

## **AEGRESCIT MEDENDO: ADDRESSING BARRIERS TO MEDICAL MALPRACTICE LITIGATION FACED BY THE ELDERLY**

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*The elderly are severely disadvantaged in both bringing claims of medical malpractice before the American court system and being successful when they do bring such claims. There are several reasons why the elderly are not bringing their claims forward when they are injured by their health care providers. First, many states have imposed non-economic damage caps, which destroy the financial incentive for the elderly to file. Second, even if the elderly are willing to bring their claims, the cost-benefit analysis plaintiff's attorneys use to screen their cases usually advises against them taking such cases. Finally, a collection of other factors, including physician-patient relationships, lower expectations, difficulties in proving causation, time considerations, and lack of advocacy discourage the elderly from filing medical malpractice claims. To effectively increase the elderly's access to the courts when they are victims of medical malpractice, true reform is necessary and will pursue the following objectives: developing systems to signal to injured elders that a medical error has occurred, increasing incentives for the elderly to bring their claims and for plaintiff's attorneys to accept them, lowering evidentiary standards to account for proximate cause issues associated with the elderly, and promoting efficient processing of claims to shorten elderly claim duration. To best combat the barriers that stand between the elderly and success, Mr. McCarthy proposes a hybrid approach that uses federalism to reform medical malpractice litigation for the elderly. By implementing a no-fault arbitration system patterned after Medicaid that would partner the state and federal levels of government, Mr. McCarthy believes that his hybrid approach will make medical malpractice claims more accessible and more successful for the elderly.*

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## I. Introduction

*"We were with mom for three hours and when we finally got hold of the nurse in charge, she said 'we didn't know that room was occupied!' (Wound dehiscence and septic shock in a 90 year old. She lived with a married daughter for 15 years. She was unable to help around the house because of profound visual problems. 'All she did was keep me company every day and she told me every night that she loved me.')*<sup>1</sup>

*"Mom was 80, but every day she cleaned the house and there was always a hot meal on the table. Every day we spoke by phone. And whenever I needed her on a weekend, I could drop off the kids. I lost my mother, my babysitter, my best friend.' (Death by malpractice)"<sup>2</sup>*

*"Jurors, you have just heard defense counsel in his closing remarks argue to you with reference to Elmer's prior medical history that notwithstanding the negligence of his client, Elmer already had one foot in the grave. After the defense lawyer made those arguments, I turned around and looked at Elmer and he winked at me – with his good eye.' (Blindness in one eye of an 80 year old from malpractice)"<sup>3</sup>*

The preceding quotes were testimony from medical malpractice cases. Everyday courts are presented with sad stories of elderly patients who are injured by their health care providers. The saddest cases, however, are the ones that do not get heard at all.

Public perception of how the elderly typically fare in the American trial system overestimates the success of elders. For instance, the case in which an elderly woman received millions of dollars after spilling scalding hot McDonald's coffee into her lap has become a legend of popular culture.<sup>4</sup> In reality, the elderly are not so fortunate,<sup>5</sup> particularly in the area of medical malpractice.

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1. David S. Shrager, *Proof of Damages on Behalf of the Elderly*, in 1 ASS'N OF TRIAL LAWYERS OF AM. ANNUAL CONVENTION REFERENCE MATERIALS 1051 (2000).

2. *Id.*

3. *Id.*

4. *Liebeck v. McDonald's Rests.*, CV-93-02419, 1995 WL 360309, at \*1 (D.N.M. Aug. 18, 1994). Liebeck, a seventy-nine-year-old resident of Albuquerque, bought coffee from a McDonald's drive through window. When Liebeck went to remove the coffee cup's lid in order to add cream and sugar to the cup positioned between her legs, the 180–190 degree coffee spilled onto her lap and absorbed into her sweatpants, keeping the hot liquid in contact with her body. Liebeck suffered third degree burns, was hospitalized for eight days, and could not continue her job as a sales clerk. It took her two years to recover. When Liebeck brought suit, McDonald's refused a settlement offer of \$10,000—the amount of Liebeck's medical bills. The jury awarded Liebeck \$160,000 in compensatory damages and \$2.7

The elderly are severely disadvantaged when it comes to bringing claims of medical malpractice before the American court system and being successful when they do.<sup>6</sup> These disadvantages include non-economic damage caps, the analysis undertaken by plaintiff's attorneys when deciding whether to accept medical malpractice cases, and barriers faced by the elderly that other segments of the population do not have to confront.<sup>7</sup> Why should we care? The issue is problematic on three different levels.

First, the barriers obviously deny elderly patients redress when injured by their health care providers and can saddle them with a serious financial burden.<sup>8</sup> Medical malpractice lawsuits are needed to provide the elderly with necessary compensation.<sup>9</sup> Sadly, on the occasions when compensation is actually received, it often does not begin to put injured patients in their rightful place.<sup>10</sup>

Second, society as a whole is done a disservice by shutting the elderly out of the courts.<sup>11</sup> Besides diminishing the incentive for doctors and hospitals to avoid mistakes,<sup>12</sup> the system's ability to flag chronic health care problems demanding government intervention and regulation may be compromised.<sup>13</sup> Providers may be aware of an unsafe care condition, but it may take a serious injury followed by a malpractice action to correct the problem.<sup>14</sup> "Malpractice lawsuits improve patient safety by making medical mistakes more visible and by making patient safety a higher priority than it might otherwise be."<sup>15</sup>

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million in punitive damages. DOMINICK VETRI, LAWRENCE C. LEVINE, JOAN E. VOGEL & LUCINDA M. FINLEY, *TORT LAW AND PRACTICE* 20-21 (3d ed. 2006).

5. VETRI ET AL., *supra* note 4, at 21. The astronomical award given to plaintiff Liebeck was reduced by the judge to \$160,000 in compensatory damages and \$480,000 in punitive damages. The case was then appealed, but the parties settled for an undisclosed figure before the appeal was heard. *Id.*

6. See Helen R. Burstin, William G. Johnson, Stuart R. Lipsitz & Troyen A. Brennan, *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 J. AM. MED. ASS'N 1697, 1700 (1993).

7. See *infra* text accompanying notes 49-130.

8. See Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1313 (2004).

9. See TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 110 (2005).

10. See *id.* at 110-11.

11. See Finley, *supra* note 8, at 1313.

12. See BAKER, *supra* note 9, at 99.

13. See Finley, *supra* note 8, at 1313.

14. BAKER, *supra* note 9, at 99.

15. *Id.* at 106. Medical malpractice litigation has prompted health care organizations to establish new risk management departments tasked with promoting patient safety. *Id.* at 106-07. "Risk managers and risk management departments

Finally, a system that excludes the elderly sends an uncomfortable message that does not square with the ideal of equality that is supposed to be the cornerstone of the American civil justice system— “[T]he elderly . . . should not bother to apply.”<sup>16</sup> We depend on medical malpractice litigation to “promote traditional American values like access to justice, personal responsibility, and freedom from intrusive government regulation.”<sup>17</sup>

Very little scholarship and data, especially current data, has been published regarding how the elderly fare in their interactions with the medical malpractice system.<sup>18</sup> New data, however, has aided in filling this scholarship void.

