**F057784**

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**IN THE CALIFORNIA COURT OF APPEAL**

**FIFTH APPELLATE DISTRICT**

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**HOLLY STINNETT,**

Plaintiff and Appellant,

vs.

**TONY TAM, M.D., ET AL.,**

Defendants and Respondents.

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*Superior Court Of Stanislaus County, Case No. 384025*
*Hon. Hurl W. Johnson, Judge Presiding*

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# *AMICUS* BRIEF OF CONSUMER ATTORNEYS OF CALIFORNIA IN SUPPORT OF PLAINTIFF AND APPELLANT HOLLY STINNETT

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## CERTIFICATE OF INTERESTED PARTIES

Pursuant to California Rule of Court 8.208, Consumer Attorneys of California certifies that it is a non-profit organization which has no shareholders. As such, *amicus* and its counsel certify that *amicus* and its counsel know of no other person or entity that has a financial or other interest in the outcome of the proceeding that the *amicus* and its counsel reasonably believe the Justices of this Court should consider in determining whether to disqualify themselves under canon 3E of the Code of Judicial Ethics.

Dated: October 15, 2010

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SHARON J. ARKIN

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## INTEREST OF *AMICUS CURIAE*

The Consumer Attorneys of California ("CAOC") respectfully submits this brief as *amicus curiae* in support of Plaintiff and Appellant Holly Stinnett. CAOC is a voluntary statewide bar association whose approximately 6,000 associated trial lawyer members primarily represent individual plaintiffs in personal injury cases, including medical malpractice lawsuits, and in other civil actions. Throughout its half-century history, CAOC has championed the constitutional rights of trial by jury, equal protection, access to the courts, full redress of injury to person, property, or reputation, and due process of law as essential parts of democratic government and as rights by which ordinary citizens hold accountable those who wrongfully have caused them harm. CAOC files this brief because the statute at issue violates the constitutional guarantees that CAOC has promoted and denies full redress for proven wrongs.

## INTRODUCTION AND SUMMARY OF ARGUMENT

CAOC submits this brief *amicus curiae* in support of the Plaintiff and Appellants' argument that MICRA's cap on noneconomic damages, Civ. Code, § 3333.2, subs. (b), violates our State's constitutional guarantee of equal protection, Cal. Const. art. I, § 7, subd. (a). *Amicus* recognizes that

the cap's constitutionality was upheld by our Supreme Court in *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137 (hereafter *Fein*). Nevertheless, *amicus* respectfully submits that neither *Fein* nor its progeny are dispositive of the instant challenge. There are two reasons why.

First, this challenge raises constitutional grounds not considered, let alone resolved, by this Court or the Supreme Court, which is important because "[i]t is axiomatic that language in a judicial opinion is to be understood in accordance with the facts and issues before the court," with the result that prior decisions may not be regarded as "authority for propositions not considered." (*Chevron U.S.A., Inc. v. Workers' Comp. Appeals Bd.* (1999) 19 Cal.4th 1182, 1195; see also *Silverbrand v. County of Los Angeles* (2009) 46 Cal.4th 106, 127; *In re Marriage of Cornejo* (1996) 13 Cal.4th 381, 388.)

Second, *amicus* demonstrates below that the factual premises that supported *Fein* no longer obtain, which is important because "a classification which once was rational because of a given set of circumstances may lose its rationality if the relevant factual premise is totally altered." (*Brown v. Merlo* (1973) 8 Cal.3d 855, 869-70 (hereafter *Merlo*).) Thus, although the Supreme Court assessed the "relevant factual premise" and rationality of MICRA's cap 25 years ago in *Fein*, and thereupon upheld the cap, *Fein*, 38 Cal.3d at 162-63, the Court has cautioned that "'[w]hen the reason of a rule ceases, so should the rule

itself.'" (*Merlo*, at 868-69, citation omitted.) For just that reason, courts consider post-enactment evidence in assessing a statute's continuing rationality. (See e.g., *Sonoma County Org. of Pub. Employees v. County of Sonoma* (1979) 23 Cal.3d 296, 311 (hereafter *Sonoma County*).)

Section I of this brief demonstrates that the perpetuation of the cap is unnecessary and irrational because the threatened physician "exodus" and the alleged malpractice "healthcare crisis" of the early 1970s, which spurred MICRA's enactment, were not cured by the cap and invalidating the cap will not cause a new exodus and new crisis. Section I explains that even assuming, *arguendo*, that the cap served a rational purpose when it was enacted, it is no longer needed, no longer rational, and, therefore, no longer constitutional. Section I also shows the cap denies malpractice victims their constitutionally-guaranteed right of access to the courts because it hampers their ability to find lawyers willing to pursue their cases.

Section II addresses an equal-protection issue that was not resolved in previous challenges to MICRA's provisions: i.e., whether the cap violates equal protection by arbitrarily "discriminat[ing] *within* the class of malpractice victims." (*Young v. Haines* (1986) 41 Cal.3d 883, 899 (hereafter *Young*).) The MICRA cap violates equal protection by: (1) arbitrarily imposing a one-size-fits-all, $250,000 limit on the amount of noneconomic damages a plaintiff may receive in any medical malpractice

action—regardless of the jury's findings about the extent and severity of the plaintiff's injuries—thereby reducing the recovery of the most grievously injured victims of malpractice, while still permitting more modestly injured individuals full recovery; and (2) arbitrarily imposing special burdens on malpractice victims who are women, children, elderly, racial minorities, or poor, thereby disproportionately reducing the total recovery such people receive because their economic damages (such as lost wages) either are nonexistent or artificially low.

## ARGUMENT

### 1.

### PERPETUATING THE CAP LACKS A RATIONAL BASIS

Neither this Court nor the Supreme Court has considered whether the MICRA cap should be assessed under any standard of scrutiny besides the rational-basis test. (See *Young*, 41 Cal.3d at 899 [finding rational-basis test appropriate to review legislative classifications among personal injury plaintiffs].) While *amicus* suggests that fundamental rights are at stake and greater scrutiny is warranted, MICRA cannot meet even the lesser rational-basis test.

To pass muster under the rational-basis standard, the distinctions MICRA establishes must have "'a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike.'" (*Young*, 41 Cal.3d at 899, citation omitted; see also *Merlo*, 8 Cal.3d at 861.)[1] In other words, the rational-basis test requires a court to determine whether the cap serves a legitimate governmental purpose, *and* whether it bears a fair and substantial relationship to that purpose. (*Young*, 41 Cal.3d at 899; see also *Cooper v. Bray* (1978) 21 Cal.3d 841, 848.) Indeed, in assessing an equal protection claim, this Court "must undertake a serious and genuine judicial inquiry into the correspondence between the classification and the legislative goals." (*People v. Hofsheier* (2006) 37 Cal.4th 1185, 1201, internal quotation marks, citations, and italics omitted.) Such an inquiry, "though limited, is not toothless." (*Young*, 41 Cal.3d at 899.)

Although the Supreme Court conducted just such an inquiry regarding the cap 25 years ago in *Fein*, and thereupon upheld it, 38 Cal.3d at 162-63, the Court has cautioned that "[o]ne of the most basic, and

[1] Thus, the "'constitutional demand of rationality'" forbids "different treatment be accorded to persons placed by a statute into different classes on the basis of criteria wholly unrelated to the objective of that statute"; rather, in order to pass muster any different treatment "'must involve something more than mere characteristics which will serve to divide or identify the class. There must be inherent differences in situations related to the subject-matter of the legislation.'" (*Young*, 41 Cal.3d at 899-900, citations omitted.)

familiar, tenets of the common law is that '[w]hen the reason of a rule ceases, so should the rule itself.'" (*Merlo*, 8 Cal.3d at 868, citation omitted.) Significantly, in invalidating an automobile guest statute enacted decades earlier, *Merlo* explained: "[r]eason and rationality . . . are not the preserves of the common law alone; [instead], they serve as a guiding standard in constitutional adjudication under our state and federal 'equal protection' clauses as well." (*Id.* at 869.) Hence, "a classification which once was rational because of a given set of circumstances may lose its rationality if the relevant factual premise is totally altered." (*Id.*; see also *Sonoma County*, 23 Cal.3d at 311 [courts may consider post-enactment matters in assessing a statute's rationality].)

### A. The Physician "Exodus" Claims Are a Myth

One of the fundamental justifications for the enactment of MICRA was the fear that potential liability and the inability to obtain affordable medical malpractice insurance would drive physicians out of the state. Even if originally a reasonable likelihood when MICRA was enacted, it no longer justifies MICRA's limitations.

### 1. MICRA did not fix a physician exodus crisis and invalidating MICRA will not cause physicians to flee California

MICRA's defenders maintain the cap was and remains a necessary and rational solution to a "healthcare crisis," a crisis caused by alleged early retirement of an unspecified number of physicians or the ostensible flight of an unspecified number of other physicians from California to states with supposedly friendlier juries, judges, and laws. (See, e.g., William G. Hamm, *et al., MICRA and Access to Healthcare* [Californians Allied for Patient Protection, Nov. 2008] 12 <www.micra.org/patient-access/documents/LECGCAPPReport.pdf> (hereafter Hamm-CAPP).)[2]

[2] The "study" argues that "[n]ewspaper headlines . . . demonstrate the extent of the crisis facing California's healthcare system." Hamm-CAPP, at 12. This type of evidence has been condemned as untrustworthy by courts and scholars. For example, federal government researchers who have studied similar anecdotal accounts of physicians fleeing from one state or another and examined survey results regarding physicians' future plans have found such accounts and surveys to be unreliable. For example, "'very few physicians tend to respond to these surveys, raising doubt about how accurately their responses reflect the practices of all [healthcare providers]. [The results] cannot be generalized more broadly [beyond anecdotal evidence].'" (*Ferdon v. Wisconsin Patients Comp. Fund* (Wis. 2005) 701 N.W.2d 440, 488 (hereafter *Ferdon*), quoting U.S. GAO, *Medical Malpractice: Implications of Rising Premiums on Access to Healthcare* (Aug. 2003) 6 <http:www.gao.gov/new.items/d03836.pdf> (hereafter GAO, *Medical Malpractice: Implications*).) Furthermore, federal researchers also found that newspaper reports and legislative testimony that physicians had retired or would move their practices to another state often were false or unsubstantiated. (See GAO, *Medical Malpractice: Implications*, at 5-7, 13-14, 17-20, & 28.) More recent research by Professor Michelle Mello, Director of the Program in Law and Public

However, disinterested, reliable government sources, subject to judicial notice, demonstrate that the claims are false.

