’s as the nation’s most active on malpractice policy. Unlike California, half of the provisions added to Act 111 through amendment – all concerning matters of trial procedure (mandatory pre-trial conferences, e.g., or strict limits on “dilatory or frivolous motions”) – were subsequently ruled unconstitutional. Table 1 indicates the principal provisions of the Health Care Services

¹⁵ “‘Defensive Medicine’ Researched,” Bucks County Courier Times, Aug. 26, 1973; PMS advertisement in (e.g.) Gettysburg Times, May 29, 1975; “House Refuses to Debate Malpractice Bill,” Valley Independent, July 19, 1975; Ferrick 1975; Weymiller 1975.

¹⁶ “Malpractice Crisis Alive,” (Connellsville) Daily Courier, Nov. 30, 1976.

Malpractice Act and three subsequent rounds of amendments, along with the current status of each provision.

**Table 1. Pennsylvania’s Statutory Malpractice Changes, 1975-1980
(Act 111 and 1976-80 Amendments)**

Provision	Result
<i>Act 111 (1975)</i>	
Medical Professional Liability Catastrophic Loss (CAT) Fund	Still in place: renamed MCARE Fund by Act 13 (2002). Scheduled to phase out by 2009
Pennsylvania Joint Underwriting Assn. (JUA)	Remains state’s insurer of last resort; modified in part by Act 13
Malpractice liability insurance coverage requirements for providers: mandated minimum of \$1.2 million (at least \$200,000 of private coverage; remainder coverable by CAT [now MCARE] Fund)	Still in place; private-coverage minimums increased in Act 135 (1996), and mandated minimum reduced to \$1 million in Act 13
Self-insurance arrangements	Still permitted
Collateral source rule (for public sources)	Struck down, Pennsylvania Supreme Court
Limits on attorneys’ contingency fees	Struck down, Pennsylvania Supreme Court
Mandatory pre-trial arbitration panels	Struck down, Pennsylvania Supreme Court
<i>Act 111 Amendments: 1976, 1978, 1980</i>	
Periodic (rather than lump-sum) payments of malpractice settlements	Still permitted
Advance payments for malpractice awards accepted	Still permitted
Provider’s affidavits of noninvolvement in injury accepted evidence in court	Still in force
Limits on malpractice punitive damages	Reaffirmed by Act 135 (1996)
Informed consent requirement strengthened	Still in place
Pre-trial conferences among parties required, along with limited mediation	Struck down, Pennsylvania Supreme Court
Discovery conference required, along with maximum discovery time limit of two years	Struck down, Pennsylvania Supreme Court
Penalties for frivolous/dilatory court motions	Struck down, Pennsylvania Supreme Court
Conciliation schedules required	Struck down, Pennsylvania Supreme Court
Complaint procedures with certification	Struck down, Pennsylvania Supreme Court
Time requirements for expert witness reports	Struck down, Pennsylvania Supreme Court

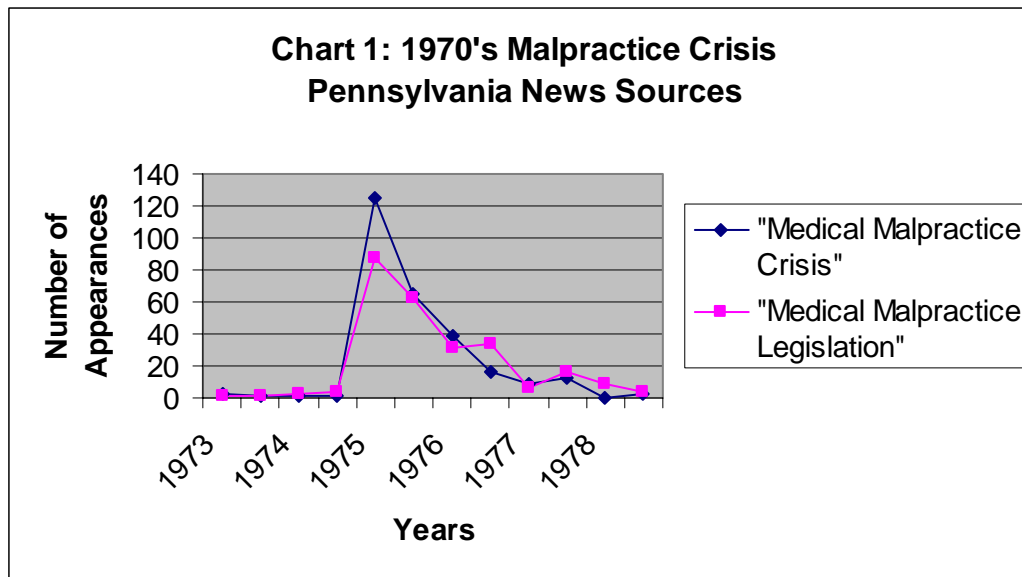
Two final features of Pennsylvania malpractice politics in the 1970s deserve mention. First, the primary stakeholders involved were, perhaps unsurprisingly, from the four sectors potentially most affected by changes to the malpractice system. Physicians,

working through the PMS and local medical societies, and lawyers, organized through the then-fledgling PaTLA and state bar association, were the principal players mentioned in media coverage and legislative histories, usually in terms like “a massive clash between Pennsylvania’s trial lawyers and the Pennsylvania Medical Society.”¹⁷ (As noted above, however, these traditional adversaries did eventually join forces to help ensure Act 111’s passage.) Also involved in malpractice debates, though less often mentioned in news accounts, were insurance and hospital representatives. These four groups accounted for all for the interest-group mentions in newspaper coverage of the 1970s crisis reviewed for this study.

A second aspect of the debate concerns media coverage of malpractice issues. This rose sharply as the crisis became apparent late in 1974, then declined almost as swiftly two years later—even while the legislature continued to debate additional reforms. Chart 1 shows the number of malpractice reports in Pennsylvania newspapers.¹⁸ The top line (dark blue, diamond-shaped symbol) tracks newspaper stories mentioning the “medical malpractice crisis.” The bottom line (pink, square symbol) indicates how often newspapers covered malpractice legislation in the state Assembly.

¹⁷ “Malpractice Issue Tackled,” Valley Independent, July 18, 1975.

¹⁸ Newspapers examined for the 1970s and 1980s periods (Charts I and II) are all those included in the research database NewspaperELITE; coverage of the present crisis is drawn from the more comprehensive Nexis database.



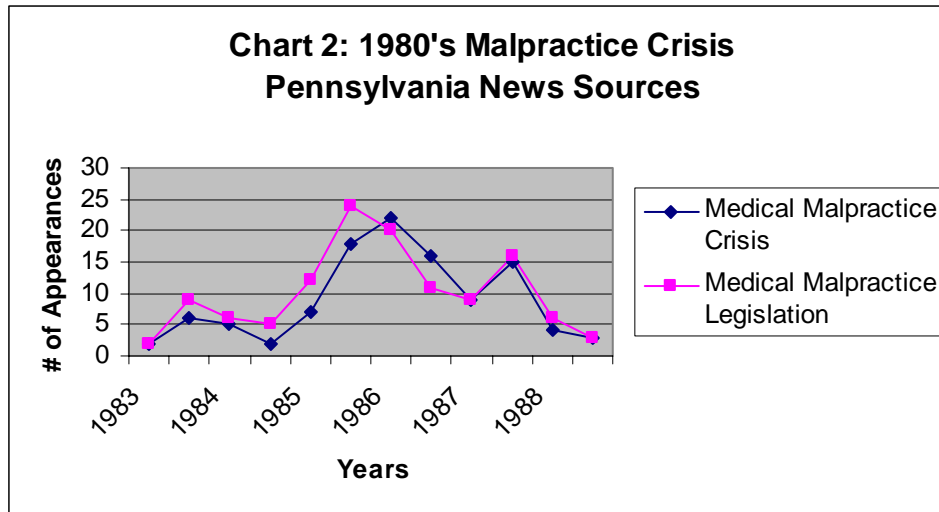
Second Crisis: 1980s-90s

The mid-1980s marked the onset of a second national malpractice crisis, as liability premiums and claims frequency rose sharply in many states. Pennsylvania was less dramatically affected than in the first (or the present) crisis, with annual premium rate increases of around 25-30 percent on average, but rhetoric surrounding malpractice issues was little less strident. Medical leaders across the Commonwealth labelled the situation “a monumental crisis,” doctors threatened (but ultimately did not undertake) a mass walkout to publicize their plight, and Governor Thornburgh urged the legislature to consider various reforms. In 1984 the Pennsylvania Medical Society promoted a bill to cap non-economic damages (at \$1.3 million), limit attorneys’ contingency fees, and restore the collateral source rules established in Act 111. The bill won only modest support in the General Assembly, and died in committee. (A former Trial Lawyers Association official, upholding a long tradition of physician-lawyer sniping, publicly termed the legislation “draconian garbage.”)