Part II of this Note provides background information discussing data on medical malpractice claims by the elderly.<sup>19</sup> Part III analyzes factors inhibiting the success of medically injured elderly patients in the American civil justice system.<sup>20</sup> Part IV offers a recommendation on how to make the medical malpractice system more accessible to the elderly, namely by implementing a no-fault arbitration system patterned after Medicaid that would partner the state and federal levels of government.<sup>21</sup>

## II. Background

Research shows that the elderly are less likely to sue their physicians for negligently provided medical care.<sup>22</sup> One study conducted by the Office of Technology Assessment found that Medicare patients in Wisconsin made up one-third of hospital admissions, where over eighty percent of medical malpractice injuries occur.<sup>23</sup> Despite consti-

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keep track of patient complaints, manage malpractice claims, provide feedback to senior administrators on unsafe practices revealed by complaints and claims, and serve as a clearinghouse for patient-safety information.” *Id.* at 107.

16. Finley, *supra* note 8, at 1313.

17. BAKER, *supra* note 9, at 114.

18. Myungho Paik, Bernard S. Black, David A. Hyman, William M. Sage & Charles M. Silver, *How Do the Elderly Fare in Medical Malpractice Litigation, Before and After Tort Reform?: Evidence from Texas, 1988–2007* (U. Ill. Law & Econ. Research Paper No. LE09-009, 2010), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1605331](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1605331). Thank you to Professor David Hyman, who generously made this work available to the author before it had been published.

19. See *infra* text accompanying notes 22–42.

20. See *infra* text accompanying notes 43–130.

21. See *infra* text accompanying notes 131–199.

22. OFFICE OF TECH. ASSESSMENT, NTIS ORDER #PB93-176972, DO MEDICAID AND MEDICARE PATIENTS SUE MORE OFTEN THAN OTHER PATIENTS? 13 (1992).

23. *Id.* at 14.

tuting a higher relative proportion of the hospital population, the elderly brought claims at a significantly lower rate than other patients.<sup>24</sup> A 1993 study done by the U.S. General Accounting Office (GAO) concurred; analyzing a nationally representative sample, it found that in 1984, the elderly accounted for one-third of hospital admissions but filed only ten percent of medical malpractice claims.<sup>25</sup>

Moreover, a study analyzing medical malpractice events in Colorado showed that the elderly were the socio-demographic group most likely to fail to bring a claim when they have been injured by medical malpractice.<sup>26</sup> A multivariate analysis, organized by socio-demographic characteristics, was conducted by comparing non-claimants to individuals who did file claims for negligent injury.<sup>27</sup> Those under eighteen and those forty-five to sixty-four years of age had under claiming odds ratios of 1.0 and 1.7, respectively.<sup>28</sup> For those sixty-five to seventy-four, the odds ratio jumped to 2.2.<sup>29</sup> However, the odds ratio for those aged seventy-five and older was significantly higher at 7.0.<sup>30</sup> Medicare beneficiaries as a group had an odds ratio of 3.5.<sup>31</sup>

New research done by Myungho Paik, Bernard S. Black, David A. Hyman, William M. Sage, and Charles M. Silver casts the issue in a slightly different light.<sup>32</sup> Using data from the Texas Closed Claims Database (TCCD), a medical malpractice (“med mal”) dataset was constructed.<sup>33</sup> The data showed that from 1990 to 2003, the number of medical malpractice claims made by the elderly in Texas increased significantly.<sup>34</sup> It should be noted, however, that once Texas imposed

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24. *Id.*

25. U.S. GEN. ACCOUNTING OFFICE, GAO/HRD-93-126, MEDICAL MALPRACTICE: MEDICARE/MEDICAID BENEFICIARIES ACCOUNT FOR A RELATIVELY SMALL PERCENTAGE OF MALPRACTICE LOSSES 8 (1993).

26. David M. Studdert, Troyen A. Brennan & Eric J. Thomas, *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643, 1683 tbl.4 (2000).

27. *Id.* at 1666.

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. See Paik et al., *supra* note 18, at 8.

33. *Id.* at 2-3.

34. *Id.* at 8. The authors were unable to attribute the increase in medical malpractice claims made by the elderly to any one cause. *Id.* at 20. The authors listed several possible explanations, including an increased number of doctors performing risky procedures, greater willingness of the elderly to bring claims, and increased willingness of attorneys to take on the cases. *Id.*

a cap on non-economic damages in 2003, the number of claims made by the elderly began to drop.<sup>35</sup>

The elderly under claim despite the fact that there are special factors, both physical and environmental, exposing the elderly to a higher risk of injury.<sup>36</sup> In fact, a Harvard study showed that patients over sixty-five were twice as likely to sustain an injury resulting from a medical procedure as those in the sixteen to forty-four age group.<sup>37</sup> In the TCCD study, the elderly (those aged sixty-five and over) filed 16.2% of the medical malpractice claims from 1988 to 2007.<sup>38</sup> By comparison, the non-elderly (those aged zero to sixty-four) filed 83.8% of the claims in the same time period.<sup>39</sup> Within the elderly group, claims decreased sharply as the claimants got older.<sup>40</sup> By dividing the percent of claims by the percent of inpatient days, the researchers calculated the claiming propensity for each group.<sup>41</sup> While the non-elderly had a claiming propensity of 1.30, the claiming propensity for the elderly was 0.45.<sup>42</sup>

What causes the elderly, who are more exposed to the health care system, to bring significantly fewer claims than the healthier, younger generations? To account for the discrepancies in claims rates between the elderly and non-elderly, it is necessary to consider factors that discourage the elderly from bringing their claims.

### III. Analysis

Why are the elderly not bringing their claims forward when they are injured by their health care providers? First, many states have

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35. *Id.* at 8.

36. Shrager, *supra* note 1, at Part I. Factors include: (1) being dependent on health care providers and, therefore, possibly implicated in multiple instances of medical malpractice; (2) a special susceptibility to physiologic drug effects ("many are overmedicated and often critical monitoring of blood levels is not maintained at proper intervals"); (3) increased susceptibility to injury due to failing eyesight and hearing or physical infirmities; (4) exposure to negligent care in nursing homes leading to "high infection rates, bedsores, falls, and all sorts of examples of indifferent care, or even abuse." *Id.*

37. Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 NEW ENG. J. MED 370, 372 (1991).

38. Paik et al., *supra* note 18, at 8 tbl.2.

39. *Id.*

40. *Id.* The "Young Elderly" (ages sixty-four to seventy-four) accounted for 9.4% of all claims; the "Moderate Elderly" (ages seventy-five to eighty-four) accounted for 5.1% of all claims; the "Very Elderly" (ages eighty-five and older) accounted for 1.7% of all claims. *Id.*

41. *Id.*

42. *Id.*

imposed non-economic damage caps that destroy the financial incentive for the elderly to file.<sup>43</sup> Second, even if the elderly are willing to bring their claims, the cost-benefit analysis plaintiff's attorneys use to screen their cases usually advises against them taking such cases.<sup>44</sup> Finally, a collection of other factors, including physician-patient relationships, lower expectations, difficulties in proving causation, time considerations, and lack of advocacy, discourage the elderly from filing medical malpractice claims.<sup>45</sup>

#### A. Non-Economic Damage Caps as a Barrier to Medical Malpractice Damages for the Elderly

Think about the different roles this woman performed for her family. She was a babysitter, an advisor and counselor, a cook, a seamstress, a comforter, a discussion partner, a teacher, a domestic, and a lover-of her children and grandchildren, and her special friends. What is the economic value on those services? Is it worth the minimum wage, or is it worth what a doctor would charge for an hour, or what a skilled electrician would charge? These are services that don't work an eight-hour day. She worked in the morning, in the evening, and on the weekends too. Is she entitled to double time?<sup>46</sup>

As the preceding quote illustrates, the legal system does a poor job valuating the contributions the elderly make to their families and society. In fact, state legislation establishing caps on non-economic damages has effectively discredited the contributions of the elderly in the eyes of the courts.