Five years ago, the Wisconsin Supreme Court faced arguments by proponents of that state's cap that are indistinguishable from the ones advanced by MICRA's proponents even today. That court rejected those arguments and struck down that state's $350,000 cap on noneconomic damages in malpractice cases on equal protection grounds after determining the cap was not "rationally related to the objective of ensuring quality health care by creating an environment that health care providers are likely to move into, or less likely to move out of, in Wisconsin." (*Ferdon*, 701 N.W.2d at 487.) Rather, the court concluded, "the available evidence indicates that health care providers do not decide to practice in a particular state based on the state's cap on noneconomic damages." (*Ibid*.)

Significantly, *Ferdon* noted that government "[s]tudies indicate that caps on noneconomic damages do not affect doctors' migration." As the court noted, the "non-partisan U.S. General Accounting Office concluded that doctors do not appear to leave or enter states to practice based on caps

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Health at Harvard's School of Public Health, found that in Pennsylvania, where medical society surveys reported that doctors were planning to flee the state in droves, such alarms were false and that such surveys, "including [her] own," were neither accurate nor reliable. (Mello, *et al*., *Changes in Physician Supply and Scope of Practice During a Malpractice Crisis: Evidence from Pennsylvania* (2007) 26 Health Affairs 425, 433 (hereafter Mello).)

on noneconomic damages in medical malpractice actions . . . [and] found that despite extensive media coverage of physician departures from states, the numbers of physician departures reported were sometimes inaccurate and were actually relatively low." (*Ferdon*, 701 N.W.2d at 485-86, footnotes omitted [citing U.S. GAO, *Medical Malpractice: Implications* at 17, 13].) *Ferdon* also observed that "[t]he conclusions reached by the [GAO] are supported by other reports and studies." (*Id.* at 486, footnote omitted.)[3]

Equally important, claims about physician shortages in the absence of a cap are completely contradicted by research published by the American Medical Association in its annual compendium, *Physician Characteristics and Distribution in the United States* ("PC&D"), which is widely regarded

[3] *Ferdon* also debunked the widespread myth that caps reduce overall healthcare costs. To be sure, a "cap on noneconomic damages appears, at first blush, to be related to the legislative objective of keeping overall health care costs down." (*Ferdon*, 701 N.W.2d at 483.) As *Ferdon* noted, however, "even assuming that a $350,000 cap affects medical malpractice insurance premiums," research had established that such "premiums are an exceedingly small portion of overall health care costs." (*Id.*, footnote omitted.) The court concluded that, "even if the $350,000 cap on noneconomic damages would reduce medical malpractice insurance premiums, this reduction would have no effect on a consumer's health care costs. Accordingly, there is no objectively reasonable basis to conclude that the $350,000 cap justifies placing such a harsh burden on the most severely injured medical malpractice victims, many of whom are children." (*Id.* at 485.) The Alabama Supreme Court reached the same conclusion in holding that state's cap was irrational and unconstitutional, explaining "the correlation between the damages cap . . . and the reduction of health care costs . . . is, at best, indirect and remote." (*Moore v. Mobile Infirmary Assoc*. (Ala. 1991) 592 So.2d 156, 168 (hereafter *Moore*).)

as the most authoritative source of information on the distribution of doctors throughout the nation.[4]

Indeed, as depicted in the following three graphs (which are derived from post-*Fein* AMA-PC&D research that is depicted in tabular form in the attached Appendix), the notions that MICRA cured a physician exodus and that striking down the cap will cause a new exodus are complete canards.

a. As shown in Graph A, physicians did not flock to California after MICRA was enacted. The critical ratio of physicians per capita (the relative rate of physicians per 100,000 people) increased from 175 physicians per 100,000 people in 1963 to 219 physicians per 100,000 people in 1975—an overall increase of 25.1 percent, or an average increase of 2.1 percent per year before MICRA was enacted. The ratio of physicians per capita increased at a slower rate from 222 physicians per 100,000 people in 1976 to 303 physicians per 100,000 people in 2006, a total

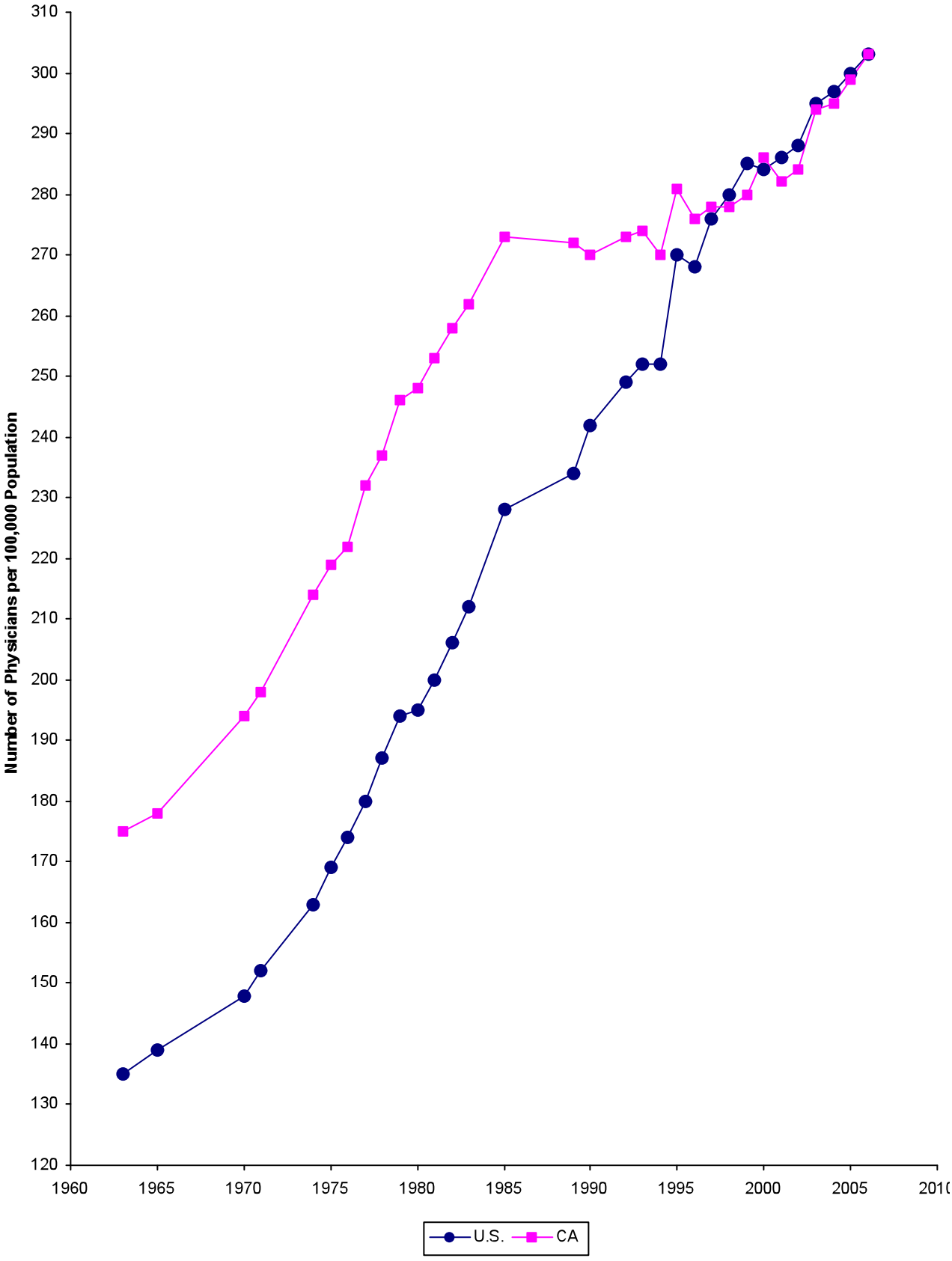
[4] The AMA describes its PC&Ds as "the most accurate and complete source for statistical data about Doctors of Medicine . . . supply in the United States." (<https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod121_0018> [as of Aug. 12, 2010].) PC&Ds are routinely relied upon by courts and scholars. (See, e.g., *FormyDuval v. Bunn* (N.C. App. 2000) 530 S.E.2d 96, 101; *Torres Vargas v. Santiago Cummings* (1st Cir. 1998) 149 F.3d 29, 35; Vidmar, *et al.*, *"Judicial Hellholes:" Medical Malpractice Claims, Verdicts and the "Doctor Exodus" in Illinois* (2006) 59 Vand. L. Rev. 1309, 1335; Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care* (2008) 83 Ind. L.J. 71, 83 n.89; Casalino, *Physicians and Corporations: a Corporate Transformation of American Medicine?* (2004) 29 J. Health Pol. Pol'y & L. 869, 881.)

increase of 36.5 percent, but an average increase of only 1.2 percent per year, far lower over those three decades than the 2.1 percent annual increase in the decade before MICRA's enactment.

In fact, as also shown in Graph A, California fell behind other states in the rate of physicians/100,000 *after* MICRA was enacted. Thus, the rate of physicians per 100,000 people in the United States as whole increased from 135 physicians per 100,000 in 1963 to 169 physicians per 100,000 people in 1975—a total pre-MICRA increase of 25.2 percent or an average pre-MICRA increase of 2.1 percent per year, nearly identical to the California experience during the same time period. The rate of physicians per 100,000 people grew faster in states other than in California after MICRA was enacted, from 174 physicians per 100,000 in 1976 to 303 physicians per 100,000 people in 2006—a total post-MICRA increase of 74.1 percent or an average post-MICRA increase of 2.8 percent per year, more than ***twice*** as fast as in California.

