Medical Malpractice Insurance Crisis: An Inquiry into the Relationship Between the Crisis and Access to Health Care for Women of Color

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I. Introduction

Over the last decade, the twin issues of rising medical malpractice insurance rates and decreasing access to health care have reached crisis proportions for select populations in the United States. In the U.S. Congress, Representative John Conyers (D-MI), Chair of the House Judiciary Committee, has characterized the legislative debate on these issues as one plagued by "an unusually high degree of misinformation," while also commenting that "little effort has been made to understand the unique role state medical malpractice laws play in our health care system."1

Most especially, the medical malpractice insurance crisis and its affect on minority women's access to health care has of yet received little national attention, despite racial and ethnic disparities in access to health care that often result in unequal health outcomes for minorities.2 The reasons for these disparities are complex and poorly understood.3 Although research is not definitive on why the disparities in access

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1 U.S. Representative John Conyers, Jr., Medical Malpractice: Myths and Realities, ROLL CALL, Nov. 13, 1995.
to health care exist, they are inadequately explained by factors such as health insurance coverage, income, availability of services or patient preferences.4

When compared with all other ethnic groups, African Americans experience higher rates of illness and death from virtually every chronic health condition—from asthma to diabetes to cancer.5 For minority women, barriers to quality health care surface at every turn in their journey for care. Professor Vernellia Randall suggests nine barriers to health care that minority women face, including: 1) lack of economic access to health care; 2) barriers to hospitals and health care institutions; 3) barriers to physicians and other providers; 4) discriminatory policies and practices; 5) lack of language and culturally competent care; 6) inadequate inclusion in health care research; 7) commercialization of health care; 8) disintegration of traditional medicine; and 9) disparities in medical treatment. 6

Until recently, however, the medical malpractice crisis has largely been ignored when analyzing the health care barriers faced by minority women. This article seeks to put into context the impact of the medical malpractice crisis and resulting state and national reforms on minority women’s access to quality health care, to broaden the debate on whether a “crisis” indeed exists, and to facilitate more meaningful research in this area.

Although many medical malpractice reformers cite increased litigation as the main reason for skyrocketing rates, the U.S. Government Accountability Office (formerly the General Accounting Office) (“GAO”) reported in a 2003 study that the agency found no significant reduction in medical malpractice rates in states with tort reform.7 Rather, medical malpractice reform opponents point to insurance companies’ declining investments, part of the cyclical insurance market, as having contributed to the underpinnings of rising rates.8

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4 Id.
5 American Medical News, as referenced in the Mississippi State Health Plan, FY 2005, Ch. III, p. 19. For the purposes of this article, minority women will refer only to African-American women.
Scholarship has revealed an ongoing debate regarding the meaningfulness of these factors on rising medical malpractice rates, which is beyond the scope of this article. Instead, this article will look at the recent bodies of work regarding medical malpractice and access to quality health care. This article will also examine national reform proposals and discuss their potential for affecting access to care issues. Further, it will review the medical malpractice insurance reforms in five states and compare various state regulatory actions with quality health care indicators to begin the discussion of how these reforms affect minority women's access to quality health care. Finally, this article will address areas ripe for future scholarship and offer pertinent recommendations for policy makers.

II. History of Medical Malpractice and Minority Women's Access to Care

Since the late 1990s, medical malpractice has been at the forefront of state and national public policy debates. State legislative trends and national policy initiatives resulted from skyrocketing medical malpractice insurance rates and their affect on physicians and health care. Rate increases have been blamed for pushing physicians out of certain specialty areas, either forcing some into retirement or into alternative geographic locations where premiums are less expensive.

Extrinsically tied to the medical malpractice crisis is the access to quality health care debate, as the diminishing availability of physicians affects the quality of care a population receives. Although disparities in health care are often attributed to differences in income and access to insurance, research has shown that, although these are important factors, they are by no means the only factors. For instance, Hispanic Americans have seen a decline in both the breadth of insurance coverage and an increase in those who lack health insurance. However, studies have shown that changes in insurance coverage explain only twenty percent of the change in access to the usual source of health care, meaning that other significant factors contributed to the decline in health care access.

Another study funded by the Agency for Health Care and Research and Quality ("AHRQ"), an agency of the U.S. Department of Health and Human Services ("HHS"), measured quality of care by both physician review and adherence to standards of care.

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10 Id.
11 Id.
There, "[t]he researchers found no difference in quality of care for patients from poor communities as compared with other patients, adjusting for other factors." They did find, however, that African American patients received lower quality of care than white patients. In a similar study reported by the AHRQ, black women were "significantly less likely than white men to be recommended for referral for diagnostic procedures related to heart disease, despite reporting similar symptoms."

Taken together, these studies indicate that socio-economic factors, although important, are just part of the multiple challenges African-American women face in accessing health care. Both physician distribution and availability, specifically by specialty, are other critical factors. The medical malpractice crisis thus is contributing to this aspect of the access to care dilemma.

"The American Medical Association [("AMA")], has reported that an alarming number of physicians are unable to obtain or afford medical liability insurance in 20 states." In addition, "The American College of Obstetricians and Gynecologists [("ACOG")], has identified nine states in which access to care is compromised due to availability and affordability of malpractice insurance for obstetricians" ("OB/GYNs").

The access to quality health care problem disproportionately falls on the

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12 Id.
13 Fact Sheet, supra note 9.
14 Id. Various studies were referenced in same AHRQ article.
shoulde rs of women due to the nature of the specialty areas most affected by the medical malpractice crisis. Approximately one out of eleven OB/GYNs nationwide has stopped delivering babies; these OB/GYNs are scaling back their practices to gynecology only.17 HHS reported that most rural communities in Mississippi, an AMA medical malpractice crisis state, have no OB/GYNs to deliver babies, resulting in travel of over 60 miles to reach care in most cases.18

The medical malpractice crisis affects more than availability of physicians; it also limits the number of available health care facilities. The American Hospital Association ("AHA"), in conjunction with the American Society of Hospital Risk Management, conducted a study which concluded that at least one-third of hospitals saw an increase of 100% or more in liability insurance premiums in 2002.19 "Over one-fourth of hospitals reported either a curtailment or complete discontinuation of one or more services as a result of growing liability premium expenses."20 African-Americans are far more likely to rely on hospitals or clinics rather than private physicians for their usual source of care than are Caucasians.21

In its Advancing Health in America report, entitled "Professional Liability Insurance: A Growing Crisis," the AHA detailed results of the 2003 AHA Survey of Hospitals on Professional Liability Experience. The report revealed that the number of OB/GYN specialists who have limited their services has caused a 17.2% decrease in the ability of hospitals to provide care in this field.22 Reduced emergency ("ER") care was second to OB/GYN, having a 10.6% negative affect on hospitals.23 Minority women receive their care primarily from these two specialty groups.24 AHA also reported that

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17 SELF (Apr. 2002).
18 HHS (Jul. 24, 2002).
19 Advancing Health in America, 2003 Annual Survey and AHA Professional Liability Survey, available at http://www.hcla.org/studies/AHALiability030428.pdf. The survey was faxed to all community hospitals in March 2003; 1089 hospitals responded representing 22% of all U.S. community hospitals [hereinafter Advancing Health in America Survey].
21 16% of African Americans rely on hospitals or clinics for their care, whereas only 8% of whites rely on the same sources. AHQR and Quality Medical Expenditure Panel Survey, 2000, available at http://www.meps.ahrq.gov/mepsweb/.
23 Id.
24 Id at 6.
the average rate of increase in medical malpractice claims from 2001-2003 was 158% in crisis states, 103% in non-reform states, and 74% in states with existing reform measures.25

The medical malpractice debate and its effect on access to care has been the subject of recent government and independent industry studies. Their findings vary and are detailed below. Despite the ambitious nature of these studies in addressing how medical malpractice affects access to quality health care, none take into consideration gender and race or ethnicity. Rather, separate studies that speak only to minorities’ access to quality health care and the generalized barriers that exist can be considered in the context of the medical malpractice reports.