In recent years, as the cost of health care and, in particular, insurance premiums have increased substantially, proponents of medical malpractice reform attribute much of these increases to costly medical malpractice claims.<sup>47</sup> Despite challenges to the validity of these assertions, they persist.<sup>48</sup> A popular reform aimed at lowering and

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43. See *infra* text accompanying notes 47-76.

44. See *infra* text accompanying notes 77-117.

45. See *infra* text accompanying notes 118-130.

46. Shrager, *supra* note 1, at Part V.

47. NICHOLAS M. PACE, DANIELA GOLINELLI & LAURA ZAKARAS, CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: CALIFORNIA JURY VERDICTS UNDER MICRA 5 (2004).

48. BAKER, *supra* note 9, at 3. Scholars like Tom Baker assert that it is not too much medical malpractice litigation that leads to higher costs but rather too much medical malpractice. *Id.* Increases in medical malpractice insurance premiums can be attributed to "financial trends and competitive behavior in the insurance industry, not sudden changes in the litigation environment." *Id.* Baker's rather cynical view is that litigation reform's true function is to "distract attention long enough

controlling costs has been to impose non-economic damage caps on medical malpractice awards.<sup>49</sup> A total of sixteen states, including Texas, Florida, and California, have passed such laws,<sup>50</sup> and Congress has considered imposing a cap nationwide as recently as 2004.<sup>51</sup> Typically, these caps are set at around \$250,000.<sup>52</sup>

Economic damages represent the most basic kind of damages, providing compensation for lost wages, both past and future, and medical expenses related to the injury.<sup>53</sup> In contrast, non-economic damages provide compensation for losses that do not have a clear market value, such as loss of consortium and pain and suffering.<sup>54</sup>

Even for plaintiffs who do not share in the disadvantages elderly plaintiffs endure, non-economic damages are crucial.<sup>55</sup> To start, "people with serious injuries receive far less money than they need even to cover their medical expenses and to replace their lost income."<sup>56</sup> Victorious plaintiffs typically use damages received for pain and suffering to pay their lawyers.<sup>57</sup> The recovery is further diminished after the plaintiff reimburses third-party payers.<sup>58</sup> Whatever is left over can then be used by plaintiffs "to put their lives in order."<sup>59</sup>

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for the inevitable turn in the insurance cycle to take the edge off the doctors' pain." *Id.*

49. Finley, *supra* note 8, at 1263.

50. Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 *ELDER L.J.* 331, 331 (2006); Catherine M. Sharkey, *Caps and the Construction of Damages in Medical Malpractice Cases*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* 154, 158 (William M. Sage & Rogan Kersh eds., 2006). "Since the 1970s, twenty-five states have imposed limits on compensatory damages in medical malpractice awards. An additional ten states have enacted more general limitations to all civil cases, including medical malpractice cases. Of these thirty-five states' caps, twenty-eight remain in effect today." *Id.* at 158.

51. Finley, *supra* note 8, at 1263-64.

52. See Rustad, *supra* note 50, at 331.

53. PACE ET AL., *supra* note 47, at 6-7. Economic damages "[c]ompensate for past or future economic losses such as wage loss, costs of medical care and vocational rehabilitation, property damage, loss of profits, replacement services, attendant care, and other such losses." *Id.* at 7 tbl.1.1.

54. *Id.* at 7. Non-economic damages "[c]ompensate for past or future non-economic losses such as pain, suffering, emotional distress, mental anguish, disfigurement, physical impairment, loss of consortium, loss of companionship, loss of parental guidance, loss of enjoyment of life, loss of society, humiliation, embarrassment, inconvenience, injury to reputation, and other such losses." *Id.* at 7 tbl.1.1.

55. BAKER, *supra* note 9, at 111.

56. *Id.*

57. *Id.*

58. *Id.* at 111-12.

59. *Id.* at 110.



Non-economic damage caps, therefore, have an adverse effect on the ability of the elderly to recover medical malpractice damages in the court system.<sup>60</sup> The elderly are unlikely to have suffered much in terms of economic damages; the elderly are likely to be retired, meaning they do not have much lost wages to recover.<sup>61</sup> “[A]ny income they do generate is less likely to be ‘lost’ because of a decline in physical capacity occasioned by negligent injury.”<sup>62</sup> The GAO study showed that, in 1984, Medicare patients on average had only \$200 in lost income, as compared with an average lost income of \$4700 for other patients.<sup>63</sup> In terms of average estimated future lost earnings, Medicare patients lost an average of only \$300, while other patients had average future losses of \$40,000.<sup>64</sup>

Moreover, the elderly are unlikely to have significant out-of-pocket medical expenses. States who have paid for an injured elderly patient’s health care expenses through their individual Medicaid programs could seek to recoup their losses through indemnification of any civil judgment won by the injured elder.<sup>65</sup> The same is true of the federal government recouping Medicare expenditures.<sup>66</sup> Future medical costs are likely to be small, as the elderly have a lower life expectancy.<sup>67</sup> According to the GAO study, in 1984, elderly patients on average had future medical expenses of about \$2400, whereas other patients had average future medical expenses of \$31,500.<sup>68</sup>

Consequently, the elderly depend on non-economic damages for their medical malpractice claims to have any value. For example, empirical research shows that in nursing home negligence cases, pain and suffering, which falls into the non-economic damage category, ac-

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60. Paik et al., *supra* note 18, at 21. It should be noted that the TCCD study found that there were “comparable declines for the elderly and non-elderly” in payouts as a result of the non-economic damage cap. *Id.* “Thus, it does not appear that the Texas cap on non-economic damages strongly ‘discriminates’ against the elderly.” *Id.*

61. Finley, *supra* note 8, at 1283. Elderly women are even more adversely affected by non-economic damages caps because they “receive a notably larger share of their compensatory damage awards in noneconomic loss categories than elderly men.” *Id.*

62. Studdert et al., *supra* note 26, at 1667.

63. U.S. GEN. ACCOUNTING OFFICE, *supra* note 25, at 14 fig.I.4.

64. *Id.* at 15 fig.I.5.

65. Marshall B. Kapp, *Malpractice Liability in Long-Term Care: A Changing Environment*, 24 CREIGHTON L. REV. 1235, 1239 (1991).

66. BAKER, *supra* note 9, at 110-11.

67. U.S. GEN. ACCOUNTING OFFICE, *supra* note 25, at 15.

68. *Id.* at 15.

counts for eighty percent of an elderly claimant's award.<sup>69</sup> According to the data collected by Paik et al., in non-nursing home Texas medical malpractice cases brought by the elderly, economic damages ultimately accounted for a 37.7% mean per-case ratio, a 24.5% median per-case ratio, and a 35.5% aggregate ratio.<sup>70</sup>

A study done by Lucinda Finley helps to illustrate the effect of the non-economic damage caps on medical malpractice awards received by the elderly. Finley looked at eighteen California cases and found that the average total compensatory award to elderly plaintiffs was \$803,267.<sup>71</sup> On average, this award was made up of \$275,267 in economic damages and \$528,000 in non-economic damages.<sup>72</sup> After adjusting for the effect of California's Medical Injury Compensation Reform Act (MICRA), however, the value of the award plummeted 34.6% to \$525,267.<sup>73</sup> A study analyzing the effects of non-economic damage caps in Florida showed a similar result.<sup>74</sup> The TCCD study showed a drop in claim value of thirty-three percent for elderly Texas claimants after a 2003 non-economic damage cap was imposed.<sup>75</sup>

The net effect of the non-economic damage caps is to make it less likely that the injuries of the elderly will be redressed through the courts. Their claims, with low economic damages but high non-economic damages, lose too much of their value to be worth pursuing.<sup>76</sup> Even if the elderly injured patient is willing to move forward with the claim, he or she still must find an attorney willing to take the case.