**GRAPH A**

**Rate of All Physicians per 100,000 Persons for California and the United States**

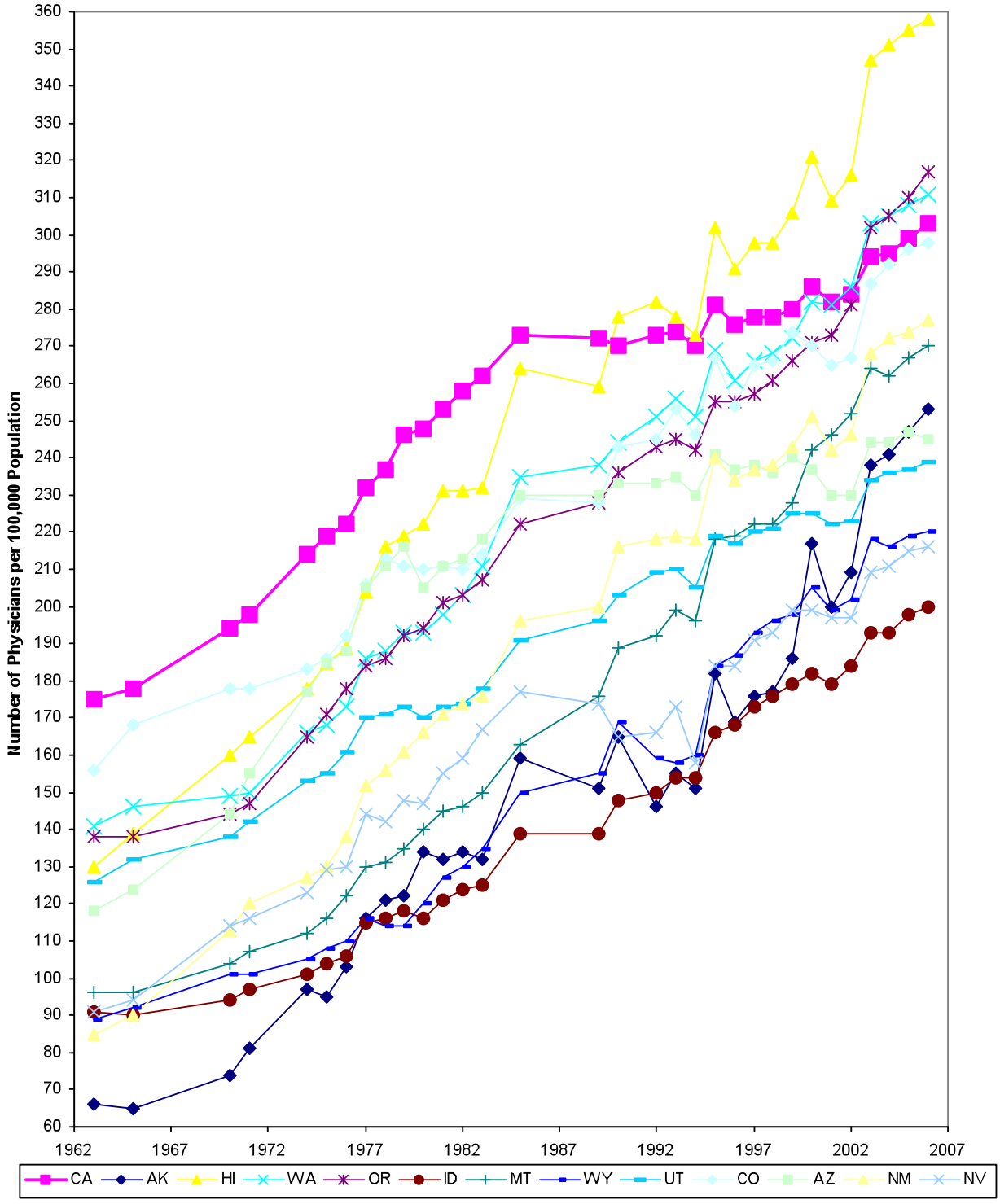


b. As shown in Graph B, the same trends are manifest in comparisons between California and the 12 nearest neighboring states, with California surging well ahead of each of its neighbors *before* MICRA was enacted, but failing to keep pace with the growth rate in those neighboring states *after* MICRA was enacted. Indeed, since MICRA was enacted California has fallen behind two states without caps—states that California once surpassed in the critical ratio of physicians/100,000: Washington (whose Supreme Court struck down its cap more than two decades ago (*Sofie v. Fibreboard Corp.* (Wash. 1989) 780 P.2d 260)); and Oregon (whose Supreme Court invalidated its cap more than a decade ago. (*Lakin v. Senco Prods., Inc*. (Or. 1999) 987 P.2d 463).)

c. As shown in Graph C, the same trends are manifest in comparisons between California and the nine next most populous states. Although California has always lagged behind New York (which never has had a cap), California now ranks behind each of these nine states in the annual rate of growth of physicians per population and actually sits behind two states it once surpassed in the number of physicians per 100,000: Pennsylvania, which never has had a cap, and Illinois, whose Supreme

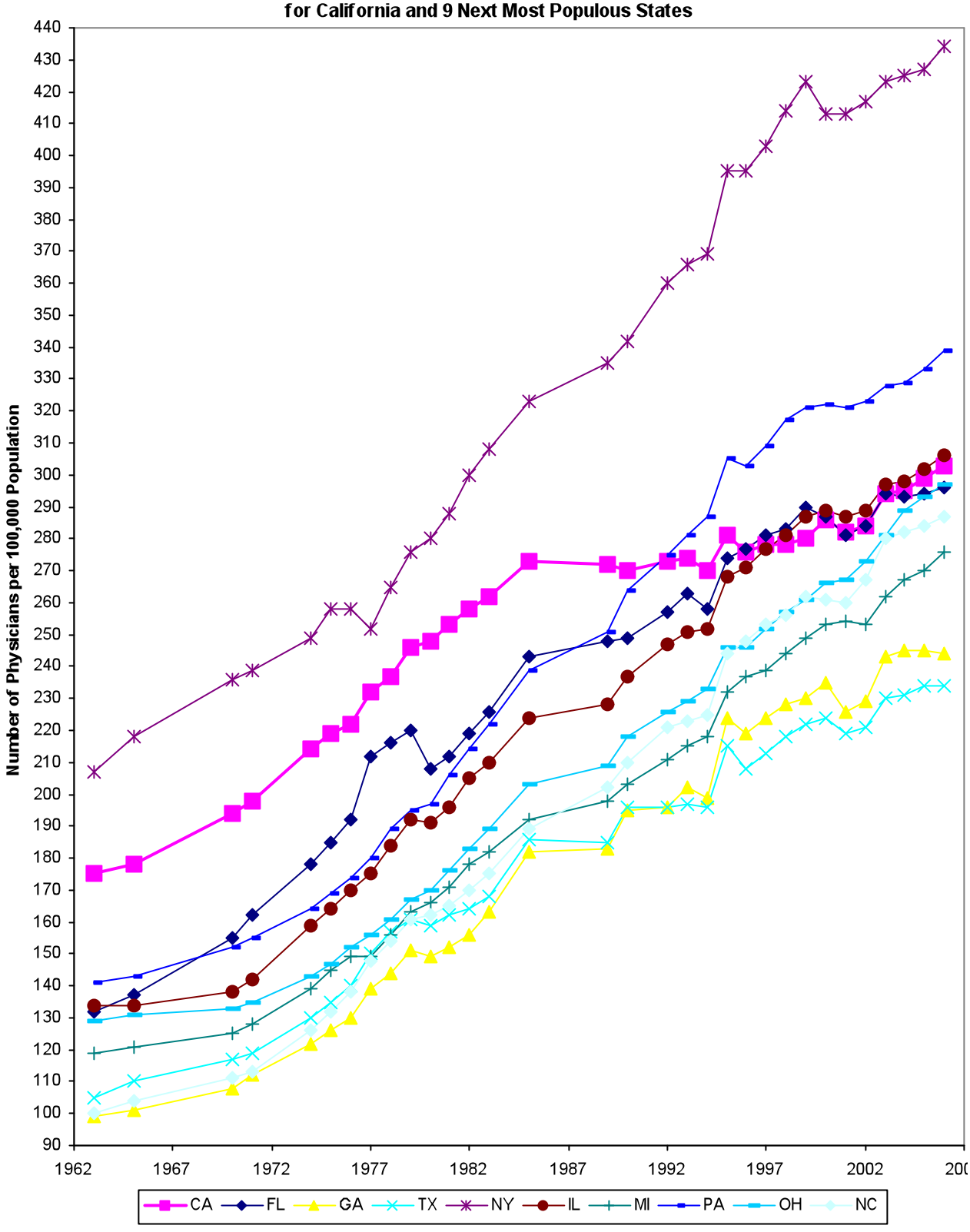
**GRAPH B**

**Rate of All Physicians per 100,000 Persons for California and 12 Neighboring States**



**GRAPH C**

**Rate of All Physicians per 100,000 Persons**
**for California and 9 Next Most Populous States**



Court repeatedly has held caps unconstitutional, most recently last February in *Lebron v. Gottlieb Memorial Hospital* (Ill. Feb. 4, 2010) 930 N.E.2d 895.