Another burst of legislative activity in 1986, featuring a pair of comprehensive reform proposals, also failed – in part because efforts earlier that year to achieve a policy compromise among physicians and attorneys, organized through a state Senate Select Committee on Medical Malpractice, yielded no workable result. A few minor measures, such as a law limiting medical liability for sports coaches and another preventing mid-term cancellation of insurance policies, passed in subsequent years, but no significant Pennsylvania malpractice legislation was forthcoming for more than a decade after the onset of the second malpractice crisis.¹⁹

Media coverage in the state traced an arc similar to that during the first crisis, rising as problems became apparent in 1985-86 and waning again within three years. There was less newspaper attention to malpractice than ten years before, reflecting the relative impact of the two crises. Chart 2 depicts the trend in newspaper coverage: again the top line (dark blue in color, diamond-shaped symbol) tracks newspaper stories about the “medical malpractice crisis.” The bottom line (pink, square symbol) displays newspaper coverage of malpractice legislation in the state Assembly. It bears noting that legislative proposals on malpractice were fairly continuous from 1985 through 1996, when Act 135 finally passed. As in the 1970s, media attention was a marker for *perception of crisis*, rather than legislative activity. The four stakeholders from the 1970s debates were again the center of attention: 92% of interest-group mentions in newspaper accounts from 1985-88 were to the PMS or other physician groups; the trial bar, spearheaded by PaTLA; the Hospital Association or other providers’ representatives; and insurance executives.

¹⁹ Quotes in DiBartolomeo and Grace 1985; see also Moody 1985; “Doctors to Meet With Legislators on Reform of Malpractice Law,” Daily Intelligencer, Sept. 14, 1986.



Among federal officials, reaction to this second flood of malpractice complaints was stronger than in the mid-1970s. President Reagan demanded that Congress limit lawsuits and directed the Department of Health and Human Services to develop recommendations for swift relief. Reagan’s successor George H.W. Bush was particularly engaged on the issue, promoting sweeping MICRA-style legislation in Congress as the health-reform centerpiece of his presidency and, in both his 1988 and 1992 campaigns, fingering high malpractice payouts as the key to spiralling U.S. health care costs. The Democratic-controlled Congress was also more active than during the first crisis; 1987 brought the first major federal legislation proposed to reform the malpractice system, and the next six years saw more than 60 malpractice bills introduced, most of them first-generation tort and insurance reforms. None were enacted, although some passed the House of Representatives. A few lawmakers floated “second-generation” proposals, including medical practice

guidelines, alternative dispute resolution, various no-fault insurance approaches, enterprise liability, and damages scheduling. Congress exhibited little enthusiasm for any of these.²⁰

Accompanying increased federal activity was another wave of state malpractice policymaking, cresting between 1985 and 1987. This round of state enactments also favored first-generation policies like shortened statutes of limitation, expert-witness requirements, and pretrial tribunals to screen liability actions. Many of these already had been enacted in Pennsylvania during the flurry of malpractice lawmaking a decade earlier. MICRA-style reforms were especially popular in state capitals—though the signature feature, caps on non-economic damages, encountered legal trouble in some jurisdictions. Seven state courts overturned existing damage caps during the late 1980s, usually on equal protection grounds.²¹ By the early 1990s, more than 40 states had debated damage caps, but only 20 actually featured statutory limits on non-economic damages. At that time Pennsylvania was one of just four states (Arkansas, Kentucky, and North Carolina were the other three) that had not enacted new tort reform legislation of some type; all four would eventually fall into line.²²

Some states did implement “second-generation” reforms, though Pennsylvania was not among these. Virginia and Florida, for example, each adopted no-fault insurance rules for birth injuries, and Vermont mandated both alternative dispute resolution in malpractice cases and medical practice guidelines. The 1980s crisis, along with related problems in affordability of automobile coverage, also inspired another state intervention: tougher

²⁰ Kinney 1996, esp. 102-10.

²¹ Haiduc 1990.

²² Fielding 1999, 148. On legislative responses to the 1980s crisis see Kinney 1996; Bovbjerg 1989.

regulation of insurers in general. Like malpractice insurance, automobile insurance features a large, politically vocal consumer constituency. Again California led the way, with an Insurance Rate Reduction and Reform Act drafted by Ralph Nader, which passed as Proposition 103 in 1988. The reform rolled back insurance rates, installed transparency regulations (most notably, insurers proposing a rate increase had to provide detailed justification), established financial incentives for efficient insurer performance, and required insurers to cut costs described as “unnecessary,” a category including “excessive expenses, bloated executive sales, and bad-faith lawsuit costs.”²³ Some analysts attribute California’s lower rate of increase in malpractice premiums to the interaction of MICRA with Proposition 103 because premium declines became evident mainly after 1988, when insurance regulation was adopted.²⁴

Insurance regulation, like most of the second-generation reforms listed by Bovbjerg or Kinney, has been largely ignored in malpractice legislation to date in Pennsylvania. Intense political opposition to MICRA-style reforms, lack of interest in more innovative approaches, and relative availability of liability coverage notwithstanding higher premiums tended to minimize legislative enactments during the second malpractice crisis – despite powerful pressures for change in Washington and other state capitals. During the current crisis, calls for better malpractice insurance regulation in the Commonwealth have come not from the principal stakeholders – physicians tend reflexively to side with insurers on

²³ Cal. Code Regs., tit. 10, § 2646.6; Cal. Ins. Code, § 1861.07.

²⁴ Foundation for Taxpayer and Consumer Rights 2003; Weiss Ratings 2003. The most comprehensive study of MICRA to date, a RAND Corporation analysis published in 2004, was unable to draw any conclusion “as to whether MICRA achieved the California Legislature’s ultimate goal of maximizing the availability of health care services by holding down insurance premiums.” RAND Institute for Civil Justice 2004, 4.

malpractice matters, while lawyers' primary focus of criticism is medical errors rather than insurance practices – but from health policy researchers.²⁵

Another Attempted Solution: Act 135 (1996)

It was not until 1996 that the Commonwealth's political establishment achieved another legislative breakthrough. Act 135, officially a 1996 amendment to the first crisis's Act 111, featured three principal reforms, as well as another set of procedural changes. A few of its provisions, similar to the 1970s reforms, were later declared unconstitutional in state court on procedural grounds. Table 2 summarizes Act 135's set of changes to Pennsylvania malpractice law.

Tort reform was one key focus of Act 135. Though, as in 1975, the Act did not include the MICRA "grail" of dollar limits on non-economic damages, a cap was enacted on punitive damages, which historically were rare in malpractice cases. Still, the measure was historic: in a state that constitutionally forbids limits on most damages, physicians and other medical providers became the only group in Pennsylvania with such protection. Act 135 specifies a punitive-damages limit of the greater of two times the compensatory damages awarded or \$100,000.

Also provided under Act 135: legal sanction for affidavits of non-involvement (if a physician or other provider swears under oath that he or she was not personally involved in a case, they are cleared of any responsibility in the case), and a staggered reduction in CAT Fund coverage. The effect of the latter was that providers were responsible for securing the first \$300,000 (up from \$200,000) of coverage before CAT Fund eligibility; that number

²⁵ See, most recently, Geistfeld 2005.

rose to \$400,000 in 1999-2000, and to \$500,000 in 2001 – just in time for the next malpractice crisis. Total minimum malpractice coverage, including CAT Fund coverage, remained at the Act 111 total of \$1.2 million. Significantly, a four-year moratorium on additional medical malpractice legislation was also mandated by Act 135.