There is a research void in exploring how non-traditional barriers, like medical malpractice, affect minority women's access to health care. In reviewing the medical malpractice landscapes in five states, this article will look at physician distribution by specialty as an indicator of access to quality care. Comparisons to the medical malpractice rates in that state, as well as quality care indicators by race and gender, will paint an initial picture of how medical malpractice rates may indeed affect minority women's access to quality health care. This analysis serves as a starting point for further study, necessitated by the lack of data and scholarship in this area.

For a general understanding of the issues of medical malpractice and access to quality health care, the following section will briefly review recent government reports and industry studies on medical malpractice and access to care. These findings, coupled with current reports specifically on minority women’s access to health care, will lay the foundation for the subsequent state-by-state analysis.

Although the criteria for evaluating quality health care vary, there is consensus on what constitutes areas of concern when discussing access issues.26 Those factors, often politically charged and plagued by characteristics difficult for social policy to remedy quickly, are frequently shelved in favor of less arduous political responses. Rather, public policy leaders respond to populous demands for regulatory action, regardless of the meaningfulness of the reform. This may be the case for tort reform as

25 Advancing Health in America Survey, supra note 19.
26 Randall, supra note 6 (highlighting lack of economic access; barriers to hospitals, health care institutions, and providers; disparities in treatment; discriminatory policies and procedures; lack of cultural competency; discrimination on the basis of gender; lack of inclusion in health care research; lack of standardized data collection; and rationing through managed care as areas of concern).
a somewhat simplistic response to the medical malpractice crisis. Although there is a plethora of evidence for and against tort reform as a means to reduce medical malpractice insurance rates, the few studies that have discussed the access to care issue are rigorously criticized by opponents as inconclusive. Furthermore, they are void of data relating specifically to minority women.

In the fall of 2002, the GAO, at the bequest of Congressional leaders, began its research into the implications of escalating medical malpractice insurance rates on access to health care. The GAO's August 2003 report, entitled: "Medical Malpractice and the Implications of Rising Premiums on Access to Health Care," was, as expected, criticized by the AMA as lacking sufficient scope to support the finding that rising malpractice premiums have not contributed to widespread health access problems. The GAO's conclusion that there is no medical malpractice crisis and no need for members of Congress to support national medical malpractice reform is burdened by more than just a limited scope of work critique. The report has also been criticized as biased, written in a light unfavorable to reform. Critics, most notably those within the U.S. government, argue that the GAO study was unable to substantiate anecdotal reports of widespread impediments to health care access.

The Joint Economic Committee ("JEC") of the U.S. Congress pointed out that, when the GAO did find evidence of access to care problems resulting from medical malpractice, the study attributed the cause to other factors. The JEC noted that problems "often occurred in rural locations, where maintaining an adequate number of physicians may have been a long standing problem." Further, critics argue that the GAO minimized its findings that hospitals included in the study confirmed a reduction

27 The AMA and the Health Coalition on Liability and Access, and as well as other industry associations, argue that the GAO Report is flawed and lacks the appropriate scope of work to be meaningful. AMA, MEDICAL LIABILITY REFORM – NOW! 58-60 (Jul. 19, 2006), available at http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnw.pdf.
28 GAO Report, supra note 7.
30 Id. at 7.
31 Dan Miller, JOINT ECONOMIC COMMITTEE, MEDICAL MALPRACTICE REFORM: PERSPECTIVES ON RECENT FINDINGS BY THE GAO, 2 (2003) (noting that the GAO report both fails to back up reports of problems yet documents other evidence that a medical malpractice problem exists).
32 Id. (highlighting that the GAO examined only five of the eighteen "crisis" states, and within those, did not attempt to verify all problems, just those which were deemed "potentially acute or concentrated").
33 Id.
34 Id.
in on-call coverage for the ER, pointing out that many of those same hospitals found ways to maintain coverage. Yet, the study did not emphasize that almost one-third of the hospitals were not able to maintain full ER coverage. As noted by the JEC, medical malpractice pressures caused nearly one-third of hospitals included in the study to reduce the range of ER services.

Importantly, the GAO study of medical malpractice and how it affects access to care did not differentiate affected populations by gender or by race. This void raises specific questions of how meaningful the GAO study is in light of the cultural impediments an access to care discussion necessitates.

The shortcomings of the GAO report, as well as the areas of concern the report identified, should help guide future scholarship in this area, and give researchers a springboard for additional research and study. Specifically, GAO calls for a broader body of research as well as a more detailed review of how medical malpractice affects specific sects of our society. Only by breaking this area of research down by socio-economic status, gender, race and ethnicity will public policy leaders be able to tailor specific meaningful regulatory responses.

In June 2003, Weiss Rating Company issued its findings on medical malpractice in a report, entitled: "Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage." The Weiss report faults the investment practices of insurance companies and the inability of the medical profession to police itself for the rise in malpractice insurance rates. The study cautions state and national legislative leaders to review all the factors contributing to medical malpractice crisis, not just those associated with tort reform.

Miller, supra note 34 at 3 (stating that while 26 of the 49 hospitals contacted confirmed a reduction in ER provider availability, 11 of those were able to maintain their full range of services).

Miller, supra note 34 at 3 (finding that 15 of the 49 hospitals were not able to maintain a full range of service).

Miller, supra note 34 at 3.


Id. at 3-4 (attributing the increase in medical malpractice premiums to the medical inflation rate, the insurance business cycle, under-reserving by insurers, declining investment income, financial difficulties, and a declining numbers of insurers offering coverage).

Id. at 4 (recommending that proposals involving non-economic damage caps should be put on hold until evidence demonstrates a reduced medical malpractice costs for physicians).
The Weiss report was limited in its scope, only addressing the impact of non-economic damage caps on physician premiums, claims payout levels, and availability of coverage. Although it was silent as to how medical malpractice reform measures, like limiting non-economic damages, affected access to care, the Weiss report was a blow to tort reform proponents who crafted the basis of their advocacy on medical malpractice litigation costs as a cornerstone for reform. The report offers some evidence that, if medical malpractice reforms are found to limit access to care, especially for minority women, there are alternatives to drive rates down without limiting access to justice. Importantly, the Weiss report, like the GAO study, also has been criticized, this time by pro-tort reform advocates, as using erroneous methodology and misusing data to mislead the reader that medical malpractice is not the cause of rising rates.41

Despite the contentious nature of both the Weiss and the GAO reports, these findings need to remain part of the dialogue when discussing whether medical malpractice reform measures limit minority women's access to health. Notwithstanding the lack of conclusive findings in this area, one cannot ignore the correlative evidence that the medical malpractice crisis is affecting the quality of health care for our most needy populations.