MICRA's defenders can only muster data from Texas to assert that MICRA has been as efficacious as they claim and that perpetuating MICRA's cap is essential to the public welfare. Indeed, one *amicus* has described Texas's experience with malpractice crises and caps in fantastical, literally, "once-upon-a-time," "fairy-tale" terms. According to the tall tale spun by California tort reformers about Texas:

> Once upon a time in Texas, 6,700 doctors, dropped by their carriers, were scrambling to find liability insurance and only four medical-malpractice carriers were operating in the state. The high cost of doing business in Texas was driving both doctors and carriers out of the state until a series of health-care and tort reforms introduced in 2003—a white knight, indeed—dramatically transformed Texas' medical-liability system. Today, the fairy tale enduring, as proponents of the reforms see it, is evidenced not only in the rate and tort environment but in the flock of doctors applying to practice in Texas, and the number of carriers eager to insure them. . . . The more hospitable legal climate—resulting from Proposition 12, a constitutional amendment that allowed the state to impose a $250,000 cap on pain and suffering-type awards—is credited with helping to stabilize the insurance market. 'The exodus of physicians has stopped,' said Jon Opelt, executive director of the Texas Alliance for Patient Access. 'Physician practices and hospital practices are in a growth mode.'

(CAPP, *MICRA: In the News* <http://www.micra.org/in-the-news/InfluxofDoctorsa FairyTaleEnding.pdf.pdf> (reprinting David

Dankwa, *Influx of Doctors a Fairy-Tale Ending to Texas Med-Mal Turmoil*, Best's Insurance News, June 19, 2007).)[5]

Two years ago, three highly-regarded empirical scholars looked behind this rhetoric and discovered that what tort reform proponents praise as the "Texas miracle"[6] is more accurately described as the "Texas mirage." Simply put: "Texas was *not* losing physicians before [the cap] took effect. The supply of direct patient care ("DPC") physicians grew every year" before the cap was enacted. (Silver, *et al*., *The Impact of the 2003 Texas Medical Malpractice Damages Cap on Physician Supply and Insurer Payouts: Separating Facts from Rhetoric* (2008) 44 Tex. Advoc. 25, 25, italics added (hereafter Silver).)

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[5] See also Hamm-CAPP, at 13. "In 2003 and in 2005, after a medical liability crisis similar to California's, Texas enacted medical liability reforms, including caps on non-economic damages ($250,000 for any and all doctors sued, with an additional cap of $250,000 for each of up to two medical care institutions). The resulting flood of doctors moving back to Texas underscores the direct connection between medical liability reforms, an increase in healthcare providers, and improved patient access to healthcare." (*Id.*; See also *Texas' Tort Reform Gives Example For Other States*, Tyler [Texas] Morning Telegraph, (May 27, 2008).) It is worth noting that the Texas Supreme Court previously struck this cap as unconstitutional (*Lucas v. United States* (Tex. 1988) 757 S.W.2d 687) and only a 2003 amendment to the Texas Constitution has protected the current caps from invalidation. (See Tex Const. art. III, § 66.)

[6] See, e.g., Protect Patients Now, *A Miracle in the Making: How Texas Became a Model for Medical Liability Reform* <http://www.kintera.org/site/c.8oIDJLNnHlE/b.2267659/k.4872/A_Miracle_in_the_Making.htm> [as of Aug. 18, 2010].

Of equal - if not greater - importance, Professors Silver, Hyman, and Black found that – tort reform "fairy tales" to the contrary - "the number of DPC physicians grew a bit more slowly *after* HB 4 was enacted than before" and "[t]he physician population also grew more rapidly during 1999-2002," the four years before Texas enacted its malpractice cap, "than it did *after* the 2003 [malpractice] reforms." (Silver, at 26-27 italics added.)

In a nutshell, evidence that has been assembled since *Fein* upheld the cap shows that there is no truth to the claim that MICRA reversed a physician exodus and caused physicians to flock to the State or that striking down MICRA's cap will cause a physician exodus. To be sure, doctors, like other human beings, move, switch professions or specialties, retire, and die. But however many physicians may have left the State, their practices, or this mortal coil, their numbers were exceeded, year-in and year-out, by new doctors beginning their practices in the State or experienced physicians moving their practices to the State. The predicted doctor "exodus" is a complete fallacy and provides no justification for upholding MICRA's cap.

### 2. The claim that periodically-rising malpractice premiums will cause physicians to flee "high-risk" practices is yet another myth

MICRA's defenders contend that the statute reversed an exodus from California of physicians who practiced in high-risk, high-premium

medical specialties (such as obstetrics/gynecology), and they predict that invalidating the cap or enacting "a higher cap would discourage physicians from entering [such] high-risk specialties." (Hamm-CAPP, at 53.) Tellingly, the only authorities cited in support of this contention are the unsubstantiated statements of a Pennsylvania hospital president (*id.* at 53-4, quoting the *Philadelphia Bulletin*, May 23, 2008), and the never-fulfilled "'plans'" by "'Long Island College Hospital . . . to close its obstetrics ward in the face of skyrocketing medical-malpractice costs.'" (*Id* at 54, quoting an editorial in the *New York Post*, Aug. 2008.)

These anecdotes are not only unproven but false. For example, although New York has never enacted a malpractice cap, the Department of Obstetrics and Gynecology of Long Island College Hospital has never closed; indeed, today it boasts that "[i]n our department there are 14 full-time faculty and approximately 40 voluntary attending physicians" and that "[m]ore than 2,700 babies are delivered at [that hospital] each year." (Obstetrics and Gynecology at LICH <http://www.wehealny.org/services/lichobgyn/index.asp> [as of Aug. 17, 2010].)

More broadly, peer-reviewed empirical evidence demolishes the "fleeing specialist" claim, just as empirical evidence belies the general physician "exodus" and "Texas miracle" claims.

For example, a study published two years ago in the peer-reviewed Journal of Empirical Legal Studies reported the results of a longitudinal

research design that assessed state-year-level data on the supply of OB/GYNs in all 50 states and the District of Columbia between 1992 and 2002. (Yang, *et al.*, *A Longitudinal Analysis of the Impact of Liability Pressure on the Supply of Obstetrician-Gynecologists* (2008) 5 J. Empirical Legal Stud. 21.) Yang and his fellow researchers found that the supply of OB/GYNs ***had no statistically significant association with liability insurance premiums or tort reforms***. The authors concluded that "[a]lthough the costs of malpractice insurance are substantial for OB/GYNs, they do not appear to be significantly associated with the supply of OB/GYNs in a state." (*Id*. at 53.) Rather, the report concluded, "[m]ost practitioners in this specialty do not respond to liability risk by relocating or discontinuing their practice." (*Ibid*.)

### 3. The notion that periodically rising malpractice premiums will cause physicians to leave "rural areas or low-income areas" also is a myth

MICRA's defenders warn that striking the cap would "reduc[e] the number of healthcare providers, particularly in rural and low-income areas." (Hamm-CAPP, at 15.) CAPP fails to cite any empirical evidence to support its prediction. To be sure, the rate of physicians per 100,000 people in rural areas does not come close to matching the rates for urban areas. Although tort reform advocates often assert that this disparity—which is

manifest throughout the country—is caused by malpractice litigation and insurance crises, that this disparity has been (or will be) cured by caps, and that invalidating caps will compel new exoduses, these contentions do not withstand scrutiny.

The notion that physicians would flee rural counties in California or other states because of rising malpractice insurance rates is simplistic and misleading. The difficulty in recruiting and retaining talented physicians to serve in rural areas has been a nationwide problem for more than a century,[7] and one that the federal government and state governments have attempted to address for many decades. For example, the National Health Service Corps ("NHSC") was created by Congress in 1970 "because of a healthcare crisis that emerged in the U.S. in the 1950's and 1960's, as rural physicians retired or moved, leaving many areas of the country without essential healthcare services." (NHSC, *National Health Service Corps*

[7] There is no doubt that physicians have been leaving rural areas for decades, and have been doing so in the absence of malpractice insurance "crises" of any kind. Perceptions of physician shortages in the U.S. date back more than a hundred years, to the late eighteenth century (Rosenblatt & Hart, *Physicians and Rural America*, *in Rural Health in the U.S.* (T. Ricketts ed. 1999) 38, 38 (hereafter Rosenblatt)), and measured declines in the number of rural physicians and concerns about these shortages date back to the 1940s. (Colwill & Cultice, *Increasing Numbers of Family Physicians-Implications for Rural America*, *in* U.S. Dept. of Health and Human Servs., *Update on the Physician Workforce* (Aug. 2000) 29-39 <http://www.cogme.gov/00_8726.pdf> (hereafter, HHS, *Update*).)

*History* <http://nhsc.hrsa.gov/about/ history.htm> [as of Aug. 17, 2010] (hereafter NHSC, *History*).)[8]

Furthermore, according to the American Academy of Family Physicians ("AAFP"):

> [America's] rural areas have been medically underserved for decades. While about 20 percent of the U.S. population lives in rural areas, rural physicians comprise only about 10 percent of the total working physicians in the country. In rural communities of fewer than 10,000 inhabitants, there are about 90 physicians per 100,000 persons. In major metropolitan areas, the ratio is about 300 physicians to every 100,000 persons. In rural cities with populations of more than 10,000 persons, there are about 170 physicians per 100,000 persons.

(AAFP, Rural Recruitment and Retention Position Paper, *Keeping Physicians in Rural Practice* (Sept. 2002) 2, internal footnotes omitted (hereafter AAFP).)

These "persistent, intractable" problems are "most likely" to be found in rural communities with "[s]parse population, extreme poverty, high proportions of racial and ethnic minorities, and lack of physical and cultural amenities." (AAFP, at 2; see also National Rural Health

[8] As the NHSC explains, the rural healthcare crisis that accelerated in the U.S. in the 1950s was caused by everything but rising medical malpractice premiums: "Increasing specialization and rapid technological advances only fed the trend. Rural areas and inner-city neighborhoods competed unsuccessfully with affluent medical practices that offered higher compensation, more interaction with other professionals, and job opportunities for spouses. Rural communities lacked resources to provide the technologically sophisticated facilities that many physicians desired. Rural states appealed to Congress, which created the NHSC." (See NHSC, *History*.)