Table 2. Act 135 Malpractice Changes (1996)

Provision	Result
Increase in primary insurance coverage required for providers and health-care facilities (with concomitant CAT Fund decrease)	Phased in beginning in 1987; reaffirmed in Act 13 (2002).
Recalculation of annual CAT Fund surcharges paid by all providers participating in Fund	Began in 1987; surcharges altered by Act 13 and subsequent Gov. Rendell policy.
Expanded list of medical procedures for which informed consent required, including surgery, radiation/chemotherapy, blood transfusions	Still in effect.
Standards toughened for awarding punitive damages; limits enacted on punitive damages	Still in effect.
Affidavit of non-involvement: malpractice suits against providers may be dismissed if they file an affidavit demonstrating they were misidentified or not involved in case	Still in effect.
Moratorium on new medical-liability legislation until 2000.	Upheld for 4-year duration.

Among the longest-standing laws of politics is the inevitability of unintended consequences. In this case, Act 135’s CAT Fund changes happened to coincide with an effort by the judicial system to resolve a large backlog of malpractice claims, many tied up in an overburdened Philadelphia court system. The result was that private insurers faced unexpected payments and began to charge more for premiums, while providers were forced by mandated CAT Fund changes to boost the amount of private coverage they had to purchase.

IOM Report: Patient Safety Re-Enters the Mix

Though financial trouble loomed on the horizon, the warning signals were partially (and temporarily) muted by a separate health care concern with relevance for malpractice. With the 1999 publication of *To Err is Human* by the Institute of Medicine (IOM) of the National Academies of Science, which itself followed a series of high-profile patient deaths in the mid-1990s, public attention turned powerfully to patient safety. The IOM's estimate that nearly 100,000 preventable deaths occurred each year because of medical error became an article of anxious faith among much of the U.S. public and a rallying cry for patient-safety advocates. Subsequent legislative debates on malpractice included commitments to enhancing patient safety and quality of care along with reducing liability burdens on providers. As Pennsylvania Hospital Association director Jim Redmond put it: "the IOM report just about did us in, so we hospitals decided to approach patient safety proactively rather than just losing [the argument]."²⁶ The only significant activity in Harrisburg in the four years following Act 135 concerned patient safety, although nothing passed. Some health systems adopted voluntary reforms. Pittsburgh, for example, was cited nationally for its "Regional Healthcare Initiative," which committed local providers and payers to a "zero tolerance" standard for preventable medical errors and hospital-acquired infections.²⁷ Patient safety had become part of the malpractice reform debate—which was again gaining steam.

²⁶ Personal interview with Jim Redmond, March 2004.

²⁷ Millenson 2005, 154-55.

II. The Current Crisis (2001-present)

Act 135's raft of changes did little to shield the Commonwealth from the current malpractice crisis, touched off by a "perfect storm" of shocks to the liability insurance market.²⁸ The precise causes are a subject of heated debate, but the symptoms were familiar. Three of the state's five major private medical-liability insurers ceased writing policies in Pennsylvania. Insurance premiums shot up in certain specialties, threatening providers' financial viability. Reinsurance costs jumped after the 2001 terrorist attacks. As bad news mounted, malpractice reform reappeared atop the political agenda in Harrisburg, as in most state capitals as well as Washington, D.C. Longtime combatants lined up behind arguments tested through years of debate (with a few novel twists, including reports in some states of physicians refusing treatment to trial lawyers).²⁹

The current crisis in Pennsylvania resembles that in other states, but in some respects has been particularly acute. Commonwealth malpractice premiums soared for primary coverage as liability insurers departed the state or severely reduced their underwriting. Annual CAT/MCARE Fund assessments on providers rose sharply, in part to cover high unfunded liabilities from past cases. The result was widespread concern among medical professionals and patients, fuelled by accounts of physicians leaving the state or retiring from practice and threatened reductions in hospital services, especially in rural Pennsylvania. For a comprehensive account of the crisis, see Bovjberg and Bartow;³⁰ of primary concern here is the political response. And Pennsylvania officials, though lagging

²⁸ Sage 2004b, 13.

²⁹ See, for example, Steffy 2004, A1; Parker 2004, A1.

³⁰ Bovjberg and Bartow 2003.

in certain respects in the 1980s crisis (and bound by Act 135 of 1996 to delay further legislative action until 2001) were swift to react this time around.

2001-02: Act 13

Pennsylvania was among the first states to respond to new signs of malpractice troubles. Its initial solution, a sweeping set of reforms passed as the Medical Care Availability and Reduction of Error Act (Act 13 of 2002) with strong involvement by then-Governor Mark Schweiker, was cited by a wide range of sources as an unusually comprehensive effort at change. Concluded one typical (and relatively impartial) observer, the Council of State Governments, “Pennsylvania is unique in that the [MCARE Act] reform package addresses all three aspects of the problem”—the health care system, including medical errors, the legal system, and the volatile medical malpractice insurance industry.³¹

Patient Safety: With the IOM’s report on medical errors still cited in every malpractice forum, efforts to enhance patient safety were an essential part of MCARE debates. The newfound political importance of patient safety is evident from the law’s title. The MCARE Act included nine different provisions on patient safety. For example, all medical facilities were required to adopt detailed patient safety plans. A new Patient Safety Authority would collect and analyze reports of medical errors and make recommendations for changes in health care practices. The Authority’s first annual report was released in April 2005. A related report on hospital-acquired infections was released in 2004 by the

³¹ Council of State Governments 2003, 21.

Pennsylvania Health Care Cost Containment Council, the first state agency in the nation to assemble such information.

Legal Reforms: In the face of spiralling premium rates, tort reform—promoted avidly across the nation, including by President Bush—was central to Act 13. As in 1996, caps on non-economic damages were not included in the compromise MCARE package, but a range of legal reforms were enacted. These fell into two categories: penalizing “frivolous” lawsuits via stronger expert witness qualifications and sanctions against lawyers filing frivolous claims; and reducing “excessive” awards, though a host of new policies.

Insurance Restructuring: The CAT Fund was a central target of Act 13, which replaced the beleaguered entity with a revised “MCARE Fund” featuring lower mandated coverage limits. This new fund was scheduled to be phased out by 2009 as long as sufficient private coverage is available.

Table 3 provides a comprehensive listing of statutory changes enacted under MCARE. To date none of the legal provisions have been reversed in state courts, in a departure from previous malpractice legislation. (As noted below, however, a subsequent act modifying joint and several liability for medical malpractice was struck down by the Commonwealth’s supreme court in 2005.)

Table 3. MCARE (Act 13) Malpractice Changes, March 2002
[Still in force, with minor alterations in some cases]

<i>Patient Safety</i>	<i>Legal Reforms</i>	<i>Insurance Restructuring</i>
Require all medical facilities to institute a patient-safety plan	Mandate stronger expert-witness qualifications	Eliminate CAT Fund and replace with new MCARE Fund; Fund scheduled to phase out by 2009
New Patient Safety Authority created to reduce medical errors; all errors reported to Authority, as well as to state health department	New sanctions for attorneys filing frivolous claims	\$400 million in state subsidies to reduce physician assessments paid into Fund in 2002-04
Require medical facility to notify patients affected by serious event (in writing, within 7 days)	Statutory limit on claim filing (except for minors): 7 years from date of injury	Increase Fund assessments for physicians with excessive malpractice claims
Strengthen state Medical Board's authority to investigate reports of serious provider error	Permit courts to reduce jury verdicts if amount impacts health-care access	Allocate 25% of punitive damages to reduce Fund liabilities
Require physicians to report various offenses (including liability complaints) to Medical Board	Limit use of vicarious liability for hospitals	Reduce mandated coverage limits
Increased penalties for licensure violations (to \$10,000)	Reduce to present value future damages for loss of earnings	Eliminate emergency Fund charges
Prohibit retaliation against health care workers reporting serious event	Periodic payment for future medical expenses	Require insurers to offer patient-safety discounts to providers and medical facilities
Protect provider reports of medical error from legal discovery	Collateral source rule reform: plaintiff cannot recover monies paid by insurer before trial	
Buttress continuing medical education (CME) patient-safety requirements		

Act 13 was widely hailed as a historic achievement, in part because of its wide appeal.