Additionally, it is fair to posit that the traditional barriers minority women navigate when accessing health care are amplified as the number of physicians serving this population is significantly diminishing.42 A resulting factor of diminished access to care for minority women is the widely accepted fact that areas heavily populated by minorities are characteristically located in medically underserved areas, and that these same areas are served by minority providers.43

The AMA's concern regarding increasing the number of minority physicians, especially in certain specialty areas, has resulted in a policy statement urging medical


42 Gwendolyn Roberts Majette, Access to Health Care: What a Difference Shades of Color Make, 12 Annals Health L. 121, 123-126 (2003) (stating that the United States health care system is based on a white male paradigm, highlighting discriminations based on race, ethnicity, sex, and economic status and noting that those discriminations are exacerbated by the limited supply of providers in minority communities).

43 Id. at 130 (referencing studies that demonstrate that minority doctors open practices in minority communities at a rate three times higher than their white counterparts).
schools and state regulatory bodies to provide incentives for minority physician recruitment and placement in medically underserved areas, which serve a predominantly minority population. The Association of American Medical Colleges also reported a decreasing trend of minority physicians who matriculate to graduation. Anecdotal evidence suggests that rising medical malpractice rates deter potential medical school applicants. Given that, further study is needed to determine how increasing rates affect future minority physicians who predominately serve minority populations.

Although studies have found that patients’ race and ethnicity are associated with physicians’ race, medically indigent patients are also more likely to receive care from non-white physicians. Minority patients are four times more likely to receive care from non-white physicians than are non-Hispanic white patients.

Reports indicating that non-white physicians provide a disproportionate amount of care to the indigent lend credence to the notion that these same doctors bear the heavy financial burden associated with caring for such patients, leading to a higher level of dissatisfaction among non-white physicians. This factor also should be considered and weighed when evaluating minority physician trends.

Additionally, physicians’ fears of malpractice suits have disproportionately affected access to care because of the unsubstantiated perception that poor women are more litigious than women of means. Demographically, African American women bear the brunt of poverty in the United States. Conjecture and anecdotal evidence also lead physicians to view poor minority women as more litigious than other sectors of the

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45 ASSOCIATION OF AMERICAN MEDICAL COLLEGES, MINORITY STUDENT OPPORTUNITIES IN UNITED STATES MEDICAL SCHOOLS (2002).


47 Id.

48 Id.

population and are deterred from serving them. This sociological factor, when combined with the medical malpractice insurance crisis, provides an unsavory picture for future recruitment of minority physicians and constitutes an area ripe for statistical quantification. The diminishing presence of minority doctors lies at the core of unraveling the barriers to minority women’s access to quality health care.

III. Federal Response to Rising Medical Malpractice Rates

Approximately 78% of Americans believe that the availability and quality of health care is threatened because of rising medical liability costs.50 The lack of medical liability insurance coverage in some states is forcing doctors and other health care providers to abandon the practice of medicine.51 This increasingly politically active constituency, coupled with the will for reform stemming from both major political parties and their leadership, has resulted in federal legislative initiatives in both the House and the Senate of the U.S. Congress.

In May 2004, the U.S. House of Representatives passed the “Help Efficient, Accessible, Low-Cost, Timely Health Care (“HEALTH”) Act”, which would have made broad changes to the health care liability system, and included provisions concerning compensation for injured patients and other issues arising out of health care lawsuits.52 This legislation offered significant savings to the federal government through a reduction in direct spending for Medicare, Medicaid, and the government’s share of premiums under the Federal Employees Health Benefits Program (“FEHBP”) and other federal health benefits programs.53 This type of reform could also mean less spending by employers for health care, freeing employees’ compensation increases to take the form of taxable wages and other fringe benefits that would increase federal revenues.54 Most importantly, it would dramatically affect medical malpractice rates nationally, which in turn could have an impact on minority women’s access to quality health care.

The crux of the HEALTH Act was the imposition of limits on medical malpractice litigation in state and federal courts by capping awards and attorneys’ fees,
modifying the statute of limitations, eliminating joint and several liability, and changing the way collateral source benefits are treated.\textsuperscript{55} The bill would preempt state laws that provide less protection for health care providers and organizations from liability, loss or damages (other than caps on awards for damages).\textsuperscript{56} The HEALTH Act would also limit attorney contingency fees.\textsuperscript{57}

The federal preemption provision, coupled with the clear Congressional intent to make a health insurer liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate, were the cornerstones of this reform measure. In addition, an essential component of the legislation was a $250,000 cap on the total amount of non-economic damages that could be recovered in any health care liability suit, regardless of the number of plaintiffs or defendants.\textsuperscript{58}

Although the HEALTH Act was introduced in both 2003 and 2004, the bill failed to pass in the Senate. U.S. Senators proposed their own reform bill called the Patient's First Act, which was remarkably similar to the HEALTH Act.\textsuperscript{59} Although both Acts were modeled after California's successful medical malpractice reforms, neither has been adopted.

Federal tort reform remains on the priority list for action by the House and Senate leadership, as well as for the President.\textsuperscript{60} HHS suggests that replicating California's reforms nationally would reduce health care costs by 5-9\%, generating savings of $70-126 billion a year.\textsuperscript{61} Conflicting with that analysis is the GAO report described above, which stated that there is no medical malpractice crisis and thus legislators should reevaluate whether insurance investments are affecting rising malpractice rates.\textsuperscript{62}

Despite these inconsistencies, medical malpractice insurance reform remains ripe for policy action. Federal reform will still have to pass constitutional challenges, as many opponents argue that federalism prohibits federal legislation in this field. However, the Congressional Research Service ("CRS") concluded that Congress did

\textsuperscript{55} HEALTH Act, supra note 53.
\textsuperscript{56} HEALTH Act, supra note 53.
\textsuperscript{57} HEALTH Act, supra note 53.
\textsuperscript{58} HEALTH Act, supra note 53.
\textsuperscript{60} Charles Hurt, Senate OK's Tort Reform Measure, THE WASH. TIMES, Feb. 11, 2005.
\textsuperscript{62} GAO Report, supra note 7.
have the “authority to enact tort reform generally, under its power to regulate interstate commerce, and to make such legislation applicable to intrastate torts, because tort suits generally affect interstate commerce.” General tort reform includes caps on damages, limitations on joint and several liability, and reforming the collateral source rule.

CRS suggests that more specialized reform measures, like a legislative requirement that portions of punitive damage awards be paid into state stabilization funds, would be ripe for constitutional challenges. CRS concluded that, although there is “no due process or federalism impediment to Congress’s limit[ation of] a state’s common law right of recovery,” Congress could not require alternative dispute resolution that limits the rights to a jury trial. CRS also declared that it might be unconstitutional for tort reform legislation to “be applied to particular intrastate torts that do not substantially affect interstate commerce.”

The future success of medical malpractice insurance reform was bolstered by the U.S. Senate’s passage of The Class Action Fairness Act (“CAF Act”) in early February 2005, signed into law by the President on February 18, 2005. The CAF Act has two key provisions: 1) to direct many large class-action lawsuits from state courts into the federal system; and 2) to rein in the multimillion-dollar payments that lawyers receive in such cases. The passage of the CAF Act may pave the way for medical malpractice liability reform, despite the continued constitutional questions regarding federalism, as well as the contentious debate that insurance regulation, not increased litigation or award payments, is at the heart of the medical malpractice crisis.

IV. Medical Malpractice And Quality Of Care Indicators: Five States And Their Experience

The threat of walkouts by physicians in various states, combined with the drastic reduction in available providers in certain rural areas in the U.S., has raised the

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64 Id.