Association ("NHRA"), *Health Care Workforce Distribution and Shortage Issues in Rural America* (official NRHA Policy Statement, Mar. 2003) 3 <http://www.ruralhealthweb.org/go/left/policy-and-advocacy/policy-documents-and-statements/official-policy-positions> [describing some of the factors that cause physicians to choose not to practice in rural areas, including the general shift toward medical specialization, lack of familiarity with rural culture, isolation from colleagues (which results in lack of coverage for illnesses, vacations, and continuing medical education), and the additional stress on spouses and family due to rural isolation].)

The principal reason why rural areas around the country have faced, and continue to face, physician shortages is sparse population and the resulting lack of volume of patients needed to support a medical practice, particularly a specialty practice such as neurosurgery.[9] Rural populations

[9] The population necessary to support a medical practice tends to be inadequate in rural areas; the sparser the population, the fewer the doctors who are needed or willing to live and serve in that area; indeed, to support a single general practice doctor, a population of at least 2,000 people is necessary and, because physicians prefer to work in groups of at least three (so that no one physician need be "on call" 24 hours a day, 365 days a year), a population of more than 6,000 people is needed to support a three-physician general practice. (HHS, *Update*, *supra*, at 33.)

The absence of a population necessary to support a practice is especially severe for sub-specialists, such as neurosurgeons; although the number of people needed to support a single family-practice doctor is only 2,000, the number needed to support a single neurosurgeon is 100,000. (Rosenblatt, *supra*, at 41; see also, HHS, *Update*, *supra*, at 33.) In fact, a minimum population of 300,000 people are needed to support a three-person neurosurgical group. (Rosenblatt, at 41; see also U.S. Congress,

have been declining in the United States as a whole for more than a century, invariably in comparison to urban populations and often even in absolute numbers as well.

Notably, the dwindling populations in rural areas—and the declining number of potential patients—plague other medically related professions, like dentistry and veterinary medicine, professions in which there has been no hint of malpractice insurance "crises."[10] Finally, the falling rural population and the consequent lack of potential clients also affect numerous non-medical businesses, trades, and professions.[11]

In the final analysis, the claims that MICRA has addressed a rational need and predictions of impending disaster should the cap be held unconstitutional are completely unsupported by empirical studies or other credible research. Moreover, claims that invalidating MICRA's cap will

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Office of Technology Assessment, *Healthcare in Rural America OTA-H-434* 318 (1990) <http://www.fas.org/ota/reports/9022.pdf> ["Health professionals may be dissuaded from choosing a rural practice location due to either a perceived or an actual lack of professional opportunities and benefits."].)

[10] See Vargas, *et al.*, *Oral Health Status of Rural Adults in the United States* (Dec. 2002) 133 JADA 1672, 1673; Pam Belluck, *A New Problem for Farmers: Few Veterinarians*, N.Y. Times, Feb. 6, 2007, A-1.

[11] Rural areas have trouble attracting and keeping even common businesses such as car dealers, clothing stores, drug stores, banks, and shoe shops. (See Timothy Egan, *Vanishing Point; Amid Dying Towns of Rural Plains, One Makes a Stand* (Dec. 1, 2003) N.Y. Times, A-1.) Nowadays, rural communities in Texas and many other states are often too small to field full, 11-man football squads. (See Jere Longman, *Not Everything Is Bigger In Texas* (Dec. 14, 2003) N.Y. Times, A-1.)

cause a new crisis have been debunked by new, post-*Fein* empirical studies authored by government agencies and neutral scholars, as well as the experience in states without similar caps. Accordingly, even if enacting the cap may once have appeared to be necessary, justified, and rational, new evidence shows the cap no longer can claim that justification. In light of these facts, this Court is not required to uphold a statute that burdens so many groups in so many ways, and offends the equal-protection guarantee.

### B. Invalidating the Cap Will Not Threaten a New Physician "Exodus" and a New "Healthcare Crisis" Because Malpractice Insurance Premiums Constitute Comparatively Small and Historically Declining Portion of the Expenses of Running a Medical Practice

There is no dispute that medical malpractice insurance premiums have periodically increased and decreased in California—just as they did in nearly every state across the country since the early 1970s. (Ambrose & Carroll, *Medical Malpractice Reform and Insurer Claims Defense: Unintended Effects?* (2007) 32 J. Health Pol. Pol'y & L. 843, 846; Mello & Zeiler, *Empirical Health Law Scholarship: The State of the Field* (2008) 96 Geo. L.J. 649, 680; Tom Baker, *The Medical Malpractice Myth* (The Univ. of Chicago 2005) 45-92.)

Yet, the notion that rising malpractice premiums are not merely undesirable but completely unbearable and therefore so "unaffordable" as to threaten to compel thousands of California physicians to abandon their practices or flee the State is no longer tenable. Recent empirical research establishes that insurance premiums, while periodically rising (and falling) and while always irksome, actually constitutes a comparatively small and historically declining part of the expenses of running a medical practice. This is important because if the practice of medicine is viewed as a business—and the AMA certainly encourages its members to regard it that way (see Relman & Lundberg, *Business and Professionalism in Medicine at the American Medical Association* (1998) 279 JAMA 169)—any rational businessperson would realize that malpractice insurance premiums are just one of many expenses, and a small one at that, at least in comparison to other business expenses.

In 2006, Suffolk Law Professor Marc Rodwin and several colleagues examined thirty years of AMA data and found that while the "list price" of malpractice premiums periodically rose and fell from 1970 to 2000, the premiums actually paid by physicians rarely exceeded ten percent of a physician's total practice expenses—typically amounting to only six or seven percent of those expenses—and an even smaller percentage of a physician's total practice income. (Marc A. Rodwin, *et al*., *Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict with*

*Empirical Evidence* (May/Jun. 2006) 25 Health Aff. 750, 751-53.) Notably, several other expenses, such as office rent, medical supplies and equipment, and health insurance for staff, absorb a far greater portion of a physician's expenses, and the prices of these items appear to be rising just as fast, if not faster, than the cost of malpractice insurance. (*Id*.)

A follow-up study published by Professor Rodwin and colleagues in 2008 focused on the prices paid by physicians for malpractice insurance from 1975 to 2005 in Massachusetts, which, despite a $500,000 statutory cap on noneconomic damages, has the fourth-highest median malpractice payouts in the country and thus has been categorized by the AMA as a "crisis state." (Marc A. Rodwin, *et al*. *Malpractice Premiums in Massachusetts, A High-Risk State: 1975 to 2005* (May/Jun. 2008) 27 Health Aff. 835.) Rodwin's 2008 article found that in 2005, mean malpractice premiums, for the coverage level and policy type most frequently purchased, were only $17,810. In fact, Rodwin found that most physicians paid lower inflation-adjusted premiums in 2005 than they did in 1990. (*Id.* at 835.)

Rodwin's 2006 article also reported that a far greater cause of physicians' overall frustration is declining gross practice revenues. (25 Health Affairs at 755.) The decline stems from the policies of Medicare, Medicaid, HMOs, and PPOs to "capitate" (or set upper limits on) reimbursements for most medical procedures. "[O]verall physician

reimbursement has diminished steadily since 1990 influenced primarily by changes in the Medicare fee schedule, negotiation of all other payment plans (including HMO reimbursement to a Medicare based fee schedule), and a significant proportion of uninsured or Medicaid patients receiving what is essentially free healthcare. Physician specialists' income has been particularly hard hit, resulting in more than a 50 percent pay cut over the past decade." (Gunnar, *Is There An Acceptable Answer To Rising Medical Malpractice Premiums?* (2004) 13 Annals Health L. 465, 470, footnote omitted; *See* Lacktman, *et al.* (Nov. 2006) *Health Care Providers and the Automatic Stay*, 25-NOV Am. Bankr. Inst. J. 32, 32 ["In recent years, hospitals, physician groups, nursing facilities and other health care providers have experienced a decrease in revenue, particularly as Medicare and Medicaid reimbursements have failed to keep pace with inflation and the increased expense for medical treatment continues to increase. Many of these providers have been forced to seek bankruptcy protection."]). Although physicians tend to scapegoat malpractice plaintiffs as the sole source of their pain, malpractice premiums are a minor irritant compared to other reasons why physicians' gross practice revenues and net practice incomes have been declining over the past four decades.

This explains why the size of, or increases in, malpractice premiums have negligible effect on the number or rate of physicians practicing in a state. (See, e.g., Baicker & Chandra, *Defensive Medicine and Disappearing*

*Doctors?* (Fall 2005) 28 Regulation 24.) Moreover, as rational businesspersons, physicians are unlikely to make decisions as fundamental as whether or where to practice based on cost increases that are episodic, minor in comparison to other practice expenses, and minor in comparison to both gross practice revenue and net practice income.[12]

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[12] A decade ago, *i.e.*, 25 years after MICRA took effect, the AMA's in-house magazine reported "[m]ore than half of the physicians in California are so dissatisfied" with the state of medicine there "that they plan to quit, retire or move out of state in the next three years" (Jay Greene, *Dissatisfied Docs May Soon Be Singing "California, Here I Go"* (Aug. 6, 2001) Am. Med. News <http://www.ama-assn.org/amednews /2001/ 08/06/prsd0806.htm>.) The AMA article relied on a comprehensive study by the California Medical Association ("CMA") 2001 Physician Survey Findings: And Then There Were None: The Coming Physician Supply Problem (2001) <http://www.cmanet.org/upload/Physician_Supply_ (Acrobat).pdf> (hereafter CMA, *And Then There Were None*).

The CMA, in turn, blamed the physician exodus on low reimbursements because "California has the greatest managed care penetration in the nation," and because California physicians are more likely than doctors in other states to have Medicare/Medicaid contracts, which capitates the fees a physician may collect. According to the CMA, "Seventy-five percent of physicians have become less satisfied with medical practice in the past five years. . . . Low reimbursement, managed care hassles and government regulation are the greatest sources of dissatisfaction. 43% of surveyed physicians plan to leave medical practice in the next 3 years. Another 12% will reduce their time spent in patient care. . . . 58% of physicians have experienced difficulty attracting other physicians to join a practice. . . . More than 1/4 of physicians would no longer choose medicine as a career if starting over today, and more than 1/3 of those who would still choose medicine would not choose to practice in California." (CMA, *And Then There Were None*, *supra*, at II.)