Pennsylvania's Senate voted unanimously in favor, and the House approved MCARE by 196-1 (the sole holdout was a Democratic legislator citing Act 13's insufficient patient-safety protections). Given this reception, along with the Act's breadth, conventional political analysis would predict a moratorium on continued legislative reforms, in order to

give the new changes time to percolate through the system. “Having passed [the MCARE Act] on Wednesday, the Pennsylvania General Assembly may be done with the liability crisis,” read a typical report. Assembly leaders concurred: then-House Majority Leader John Perzel commented that “the legislature has already gone great lengths to cure what ails the malpractice system.”³² In this instance, however—much as in the aftermath of Act 111 in 1975—Pennsylvania’s officials waited only weeks before returning to the subject.

2002 Changes Continued: Joint & Several Liability, Venue Shopping

Two additional measures that were debated during the run-up to MCARE, but proved too divisive to win inclusion in that compromise legislation, won approval in June and October 2002. The first, a “Fair Share Act” (Act 57) that was passed over the bitter opposition of the trial bar, changed joint and several liability. Previously, any defendant found negligent in a malpractice case could be held responsible for all of the plaintiff’s financial loss even if others had been negligent as well. Negotiations in Harrisburg revolved around how much of an injury a negligent defendant must cause to be held liable for the remainder as well. A “fair share” of 60% was eventually adopted – “effectively 100%” in the disgruntled judgment of the attorneys’ lobbyist.³³ As a result, a defendant less than 60% responsible for a patient’s harm is liable for only a proportionate share of the damages awarded. In 2005, however, the Fair Share Act was ruled unconstitutional by the

³² Goldstein 2002; Kenny 2002. Perzel was an active supporter of damage caps in subsequent House malpractice debates.

³³ Personal interview with Mark Phenicie of Pennsylvania Trial Lawyers’ Association, March 20, 2003.

Commonwealth Court because it violated the state constitutional requirement that each bill address a single subject (it had been appended to a bill governing DNA testing).³⁴

A third major 2002 malpractice law concerned another controversial issue in the Act 13 debates: “venue shopping.” Providers in Pennsylvania had long complained that malpractice plaintiffs’ attorneys sought the most favorable jurisdiction to try their cases—usually Philadelphia, which typically generated the state’s highest payouts as well as rates of successful claims. Then-CAT Fund director John Reed said in 2001 that “physicians in counties surrounding Philadelphia are apparently being sued in Philadelphia courts in increasing numbers because of the ease with which plaintiff attorneys can shift trial venues.”³⁵ Stakeholders in the MCARE debate were unable to reach agreement on reforming venue rules, and established an “Interbranch Commission on Venue” to study the problem—a commission including members of the judiciary. The Commission’s recommendation that malpractice cases be filed only in the county where an injury occurred passed the legislature in October as Act 127 of 2002, and was upheld by the Pennsylvania Supreme Court, which had already adopted similar procedural rules.³⁶

An Issue Regime Snaps Into Focus

By autumn 2002, therefore, Pennsylvania had enacted three important malpractice reforms in swift response to alarms raised by the state’s medical society and its thousands of physician members. Apart from the MCARE Act’s patient safety features, these reforms were primarily first-generation proposals aired, in Pennsylvania and other states, three

³⁴ *DeWeese v. Weaver*, No. 567 M.D. 2002.

³⁵ Brophy 2002, 1.

³⁶ For a detailed discussion, see Rogoff and Ahonkhai 2003.

decades before. Despite public sniping, PMS and PaTLA lobbyists, along with hospital/health system and insurance representatives, met privately with Assembly leaders on several occasions to seek legislative compromises on malpractice, ultimately hammering out the details of Act 13. The result of this whirlwind of legislation, however, was not a pause, self-congratulatory or otherwise. Instead, politicians and stakeholders continued to press for further reform, centered around a damage caps proposal opposed by the state's governor.

All these features—and most of the main players—were present in the 1970s crisis. This consistency in political style and outcome is matched in rhetoric. Physicians and insurers continue to insist that malpractice crises are caused by lawyers' over-eagerness to file suits, and call primarily for changes to the legal system. Attorneys continue to respond in terms like those of one Pennsylvania trial lawyer: "Doctors' premiums are rising because of the amount of malpractice committed by doctors, the refusal of the medical community to police itself, and poorly managed insurance companies."³⁷ Although the medical community interpreted the IOM report and ensuing patient-safety movement as supporting tort reform because physicians could then be more openly self-critical, patient safety mainly provided arguments to the trial bar. After 1999, malpractice lawyers' standard message was as follows: "If you want to address the medical malpractice crisis in this country, do something about the medical errors. That's the real problem."³⁸

³⁷ Smerconish 2002.

³⁸ ATLA president Todd A. Smith quoted in Lohr 2005, 8.

The Governor-Elect Tackles Malpractice

Governor Schweiker chose not to stand for re-election in 2002, leaving an open race between popular former Philadelphia mayor Edward Rendell, a Democrat, and Republican state attorney general Mike Fisher. Medical malpractice reform was an important issue; one insider's assessment confirms that "during the [gubernatorial] campaign, everywhere Rendell went he ran into complaints about how horrible Act 13 was, and how the legislation hadn't done anything, and so on."³⁹

Political pressures around malpractice continued to mount after election day, swamping assurances that the MCARE Act and subsequent reforms would provide sufficient assistance. Large premium increases by the state's remaining private malpractice insurers were expected for 2003 policy renewals. Moreover, providers were also scheduled to pay assessments at the beginning of the year to the newly-renamed MCARE Fund, the state-manded second tier of malpractice insurance. An estimated 60% of the state's physicians faced major increases in both private and public payments.⁴⁰

Governor-elect Rendell convened a task force on medical liability within days of his election and, in late December, announced a complete MCARE Fund abatement for the four hardest-hit medical specialties and a 50% abatement for other Commonwealth physicians. Both reductions would be effective through 2005. Upon assuming the governorship, Rendell created a cabinet-level Office of Healthcare Reform designed to rationalize health policymaking, which signaled the importance of health issues, especially malpractice, to his

³⁹ Redmond interview, *op. cit.* See also O'Toole 2002.

⁴⁰ Task force report, p. 6.

administration. Soon thereafter, the report of his task force was released, raising the political ante on malpractice reform.

Task Force Report and Results

The Governor's medical liability task force was chaired by two well-respected professionals: former Judge and current Villanova Law Professor Abraham Gafni, and law-firm executive director Susan Schulman. Originally envisioned as a small group representing principal malpractice stakeholders, the task force swelled to 30 members and five "legislative representatives," all top Assembly and Senate staffers. Four months' intensive work yielded a substantial report, including 38 recommendations divided among the three broad areas at issue in malpractice debates (not coincidentally, those covered in Act 13): patient safety, insurance, and tort reform/dispute resolution. A number of "areas for further study" were also listed, including some of the most controversial reform proposals, especially non-economic damage caps.

On June 9, 2003, nine weeks after the task force issued its report, the Governor announced a new round of malpractice reforms, including about half of those recommended by the task force. A number of additional items were also included—some potentially quite expensive. For example, Rendell proposed to increase state payments to obstetricians and hospital trauma centers, limit attorneys' contingency fees, and grant judges new powers to reduce malpractice jury verdicts.

Rendell's reforms were taken up piecemeal by the General Assembly. A few were passed swiftly, such as reauthorization of the state's Health Care Cost Containment Council (PHC4) with expanded ability to collect patient-safety data. Others bogged down in

legislative jockeying, such as modest expansions of the state Insurance Commissioner’s authority over malpractice rate regulation. The Pennsylvania Supreme Court also undertook expanded data-collection efforts, and presented an implementation plan for voluntary medical malpractice mediation (as originally proposed years earlier, in Act 135). The Supreme Court also approved a proposed “certificate of merit” rule requiring higher standards of medical screening before a malpractice lawsuit could be filed. Most significant in terms of financial relief, the General Assembly passed the MCARE abatement late in 2003, funded by a 25 cent per pack tax on cigarette sales.

The Governor’s proposals were duly reported by the media, but most stories led with a feature not included: a cap on non-economic damage awards. A typical headline, from the *Allentown Morning Call*: “Malpractice Plan Has No Awards Cap.”⁴¹ For by summer 2003, caps had become the central focus of Pennsylvania’s continuing legislative debate on medical liability reform.

Damage Caps: Heart of the Debate, 2003-05

At a public press conference accompanying the signing of the new joint and several liability law in 2002, the state Senate Majority Whip, Jeffrey Piccola (R-Dauphin), declared that “we’re not done” with malpractice reform. Soon thereafter, legislation was introduced in both chambers of the state legislature to cap non-economic damages in malpractice cases at MICRA’s \$250,000 level, and the largest political battle of the contemporary malpractice crisis was joined.