#### **B. Plaintiff's Attorneys' Tendency to Refuse Medical Malpractice Cases Brought by the Elderly**

Even assuming that medically injured elders are aware of their injuries and have the desire to bring their claims forward, the unwillingness of plaintiff's attorneys to represent them serves as a significant barrier to the elderly bringing their suits. "Malpractice litigation is rarely initiated without attorney involvement, hence a prospective

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69. Rustad, *supra* note 50, at 345.

70. Paik et al., *supra* note 18, at 12 tbl.4.

71. Finley, *supra* note 8, at 1287 tbl.3.

72. *Id.*

73. *Id.*

74. *Id.* at 1305-06 tbls.21 & 22.

75. Paik et al., *supra* note 18, at 18. The non-elderly experienced a twenty-nine percent drop in payout per claim. *Id.*

76. Finley, *supra* note 8, at 1265.

litigant's ability to claim typically hinges on an attorney's willingness to take a case."<sup>77</sup> Plaintiff's attorneys, regardless of a potential client's age, carefully evaluate whether taking a medical malpractice case is worth their time and effort.<sup>78</sup> An attorney's chances of success, even without the litigation burdens associated with older clients, are not good. A study done by the Insurance Information Institute examining approximately 11,000 medical malpractice trials from 1985 to 1999 found that plaintiffs were victorious only nineteen percent of the time.<sup>79</sup>

With all medical malpractice clients, lawyers are aware of the biases jurors may have against plaintiffs.<sup>80</sup> "[The jurors] have been conditioned to believe that medical negligence plaintiffs bring frivolous claims against heroic physicians who can't be blamed for their inability to save the patient from a disease's inevitable progression."<sup>81</sup> Plaintiff's attorneys are accustomed to these biases and know how to combat them.<sup>82</sup>

The elderly, however, bring an additional set of biases with them into their medical malpractice cases.<sup>83</sup> Jurors may have an ungenerous view of the elderly that may make medical malpractice cases difficult.<sup>84</sup> "People assume that because old people typically don't work, they aren't 'contributing to society,' and their days of achievement are long over. Their lives are spent watching television, waiting for visitors, and perhaps slipping in and out of dementia, awaiting a fast-approaching death."<sup>85</sup> Defense attorneys may even subtly exploit these ageist attitudes.<sup>86</sup> Often, the defense attorney will frame the elderly plaintiff not as an individual, but as part of a larger statistic.<sup>87</sup> Tools like the U.S. Life Tables, which provide death rates using factors like age, race, and sex, may be used by the defense "to lump the plain-

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77. Studdert et al., *supra* note 26, at 1666.

78. David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1102-03 (2006).

79. *Id.* at 1107; PACE ET AL., *supra* note 47, at 19 (giving a similar success rate of 22% for plaintiffs in California).

80. Elizabeth H. Faiella & Peter J. Gulden III, *Battling Ageism in Cancer Negligence Cases*, TRIAL, May 2007, at 20.

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.* at 25.

tiff in with all the others in his or her age group on a statistical table."<sup>88</sup>

Ageism may have a direct impact on any award given to an elderly plaintiff, because life expectancy is an important component in the jury's assessment of economic and non-economic damages.<sup>89</sup> Rather than giving the elderly plaintiff an individualized assessment of how much longer he or she can be expected to live, juries instead rely on their own biases.

Even if a plaintiff's attorney is confident that biases against the elderly plaintiff can be overcome and that the case is strong enough to win, the attorney may still refuse to accept the case, because the expected award would not justify the costs associated with litigation. Plaintiff's attorneys will screen medical malpractice claims brought to them by estimating how much a potential claim is worth and comparing that approximation to how much expense can be expected in litigating the case.<sup>90</sup>

In terms of claim worth, claims brought by the elderly are less lucrative than claims brought by the non-elderly. Data derived from the TCCD show that from 1988 to 2007, medical malpractice cases in Texas resulted in average payouts to elderly claimants that were significantly below the average payouts received by non-elderly claimants.<sup>91</sup> While the non-elderly had a mean payout per claim of \$333,000, the elderly group's figure for that same statistic was only \$190,000.<sup>92</sup> "The elderly account for 10% of population, 25% of hospital discharges, 35% of medical spending, and 36% of inpatient days . . ."<sup>93</sup> The aforementioned GAO report, while older than the TCCD study, has the benefit of being national in scope.<sup>94</sup> From October 1, 1985 to September 30, 1990, the GAO found that the elderly received only ten percent of the total malpractice awards paid by hospitals nationally.<sup>95</sup>

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88. *Id.*

89. *Id.* at 20. "The standard of care is also affected. What is clear medical malpractice in the case of a younger plaintiff is often less clear when the plaintiff is elderly." *Id.*

90. Hyman & Silver, *supra* note 78, at 1120.

91. Paik et al., *supra* note 18, at 8 tbl.2.

92. *Id.* at 8 tbl.2.

93. *Id.* at 7.

94. U.S. GEN. ACCOUNTING OFFICE, *supra* note 25, at 21.

95. *See id.* at 2 fig.1 (calculated ten percent by dividing Medicare losses by total losses from 1986 to 1990).

It should be noted, however, that the TCCD study shows that after 2003, when the non-economic damage cap was instituted, the mean and median payouts for both the elderly and non-elderly dropped, and the gap between the two groups shrunk significantly by 2007.<sup>96</sup> Even prior to 2003, mean and median payouts to elderly claimants were converging toward non-elderly levels.<sup>97</sup> If these trends are accurate,<sup>98</sup> they would only suggest that claims of the elderly are not as unattractive in the eyes of plaintiff's attorneys relative to non-elderly claims as originally thought.

Plaintiff's attorneys also are unlikely to hold out any hope of getting a blockbuster payout with elderly medical malpractice clients. The chances of an elderly claimant getting a huge jury award are much lower than a non-elderly claimant's chances.<sup>99</sup> The TCCD data show that even though elderly claimants account for sixteen percent of all medical malpractice claims, only two of the 200 largest verdicts were awarded to elderly claimants.<sup>100</sup>

Victorious medical malpractice plaintiffs see only a fraction of the damages that juries award them.<sup>101</sup> This is true of both elderly and non-elderly plaintiffs. Jury awards undergo what Professor David Hyman, legal expert in medical malpractice, calls a "haircut."<sup>102</sup> Typically, the bigger the adjusted jury verdict, the greater the percentage never paid to the plaintiff.<sup>103</sup> Insurance policy limits are an important cause of haircuts.<sup>104</sup> Interestingly, plaintiffs rarely go after the personal assets of a defendant if the award is above the defendant's insurance policy limit.<sup>105</sup> Other factors in reducing awards include judicial oversight, death, and punitive damages caps.<sup>106</sup> With less money

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96. Paik et al., *supra* note 18, at 11 fig.4.

97. *Id.* at 20.

98. The researchers warn that their conclusions regarding the effects of the 2003 reforms are tentative, as the effects of the reforms are not fully reflected in their data. *Id.* at 20.

99. *Id.* at 13, 14 fig.4.

100. *Id.* at 13. These two cases preceded the 2003 non-economic damage caps; "[i]f the non-econ cap had applied during our entire sample period, it is possible that none of the top 200 payouts would have gone to elderly claimants." *Id.*

101. David Hyman, Bernard Black, Kathryn Zeiler, Charles Silver & William Sage, *Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988-2003*, 4 J. EMPIRICAL LEGAL STUD. 3, 27, 29 (2007).