Medicare, Medicaid, and HMO/PPO "caps" on physician reimbursements are far more disruptive than increases in malpractice premiums, as shown by the fact that California physicians actually have followed through on their threats to flee because of declining

As described in Rodwin's articles and as reflected in the California Medicare/Medicaid/HMO/PPO reimbursement fiasco, malpractice premiums are a comparatively small part of a physician's total practice expenses and, as such, have an immaterial impact on decisions about whether or where to practice medicine. In fact, simple economics suggests there is a greater likelihood of physicians withdrawing from practice in a given location due to increases in office rents, payroll costs, and automobile lease rates than due to increases in malpractice insurance costs.

Although insurance industry economics cause periodic and temporary spikes in malpractice premiums (see, e.g., Baker, *Medical Malpractice and the Insurance Underwriting Cycle* (2005) 54 DePaul L. Rev. 393, 394-96) it is necessary to look at the larger and longer-term picture of the economics of a physician's practice. Specifically, although physicians spend 3-5 percent of their gross practice income on medical malpractice-related costs, they spend substantially more on payroll costs and office rent. A physician who stops practicing because of a malpractice insurance rate increase would be just as likely to retire due to slow health

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reimbursements—which they never did because of rising malpractice premiums. The AMA's 2001 article stated "[t]he U.S. Census Bureau reports that over the past decade, California has fallen from 8th to 12th place in the nation in per capita ratio of doctors to population," despite MICRA. (Greene, *Dissatisfied Docs*) AMA data, from 2005, show that California now ranks as the 18th state in the nation in Physician/Population ratio. (AMA, *Physician Characteristics & Distribution in the United States* (2007 ed.), Tbl. 5.19.)

insurance reimbursement dispersals, or increased rent for office space. If increased malpractice insurance costs justify legislation to bail out physicians, they could just as easily demand that the Legislature require quicker insurance payments, lower office rental fees, or discounted costs for bandages.

Affordability is a relative term, not an absolute one, which explains why extremely few physicians—typically older ones with substantial financial assets—have the will and the wherewithal to carry out their threats to retire.

This insight about physicians' retirement threats leads to similar insights about their threats to flee one state for another. In 2004, the President of the AMA wrote an article in the journal of the American Heart Association in which he asserted that "the sheer volume of [malpractice] lawsuits," combined with "outrageous awards for noneconomic damages . . . are driving insurance rates up" all across America, with the result that "medical liability has reached crisis proportions in 19 states, with another 35 states on the brink of crisis," i.e., fifty-four (54) states either "in" or "on the brink of crisis." (Palmisano, *Health Care in Crisis*, (2004) 109 Circulation 2933, 2933-34 <http://circ.ahajournals.org/cgi/reprint/109/24/2933?maxtoshow=andHITS=10andhits=10andRESULTFORMAT=andfulltext=%22Health+Care+in+Crisis%22andsearchid=1andFIRSTINDEX=0andresourcetype=HWCITATION>.)

If *54 states* truly were "in" or "on the brink of crisis" in 2005, any rational businessperson would think twice about moving his or her practice and family out of a known frying pan and into an unknown fire.

Similar considerations apply to rural physicians who might contemplate fleeing to urban neighborhoods. Even if rural physicians could find positions compatible with their training and experience, malpractice premiums are rarely lower in urban areas, while the cost of living is higher and the competition stiffer. Thus, in addition to the not inconsiderable costs of relocating both a practice and a family, rural physicians face a lower "real" standard of living than those in urban areas.[13]

Finally, along the same vein, it is rather difficult and consequently extremely rare for physicians to switch specialties in mid-career, *e.g.*, from obstetrics/gynecology to ophthalmology or from dermatology to cardio-surgery. This fact, combined with the fact that the AMA and the CMA say

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[13] Although "[a]verage annual physician incomes are somewhat lower in rural areas than in urban areas—$204,000 vs. $218,000," a very "different picture emerges when one looks at physicians' 'real' compensation, or the purchasing power of their incomes after accounting for differences in the cost of living, which varies considerably across the nation and generally is lower in rural areas. . . . The average income of rural physicians adjusted for the cost of living was significantly higher than urban physicians'—$225,000 vs. $199,000. This translates into rural physician incomes providing about 13 percent more purchasing power than urban physician incomes." (Reschovsky & Staiti, *Physician Incomes in Rural and Urban America* Issue Brief No. 92 (Center for Studying Health System Change, Jan. 2005), 1-3 and Figs. 1 and 2 <http://www.hschange.com/CONTENT/725/725.pdf>.)

that almost all specialties are suffering from malpractice premium increases, make it extremely unlikely that a physician would make the onerous and expensive jump from one beleaguered specialty—one in which they have trained for years and established a reputation in the community—to a different and potentially equally beleaguered specialty. The AMA's data confirm that physicians, like most people, prefer to stick with the devil they know.

### C. The Cap Is Irrational Because it Reduces Tort Law's Deterrent Effects and Thereby Undermines the Public Health and Welfare

Tort law not only compensates injured victims; it also protects the rest of society by deterring similar wrongful conduct. (Prosser & Keeton, Prosser & Keeton on the Law of Torts § 4 (W. Keeton, 5th ed. 1984) 25.) Potential liability for full compensatory damages gives potential tortfeasors incentives to invest in safety. Indeed, "[o]ptimal deterrence requires that injurers bear the full social cost of their risk-taking activities, including nonpecuniary losses," *i.e.*, noneconomic damages. (Jennifer Arlen, *Tort Damages*, *in* 2 *Encyc. of Law and Econ*. (B. Bouckaert, ed., 2000) 682, 702.) But the cap essentially immunizes tortfeasors for all noneconomic

damages above $250,000, greatly undermining incentives and irrationally rewarding those who skimp on safety.[14]

> If negligent physicians cause noneconomic damages that exceed $250,000, and yet are only liable for $250,000, then insurance companies, physicians, and healthcare providers burdened with the liability costs will have fewer incentives to regulate physicians who commit malpractice. Moreover, since the resulting insurance rates will not reflect the true cost of physicians' negligent conduct, more malpractice-committing physicians will be able to continue practicing medicine.

(Van Grack, *The Medical Malpractice Liability Limitation Bill* (2005) 42 Harv. J. on Legis. 299, 311. See Matsa, *Does Malpractice Liability Keep the Doctor Away? Evidence From Tort Reform Damage Caps* (2007) 36 J. Legal Stud. S143, S176 [while "tort liability reduces the rate of negligent injuries per [hospital] admission by 29 percent and the overall rate of medical injuries by 11 percent," caps "may undermine the deterrence incentive provided by medical malpractice liability."]. See also Galligan, Jr., *The Risks of and Reactions to Underdeterrence in Torts* (2005) 70 Mo. L. Rev. 691, 721 [same] (hereafter Galligan).)

MICRA's cap also has a disproportionately negative effect on disadvantaged groups. As discussed, below, the cap has pernicious effects

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[14] The civil justice system suffers from significant underdeterrence even in states without caps or other tort "reforms." "[D]emands for widespread tort reform, while directing attention to dissatisfaction with the tort system, tend to miss their mark, since significant underdeterrence . . . already exists." (Ashford & Stone, *Liability, Innovation, and Safety in the Chemical Industry*, in *The Liability Maze: The Impact of Liability Law on Safety and Innovation* (P. Huber & R. Litan, eds., 1991) 367, 419.)

on everyone who has a lower income – even assuming that all malpractice victims suffer physical injuries that are identical in degree and type. But women and the elderly often suffer relatively unique injuries. For example, "[s]everal types of injuries that are disproportionately suffered by women—sexual assault, reproductive harm, such as pregnancy loss or infertility, and gynecological medical malpractice—do not affect women in primarily economic terms." (Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly* (2004) 53 Emory L. J. 1263, 1281 (hereafter Finley).) Such injuries commonly are "compensated through noneconomic loss damages: emotional distress and grief, altered sense of self and social adjustment, impaired relationships, or impaired physical capacities, such as reproduction," *i.e.*, in ways "that are not directly involved in market based wage earning activity," and therefore are not readily subject to market-based awards of economic damages. (*Id*.)

A cap hurts women more then men because awards to women are "almost three times more likely to include a pain and suffering component as those given to men" and because the "typical pain and suffering verdict awarded to a female" is "twice as large." (Koenig & Rustad, *His and Her Tort Reform: Gender Injustice in Disguise* (1995) 70 Wash. L. Rev. 1, 84-85 (hereafter Koenig & Rustad); see Chamallas, *The Architecture of Bias: Deep Structures in Tort Law* (1998) 146 U. Penn. L. Rev. 463, 499-500 (hereafter Chamallas).) A cap also disproportionately affects the elderly,

who usually have no lost wages to claim. Moreover, nursing home malpractice is a nationwide scandal, inasmuch as many of the 1.6 million elderly Americans who live in licensed nursing homes (plus another million who live in residential care facilities) are at risk of physical harm and even death in understaffed, ill-equipped, and poorly maintained facilities. (Catherine Hawes, *Elder Abuse in Residential Long-Term Care Settings: What is Known and What Information is Needed?*, *in Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America* (R. Bonnie, ed. 2003), 446, 446-47.)[15]

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[15] While nearly one in twenty elders experience abuse or neglect every year, "seven out of every eight instances . . . are never reported." (Ramey, *Putting the Cart Before the Horse: The Need to Re-Examine Damage Caps in California's Elder Abuse Act* (2002) 39 San Diego L. Rev. 599, 602.) Federal enforcement efforts are inadequate to prevent or remedy these problems, as even in nursing homes repeatedly cited for neglect and abuse continue substandard practices that harm, and sometimes kill, residents. For example, two years ago, the GAO's Director of Health Care found a "significant proportion of nursing homes nationwide continue to experience quality-of-care problems—as evidenced by the almost 1 in 5 nursing homes nationwide that were cited for serious deficiencies in 2006." (Kathryn G. Allen, Director of Health Care, Nursing Home Reform, Testimony Before the Senate Special Comm. on Aging, 110th Cong., 1st Sess (May 2, 2007) 9 <http://www.gao.gov/new.items/d07794t.pdf>.) These "deficiencies . . . cause actual harm or place residents in immediate jeopardy." (*Id.* at 3.) The U.S. Dept. of Health and Human Services found that poor quality care endangers many home residents. (HHS, Memorandum Report: Trends in Nursing Home Deficiencies from Daniel R. Levinson, Inspector General to Kerry Weems, Acting Administrator (Sept. 2008) 1 <http://www.oig.hhs.gov/oei/reports/oei-02-08-00140.pdf> [91 percent of nursing homes were cited for health and safety deficiencies in 2006-08 and, in 2007, nearly 17 percent were cited for harming residents or putting them at imminent risk of substantial harm].)