⁴¹ Micek and Wlazelek 2003.

Pennsylvania’s effort to cap damages is complicated by the requirement that any such reform be achieved via constitutional amendment, a lengthy process. The measure must pass the General Assembly in two consecutive legislative sessions, and then win approval from Pennsylvania’s voters in a statewide referendum. Sen. Jake Corman’s original caps bill, introduced in mid-2001 before the malpractice crisis was fully apparent, attracted only three co-sponsors and relatively little public attention. His 2003 legislation, however, was backed by 15 fellow Senators and was widely covered in the media. In a Pennsylvania malpractice-politics tradition, meetings among the PMS, PaTLA, HAP, and the Insurance Federation—and, this time around, business representatives—were convened during September-November 2003 to seek a compromise on caps.⁴²

No compromise emerged. Governor Rendell publicly opposed damage caps, and continued to press other ways to improve medical liability. During his Medical Malpractice Task Force’s initial meetings, one subcommittee reportedly recommended caps on non-economic damages.⁴³ However, Rendell had already insisted that only reforms winning widespread consensus on the task force would be promoted, effectively sidestepping the issue. The governor lacks the power to veto an Assembly vote to place caps—or any other constitutional amendment—on the ballot, limiting his direct influence on the debate over caps.

In March 2004, however, the Governor lamented “unfortunately, the issue of capping damage awards is being seen as the only reform issue for many people,” and

⁴² Personal interviews with Roger Mecum of the PMS, July 9, 2004; Jim Redmond of the HAP, *op. cit.*

⁴³ See Piccola 2004.

proposed a three-part package of alternative policies.⁴⁴ Part one was a renewed call for limits on attorneys' contingency fees, a measure already twice struck down by Pennsylvania's Supreme Court. A second feature required hospitals to set up a voluntary mediation system designed to reduce lawsuits. Rendell's third proposal was to extend the MCARE assessment exemptions, which were scheduled to expire at the end of 2004, through 2007.⁴⁵ These received relatively little public attention; most eyes were fixed squarely on the damage-caps battle.

Explaining the Appeal of Damage Caps

In Pennsylvania as elsewhere, the causes, consequences, and even extent of the malpractice problem remain difficult to specify. Nationally, detailed studies by academics and nonpartisan organizations like the Government Accountability Office (GAO) and Congressional Budget Office (CBO) have been unable to pinpoint the reasons for rising malpractice losses, due to incomplete data and wide variation over time and by state.⁴⁶ Both reports identify, with extensive qualifications, two principal factors behind the premium hikes sparking the current crisis: increased malpractice payouts by insurers, especially in some specialties and geographic locales; and insurance market problems including declining investment income, diminished competition after the default of several malpractice insurers (especially the national carrier St. Paul's), soaring reinsurance costs after September 11, 2001, and depleted loss reserves.

⁴⁴ Bull 2004a, A1.

⁴⁵ Appendix I provides a chart showing the current MCARE assessment-relief policy.

⁴⁶ GAO 2003; Congressional Budget Office 2004.

But little nuance marks most advocates' positions. In one representative comment, Senate Majority Whip Piccola declared "The fight we face is clear – the personal injury attorneys are waging a tremendous battle to thwart reform. I am honored to stand with Pennsylvania physicians and hospitals to fight against them to 'save Pennsylvania medicine.'"⁴⁷ Piccola's preferred legislative solution to the dangers facing "Pennsylvania medicine," one that by 2002 had come to be shared by most of the Commonwealth's physicians and hospitals, was to cap non-economic damages, which he termed "the cornerstone of reform."⁴⁸ During 2002 and early 2003, over 160 Pennsylvania providers' organizations signed a "unity pledge," organized by the PMS, calling for "immediate" relief in the form of a \$250,000 cap on non-economic damages along with limits on attorney contingency fees.⁴⁹ Pennsylvania was one of 44 states to debate bills between 2002 and 2004 either to cap non-economic damages for the first time or to lower existing ceilings, usually aiming at MICRA's \$250,000 level.

Why so much attention in so many states to a single solution, especially when damage caps' benefits remain widely questioned? Within Pennsylvania, voices other than the trial bar's have been raised about the inefficacy of damage caps in reducing liability premium costs. In early 2002, for example, then-CAT Fund director John Reed warned that "even with the adoption of tort reform, the insurance availability and affordability problems being faced by medical professionals today in the commercial marketplace will not be

⁴⁷ Piccola 2003, p. 3.

⁴⁸ Piccola's views are set out at length in his contribution to "Issues PA," a Pennsylvania Economy League forum, to discuss "policy solutions to the medical malpractice crisis. At www.issuespa.net/viewpoints/6371/ (last accessed July 30, 2004).

⁴⁹ Personal interview with Roger Mecum, *op. cit.*; pledge posted at <http://www.pamedsoc.org/> (accessed May 4, 2003).

corrected in the near future.” Reed further declared that “[w]hat now seems to be a looming crisis can be averted,” and described a specific set of options to “immediately reduce malpractice premiums.”⁵⁰ Many health-policy analysts question the effect and benefits of damage caps on premium rates. There is no guarantee, skeptics note, that insurers will reduce premiums in response to a damage cap; of the 18 states besides Pennsylvania reported by the AMA as facing a full-blown malpractice liability crisis in 2003, seven—or just under 40%—featured statutory caps on non-economic damages. Damage caps also have little logical connection to other goals, such as reducing injuries to patients or providing fair compensation for medical errors. But advocates’ impassioned defense of caps, especially after the round of legislative changes in 2002, overrode most such objections.

Silver Bullet. Damage caps have been described, in political debates inside Pennsylvania and beyond, as the way to swiftly reduce liability premium rates; improve the “broken” malpractice system; and solve the larger dilemma of mounting health-care costs, as both President Bushes (among others) have repeatedly asserted. The latter two claims are exaggerated at best, and very likely wrong. The most plausible rationale for damage caps is their demonstrated, if limited, efficacy in slowing or halting malpractice premium increases. Duelling sides in the debate point to preferred sources of “evidence” concerning damage caps’ efficacy. Two of the most thorough reports to treat the issue are the RAND study of MICRA’s effects in California and a detailed analysis of caps conducted in 2003 by the

⁵⁰ Internal memorandum of February 28, 2002, introduced as testimony before the Pennsylvania House Insurance Committee, August 20, 2002. Reed’s proposed fixes included restoration of pre-Act 135 primary premium limits, and alterations in CAT Fund financing and operations.

independent insurance analysts Weiss Ratings Co.⁵¹ Neither was able to conclude that caps had a beneficial long-range impact on reducing malpractice premium levels. Some estimates suggest that caps may have the additional economic benefit of reducing expenditures for “defensive medicine” (unnecessary practices resulting from providers’ fear of liability exposure).⁵² But these benefits typically take years to be realized. California, the star exhibit in caps advocates’ accounts, saw liability premium levels stabilize in 1989, 14 years after MICRA’s passage (and, as noted earlier, following major insurance regulatory reform the year before, muddying the causal case for caps’ efficacy). Yet damage caps are routinely advertised as a short-term solution to the liability crisis.

Breaking the Logjam. Damage caps have been promoted in Commonwealth political debates (and, again, in almost every other state) for three decades. An informal rule of politics suggests that accusations of “gridlock” can be a powerful impetus to action, as constituents press their elected and interest group representatives for a long-promised reform. Here again the politics of perception become vital: in a longstanding American tradition of pragmatism, action for its own sake can be very appealing politically. Think Franklin Roosevelt’s “do something!” justification for the New Deal.

Presidential Prerogative. A further reason for damage caps’ widespread appeal was the tone set in Washington, D.C. President Bush made statutory caps on non-economic damage awards a high priority early in 2002, and announced his position in a speech in Pennsylvania. Caps became the central focus of Washington debate on malpractice reform in the wake of Bush’s address, marking national officials’ most intense and sustained

⁵¹ See Rand 2004; Weiss Ratings 2003.

⁵² Thorpe 2004, W4-26; Kessler and McClellan 1996.

involvement in malpractice debates since the issue’s initial emergence as a political matter in the late 1960s and helping to fuel support in Pennsylvania and elsewhere.