102. *Id.* at 29.

103. *Id.* at 32.

104. *Id.* at 46 tbl.14.

105. *Id.* at 39.

106. *Id.* at 34-39.

coming the plaintiff's way, the plaintiff's attorney has less incentive to accept the case.

Many plaintiff's attorneys work on a contingency fee basis, typically taking one-third of the award recovered by the plaintiff.<sup>107</sup> Because the awards received by the elderly are typically less than those given to the non-elderly (although the TCCD study disagrees, at least post-reform),<sup>108</sup> an attorney accepting medical malpractice cases from the elderly is likely to receive a smaller attorney's fee. As discussed previously, the elderly typically get smaller awards than other socio-demographic groups, because they have little in terms of economic damages, meaning that the attorney's fee would necessarily be smaller as a result. Attorneys can maximize their own income by choosing to represent clients with ongoing sources of income.<sup>109</sup> This problem is exacerbated in jurisdictions with non-economic damage caps, which reduce plaintiffs' awards and attorneys' fees even further. David Greco, a plaintiff's attorney in Southfield, Michigan, asserts that the cap is the primary factor in the decision whether to take on a client: "[The cap] has affected the way we initially assess potential claims, you have to look at it differently given the high costs involved in malpractice cases . . . cases we used to take we can no longer because they are just not economically feasible."<sup>110</sup>

As Mr. Greco mentioned, medical malpractice cases are not cheap to litigate, because they require testimony from a medical expert to show that there was a deviation from a standard of care.<sup>111</sup> This requirement imposes a significant expense, a cost the attorney bears if the plaintiff loses.<sup>112</sup> Finding a qualified expert is also costly in terms of the attorney's time; obtaining the testimony of an expert can be very difficult.<sup>113</sup> Attorneys who agree to take on clients with

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107. A contingency fee is "a fee charged for a lawyer's services only if the lawsuit is successful or is favorably settled out of court. • Contingent fees are usu. calculated as a percentage of the client's net recovery." BLACK'S LAW DICTIONARY (8th ed. 2004).

108. See *supra* text accompanying notes 91-98.

109. Studdert et al., *supra* note 26, at 1666-67.

110. John Zevalking, *Cast Adrift: The Patently Unjust Shift of Healthcare Costs to Those Who Can Least Afford Them is Constitutionally Intolerable*, 24 T.M. COOLEY L. REV. 347, 408 (2007).

111. *Id.* at 410-11.

112. PACE ET AL., *supra* note 47, at 12. Plaintiff's attorneys who take on nursing home lawsuits can expect to spend anywhere from \$250,000 to \$350,000 on investigators, experts, accountants, and paperwork if they want to be well-prepared. Rustad, *supra* note 50, at 361.

113. Zevalking, *supra* note 110, at 410-11.

low economic damages have to incur longer hours thinking of creative ways to transform non-economic damages into uncapped economic damages, and these additional work hours diminish the value of the attorney's contingency fee.<sup>114</sup> Also, difficult issues of proving causation between the provider's negligence and the elder's injury require even more of an attorney's time.<sup>115</sup>

Overall, the relatively small awards given to elderly medical malpractice plaintiffs, coupled with the expense of litigating medical malpractice cases, reduce the likelihood that an attorney will represent an injured elder in his or her medical malpractice claim.<sup>116</sup> Even if a plaintiff's attorney accepts an elder's case, the case is frequently dropped as soon as it becomes clear that it is weak.<sup>117</sup>

### C. Other Factors Adversely Affecting the Success of the Elderly in the Medical Malpractice System

Along with the difficulties presented by non-economic damage caps<sup>118</sup> and unfavorable attorney screening practices,<sup>119</sup> the elderly face a number of other obstacles in being successful with their medical malpractice claims. Besides the fact that the elderly tend to have low value claims, other factors might influence the elderly to decide not to sue when they are medically injured. These obstacles may be self-imposed.

Helen R. Burstin hypothesizes that the elderly may have closer, more established relationships with their doctors, making them more

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114. Sharkey, *supra* note 50, at 158.

115. MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS* 412 (Vicki Been et al. eds., 2d ed. 2008). Unlike conventional personal injury litigation where the defendant first encounters the victim who is generally in a healthy condition, malpractice plaintiffs usually start out sick. Moreover, the injury is more often failure to improve rather than a more garden variety bodily injury. These factors, coupled with the complexities of human biology, result in causation issues demanding as much or more of a lawyer's time and attention as do issues regarding standard of care. *Id.* at n.1.

116. Hyman & Silver, *supra* note 78, at 1120. "A lawyer would have to be woefully incompetent to 'double-down' on what discovery reveals is a weak case, instead of dumping it and finding a strong case to pursue." *Id.*

117. *Id.* A case being considered "weak" does not necessarily mean that there is no negligence, but that the fees generated simply are not worth litigating the case. *Id.* at 1121. Lawyers care about which cases they take because they invest heavily in their reputations. *Id.* "The most successful plaintiffs' lawyers rely on their reputations, and marketing of the same, to attract clients, rather than hanging around hospital wards and emergency rooms." *Id.*

118. See *supra* text accompanying notes 47-76.

119. See *supra* text accompanying notes 77-117.

hesitant to bring suit.<sup>120</sup> “Furthermore, although elderly patients may be at greater risk of medical injury, they may have lower expectations and be less demanding of their physicians.”<sup>121</sup> Potential lawsuits can also be long in duration and the elderly might be unwilling to spend their remaining years litigating a claim that could outlive them.<sup>122</sup> This could help explain why, on average, the elderly settle their medical malpractice claims more quickly than non-elderly adults.<sup>123</sup> “The elderly are also more likely than the adult non-elderly to resolve a large paid claim prior to filing a lawsuit, and less likely to take a case to trial.”<sup>124</sup>

Sometimes, the elderly will not even be aware that a medical error caused an injury, whether it is because of dementia or some other cause.<sup>125</sup> Causation in medical malpractice is difficult to prove regardless of who is the patient.<sup>126</sup> Patients seek out doctors because they already have something wrong with their health—“death or disability might well have occurred whether the doctor acted properly or not.”<sup>127</sup> “Moreover, the injury is more often failure to improve rather than a more garden-variety bodily injury.”<sup>128</sup> This dilemma is exacerbated with elderly injured patients, who often are already frail and afflicted with a host of other medical ailments, which make medical error extremely difficult to spot and proximate or direct cause difficult

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120. See Burstin et al., *supra* note 6, at 1700.

121. *Id.* (citation omitted).

122. See Kapp, *supra* note 65, at 1238.

123. See Paik et al., *supra* note 18, at 14. Data from the TCCD show that the elderly close their claims ten percent more quickly than the adult non-elderly. *Id.* at 15. The average medical malpractice claim for the elderly had a duration of 3.47 years as opposed to 4.29 years for the non-elderly. *Id.* at 14. “[C]laim duration is shorter for the elderly partly because they bring claims more quickly after they are injured, and partly because the claims close faster once they are brought.” *Id.* (citation omitted). Compared to the non-elderly, elderly claimants are also much more likely to settle before trial. *Id.* at 15.

124. *Id.*

125. See Hyman & Silver, *supra* note 78, at 1113. In one instance, an elderly woman was found dead with no apparent cause. Later, a vial containing insulin was found in the ICU by a nurse that resembled the blood thinner heparin. The nurse had intended to inject heparin in order to keep the intravenous line open but had instead accidentally injected a fatal dose of insulin. *Id.* at 1113 n.93.