65 Id. See also CRS Report, supra note 64.

66 CRS Report, supra note 64.


68 Id.
issue of medical malpractice insurance reform to center stage of the national health care debate. GAO has reported that "[m]edical malpractice insurance premium rates increased rapidly in some states beginning in the late 1990's after several years of relative stability, similar to previous cycles of rising premiums during the 1970's and 1980's."69 Between 2001 and 2002, premium rates for general surgery, internal medicine, and OB/GYN increased by 15% on average nationally and over 100% for certain specialties in some states.70 There have been repeated reports of physicians leaving specialty areas and states where malpractice insurance rates are growing exponentially.

Burgeoning medical malpractice insurance rates, coupled with physician shortages, have prompted many states to undertake some form of tort reform as a regulatory response. The AMA has declared twenty states to be in a medical liability crisis.71 Although President George W. Bush had included national tort reform as a major policy initiative in his State of the Union speech two years in a row, the future of federal medical malpractice reform remains unclear. Regardless of the absence of national reform, states have sought their own regulatory responses.

This section will address medical malpractice reforms in five states, in conjunction with quality of care health indicators used by the HHS “Healthy People 2010” initiative.72 Healthy People 2010 builds on two decades of federal public health initiatives and “was developed through a broad consultation process, built on the best scientific knowledge and designed to measure [public health] programs over time.”73 The data used in this initiative also guides the federal government in its access to care efforts.74

Due to the deficit of minority and women health care providers in the U.S. and their disproportionate impact on the female minority communities whom they serve,
this analysis will investigate minority physician distribution by specialty in each state, based on the national average of African American physicians. While racial and ethnic minorities comprise 21% of the U.S. population, they constitute only 8.6% of U.S. physicians.75 The AMA has concluded that the lack of diversity in the medical profession exacerbates existing obstacles to health care for minority populations.76

Data by race, gender, ethnicity and specialty as yet remains unavailable on a state-by-state basis. The OB/GYN specialty is singled out in this discussion, since it is the predominant specialty that serves minority women.77

Indicators will also include graduation rates of physicians in the OB/GYN specialty. The AMA reports that, from 1975 to 2002, there was a slight increase and stabilization for physicians in the OB/GYN specialty.78 Between 1994 and 1998, the number of minority medical school applications declined by 12%, and the number of minority medical school graduates decreased by 7.5%.79 In states where affirmative action has been restricted by law, the drop in applications was even greater; over this same time period, California saw a 19% decrease and Mississippi experienced a 22% drop in minority applicants.80

However, graduation rates by medical specialty in each state are not dispositive since many graduating students leave the state where they trained when their residency ends. Further, inconsistent tracking of graduating students remains a problem. The AMA has identified the race or ethnicity of just 67.5% of its members: only 2.4% of all physicians reported being Black, 3.3% Hispanic and 8.6% Asian.81 Blacks had the highest proportion to enter OB/GYN with 4.6% of this physician group choosing the

75 Press Release, AAMC, Efforts to Increase Medical School Minority Acceptance Rates Will Benefit from MMEP Reauthorization (Sept. 2, 1998).
77 Id., as referenced in NARAL Pro-Choice America, Minority Health Care Providers: The Need to Increase the Number, Diversity, and Distribution, Feb. 15, 2002.
80 AAMC, supra note 81.
Minority women predominantly rely on this small portion of physicians for their care.

The following comparison will serve only as a snapshot of the correlation between the states' medical malpractice environment and the health of the states' female minority population. Access to health care is a complex labyrinth of social, political and economic issues, and can only be gauged by a more complete evaluation of the health status of a population.\(^8\)

This analysis focuses on the following five states: California, Nevada, Arizona, Mississippi and Maryland. The AMA has characterized both Nevada and Mississippi as "states in crisis," while Arizona and Maryland are labeled as "states showing problem signs."\(^9\) California alone has remained free of intense medical malpractice criticism, and often is heralded as a model state for reform measures.\(^10\)

When confronted with the medical malpractice insurance crisis, the National Governors Association ("NGA") has posited that states have several regulatory options available.\(^11\) As examples, NGA suggests that states can explore insurance market interventions, tort reform, alternative dispute resolution and patient safety efforts.\(^12\)

Insurance market interventions are often heralded as merely stop-gap solutions to address the lack of affordable or available insurance.\(^13\) This strategy usually involves providing subsidies to providers or creating state-run insurance programs. Although helpful, this response will not singularly solve the systemic issues that insurers and providers believe exist in the medical liability insurance market.\(^14\)

States can also pursue tort reform, which often targets medical malpractice

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\(^{9}\) Although the extent of the meaningfulness of how medical malpractice rates affect the quality of care indicators cannot yet be determined, this preliminary view will help guide additional scholarship.

\(^{10}\) See supra note 15.

\(^{11}\) See supra note 15.


\(^{13}\) Id.

\(^{14}\) Id.
claims as they proceed through the court system. Tort reform generally encompasses abolishing the collateral source rule; placing caps on both economic and non-economic damages; securing sovereign immunity caps; establishing expert witness rules; eliminating joint and several liability; placing limits on contingency fees; requiring periodic payments of awards; establishing pre-trial screening panels; and enacting a statute of limitations.

However, states often want to resolve medical malpractice claims outside the court system altogether, by using alternative dispute resolution. Finally, states can couple any regulatory action with patient safety efforts focusing on resolving the issues that contribute to medical errors.

California


California often is held up as the “gold standard” for state action and national tort reform initiatives. In 1975, California passed the Medical Injury Compensation Reform Act (“MICRA”).

This landmark medical liability reform bill included the following tort reforms:

- Limits on damage awards—$250,000 limit on non-economic damages, applied per occurrence and not indexed for inflation;
- Collateral Source Rule—discretionary offset for collateral sources introduced at trial;
- Periodic award payments—mandatory periodic payment of future damages over $50,000 (upon request);
- Pretrial expert certification—generally, no expert certification is required for medical malpractice in CA;

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90 See NGA Center for Best Practices, supra note 88, at 1, 4.
91 See NGA Center for Best Practices, supra note 88, at 4-6.
92 See NGA Center for Best Practices, supra note 88, at 6.
93 See NGA Center for Best Practices, supra note 88, at 9.
o Attorney contingency fee—limited to 40% of the first $50,000, 33.3% of the next $50,000, and 25% of the next $500,000, and 15% of any amount exceeding $600,000;

o Joint and several liability—no joint and several liability for non-economic damages;

o Statute of Limitations—plaintiffs must file within one year of discovery of injury or within three years of the injury, whichever is first; and

o Bad faith claims—insurers consider this to be a significant problem. 95

Since 1975, medical liability premiums have risen an astonishing 505% nationally, compared with only 167% in California.96 California’s successful medical liability reform efforts have translated into dramatic savings on malpractice insurance premiums for doctors who practice in the state. An OB/GYN in California can expect to pay between $33,000 and $78,000 in medical liability premiums, as compared with $80,000 to $124,000 in Connecticut, a state that has no tort reform.97

Prior to 1988 and the passage of Proposition 103, California had limited regulatory interaction with its medical malpractice insurers. Proposition 103 requires prior approval of insurance rates.98 Additionally, if a commercial carrier demands an increase of greater than 15%, the Commissioner of Insurance must grant a public hearing upon request.99


98 See GAO Multiple Factors, supra note 97, at 59.

99 See GAO Multiple Factors, supra note 97, at 59.
b. Statistics and Quality of Care Indicators

A review of the female minority population and quality of care indicators in California reveals that the female population totals approximately 16.9 million. Of this population, 7% are non-Hispanic Blacks, 31.5% are Hispanics and 12.6% are Asian-Pacific Islanders.100

In an HHS fifty-state comparison, California ranks as having the fewest women who smoke and the most who eat the recommended number of fruits and vegetables per day.101 However, the state ranks last for women who have had a routine checkup in two years and 20th for women who receive early and adequate prenatal care.102 The female minority population in California ranks 35th for number of women with health insurance; however, 85.1% of non-Hispanic Blacks, 67% of Hispanic, and 90.8% of Asian/Pacific Islanders do have insurance.103 This survey includes only women between the ages of eighteen and sixty-four who have private health insurance.