Pennsylvania’s political response to the malpractice crisis was in important part home-grown, with physicians and other providers reacting ardently to spiralling medical malpractice insurance rates. But links to national organizations and advocates intensified the Commonwealth debate. *Washington Monthly* magazine reported in October 2003 that “doctors in Scranton, Pa. [recently] sat down to talk strategy with Frank Galitski, the former Bush campaign worker—who admits that ‘there is some coordination’ between the doctors’ protests and the White House.”⁵³ PMS officers worked with national AMA officials, much as Pennsylvania’s trial bar leadership exchanged ideas and information with the Association of Trial Lawyers of America.

Business Involvement. Galitski’s acknowledgement points to a novel feature of present malpractice politics, one evident in Pennsylvania. Tort reform advocates from the business community are more actively lobbying on malpractice issues. In Pennsylvania, the SMC Business Councils, which counts more than 5,000 small businesses in southwestern Pennsylvania as members, listed malpractice tort reform “as one of its top three issues when lobbying legislators.” This priority was shared by Chamber of Commerce chapters around the state, including in Philadelphia and Pittsburgh. The reason these newer players promote damage caps? SMC president Cliff Shannon cites “health care affordability” concerns, and notes further that damage caps “help advance the overall process of tort reform.”⁵⁴ A similar judgment also inspired the American Tort Reform Association, a lobbying group

⁵³ Mencimer 2003, 24.

⁵⁴ Guadagnino 2003.

representing more than 300 corporations and trade/professional associations, to organize efforts in the state during the present crisis.

These novel entrants into Pennsylvania’s malpractice debate mirror a national attempt to connect damage caps and related malpractice measures to a broader tort reform agenda. The Chamber of Commerce and its Institute for Legal Reform outspent all other groups (in all sectors, not just health care) nationally in 2004 and again during the first six months of 2005, together devoting nearly \$15 million during the latter period to enact national and state tort reform legislation—including damage caps in malpractice cases.⁵⁵

Successfully Framing the Debate

Public opinion analyses indicate that the battle over causes of the liability crisis and preferred solutions was at least initially ‘won’ by physicians and their allies. Polling by Gallup, Harris, and other national organizations demonstrated strong popular support for damage caps after 2001, and revealed that much of the American public viewed physicians as victimized by a deeply flawed medical liability system. In Pennsylvania, where reliable polling data is harder to come by, a nonpartisan poll found in August 2004 that 68% of the public supported changing the state’s constitution to cap non-economic damages, while only 24% were opposed. A Mansfield University survey, performed in March 2003, found 53% in favor of a \$250,000 cap on damages, and 25% opposed. On the ‘framing’ question of responsibility for the malpractice insurance crisis, lawyers were blamed by 36% of respondents, “multiple parties” by 31%, insurance companies by 13%, and doctors by just

⁵⁵ Spending figures from www.fecinfo.com, which monitors all lobbyist registrations, FEC filings, and related sources. On tort reform more broadly, see Zeller and Serafini 2002.

under 8%. In a summer 2002 survey, 57% of Pennsylvanians reported seeing “some form of advertising about malpractice,” with most respondents recalling providers’ claim that insurance rates were “out of control.”⁵⁶

Further evidence of damage caps’ centrality to the Pennsylvania debate can be found in newspaper coverage of malpractice issues between January 2000 and June 2005. Table 4 reports the results of a content analysis of newspapers across the state. The prominence of damage caps as opposed to second-generation reforms is plain. During the years indicated, all articles on malpractice policy (of more than two paragraphs in length) that ran in the newspapers listed were collected and analyzed.⁵⁷ The proportion of those articles mentioning damage caps at least once is reported in column 2; column 3 reports the proportion of articles mentioning any “second-generation” reform.

Table 4. Mentions of Damage Caps and Other Reforms, Selected Pennsylvania Newspapers, 2000-2005

Year: # Stories	Proportion Mentioning Caps	Propn. Mentioning Any 2nd-Generation Reform
2000: 31	32%	24%
2001: 78	52%	27%
2002: 214	83%	33%
2003: 306	88%	18%
2004: 230	81%	12%
2005 (to July 1): 92	85%	15%

⁵⁶ IssuesPA (Pew Trust) poll, released Sept. 8, 2004; Mansfield University results in Wenner 2003; see also Princeton Survey Research Associates 2002. National poll results are reported in Kersh forthcoming.

⁵⁷ Newspapers surveyed were: Allentown *Morning Call*; Erie *Times-News*; Harrisburg *Patriot-News*; Jenkintown *Times Chronicle*; Philadelphia *Inquirer*; Philadelphia *Daily News*; Pittsburgh *Post-Gazette*; and Scranton *Times-Tribune*.

The success of the AMA and allied medical societies like the PMS in framing the issue is attributable in significant part to an intensive public lobbying campaign. Arguments and tactics advanced in state after state during the present crisis echo malpractice debates from 30 years before. Individual physicians and other providers engaged in work stoppages and large-scale protests at state capitals. Some 20,000 New Jersey doctors staged a work slowdown for over a week in February 2003. A Maryland physicians' protest in 2004 helped push the state's governor to call a special legislative session on malpractice reform. Other AMA-coordinated techniques included political messages on liability reform mailed along with patient bills, mass e-mail campaigns from patients and doctors to public officials, media buys of print and television ads (and, in some places, a 30-minute 'infomercial' deploring rising premiums and touting damage caps in response). As in any successful public-health framing campaign, "crisis" rhetoric abounds. In June 2002, the AMA warned that 12 states were experiencing a full-fledged malpractice crisis and another 30 faced "severe problems" with premiums; in subsequent months the number of crisis states was revised upward to 19 and then 21. Major media outlets reinforced these reports: *U.S. News*, to take one example, profiled "Healthcare's 'Perfect Storm'" in a July 2002 piece that blamed "skyrocketing premiums" on "the increasing number of personal injury lawsuits—and high-priced damage awards." (A year later, the magazine drew a very different conclusion: that the "dramatic crisis" had been overstated, and that "it's not clear that juries

or the courts are the culprits...left out of [doctors and insurers'] argument is recognition that ordinary market forces may be at work instead.”⁵⁸

Many of these political framing techniques were present in the Pennsylvania malpractice debates. Commonwealth doctors staged walkouts at various state locales, including a thousands-strong “Code Blue Emergency” march on the Capitol in Harrisburg on May 6, 2003, to demand immediate relief including “legislation that would cap jury awards for medical malpractice.”⁵⁹ The state’s Medical Society, especially through its grassroots lobbying arm, helped organize many of the actions. One innovation was a list of “disappearing doctors”; i.e., those leaving the state since 2001. While widely reported, the list’s utility was diminished somewhat by reports that several of the named physicians were deceased or had already retired, and that others had never left the state.⁶⁰

With opinion polls generally favoring physician and insurer viewpoints, trial lawyers were less inclined to appeal to the general public. Instead, PaTLA targeted legislators directly. One campaign was cited by several Assembly staff members as particularly effective: weekly mailings by the Trial Lawyers Association to all state lawmakers, each featuring a different medical malpractice victim. In one observer’s assessment, “the lobbying campaign seeks to put a human face on the types of people who trial lawyers say would be harmed if Pennsylvania caps awards on damages.”⁶¹

⁵⁸ American Medical Association, “Medical Liability Reform” (self-published reports; June 2002, March 2003, November 2003). Marcus 2002, 39; Schmitt 2003, 24.

⁵⁹ Worden 2003.

⁶⁰ Hinkelman 2003; Guadagnino 2004; Bull 2004b. A detailed account of the departing-doctors debate, including summaries of several Pew Medical Liability Project reports on the subject, is in Reisman 2005.

⁶¹ Goldstein 2003.

Outcome of the Caps Wars

Successfully framing an issue, by achieving widespread acceptance for a preferred solution and minimizing the appeal of other proposals, is only part of a victorious policy campaign. Steering a desired measure to legislative enactment—in this case, limits on noneconomic damage awards—involves another set of daunting obstacles. As of this writing in 2005, those barriers remained too forbidding to overcome for Pennsylvania’s supporters of damage caps.