### 1. The cap undermines safety measures in hospitals, generally

The number of preventable medical deaths is also a tremendous problem in American hospitals. The National Institutes of Science/Institute of Medicine ("IOM") found that preventable "medical errors" in hospitals kill as many as 98,000 people each year, which is more than twice the number of deaths caused each year by motor vehicle accidents and breast cancer, and nearly six times the number of deaths caused by AIDS each year. (IOM, *To Err Is Human: Building a Safer Health System* (Kohn, Corrigan & Donaldson, Ed. 2000) 1, 26 & 31 <http://www.nap.edu/openbook.php?isbn= 0309068371>.)[16]

AARP studied this issue in depth and found that "[p]reventable medical error and injury are of particular concern for older people because there is evidence that they are injured at a substantially higher rate than patients in other age groups," with "patients age 65 and older experienc[ing] medical injury two to four times as often as patients . . . under the age of 45." (Smith, *Medical Error and Patient Injury* (Sept. 1998) AARP 3.) A survey of nursing home malpractice cases in California,

[16] The Institute of Medicine also found "at least 1.5 million preventable ADEs ['adverse drug events'] occur in the United States each year," or at least one medication error per hospital patient per day. (IOM, *Preventing Medication Errors* (July 2006) 1 <http://iom.edu/~/media/Files/Report%20Files/2006/Preventing-Medication-Errors-Quality-Chasm-Series/medicationerrorsnew.pdf>.)

Florida, and Texas found 79 percent "of the residents suffered from multiple injuries including burns, falls, starvation, sexual abuse, and the failure of pain management." (Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits* (2006) 14 Elder L.J. 331, 381 (hereafter Rustad).) Noneconomic damages account for roughly 80 percent of awards in such cases. (*Id.* at 345.) A cap on awards in such cases not only deprives elderly victims of full compensation, it actually fosters such injuries by reducing incentives to invest in the personnel, training, management, nutrition, security, and equipment that are needed to make such facilities safer.

### 2. The cap jeopardizes healthcare for minorities and the poor

Disparities in income also produce disparities in the quality of healthcare. The IOM found that healthcare facilities that predominantly serve racial and ethnic minority populations typically use the oldest, least reliable, and least effective diagnostic tests and therapeutic treatments. (IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (2002) 5 <http://www.nap.edu/openbook.php?record_id = 10260&page=1>.) Similarly, the U.S. Dept. of Health and Human Services reports that members of such minority groups are less likely to receive appropriate cancer, cardiac, or pediatric care. (HHS, *Addressing Racial and*

*Ethnic Disparities in Health Care* (Feb. 2000) 1 <http://www.ahrq.gov/research/disparit.htm>. See Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990) 2-6 [medical errors are far more frequent in hospitals that serve largely minority populations].)

For these reasons, potential tortfeasors should be given every incentive to meet appropriate standards of care and prevent injuries. Caps, however, are irrational and counterproductive because diminish[ing] tort liability "diminishes the deterrent effect of tort law." (*Ferdon*, 701 N.W.2d at 464, footnote omitted; see also *Farley v. Engelken*, (Kan. 1987) 740 P.2d 1058, 1067.)

**2.**

**MICRA IMPERMISSIBLY TREATS SIMILARLY SITUATED PLAINTIFFS DIFFERENTLY IN VIOLATION OF THE EQUAL PROTECTION GUARANTEE**

The foregoing discussion of the various bases upon which MICRA discriminatory treatment has been rationalized demonstrates that the cap no longer enjoys rational justification. That time has undermined the basis upon which the statute was previously upheld is a proper consideration for

a court. After all, it is "well settled" hornbook law that over a period of time social, political, and economic changes may render a statute obsolete and "that *the continued existence of facts upon which the constitutionality of legislation depends remains at all times open to judicial inquiry*." (Singer & Singer, 2 *Sutherland Stat. Construction* (7th ed. 2010) § 34:5, italics added; citing cases.)

The Wisconsin Supreme Court recently explained in holding a damages cap was factually unsupported and unreasonable and therefore violated equal protection that "[a] statute may be constitutionally valid when enacted but may become constitutionally invalid because of changes in the conditions to which the statute applies. *A past crisis does not forever render a law valid*." (*Ferdon*, 701 N.W.2d at 468, italics added; footnote omitted; citing, *inter alia*, *Baker v. Carr* (1962) 369 U.S. 186, 254; *United States v. Carolene Prods. Co*. (1938) 304 U.S. 144, 153; *Chastleton Corp. v. Sinclair* (1924) 264 U.S. 543, 547-48 (per Holmes, J.).)

Indeed, as the United States Supreme Court famously explained in *Carolene Products*, "*[w]here the existence of a rational basis for legislation whose constitutionality is attacked* depends upon facts beyond the sphere of judicial notice, such facts may properly be made the subject of judicial inquiry, and *the constitutionality of a statute predicated upon the existence of a particular state of facts may be challenged by showing to the*

*court that those facts have ceased to exist*." (*Id.*, at 153, italics added, citations omitted.)

As *Ferdon* shows, this doctrine has particular resonance in decisions invalidating damage caps and other tort "reform" statutes. Thus, in striking down a damages cap, the North Dakota Supreme Court reasoned that whatever the evidence presented to and credited by the state legislature, new, post-enactment evidence "indicate[d] that either the Legislature was misinformed or subsequent events ha[d] changed the situation substantially." (*Arneson v. Olson* (N.D. 1978) 270 N.W.2d 125, 136.)

Thirty-five years have passed since MICRA was enacted in response to a crisis[17] and 25 years have lapsed since *Fein* upheld MICRA's cap. It is time enough to consider if our "Legislature was misinformed or [if] subsequent events," *id.*, have erased the crisis that spurred the Legislature into action and nullified the need for the cap—or for a cap set unreasonably and arbitrarily at an especially low number and whose value has eroded over time. Thus, as demonstrated above, the crises that may once have justified the cap can no longer provide a basis for its continued existence. As detailed below, the cap makes arbitrary distinctions that the Constitution cannot sanction.

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[17] See MICRA's preamble (Stats. 1975, Second Ex. Sess. 1975-1976, ch. 2, § 12.5, p. 4007), which establishes that MICRA was an emergency measure enacted in extraordinary session to address a "major health care crisis."

### A. MICRA's Cap Draws Arbitrary Distinctions Between Similarly Situated Persons "*Within* the Class of Malpractice Victims"

"The first prerequisite" for a valid equal protection claim "is a showing that the state has adopted a classification that affects two or more similarly situated groups in an unequal manner." (*People v. McKee* (2010) 47 Cal.4th 1172 [233 P.3d, 566, 582] internal quotation marks, italics, and citations omitted.)

Significantly, although the California Supreme Court has determined "that the Legislature could constitutionally treat malpractice victims as a class *differently from other personal injury plaintiffs*, in light of the perceived crisis in medical malpractice insurance," (*Young,* 41 Cal.3d at 899, italics added, citations omitted), the *Young* court went out of its way to construe MICRA's statute of limitations provision in a fashion that did not discriminate against some malpractice victims in order to avoid holding that MICRA provision violated equal protection, explaining that to "discriminate *within* the class of malpractice victims" would be constitutionally problematic. (*Id.* at 899, italics in original.)

Accordingly, this case raises an issue of first impression in this State, one that was never ruled on in *Fein*, and one that *Young* carefully avoided: whether the cap violates equal protection by "discriminat[ing] *within* the

class of malpractice victims." (*Young*, 41 Cal.3d at 899.) As shown below, the cap undeniably discriminates within that class of victims in two ways: first, the cap discriminates against the most severely injured malpractice victims; and second, the cap discriminates against malpractice victims who are women, elderly, children, minorities, or poor.

### 1. The cap discriminates against the most severely injured malpractice victims

MICRA's cap capriciously allows persons with modest injuries to receive all the noneconomic compensatory damages the factfinder deems warranted by the evidence, while it compels a court to cut the noneconomic compensation of the most severely injured tort victims. Consequently, like caps in other states whose courts have invalidated those statutes on equal protection grounds, "the burden of the cap falls entirely on the most seriously injured victims. . . . Those who suffer the most severe injuries will not be fully compensated for their noneconomic damages, while those w[ith] relatively minor injuries . . . will be fully compensated." (*Ferdon*, 701 N.W.2d at 465.)

Perversely, "the greater the injury, the smaller the fraction of noneconomic damages the victim will receive" (*Ferdon*, 701 N.W.2d at 465) and the higher his or her involuntary contribution to correcting an allegedly society-wide problem. For example, a plaintiff with $250,000 in

noneconomic damages keeps 100 percent of a jury's award, a plaintiff with $500,000 in noneconomic damages keeps 50 percent, and a plaintiff with $1,000,000 in noneconomic damages keeps only 25 percent. The court concluded that "no rational basis exists for treating the most seriously injured patients of medical malpractice less favorably than those less seriously injured . . . [or] for forcing the most severely injured patients to provide monetary relief to [tortfeasors] and their insurers." (*Id.* at 466.)