The Medical Liability Monitor 2004 rate survey, which provides an overview of changing rates for physicians' liability insurance, indicated that California has the lowest rate of increase in medical malpractice insurance rates in the country, with rates for OB/GYNs state-wide reduced by 16.8%.104 The average OB/GYN in California paid $30,463 for medical malpractice insurance in 2004, down from $36,611 in 2003.105

The AMA reported that, since it began collecting national data in 1975 through 2002, a total of 101,940 physicians practiced in California, 4,301 of which are OB/GYNs.106 From 1975 to 2002, there have been 77,554 graduates from California medical schools, of which 3,340 entered OB/GYN.107 During this same period, California experienced a 47.2% increase in its supply of doctors.108 The trend in

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101 Id. at 67.
102 Id.
103 Id.
104 29 Medical Liability Monitor 10, Oct. 2004 [hereinafter Medical Liability Monitor Rate Survey].
105 Id. at 5.
106 Hurt, supra note 61. The AMA began compiling statistical data in 1969. Physician trends and characteristics of specialty are comprised from data between 1975 and 2002. See also Cohen, supra note 64.
107 See Hellinger & Encinosa, supra note 98.
108 See Hellinger & Encinosa, supra note 98, at Table 1A (noting increase in supply of doctors
distribution of OB/GYNs has increased slightly since 1975 and remained constant over the last few years, not indicating an exodus from the OB/GYN specialty area despite anecdotal reports. There is no state-specific data on the number of minority physicians or minority OB/GYNs. Table 1 describes these figures based on national statistics provided by the AMA.

Maryland


Maryland, like so many states, has battled rising medical malpractice insurance rates especially in the past few years. The Maryland Medical Society’s (“MedChi”) past president, Dr. Mark Siegel, has reported that Maryland physicians are being pushed out of the state and that shortly, Maryland will face a physician shortage due to these escalating rates.

The Medical Liability Monitor reported a 61.6% statewide average rate increase between 2003 and 2004 for OB/GYNs’ medical malpractice insurance. Most OB/GYNs saw their rates double in one year, leading former Governor Robert Ehrlich to call for a special legislative session in December 2004 to address the drastic rate increases. This session resulted in the passage of legislation subsequently vetoed by the Governor. However, in January 2005, Maryland’s General Assembly overrode the Governor’s veto. In contrast with California, the approved legislative initiative failed to include “MICRA”-like reforms.

The main provisions of Maryland’s medical malpractice legislation include the following provisions:

- Use of $40.7 million (in the first year) derived from a 2% tax on HMOs to limit increases in doctors’ insurance rates to 5%

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109 See Hellinger & Encinosa, supra note 98.
110 Dr. Mark Siegel, MD, International Health Policy Forum, Feb. 23, 2005, American University Washington College of Law.
111 See Medical Liability Monitor Rate Survey, supra note 106.
113 Id.
114 Id.
115 See supra note 97 (outlining the MICRA tort reforms).
in the subsequent year. Doctors insured by the state’s largest malpractice carrier were facing an average increase of 33%;

- Reduce cap on damages for pain and suffering in wrongful death cases from $1.6 million to $812,500;

- Freeze damages available for pain and suffering in other malpractice cases at $650,000 for 4 years: (the law calls for a $15,000 annual increase in the cap);

- Limit past medical expenses allowed in suits to the amount actually paid by or on behalf of the plaintiff;

- Allow court to call a neutral witness to testify about future medical expenses and loss of earnings;

- Tighten qualifications for expert medical witnesses in malpractice cases;

- Require mediation unless both parties in a case agree to proceed without it;

- Reduce the standard of proof in physician discipline proceedings from “clear and convincing” to “preponderance of the evidence”;

- Require Maryland Insurance Administration to publish a comparison guide to malpractice insurance rates;

- Allow for swifter cancellation of malpractice policies by insurers; and

- Create a “people’s insurance counsel” to advocate for consumers against insurance companies.116

b. Statistics and Quality of Care Indicators

Maryland has approximately 2.7 million females in the state, 29.2% of which are non-Hispanic Black, 4% are Hispanic and 4.3% are Asian/Pacific Islanders.\(^{117}\)

Although Maryland has the highest rates of death in the U.S for women due to breast cancer and colorectal cancer, the state shares a high ranking with California for a high percentage of women who do not smoke and who consume the recommended number of fruits and vegetables a day. Maryland is ranked as having one of the best records of preventive care for its female population.

Maryland also ranks 13\(^{th}\) in the country for women with health insurance; and 86.4% of non-Hispanic Blacks, 76.9% of Hispanics and 88.6% of Asian/Pacific Islanders have coverage.\(^{118}\) Over 97% of Black women in Maryland receive routine check ups, with 93.1% of Hispanic and 89.8 Asian women receiving similar care.\(^{119}\)

Since 1975, Maryland has seen a 143.9% increase in its supply of doctors.\(^{120}\) In 2004, there were a total of 24,396 physicians in Maryland, 989 of whom were OB/GYNs.\(^{121}\) With such few numbers of OB/GYNs in relation to the population, there is a glaring deficit in the number of minority OB/GYNs available to treat minority women. Since 1975 to 2002, there have been 17,580 graduating physicians from Maryland Medical Schools, with 734 selecting an OB/GYN specialty.\(^{122}\) Astonishingly, in 2004, not one physician graduating from the University of Maryland’s medical school entered an OB/GYN residency.\(^{123}\) Despite the increasing numbers of physicians in the state, specialty areas that are more prone to higher medical malpractice claims and who happen to also serve the female minority population are dwindling.


\(^{118}\) Id.

\(^{119}\) Id.

\(^{120}\) See Majette, supra note 31.

\(^{121}\) See Physician Characteristics and Distribution in the U.S., supra note 61.

\(^{122}\) See Physician Characteristics and Distribution in the U.S., supra note 61.

\(^{123}\) See Physician Characteristics and Distribution in the U.S., supra note 61.
Mississippi


In 2004, Mississippi passed long-awaited and heavily debated tort reform.\(^{124}\) This was in response to the litigious nature of the state, where, in the first five months of 2002, Mississippi juries awarded nearly $28 million in four medical malpractice cases involving physicians and hospitals.\(^{125}\) In Mississippi, at least 15 medical malpractice insurers have left the market since 1997.\(^{126}\)

Although insurance rate regulation was not part of the tort reform package, and reforms were not similar to MICRA, the legislation did include the following provisions:

- Limits on damage awards—$500,000 limit on non-economic damages, increasing to $750,000 on July 1, 2011 and $1 million on July 1, 2017; the limit does not apply in disfigurement cases or at the judges discretion;

- No collateral source rule;

- Periodic award payments—no provisions for such payments;

- Pretrial expert certification—plaintiff’s attorney must file a certificate of expert consultation, unless an exception applies;

- Attorney contingency fee—no limitation

- Joint and several liability—no joint and several for one economic damages in medical malpractice cases. For economic damages, MS has a sliding scale, where Defendants less than 30% responsible pay only their proportionate share, but defendants over 30% responsible pay up to 50% of

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economic damages;

- Statute of limitations—plaintiff must file within two years of the malpractice or reasonable discovery of malpractice or seven years from the act; and

- Bad faith claims—not significant problem in the state.  

b. Statistics and Quality of Care Indicators

Mississippi has one of the highest rates of death in the U.S. among women due to heart disease, breast cancer, stroke, diabetes-related illnesses, influenza and pneumonia. Like several other states in the South, Mississippi women have high rates of health risk factors, such as high blood pressure, obesity, and physical inactivity, which are most notably higher in the black female population.