The first round of caps battles, in the Pennsylvania House, resulted in a broad-gauged bill to approve a constitutional referendum to limit noneconomic damages in all civil cases, including product liability and other subjects along with medical malpractice. This measure, House Bill 2722, was backed by a coalition of medical professionals and business groups—the latter, as noted above, less interested in malpractice damage caps than in wider liability restrictions. H.B. 2722 passed in June 2003 by a comfortable margin. After months of jockeying and debate, the Senate in March 2004 brought a similar caps provision to the floor (Senate Bill 9, sponsored by Republican Sen. James Rhoades). Rhoades’s proposal initially failed on a procedural vote that appeared to doom the legislation. In a dramatic move well after midnight, however, the Senate’s two principal champions of damage caps, Sens. Piccola and Corman, agreed to support a narrower measure capping only medical malpractice awards, which then won Senate approval by a 30-20 margin.

Because the House and Senate bills differed, one version had to gain majority approval in both chambers during 2004 in order to place malpractice reform (and/or broader tort reform) on the ballot as a public referendum in 2005. With the Independence Day

weekend (and summer recess) looming, the Senate's Judiciary Committee tabled the House version in the early hours of July 2, dooming broader liability reform. This left the House to act on S.B. 9, the malpractice-only measure passed by the Senate in March. House Judiciary Chair O'Brien refused to consider a vote on S.B. 9. When a discharge resolution seeking to force a full House vote on the measure failed, 107-93, on the afternoon of July 2, with twenty Republican members joining all but five Democrats in opposition, malpractice damage caps were dead.

Thus far in 2005, though caps legislation has been introduced in each chamber, prospects for passage are unlikely. Malpractice reform appears to be farther down the state's policy agenda than in any year since the crisis began in 2001. The main action during summer and early autumn 2005 concerned House legislation (H.B. 501) to remove the mandatory liability insurance requirement for physicians. This relative calm, after three years of raging political storms, contributes to an impression that the malpractice crisis is abating.

Assessing Results to Date

Any political campaign, whether for elected office or around a high-profile policy issue, involves winners and losers. Results are easier to analyze in contests for office: except in rare cases, like Bush-Gore 2000, election day tells a clear tale. In policy debates, more subtle gradations of success are the rule; surviving to fight another day can sometimes be a landmark achievement. How did the leading stakeholders in Pennsylvania's malpractice-politics debate fare during the current crisis?

Physicians/providers: These stakeholders may be beginning to realize benefits from malpractice reform, including the MCARE Act. Malpractice payouts and cases filed appear to be declining, as are the rates of premium increases. This is positive news for the Pennsylvania Medical Society, Hospital Association of Pennsylvania, and other provider representatives—but that success is tempered by the failure of the damage-caps legislation they pursued so energetically. Moreover, some political observers believe that physicians’ representatives pushed damage caps so strenuously that many doctors objected to any lesser legislative change, reflecting expectations boosted to unreasonable levels. Such views were voiced in 2002, when an initial version of the MCARE compromise was scuttled by the PMS. Lawmakers of both parties, including then majority and minority leaders of the state Senate, complained that “the doctors walked away from a tremendous deal in the Pennsylvania Senate.”⁶² Similar concerns were voiced in the 1970s malpractice crisis, when one state legislator lamented that “PMS oversold [damage caps] to their members....Now the Society’s leadership is ready to compromise, but the doctors back home will take [caps] and nothing else.”⁶³

Patients: Patient-safety advocates in Pennsylvania, such as the Pennsylvania Patient Safety Collaborative and the Committee for Justice for All, pressed for reforms in MCARE—and these have yielded some positive developments for patients. Technical advances in patient safety have been slight. By most measures, medical error rates in or

⁶² Minority Leader Mellow quoted in Goldstein and Wiggins 2002; several personal interviewees in offered similar views unprompted.

⁶³ Quoted in “House Refuses to Debate Medical Malpractice Bill,” Valley Independent, July 19, 1975.

outside Pennsylvania remain little improved since the IOM report was issued in 1999.⁶⁴ Other patient care benefits, such as frank, open discussions of errors between providers and patients, as well as consistent, swift compensation for medical injuries, are potential outgrowths of legislation such as the MCARE Act, but require additional broad-gauged changes to the malpractice system. Legislative mandates that reduce medical errors and the complexity and time involved in liability lawsuits seem unlikely so long as the system of medical justice remains an adversarial one.

Malpractice trial lawyers: Pennsylvania's trial bar lost on the venue issue, as well as on joint and several liability – at least until changes to the latter were struck down by the courts. PaTLA successfully thwarted a damage caps amendment, though at considerable financial cost. It is difficult to point to concrete political gains for malpractice lawyers in the current debate, but the continued absence of damage caps (and of broader tort liability reform) counts as a meaningful victory.

Malpractice insurers: Although sometimes excluded from the deliberations of the Governor's task force, this set of stakeholders has been politically successful by most measures of legislative activity and lobbying. No additional regulations on insurers were even seriously discussed during the present crisis. Governor Rendell's original proposal for MCARE Fund assessment relief covered the estimated \$220 million cost by tapping surplus funds of health insurance companies in the state, and alarmed both Commonwealth insurers and national companies "worri[ed] that Pennsylvania's novel idea could catch on."⁶⁵ In a major victory for insurance companies, this plan was abandoned and other funding sources

⁶⁴ Leape and Berwick 2005.

⁶⁵ Wysocki 2003.

were found. Insurers, of course, took a hard economic hit in 2001 and afterwards, but the political results of the current malpractice debates must be judged very favorably.

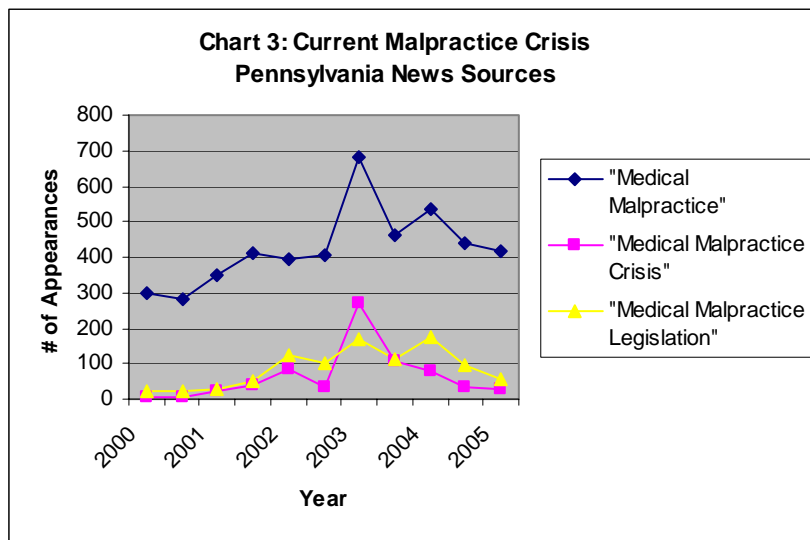
Tort reform groups: Businesses and allied groups were deeply disappointed by the last-minute defeat of wider tort reform legislation in the dramatic March 2004 Pennsylvania Senate session. A national tort reform bill curtailing class-action lawsuits passed Congress in 2005, possibly reducing these groups' inclination to press for additional advantage on the more closely contested terrain of individual injury claims. It is therefore unclear whether the political coalition of providers' representatives, business groups, and other tort reformers active in Pennsylvania after 2003 will play a major role in future malpractice debates.⁶⁶

Malpractice Today: A Crisis in Decline

Though no one has declared the four-year crisis period finished, signs of its alleviation were apparent by late 2004 or 2005. Cyclical trends in media coverage of malpractice politics during the present debate also resemble prior "crisis" periods. Chart 3 displays the rise and fall since 2000 of newspaper stories covering "medical malpractice" (top line, dark blue, diamond symbols on line), "medical malpractice crisis" (middle line, pink, square symbols), and "medical malpractice legislation" (bottom line, yellow, triangle symbols).⁶⁷ By mid-2005, as in 1977 and 1987, media attention had turned to other urgent issues, and legislative pressure for a solution had declined as well.

⁶⁶ On the insurance industry more generally, including political aims and strategies, see Robinson 2004.

⁶⁷ The much higher number of appearances in the left-hand column reflects advanced technology: Nexis allows a count of all major Pennsylvania newspapers, while the chart for the 1980s crisis was based on an issue-by-issue search of four representative papers.