126. BAKER, *supra* note 9, at 15. “Causation can be much more complicated in a medical malpractice case. Cars do not usually run over people who are about to die or lose their leg. If the death or dismemberment follows an auto accident, we can be pretty sure that the accident was the cause. But patients usually go to doctors because they are sick or injured. So it can be harder to sort out what difference a mistake by the doctor may have made.” *Id.*

127. *Id.*

128. HALL ET AL., *supra* note 115, at 412.



to prove.<sup>129</sup> Moreover, even when medical error is apparent, “[w]here the older person lacks the physical or mental wherewithal to initiate and prosecute a civil claim personally, there frequently is not available a willing, capable family member or friend to advocate on the injured party’s behalf in gaining access to the legal system.”<sup>130</sup> If the elderly are to have access to the medical malpractice system, the system itself has to change.

#### IV. Resolution

As is apparent, many of the obstacles faced by the elderly in bringing successful medical malpractice claims are structural and cannot be solved with a quick fix. Instead, effectively increasing access for the elderly is going to require a comprehensive system overhaul. True reform will pursue the following objectives: developing systems to signal to injured elders that a medical error has occurred, increasing incentives for the elderly to bring their claims and for plaintiff’s attorneys to accept them, lowering evidentiary standards to account for proximate cause issues associated with the elderly, and promoting efficient processing of claims to shorten elderly claim duration.

##### A. Current Proposals to Reform the Medical Malpractice System

###### 1. REFORMING A REFORM

In the past few years, there have been attempts to nullify the non-economic damage caps or at least to lessen their effects.<sup>131</sup> This, in a way, can be seen as reforming a reform. First, plaintiffs have attacked the constitutionality of the caps in courts in over half the states and have been successful in about half of these instances.<sup>132</sup> Second, plaintiffs have used creative means to avoid the scope of the damage caps.<sup>133</sup> One approach has been to frame the claim under “an alternative common law theory, such as breach of contract, fraud, battery, or

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129. John A. Pearce II, John J. O’Brien & Derek A. Rapisarda, *Protecting Nursing Home Residents from Attacks on Their Ability to Recover Damages*, 61 RUTGERS L. REV. 705, 718 (2009).

130. Kapp, *supra* note 65, at 1238–39.

131. See HALL ET AL., *supra* note 115, at 521–22.

132. *Id.* at 521–22.

133. See *id.* at 521.

as institutional rather than professional negligence.”<sup>134</sup> This method has achieved mixed results.<sup>135</sup> Another avenue has been to sue non-physicians or the physicians’ professional corporations, as some courts have found that the caps do not apply to them.<sup>136</sup>

## 2. MEDICARE-LED MALPRACTICE REFORM

William M. Sage, Professor of Law at Columbia Law School, and Eleanor D. Kinney, Professor of Law at Indiana University-Indianapolis, have proposed fixing the American medical malpractice system by using Medicare as a vehicle for reform.<sup>137</sup> The authors suggest several ways that malpractice reform could be Medicare-led. First, the Medicare administrative infrastructure could be co-opted to adjudicate disputes.<sup>138</sup> Before structured proceedings are even initiated, Medicare’s existing independent medical review system, which utilizes medical expertise, could be used to resolve medical issues.<sup>139</sup> An administrative law judge within the Centers for Medicare and Medicaid Services (CMS) would then hear the case, and the judge’s ruling could be appealed to a federal district court.<sup>140</sup> The Medicare Beneficiary Ombudsman could play an important role in helping the elderly—especially those who are incapable of bringing claims themselves and do not have anyone else to assist them—by helping them navigate the process.<sup>141</sup>

Second, health care providers would “earn” their way into the program by implementing systems that encourage injury prevention.<sup>142</sup> Those that did not qualify would have incentive to develop similar systems.<sup>143</sup> Health care providers would want to be part of a Medicare-led malpractice reform demonstration, because it would allow them to bypass traditional tort litigation and be eligible for federal

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134. *Id.* Another way to avoid the scope of the statute was to use the federal anti-dumping statute, as state-imposed restrictions did not apply to it. *Id.* However, courts eventually curtailed this particular practice. *Id.*

135. *Id.*

136. *Id.*

137. William M. Sage & Eleanor D. Kinney, *Medicare-Led Malpractice Reform*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* 318, 318 (William M. Sage & Rogan Kersh eds., 2006).

138. *Id.* at 323.

139. *Id.* at 327–28.

140. *Id.* at 328–29.

141. *Id.* at 345.

142. *Id.* at 335.

143. *Id.*

financial funds to help cover their liability costs.<sup>144</sup> Sage and Kinney were somewhat unsure whether to make Medicare patient participation mandatory.<sup>145</sup> While mandatory participation would work better in terms of policy, voluntary participation would be easier politically.<sup>146</sup>

Third, the problem the elderly face in identifying medical error that causes them injury could be mitigated by having procedures in place requiring health care professionals to disclose such errors.<sup>147</sup> “Specifically, when a medical injury is identified using the processes that Medicare now mandates for participating providers and health plans to review and report patient safety problems . . . that problem would be referred to the relevant Medicare contractor or health plan for assessment of potential for compensation.”<sup>148</sup> Participants also would be required to notify the elderly patient or their families.<sup>149</sup>

Fourth, Medicare-led malpractice reform would employ a more appropriate standard of proof. The system today uses a standard of negligence that relies on medical experts, and juries tend to evaluate these experts more on their demeanor “than the scientific underpinnings of their testimony.”<sup>150</sup>

The new system would use a standard of avoidability or preventability that would focus on “designated events.”<sup>151</sup> These designated events would determine liability and limit the need for formal proceedings and further resources.<sup>152</sup> Contested avoidability would be

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144. *Id.* at 337.

145. *Id.* at 338–39.

146. *Id.* “If decisions to participate are nonrandom, so that claims channeled into administrative resolution are not a representative sample of events or disputants, evaluation becomes more difficult.” *Id.* at 338. However, “even a constrained demonstration proposal is likely to provoke tests of political allegiance on both sides, which might delay or derail meaningful reform . . . . Enhancing reform with a patina of voluntary choice might sustain a demonstration program until it can credibly establish its effects on participants and on the health care system as a whole.” *Id.* at 339.

147. *Id.* at 339–40.

148. *Id.* at 340.

149. *Id.* “Health care providers participating in a Medicare malpractice demonstration should be required promptly to disclose serious, unanticipated outcomes of care to patients (or, when appropriate, families) in writing.” *Id.* The hope is that “hospitals and physicians would have a strong interest in productive conversations that air concerns, relate information valuable for patient safety, and reach settlements in as many cases as possible.” *Id.*

150. *Id.* at 341.

151. *Id.*

152. *Id.*

dealt with in the administrative review setting and would encourage quick resolution of cases.<sup>153</sup>

Medicare-led malpractice reform as suggested by Sage and Kinney, however, does have weaknesses. Most importantly, “[t]he maximum amount of noneconomic damages for the most severely and persistently injured could not exceed a preset figure,” which sounds dangerously like a non-economic damage cap.<sup>154</sup> This maximum amount would be retained or even imposed in areas where caps did not exist before.<sup>155</sup> This policy essentially would ignore all of the problems faced by the elderly because of the caps.<sup>156</sup> The authors mitigate the problem somewhat by suggesting the use of schedules for non-economic damages in which awards would be predetermined based on the nature, severity, and permanency of the injury.<sup>157</sup> The proposal focuses too narrowly on developing ideas at the federal level and implementing them without state input.