The state has one of the lowest rates of binge drinking among women. Even though Mississippi ranks near the bottom of states in the percentage of women with health insurance, 70.6% of non-Hispanic Black, 70.1% Hispanic and 89.9% of Asian/Pacific Islanders do have health coverage.

Of the approximately 1.47 million women in Mississippi, 37.3% are non-Hispanic Black, with only 1.1% of Hispanic women and 0.7% of Asian/Pacific Islanders represented. Of the Black female population, only 69.1% receive prenatal care and

127 See U.S. Gen. Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates 1, 62 (2003), available at http://www.gao.gov/new.items/d03702.pdf [hereinafter GAO Insurance Report]. The Mississippi Department of Insurance stated that most medical malpractice insurance in Mississippi is presently being written in the non-admitted market, which is not rate or form regulated. Id. The Department of Insurance does not regulate the rates or forms of Medical Assurance Company of Mississippi (MACM)—largest writer in Mississippi, with 60% of market—because it is a non-profit, mutual insurance company. Id. In 2003, the MACM was the only medical malpractice insurer left in state. Id.
129 Health Status of Women Region IV', supra note 130, at 52-3, 100-01.
130 Health Status of Women Region IV', supra note 130, at 101.
131 See Health Status of Women Region IV', supra note 130, at 115.
132 See, Health Status of Women Region IV', supra note 130, at 21 tbl. 4.
only 64.6% of the small Hispanic population receives such care.\(^\text{133}\) Also, 94.4% of Black women and 90.2% of Hispanics receive routine checkups.\(^\text{134}\)

Since 1975, Mississippi has seen an 84.3% increase in supply of doctors.\(^\text{135}\) In 2002, there were a total of 5,680 doctors, but only 302 practiced in the OB/GYN specialty area.\(^\text{136}\) Since 1975, Mississippi Medical Schools graduated 4,965 physicians, with only 285 entering the OB/GYN specialty.\(^\text{137}\) Mississippi’s average medical malpractice insurance rates for an OB/GYN increased 59% from 2003 to 2004, raising the average insurance payment to $80,000.\(^\text{138}\) The limited supply of OB/GYNs, especially in light of the high female minority population, begs the question of whether these women are receiving health care.

**Arizona**\(^\text{139}\)

\(\text{a. Statutory/Regulatory Provisions}\)

The AMA has not labeled Arizona as a medical malpractice crisis state, but rather as a state showing signs of escalating rates.\(^\text{140}\) Arizona has very few regulatory provisions affecting medical malpractice or tort reform. The few existing provisions include the following:

- Limits on damage awards—none; limits are constitutionally prohibited;
- Expert Witnesses—no provisions;
- Pre-Trial Screening & Arbitration—good cause hearing determines if basis exists to go to trial;
- Attorneys’ fees—not limited, but court reviews reasonableness

\(^{133}\) See *Health Status of Women Region IV*, supra note 130, at 85 tbl. 59.

\(^{134}\) See *Health Status of Women Region IV*, supra note 130.

\(^{135}\) Hellinger & Encinosa, supra note 98, at 17 tbl. 1B.

\(^{136}\) *See Health Status of Women Region IV*, supra note 130.

\(^{137}\) *Physician Characteristics and Distribution in the U.S.*, supra note 80.

\(^{138}\) *See Medical Liability Monitor*, supra note 99, at 13.


\(^{140}\) *See America’s Medical Liability Crisis*, supra note 73.
of fees upon request of either party;

- Joint & severable liability—defendants are proportionately liable for damages awarded according to percentage of fault unless defendant acted in concert with another person;

- Statute of Limitations—2 years after cause of action, and not afterward for personal injury or death;

- Patient Compensation or Stabilization Fund—none.

b. Statistics and Quality of Care Indicators

Only 3% of Arizona's approximately 2.6 million female population is non-Hispanic Black; 24% are Hispanic and 2.3% are Asian/Pacific Islander. Arizona has very low rates of diabetes-related deaths and deaths from all cancers; it is one of the few states in which females have already met the Healthy People 2010 (HP 2010) death rate targets from these diseases. Arizona also has a low percentage of women with high blood pressure and obesity, and the state has the highest percentage of women who abstain from smoking during pregnancy.

Within this population, 95.8% of Black women have had a routine check up and 69.8% of Blacks receive pre-natal care. 82% of Hispanics have routine checkups, compared with 96.3% of Asian/Pacific Islanders. However, only 60% of Hispanic women and 75.4% of Asian/Pacific/Islander women receive pre-natal care. 85.1% of Black women have health insurance coverage, compared with to 62.7% of Hispanic and

141 Office on Women's Health, United States Dep't of Health and Human Services, Health Status of Women in Region IX 1, 21 tbl. 4, http://healthstatus2010.com/owh/Reg09%20Report.pdf (charting female population of Arizona by race and ethnicity) [hereinafter Health Status of Women Region IX].
142 Health Status of Women Region IX supra note 143, at 40 tbl. 19. The HP 2010 goal for diabetes related deaths is 45 deaths per 100,000. Health Status of Women Region IX supra note 143, at 40.
143 Health Status of Women Region IX supra note 143, at 54, 85, 102. Women in Nevada reported fewer diagnoses of high blood pressure than the average for women in the nation. Health Status of Women Region IX supra note 143, at 102. The areas surrounding Phoenix and Tucson had lower smoking percentages among pregnant women than the national value. Health Status of Women Region IX supra note 143, at 67-68.
144 See Health Status of Women Region IX supra note 143.
145 See Health Status of Women Region IX supra note 143.
146 See Health Status of Women Region IX supra note 143.
90.6% of Asian women.\textsuperscript{147}

Medical malpractice rates have increased at an average of 51.85% since 2003.\textsuperscript{148} OB/GYNs’ average payments of close to $100,000 are nearly double that of other specialties.\textsuperscript{149} Since 1975, Arizona has seen a 76.5% increase in supply of doctors, despite no caps on medical malpractice awards.\textsuperscript{150} This increase is illusory in regards to the availability of OB/GYNs.

Between 1975 and 2002, the AMA reported that Arizona had a total of 12,989 physicians, with 221 in the OB/GYN specialty.\textsuperscript{151} During that same time period, Arizona medical schools graduated 322 doctors, with only six planning to practice OB/GYN.\textsuperscript{152} Although Black females only account for 3% of the female population, the ratio of an OB/GYN to black females is one to 12,847.\textsuperscript{153} Minority OB/GYN data for Arizona is not available; however, the number of minority OB/GYNs servicing this population predictably would be extremely low.