In 2001 and 2002, the loudest alarms were sounded by liability insurance companies leaving the market, leading to sharp increases in premiums among remaining insurers. In recent months, a number of start-up companies have begun writing malpractice liability policies, prompting industry analysts to cautiously predict “significant” downward pressure on premium rates in many states. After Nevada and West Virginia – states also plausibly emerging from crises – Pennsylvania enjoys the nation’s third highest proportion of start-up companies as a percentage of private malpractice insurers, with 31.9% of the Commonwealth’s malpractice insurance market held by new insurers as of January 2005.

Expanded insurance availability typically leads to a reduction in premium increases, and possibly even to lower premiums overall.⁶⁸ Pennsylvania’s malpractice premiums remain at unprecedented heights in some specialties, but the rate of increase in 2004 was

⁶⁸ Gale Group 2005.

much slower than in previous years, according to initial estimates.⁶⁹ Reports of declining malpractice payouts since 2003 also fuel hope that the worst is over, as does as a reduction in the number of cases filed in 2004 recorded in an annual survey by insurance-risk analysts.⁷⁰

Finally, though underlying economic pressures may remain, a “crisis,” with its connotations of immediate urgency, cannot continue indefinitely. As indicated in Chart 3, political attention was turning to other concerns by late 2004. The easing of the medical liability system’s most urgent problem – insurance affordability – is welcome news. But as the issue disappears from legislative agendas in Harrisburg and other state capitals, many observers fear a continuation of the status quo: a malpractice system that serves neither patients nor health care providers well.

III. Conclusion and Recommendations

Medical malpractice reform in Pennsylvania has become an “issue regime.” From stakeholders like the PMS, PaTLA, and HAP advancing well-honed arguments to legislators pushing for reforms in the immediate aftermath of a comprehensive act, Pennsylvania’s malpractice politics in 2002-05 looked surprisingly similar to that of 1975-79. To this characteristic of an issue regime, add the fact that novel entrants into the Commonwealth’s malpractice politics – patient-safety advocates aroused by the IOM report and tort reformers

⁶⁹ Aon Corp. and American Society of Healthcare Risk Managers 2005.

⁷⁰ Law & Health Weekly 2004; AOPC 2004; Aon Corp. and American Society of Healthcare Risk Managers 2005. (The Aon/ASHRM study has been conducted each year since 1995; 2004 marked the first report of a year-to-year decline in frequency of malpractice cases.)

attracted to malpractice politics as a vehicle for their broader agenda – were absorbed fairly easily into existing debates.

Understanding malpractice politics as an issue regime helps explain one of the enduring puzzles surrounding the issue: why second or third-generation reforms, widely promoted by outside experts, gain so little purchase in Pennsylvania debates. Attempting change outside the boundaries of an established issue regime is difficult at any time; as that regime calcifies over time, novel reforms become even harder to advance. How might Pennsylvania escape existing issue regime strictures and approach malpractice in a different way?

Political innovation within a durable institutional order generally arises in response to “exogenous shocks”: crises, emergencies, or other outside forces that shake up routine ways of doing business politically. Pennsylvania’s malpractice politics over the past 30 years represents an exception to this rule, as the malpractice issue regime formed in response to successive systemic shocks. Thus, paradoxically, the diminishing crisis at present could represent a real opportunity for change. Because the political system is geared to respond to crises, reduced alarmist rhetoric provides a climate favorable to comprehensive reform, at least in clearly circumscribed, experimental settings. A wide range of substantive proposals for overhauling the Commonwealth’s malpractice system has been floated in recent years, including several by Pew Project on Medical Liability analysts. Second- and third-generation proposals linked to patient safety improvement, such as no-trial compensation, enterprise liability, medical courts, and/or early mediation, hold promise

of achieving the widely shared goals of reducing protracted, adversarial litigation and creating a faster, fairer, more predictable system of helping injured patients.

One advocate for such reforms, who helped prepare an Institute of Medicine report on the subject for former Health & Human Service Secretary Tommy Thompson, explains:

Because the risk associated with the unpredictable outcome of a lengthy suit would disappear, plaintiffs' attorneys would no longer have a claim to a high-percentage contingency fee. For many avoidable medical errors, compensation would be automatic based on the nature of the injury. In this new environment, with more assured compensation...limits might be fairly placed on the damage awards. Importantly, [health courts] would substitute the standard of 'avoidability' for the current one of 'negligence' in assigning liability for errors....Although avoidable occurrences represent a broader set of cases than those deemed negligent, judging cases would be much easier because it would not require determining whether a particular standard of care had been breached....Perhaps most important, errors would no longer be kept hidden [by physicians fearing a liability suit, e.g.], and providers could be held accountable for their performance in protecting patient safety.⁷¹

Translating promising ideas into legislative proposals with a chance of passage is challenging. Four political tactics could help break the malpractice legislative logjam in Pennsylvania.

Think Small. Demonstration projects provide a way to test promising reforms—including clusters of reforms—before committing to a major change that might prove prohibitively expensive or otherwise unworkable. Federal and perhaps state funding to encourage pilot programs has been proposed by analysts including the Institute of Medicine. Such an approach has already yielded some benefits in the realm of patient safety, and would seem a more promising solution to the Commonwealth's malpractice problems than

⁷¹ Berenson 2005; see also Struve 2003, Witman et al. 1996.

another round of bitter political disputes between longstanding combatants in the medical and legal communities.

Refocus Debates. The “malpractice system” comprises three principal parts: the liability insurance market, the legal process of claims filing and dispute resolution, and health care financing and delivery. Pennsylvania’s modern malpractice crises have been triggered by the first of these—the insurance market. Yet the Commonwealth’s legislative debates have primarily been about legal processes, especially damage caps and other tort reforms. As one recent analysis concludes: “attempts to avoid crises in malpractice insurance prices should focus on insurance, not litigation.”⁷² Enterprise liability and other proposals addressing liability insurance markets ought to be central to reform debates. Similarly, the financing and delivery of health care—which directly affects patient safety, physician-patient relationships, and other central features of malpractice—has been largely ignored in malpractice politics, in Pennsylvania as well as nationally. Shifting attention to this aspect through improvements in patient safety and quality of care could open a path to a political breakthrough. Health policy innovations often arise from addressing familiar problems from different angles; malpractice could benefit from such a shift in focus.

Collaborate. One promising feature of Pennsylvania’s malpractice issue regime is the willingness of stakeholders, especially physicians and trial lawyers, to meet privately with legislative experts to hammer out a consensus. This typically occurs in the crucible of a full-blown malpractice crisis, with its attendant partisan rhetoric and posturing. The nationalization of malpractice politics during the present crisis, with Washington leaders and

⁷² Black, Silver, Hyman, and Sage 2005.

tort-reform groups weighing in on Pennsylvania debates, sharpened differences and diminished opportunities to seek consensus. A series of discussions in a less charged atmosphere, away from intensive media coverage and urgent demands for short-term solutions, provides another path towards meaningful reform.

Keep Tabs on the Neighbors. Political science research suggests that one likely driver of policy innovation is regional diffusion, in which a state is influenced by other states' actions, especially those located nearby.⁷³ A number of Pennsylvania's neighboring states have enacted or extensively debated latter-generation reforms like provider apology, mediation and other alternative dispute resolutions, insurance regulation, public access to information about medical professionals (including malpractice judgments), no-trial systems, and so forth. More than 25 different malpractice policy innovations earned widespread discussion (i.e., were considered in at least 7 state legislatures) during the first 9 months of 2005 alone. For example, several states considered programs similar to Virginia and Florida's no-trial systems for compensating birth-related injuries. Twenty states have adopted versions of a program first piloted in Kentucky, featuring doctors' apologies combined with swift compensation offers for medical injuries.⁷⁴ Successful examples like these provide a reform laboratory for Pennsylvania's lawmakers.

Nearly all those engaged in Pennsylvania malpractice politics agree that the time for comprehensive change is now – before a fourth medical malpractice crisis arrives. It is also clear that the present system satisfies almost no one involved in the debate. The boundaries around policy reform erected by an issue regime are only as strong as each generation of

⁷³ Gray 1994.

⁷⁴ Gertner 2005.

decision-makers allows them to be. In a state with an impressive history of health-politics innovation, that tradition deserves revival and embrace.

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