### 3. STATE-BASED ADMINISTRATIVE COMPENSATION REFORM

A state-based approach suggested by the Institute of Medicine solves this latter problem. Rather than using Medicare as a vehicle for reform, individual states would resolve medical malpractice claims administratively, similar to the way many states run their workers’ compensation systems.<sup>158</sup> Notice that this scheme does not restrict claimant participation to the elderly but is open to any citizen of the state running the system.<sup>159</sup> Under one of the approaches suggested by the Institute, “states would grant all health care professionals and facilities, however organized, immunity from tort liability (under most circumstances) in exchange for mandatory participation in a

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153. *Id.* at 342.

154. *Id.* at 343.

155. *Id.*

156. See *supra* text accompanying notes 44–74.

157. Sage & Kinney, *supra* note 137, at 343. In the arena of workers’ compensation, “[t]he typical schedule provides that, after the injury has become stabilized and its permanent effects can be appraised, benefits described in terms of regular weekly benefits for specified number of weeks shall be paid . . . .” LEX K. LARSON & ARTHUR LARSON, *WORKERS’ COMPENSATION LAW: CASES, MATERIALS AND TEXT* 341 (4th ed. 2008).

158. INST. OF MED., *FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS* 81 (Janet M. Corrigan, Ann Greiner & Shari M. Erickson eds., 2003), available at [http://books.nap.edu/openbook.php?record\\_id=10565&page=R1](http://books.nap.edu/openbook.php?record_id=10565&page=R1); Sage & Kinney, *supra* note 137, at 321.

159. INST. OF MED., *supra* note 158, at 82 (showing no indication that proposals would include only the elderly).

state-sponsored, administrative system established to provide compensation to patients who have suffered avoidable injuries.”<sup>160</sup>

Like Medicare-led malpractice reform, this state-based system also makes use of an avoidability standard rather than a negligence standard and of systems that require mandatory reporting of incidents of medical error.<sup>161</sup> The use of compensatory events and scheduled damages for pain and suffering would factor into the system as well.<sup>162</sup> Unlike Medicare-led malpractice reform, however, states play a much larger role in this scheme. While the federal government might provide start-up money to the states through the Department of Health and Human Services, “all participating states will refine the technical and scientific underpinnings of such a system through an expert or participatory process, depending on the state’s preference.”<sup>163</sup> States also would have discretion in how reporting mechanisms would operate.<sup>164</sup>

Increased communication also would play heavily into a state-based administrative compensation system.<sup>165</sup> States would encourage increased dialogue between health care providers and injured patients through apologies and mediation.<sup>166</sup> In addition, the state would take an active role in educating “the public with respect to the trade-off involved in replacing tort liability with administrative remedies for avoidable medical injury: faster, fairer, surer compensation but foregoing a jury trial.”<sup>167</sup>

#### **B. The Hybrid Approach: Using Federalism to Reform Medical Malpractice Litigation for the Elderly**

A more effective way to reform the medical malpractice system for the benefit of the elderly would be to combine certain elements of the aforementioned proposals. Federal and state governments should be partners in any attempt at increasing the elderly’s access to medical malpractice damages. An ideal partnership would be structured in a

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160. *Id.*

161. *Id.* at 83. “The collection and reporting of patient safety information would need to rely on computer-based monitoring systems within health care institutions.” *Id.* at 86.

162. *Id.* at 83.

163. *Id.*

164. *Id.* at 84.

165. *See id.*

166. *Id.*

167. *Id.*

manner similar to the federal-state relationship created by Medicaid.<sup>168</sup> In exchange for federal funds to cover the cost of operating a no-fault, administrative review system and additional federal monies to subsidize the liability costs of health care providers, the states, in turn, would be required to accept certain minimum requirements mandated by the federal government.<sup>169</sup> States entering into this arrangement would be completely voluntary;<sup>170</sup> however, the federal subsidies and cost savings associated with the administrative system would provide sufficient incentive for states to join the program.

Similar to Sage and Kinney's proposal to use the Medicare adjudication system in Medicare-driven reform,<sup>171</sup> Medicaid also has an existing dispute resolution system.<sup>172</sup> "Federal Medicaid regulations establish procedures for hearings involving the suspension, termination, or reduction of services. Specifically, the state plan may provide a hearing before the state agency or an evidentiary hearing at the local level with the right to appeal to the state agency."<sup>173</sup> This administrative adjudication system, too, can be co-opted to serve reform needs. "Further, when a state agency takes any action affecting an individual's claim for Medicaid benefits, the state agency must give notice and include reasons for the action and an explanation of the applicable law and regulations as well as the procedures to be invoked in the hearing."<sup>174</sup> Thus, these state agencies are already accustomed to applying

168. Robert F. Rich, *Health Policy, Health Insurance and the Social Contract*, 21 COMP. LAB. L. & POL'Y J. 397, 405 (2000).

169. See *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006).

The Medicaid Act is a federal aid program designed to help the states provide medical assistance to financially-needy individuals, with the assistance of federal funding. Participation is voluntary, but if a state decides to participate, it must comply with all federal statutory and regulatory requirements. To participate, a state submits a plan to the Secretary of the Department of Health and Human Services that meets the requirements of 42 U.S.C § 1396a(a). Once the plan is approved, the federal government subsidizes the state's medical-assistance services.

*Id.* (citations omitted). Medicaid plays an important role in the lives of many elders, because Medicaid has become a Medicare supplement health insurance policy that covers Medicare premiums and cost-sharing obligations for certain beneficiaries. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES MATERIALS AND PROBLEMS* 823 (6th ed. 2008).

170. *Lankford*, 451 F.3d at 504.

171. See *supra* text accompanying notes 138-141.

172. Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 874 (1990).

173. *Id.*

174. *Id.*

law and providing written opinions, attributes that would be useful in adjudicating medical malpractice claims administratively.<sup>175</sup> Although the hybrid system is modeled on Medicaid, it does not necessarily have to be run through Medicaid. If the federal government would rather use the existing Medicare dispute resolution system, it would be free to do so through its rulemaking authority.

The federal government could use its rulemaking authority to achieve broad policy goals. Most importantly, it could require participating states to repeal non-economic damage caps. This would add value to the medical malpractice claims of the elderly, which would encourage injured elders to bring their claims forward and plaintiff's attorneys to accept them. The system could also be made for the exclusive use of the elderly. This could help expedite the resolution of the elder's claims, as they would not be sharing an adjudication system with younger medical malpractice claimants. This would shorten the line in front of the courthouse doors, so to speak, and encourage elderly medical malpractice victims to bring their claims, as they will have less reason to fear spending their remaining years tied up in litigation.<sup>176</sup> The federal government also could institute quality standards and determine how the mechanism for reporting medical errors would work.

It would be wise for the government to mandate a reporting system similar to the one proposed by Tom Baker.<sup>177</sup> Doctors who have committed medical malpractice would be required to tell patients what happened, what should have happened, and how what happened differed from what should have happened.<sup>178</sup> Providers would then be obligated to report the incident to the state health department, which would, in turn, "make the information from the reports available to the public in a form that would promote patient-safety research and awareness."<sup>179</sup> The virtue of this system, besides the moral right of telling the elderly how they have been wronged, is that it compiles statewide information to flag areas where health providers can improve.<sup>180</sup> This way, steps can be taken to make sure that the same mistakes are not made twice.

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175. *Id.*

176. *See supra* text accompanying notes 122-124.

177. *See* BAKER, *supra* note 9, at 159.

178. *Id.*

179. *Id.* at 160.