\textbf{Nevada}

\textit{a. Statutory/Regulatory Provisions}

Nevada is one of the AMA’s twenty crisis states.\textsuperscript{154} In July 2002, Nevada’s only Level I trauma center, which is one of the five busiest in the nation, was forced to close its doors for 10 days when all but one of the fifty-eight trauma surgeons resigned, citing unaffordable medical malpractice insurance premiums.\textsuperscript{155} Physicians attempted to pressure the Governor and the legislature to enact tort reform.\textsuperscript{156}

State officials took action later that same year and created the Medical Liability Association of Nevada (“MLAN”), which established an emergency regulation of the Nevada Commissioner of Insurance to provide medical professional liability insurance coverage for eligible physicians and other appropriate medical professionals on a self-

\textsuperscript{147} See Health Status of Women Region IX, supra note 143.
\textsuperscript{148} See Medical Liability Monitor, supra note 99.
\textsuperscript{149} Medical Liability Monitor Rate Survey, supra note 106.
\textsuperscript{150} See Hellinger & Encinoca, supra, note 98, at 17 tbl. 1B.
\textsuperscript{151} See Physician Characteristics and Distribution in the U.S., supra note 80.
\textsuperscript{152} See Medical Liability Monitor, supra note 99.
\textsuperscript{153} See Health Status of Women Region IX, supra note 143.
\textsuperscript{154} See America’s Medical Liability Crisis, supra note 73.
\textsuperscript{155} See America’s Medical Liability Crisis, supra note 73.
\textsuperscript{156} See Cornell, supra note 88.
supporting basis.\textsuperscript{157} MLAN guarantees the availability of insurance from a financially sound insurance provider until a strong insurance marketplace can be reestablished in Nevada.\textsuperscript{158}

Later in 2002, "[n]ew state medical liability laws were enacted during the . . . special session of the legislature to help stem the tide of departing doctors."\textsuperscript{159} Physicians and insurance officials argued, however, that those reforms did not go far enough.\textsuperscript{160} In November 2004, voters in Nevada approved a ballot initiative establishing MICRA-like reforms that went into effect immediately.\textsuperscript{161}

The main provisions that passed include the following:

- Limits on damage awards—$350,000 limit on non-economic damages, no exceptions. $300,000 or 3 times compensatory damages limit on punitive damages, only awarded by court for fraud, oppression, or malice;

- Pre-trial screening and arbitration—all parties, insurers and attorneys required to participate in settlement conferences before a district judge other than trial judge;

- Expert witnesses—affidavit must be filed by medical expert practicing in area similar to defendant; failure to submit results in dismissal;

- Attorneys’ fees—sliding scale for attorneys fees, not to exceed 40% of first $50,000, 33.3% of next $50,000, 25% of next $500,000, and 15% of any amount over $600,000;

\textsuperscript{157} Medical Liability Association of Nevada, at http://www.mlan.org (last visited Nov. 1, 2007).

\textsuperscript{158} Id.


\textsuperscript{160} Id. (noting physicians and insurance officials unsuccessfully pushed for more reforms during 2003 legislative session).

Joint and several liability—defendants proportionally liable according to percentage of fault for economic and non-economic damages awarded;

Statute of limitations provision—four years from injury or two years from reasonable discovery of injury in wrongful death prior to Oct 1, 2002. If after October 1, 2002, then three years from injury or one year from discovery; and

Patient Compensation Fund—State Insurance Commissioner may create insurance coverage through regulation if access to essential insurance involuntary market is limited.\(^{162}\)

\(b.\) Statistics and Quality of Care Indicators

Nevada has a relatively small percentage of minority women, with only 7.15% of its approximately 980,000 female population being non-Hispanic Black, 18.8% Hispanic, and 6.1% Asian/Pacific Islander.\(^{163}\) Although Nevada women have high rates of deaths related to smoking, the state has one of the lowest rates of diabetes-related deaths in the nation.\(^{164}\) Further, Nevada has very low rates of obesity among women.\(^{165}\) Nevada ranks near the bottom of all fifty states for the number of women who receive preventive care and has one of the lowest percentages of women who have health insurance coverage.\(^{166}\)

Within this population, 84.1% of Black women receive routine check ups, and 84% of Hispanics and 82.2% of Asian/Pacific Islanders receive such care.\(^{167}\) Only 62.2% of Black women and 55% of Hispanic women receive adequate pre-natal care, but 72.3% of Asian Pacific Islander women receive such care.\(^{168}\) 76.9% of Black females, 60.6% of Hispanic females and 85.4% Asian/Pacific Islanders have health insurance coverage.\(^{169}\)

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\(^{163}\) HHS State Profiles at 21.

\(^{164}\) \textit{Id.} at 40, 103.

\(^{165}\) \textit{See id.} at 102.

\(^{166}\) \textit{Id.}

\(^{167}\) \textit{See HHS State Profiles.}

\(^{168}\) \textit{Id.}

\(^{169}\) \textit{Id.}
Since 1975, Nevada has only seen a 24.7% increase in its supply of doctors. From 1975 until 2002, Nevada's reports having 4,417 physicians, 231 of whom are OG/GYNs. Since 1975, there have been 3,260 graduates of Arizona-based medical schools, with only 194 choosing to enter the OB/GYN specialty. The average medical malpractice insurance rate increase is only 15%, due to the establishment of the government regulated and subsidized MLAN.

Figure 1: Minority Physicians, OB/GYN Physicians and Minority Women

<table>
<thead>
<tr>
<th>State</th>
<th>Doctors</th>
<th>Black Doctors</th>
<th>Black OB/GYNs</th>
<th>Black OB/GYNs per Black Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>101,940</td>
<td>2,447</td>
<td>113</td>
<td>1/10,572</td>
</tr>
<tr>
<td>Maryland</td>
<td>24,396</td>
<td>586</td>
<td>27</td>
<td>1/29,692</td>
</tr>
<tr>
<td>Mississippi</td>
<td>5,680</td>
<td>136</td>
<td>6</td>
<td>1/87,740</td>
</tr>
<tr>
<td>Arizona</td>
<td>12,989</td>
<td>312</td>
<td>14</td>
<td>1/5,376</td>
</tr>
<tr>
<td>Nevada</td>
<td>4,417</td>
<td>106</td>
<td>5</td>
<td>1/14,272</td>
</tr>
</tbody>
</table>

170 See Hellinger & Encinosa, supra note 98
171 See America's Medical Liability Crisis, supra note 73.
172 See America's Medical Liability Crisis, supra note 73.
173 Medical Liability Monitor Rate Survey, supra note 106.
Additional reforms include a variety of measures designed by individual states to address the medical malpractice insurance crisis in that state. The following additional provisions are specific to Maryland, including: taxing HMO's; freezing damages for a certain number of years; limiting the admittance of past medical expenses; requirement of mediation; requirement that state Insurance Commissioner publish a malpractice insurance rate comparison guide; and the creation of a “people's insurance counsel” to advocate for consumers against insurance companies. Provisions specific to Arizona include a pre-trial screening & arbitration requirement that provides for a good cause hearing to determine if a basis exists to go to trial. Nevada also requires a pre-trial screening process before a district judge rather than a trial judge. Nevada reforms also provide for the creation of a state compensation fund and a state sponsored medical malpractice insurance program if access to market is limited. HHS Healthy People 2010.
V. Discussion

Comparing state reforms designed to address the medical malpractice insurance

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177 HHS *Healthy People 2010* rankings by state include the following designations: CA has the highest number of women in the country who eat the recommended fruits and vegetables a day and do not smoke. Maryland also has a high ranking in this area, however, also has the highest rate of death in the US for women due to breast cancer and colorectal cancer. Despite that statistic, MD continues to have one of the best records of preventive care for its female population. MS has the lowest number of women who engage in binge drinking, but ranks near 50th for women with private health insurance. AZ has low rates of diabetes-related deaths and deaths from all cancers, and one of the few states that has met the “Healthy People 2010” standards. NV has one of the lowest rates of obesity in nation. However, NV also has one of the lowest percentages of women who received preventive care and have private health insurance. *HHS Healthy People 2010*. 
crisis with quality health care indicators does not give rise to an obvious correlation between reforms and quality of care. This may be due to the lack of data in this area specific to medical malpractice. The access to health care dilemma is complex, but from a preliminary viewpoint, looking at the number of minority women who receive routine care every two years, there seems to be an adverse correlation. California, characterized by having the most comprehensive reform, has the lowest number of women receiving routine care. Mississippi, having only recently implemented medical malpractice insurance reform, has near 100% of its female Black population receiving routine care. State comparisons of the percentage of female minorities that receive prenatal care reveal that all five states are within a few percentage points of each other.