180. *See id.*

Granted, a scheme such as this, under which federal funds are conditioned on states complying with federal policy goals, could invite constitutional challenges. However, it is likely that the scheme would pass constitutional muster. In *South Dakota v. Dole*, the Supreme Court held that pursuant to its spending power, "Congress may attach conditions on the receipt of federal funds, and has repeatedly employed the power 'to further broad policy objectives by conditioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives.'"<sup>181</sup> Congress may induce the states this way even if it does not have the power to regulate health care or other tangential issues directly.<sup>182</sup>

There are a few limitations on the ability of Congress to put conditions on federal money.<sup>183</sup> First, "the exercise of the spending power must be in pursuit of the general welfare."<sup>184</sup> Second, the conditions put on the receipt of the funds must be unambiguous, so states have a clear understanding of the consequence of their choices.<sup>185</sup> Third, the conditions on the funds must be related to the national policy or interest that Congress is pursuing.<sup>186</sup> Fourth, other constitutional provisions may exist that act as an independent bar to imposing conditions on federal funds.<sup>187</sup> Finally, the inducements imposed by the government may not be so coercive that "pressure turns into compulsion."<sup>188</sup>

The hybrid approach should be able to meet the standards set out in the above limitations. Typically, courts have given deference to the judgment of Congress in determining whether the general welfare is being pursued.<sup>189</sup> The funds for running the proposed medical malpractice adjudication system are certainly related to the rules and minimum standards the federal government will set governing the system itself. This author knows of no constitutional provision that would act as an independent bar to the system.

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181. *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). In this case, South Dakota unsuccessfully challenged a federal statute that withheld five percent of federal highway funds to states where it was legal for persons under the age of twenty-one to purchase and possess alcohol. *Id.* at 205, 211-12.

182. *See id.* at 207.

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.* at 208.

188. *Id.* at 211 (quoting *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1997)).

189. *Id.* at 208.



The second and fifth limitations are bound to present more difficult hurdles. Because of the intricacies and interconnecting issues that are woven into our health care system, any rules with funding inducements attached will have to take care that the consequences are clear to the states facing them. Otherwise, the voluntariness of their participation in the system could be compromised. Additionally, because cash-strapped states desperate to lower costs may be scrambling to enter the program, the take-it-or-leave-it conditions on which federal funding depends may be seen as passing the point where pressure becomes compulsion. However, as the United States District Court for the District of Kansas noted, “[t]he Supreme Court and other courts have recognized that the judiciary should attempt to avoid becoming entangled in ascertaining the point at which federal inducement to comply with a condition becomes compulsion.”<sup>190</sup> The compulsion test has been described as “probably unworkable” and is often criticized by academics.<sup>191</sup>

In areas where the federal government did not legislate or create rules or where only vague standards or policy outlines were provided, states would then “fill in the gaps.” State governments are a closer level of representation to the people and, as such, should have a better sense of how best to serve their respective elderly populations. “[T]he more local the unit of government is that can deal with a political problem, the more effective and efficient the exercise of power.”<sup>192</sup>

Perhaps the most exciting aspect of the hybrid approach is that it takes advantage of our federal system of government. Instead of the federal government dictating a uniform scheme nationwide, “[s]tates may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear.”<sup>193</sup> There are three primary virtues to these laboratories of experimentation. First, it allows more local participation in the decision-making process

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190. *Kansas v. United States*, 24 F. Supp. 2d 1192, 1198 (D. Kan. 1998).

191. *Id.* at 1198–99. “In *Dole*, the Court never defined ‘compulsion’ or ‘pressure,’ explained how one should or could consistently distinguish between the two, or provided any example of an impermissibly ‘coercive’ offer of federal funds to the states.” *Id.* at 1199.

192. *State v. Hutchinson*, 624 P.2d 1116, 1121 (Utah 1980).

193. See *United States v. Lopez*, 514 U.S. 549, 581 (1995) (Kennedy, J., concurring) (asserting that the Gun-Free School Zones Act of 1990 unconstitutionally exceeds congressional commerce clause powers because the conduct the legislature sought to regulate was not of a commercial nature and was traditionally an area of state prerogative).

that will lead to better program customization.<sup>194</sup> More local units can “tailor local programs to local needs.”<sup>195</sup> What is best for the elderly in Florida is not necessarily what is best for the elderly in West Virginia. Second, if one of the state’s “experiments” is a total failure, only one state will have to carry the burden of that failure, rather than the entire country.<sup>196</sup> Finally, and conversely, if a particular aspect of an individual state’s hybrid system is a wild success, the federal government can use its rulemaking authority to mandate the practice nationwide. Overall, the system insulates the country from bad practices by compartmentalizing them in one state, while simultaneously keeping the entire country open to good practices through federal prerogative.

A final remedy worth pursuing is investing more resources into the public health system, as opposed to the personal health care system. Public health is promoted by public health agencies and is most concerned with disease prevention.<sup>197</sup> “Problems resulting from the failure of public health to prevent disease inevitably become personal health care issues and often private litigation issues.”<sup>198</sup> By strengthening the public health system’s ability to curb chronic but preventable diseases in the elderly, like heart disease, cancer, diabetes, and obesity, we can protect the elderly from medical malpractice by limiting their exposure to the personal health care system that ultimately injures them.<sup>199</sup> Whether the federal government provides funding directly or requires the states to do so pursuant to its rulemaking authority, improving public health would be a worthwhile endeavor.

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194. See *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 49-50 (1973) (expressing a preference for local control of education because of “the opportunity it offers for participation in the decision-making process that determines how those local tax dollars will be spent”).

195. *Id.* at 50.

196. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). “It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.” *Id.* In this dissenting opinion, Justice Brandeis recognized that the Court has the power to strike down experiments implemented by statute but cautioned that justices should be careful not to inject their prejudices into the law. *Id.* “If we would guide by the light of reason, we must let our minds be bold.” *Id.*

197. LAWRENCE O. GOSTIN & PETER D. JACOBSON, *LAW AND THE HEALTH SYSTEM 3* (photo. reprint 2009) (2006).

198. *Id.* at 5.

199. See *id.*

## V. Conclusion

Statistics show that despite their considerable consumption of health care services in the United States, the elderly are underreporting instances of medical malpractice.<sup>200</sup> The American public should be concerned, because this under claiming could compromise the ability of the tort system to keep doctors honest and to flag areas where legislation and regulation are needed for consumer protection.<sup>201</sup>

Several barriers stand between the elderly and success in the medical malpractice arena. First, the elderly themselves may be unwilling to bring suit because non-economic damage caps devalue their claims.<sup>202</sup> Even if the elderly want to come forward, plaintiff's attorneys may be unwilling to accept their cases, because they are not lucrative enough.<sup>203</sup> A host of other factors unique to the elderly also exacerbate the problem, including more established relationships with doctors,<sup>204</sup> lower expectations,<sup>205</sup> unwillingness to participate in protracted litigation,<sup>206</sup> inability to perceive injury,<sup>207</sup> muddled causation,<sup>208</sup> and lack of advocacy.<sup>209</sup> To best combat this problem, the medical malpractice system should be overhauled by creating a new administrative compensation system jointly run by the federal and state governments.<sup>210</sup> This system could help prevent injuries to the elderly and compensate them better when injuries do occur.

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200. See *supra* text accompanying notes 22–42.

201. See *supra* text accompanying notes 8–17.

202. See *supra* text accompanying notes 47–76.

203. See *supra* text accompanying notes 77–117.

204. See *supra* text accompanying note 120.

205. See *supra* text accompanying note 121.

206. See *supra* text accompanying notes 122–124.

207. See *supra* text accompanying note 125.

208. See *supra* text accompanying notes 126–129.

209. See *supra* text accompanying note 130.

210. See *supra* text accompanying notes 171–199.