Lack of quality data on minority women, medical malpractice insurance reform, access to health care, and health care indicators makes evaluating the effect of such reform on minority women's health difficult to determine. Thus, it is necessary, due to the increasing number of anecdotal reports of decreasing access to health care for minority women, to investigate this issue more thoroughly. Otherwise, as with the first blush of many statistical evaluations, the real story will not surface. It is essential to the crescendo of public policy debate regarding this topic that the correlation between the medical malpractice insurance crisis and access to health care for minority women is determined with more certainty than what currently exists.

At the heart of the medical malpractice insurance crisis and tort reform debate is the states' interest in supporting access to health care by ensuring that physicians remain in practice. Most state reforms include some type of cap on economic and non-economic damages. Reformers argue that caps on non-economic damages are necessary to prevent large awards for damages that are difficult to quantify, such as the worth of reproductive rights or the cost of sexual assault. However, restricting the rights of women to collect for non-economic damages has unintended consequences on their ability to use the justice system.

In “The Hidden Victims of Tort Reform: Women, Children and the Elderly,” Lucinda Finley explains that non-economic damages are usually awarded for several types of injuries disproportionately suffered by women, such as sexual assault, reproductive harm, pregnancy loss or infertility, and gynecological medical malpractice. Resulting emotional distress and grief, altered sense of self and social adjustment, impaired relationships or impaired physical capabilities such as

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178 Lucinda Finley, supra note 8 at 1266.
reproduction, are not directly involved in market-based wage earning activity.\textsuperscript{179} Most of these aspects of human life are priceless and have not been deemed economically worthy in the marketplace, and so compensation is usually found through non-economic damages.\textsuperscript{180} Finley's research shows that caps on these damages could make it more difficult for victims to find legal representation, as they often do not meet an economic loss threshold.\textsuperscript{181} Additionally, Finley argues that medical malpractice reforms do not affect medical malpractice insurance premiums and only result in limiting women's access to justice.\textsuperscript{182}

Limiting attorneys' fees may also inhibit a woman's ability to retain an attorney, since projected fees—once adjusted for the caps—may not substantiate a lawyer taking a case. Minority women's access to justice would be felt more acutely since this sector of the population relies heavily on contingency fees to retain an attorney. More importantly, this type of medical malpractice insurance reform may decrease minority women's access to quality care by limiting the accountability and consequences to providers offering care to women. Future research must address the unintended affects of medical malpractice insurance reforms on minority women, including their decreased access to justice and place in the solving of medical errors debate.

VI. Conclusion: Research And Policy Recommendations

The relationship between the medical malpractice insurance crisis and its affect on minority women's access to health care remains murky and is plagued by unknown, perhaps mystifying, variables. To date, insufficient data has become the most arduous hurdle to overcome, thus highlighting future policy and research recommendations in this area.

Despite reports of increasing numbers of graduating physicians, anecdotal evidence suggests that the medical malpractice insurance crisis is affecting the availability

\begin{itemize}
  \item \textsuperscript{179} Lucinda Finley, \textit{supra} note 8 at 1266 (listing the impact of injuries disproportionately suffered by women: impaired fertility or sexual functioning, miscarriage, incontinence, trauma associated with sexual relationships, and scarring or disfigurement in sensitive, intimate areas of the body).
  \item \textsuperscript{180} \textit{Id.} (noting that in recovery for these injuries disproportionately suffered by women, economic damages are inadequate).
  \item \textsuperscript{181} Finley, \textit{supra} note 8 at 1265 (“While damages caps are not likely to alter the hard market/soft market cycles that affect premium rates and insurance availability, they do make it less likely that certain types of injuries will be redressed through the courts, because claims with low economic loss recovery value, but high noneconomic loss and significant deterrent impact, are no longer worth pursuing.”).
  \item \textsuperscript{182} Finley, \textit{supra} note 8 at 1314.
\end{itemize}
of OB/GYNs, especially those who serve minority populations. However, there is insufficient data on precisely how many OB/GYNs practice the full range of their specialty. OB/GYNs may be limiting their practice area to less litigious services, like gynecology or pre-natal care. There is no reliable evidence as to which types of services OB/GYNs offer their patients. Nor does a breakdown of this specialty by physicians' race, gender or ethnicity by state exist. These features remain essential ingredients in evaluating how the medical malpractice insurance crisis affects access to health care for minority women.

In sum, there needs to be a comprehensive, statistically accurate accounting of how many minority physicians, especially minority OB/GYNs, practice in each state and by specialty. In addition, future studies should determine OB/GYN service populations in correlation with the above factors, including socio-economic status. This would allow characteristics of OB/GYNs to be compared with the population they serve. This could be accomplished through joint research projects with the AMA and ACOG, which could study physician characteristics by specialty by state.

Additional data needed to further this investigation includes more complete tracking of medical school graduates by a number of variables, including the following features: state/geographical region of medical school graduates, state where residency is performed, and state where the graduates practice for the first two years after residency is completed. This data should also be broken down by race, gender, ethnicity and specialty.

The quality of health care indicators for women nationwide also is insufficient. The ambiguity of the criteria makes it difficult to determine the meaningfulness of current statistics when analyzing the access to health care dilemma in relation to the medical malpractice insurance crisis. Although this article notes that almost 80% of female minorities in every reviewed state received some type of health care in the last two years, neither the quality of that care nor the access issues those women faced have been measured and evaluated. However, it is clear that minority women are less likely to receive care than their Caucasian counterparts, as most access to health care studies indicate. Further, those studies that did address access to health care had insufficient findings as to the extent of how socio-economic and cultural impediments affect minority women. They failed as well to compare and weigh those factors with other social issues, such as the medical malpractice insurance crisis.

IOM Report, supra note 2.
Anecdotal evidence alone is not sufficient enough reason to effectuate change, especially in light of the conflicting reports on the effectiveness of medical malpractice insurance reform and its impact on access to justice. More research into the effect that caps on non-economic damages have on minority women and the limits caps impose on access to justice and health care for minorities is necessary to craft meaningful policy and reform strategies.

Public policy measures that advance minority physicians' access to minority women should also be pursued. The IOM suggests offering, as one solution, financial incentives to minority physicians who serve minority populations. Both OB/GYN and ER physicians have the highest propensity to serve minority women, yet there is no obvious incentive for these specialty groups to do so. This recommendation is repeatedly made by not only the IOM, but by the AMA, ACOG and public health advocates who have researched this area. If implemented, incentives could immediately increase the number of minority women who have access to health care.

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184 IOM Report, supra note 2.