*Ferdon* hardly stands alone, as numerous post-*Fein* courts across the country have found such distinctions are not just arbitrary or irrational, but completely backwards and abhorrent.

> There is no logically supportable reason why the most severely injured . . . should be singled out to pay for special relief to . . . tortfeasors and their insurers. The idea of preserving insurance by imposing huge sacrifices on a few victims is logically perverse. Insurance is a device for spreading risks and costs among large numbers of people so that no one person is crushed by misfortune. In a strange reversal of this principle, the statute concentrates the costs of the worst injuries on a few individuals.

(*Moore*, 592 So.2d at 169, citations omitted. See also *Best v. Taylor Mach. Works* (Ill. 1997) 689 N.E.2d 1057, 1075; *State ex rel. Ohio Acad. of Trial Lawyers v. Sheward* (Ohio 1999) 715 N.E.2d 1062, 1095; *Brannigan v. Usitalo* (N.H. 1991) 587 A.2d 1232, 1236.)

Recent research by the RAND Institute for Civil Justice regarding MICRA's effects on plaintiffs' recoveries reveals that the cap imposes its greatest hardships on the most catastrophically injured and most vulnerable

Californians. (Pace, *et al.*, RAND Inst. for Civil Justice, *Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA* (2004) (hereafter RAND Study) <http://www.rand.org/pubs/monographs/2004/RAND_MG234.pdf>.)

The RAND Study found the cap was imposed in 45 percent of the cases in which plaintiffs won jury verdicts. *Id.* at xx. But MICRA's cap does not produce equal results in each case. To the contrary, the cap burdens some successful malpractice plaintiffs far more than others:

- Plaintiffs who have small economic losses, but suffer significantly diminished quality of life (as reflected by larger awards for extreme levels of pain and suffering) are stripped of the highest percentage of their fairly determined damage awards. *Id.* at xxi, xxvii.
- Plaintiffs with the most catastrophic injuries, such as brain damage and quadriplegia, have their damage awards reduced most frequently. *Id.* at xxii, xxvii.
- Plaintiffs less than a year old have their damages reduced 71 percent of the time. *Id.* at xxiii.
- Plaintiffs over the age of 65 see their damages reduced 67 percent of the time. *Id.*
- Female plaintiffs had larger cuts to their damage awards than their male counterparts. *Id*.

Notably, three other highly-regarded empirical researchers studied similar data regarding post-MICRA verdicts in California and reached the same conclusions. (Studdert, *et al.*, *Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California* (2004) 23 Health Aff. 54, 63.)

The cap's discriminatory treatment of malpractice victims in general, and the most severely injured victims in particular, is especially onerous in light of the fact that many malpractice victims never sue and those that do so traditionally are undercompensated by the tort system even in the absence of a cap on damages; this is especially true for the most seriously injured individuals.[18] Kenneth S. Abraham, a respected insurance law

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[18] Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?* (1992) 140 U. Pa. L. Rev. 1147, 1218 ["[O]vercompensation at the lower end of the range and undercompensation at the higher end is so well replicated that it qualifies as one of the major empirical phenomena of tort litigation."]. See also 2 ALI, Reporters' Study, *Enterprise Responsibility for Personal Injury, Approaches to Legal and Institutional Change* (1991) 4 (hereafter ALI Reporter's Study); Galligan, 70 Mo. L. Rev. at 699-720; Baker, *The Medical Malpractice Myth* (2005); Weiler, *et al.*, *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (1993) 70, tbl. 4.1 (1993); Donald N. Dewees, *et al.*, *Exploring the Domain of Accident Law: Taking the Facts Seriously* (1996) 422-23; Sloan, *et al., Compensation*, *in Suing for Medical Malpractice* (Sloan, *et al.*, eds., 1993) 187, 220.

Furthermore, inflation over the 35 years since MICRA was enacted has resulted in an even greater burden on malpractice plaintiffs than was presented to the *Fein* Court in 1985. Today's $250,000 cap is equivalent in buying power to $61,694.13 in 1975, less than a quarter of what the cap bought in 1975. (See U.S. Dep't of Labor, Bureau of Labor Statistics, *CPI*

scholar, and two other distinguished Reporters of the American Law Institute ("ALI") have pointed out:

> [S]cholarly research documents that more seriously injured victims tend to recover only a part of their total financial losses, notwithstanding the supposed legal entitlement to full compensation for both economic and noneconomic losses. That is why we strongly oppose the politically popular tool of caps on damages . . . Such a legal measure is highly regressive because capping awards imposes the burden of containing liability costs and premiums upon the most severely disabled, the people who are most likely to be undercompensated even without a damage cap.

(Abraham, *et al.*, *Enterprise Responsibility for Personal Injury: Further Reflections* (1993) 30 San Diego L. Rev. 333, 340, footnote omitted.)[19]

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*Inflation Calculator*, <http://data.bls.gov/cgi-bin/cpicalc.pl> [as of Aug. 16, 2010] (hereafter *CPI Inflation Calculator*).) The passage of time has eroded the value of the capped damages successful plaintiffs can receive, and thus the statute no longer serves one of it primary purposes, "to provide an adequate and reasonable remedy" to malpractice victims. (Preamble to MICRA, Stats.1975, Second Ex. Sess. 1975-1976, ch. 2, § 12.5, p. 4007.) To obtain the same buying power that $250,000 had in 1975 dollars requires $1,013,062.27 today. (*CPI Inflation Calculator*.)

[19] Indeed, the cap works contrary to the purpose of insurance, which is to spread the costs of harm among many so that a few are not crushed by a financial catastrophe. The cap seeks to save a relatively modest amount for the many by imposing heavy costs on a few.

### 2. The cap discriminates against malpractice victims who are women, elderly, children, racial and ethnic minorities, or poor

Objective and peer-reviewed empirical research by neutral, well-regarded scholars—much of which is based on analysis of post-MICRA California cases—corroborates the RAND and ALI studies and demonstrates that caps greatly diminish the total tort damages recovered by women, children, the elderly, racial and ethnic minorities, and people with little or no wages. These studies show that the Californians who lose the most under the cap are those with the least financial ability to absorb such losses.

This research also has led scholars to conclude that a cap is a form of *de facto* discrimination, inasmuch as a cap essentially categorizes the injuries and suffering of the members of some groups as less "worthy" of compensation than the injuries and suffering of other groups. Finally, this research has led scholars to conclude that a cap distorts the civil justice system by rendering cases involving many of the most distressing types of harm - *e.g.*, a woman's loss of fertility, a couple's loss of a child, or a senior citizen's loss of the ability to engage in meaningful activities - into ones in which such injuries are the ones least likely to be fully compensated.

In sum, a cap transforms the civil justice system from one that promises equal justice under law into one that dispenses justice according to a person's income-generating activities.

### a. The cap disproportionately burdens women

One leading torts scholar, Lucinda M. Finley, has established that caps on noneconomic damages exacerbate existing gender-based disparities in the tort system because, overall, jury awards to men tend to be higher than to women, largely due to men's higher wage-based economic damages. (Finley, 53 Emory L. Rev. at 1280-81.) Her research was accorded significant credit by the Wisconsin Supreme Court. (See *Ferdon*, 701 N.W. 2d 440.) Because a cap operates to deprive women of a greater portion of an overall award, it effectively heightens longstanding disparities between the average damages that injured men receive compared to the average damages that women recover. (Finley, 53 Emory L. Rev. at 1281-86, 1288-99.)[20] Finley also found that:

[20] Professor Finley found that although "[w]omen's pre-cap median jury award was 94%" of men's pre-cap awards, post-cap "women's median was down to 58.6% of the male median." (53 Emory L. J. at 1286.) She found even greater gender disparities when a tort causes death; post-cap, women's median recovery in such cases was only 71.3 percent of males', and the average woman's recovery was only 51.7 percent of the average man's. (*Id.* at 1291.) For men, noneconomic damages made up less than 50 percent of the average verdict. For women, that portion was 78 percent. (*Id.* at 1284-85.) Because noneconomic damages are a much larger part of women's verdicts, a $250,000 cap affects women much more than men. In

> Several types of injuries that are disproportionately suffered by women—sexual assault, reproductive harm, such as pregnancy loss or infertility, and gynecological medical malpractice—do not affect women in primarily economic terms. Rather, the impact is felt more in the ways compensated through noneconomic loss damages: emotional distress and grief, altered sense of self and social adjustment, impaired relationships, or impaired physical capacities, such as reproduction, that are not directly involved in market based wage earning activity. Many of these most precious, indeed priceless, aspects of human life are virtually worthless in the market, and there is social resistance to seeing them solely or primarily in commodified, market-based terms.

(*Id*. at 1281.)

Other scholars have found that the unfair burdens created by the cap are compounded by the fact that women and minorities generally receive smaller economic awards than white men for comparable physical injuries. (Koenig & Rustad, 70 Wash. L. Rev. at 78-79. See Chamallas, 146 U. Penn. L. Rev.at 464-65.) Thus, noneconomic damage caps are inherently regressive, as they "exacerbate existing problems of fairness in compensation." (Studdert, 23 Health Aff. at 65. See also RAND Study, at xxiii [MICRA's cap imposes disproportionately larger verdict cuts on female plaintiffs].)

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fact, a cap reduces women's average recovery by nearly 50 percent, but reduces men's average recovery by only 40 percent. (*Id.* at 1285.) The cap's discriminatory impact is even more manifest when comparing median awards: a $250,000 cap reduces men's pre-cap recoveries by 31 percent but reduces women's by 57 percent, nearly twice as much. (*Id*.)

### a. The cap disproportionately burdens the elderly and children

Professor Finley found that because the elderly often live on fixed and limited incomes and because children often do not have any income at all, caps effectively discriminate against children and the elderly when they seek damages in tort. (Finley, 53 Emory L. Rev. at 1286-88, 1302-04.) This occurs largely because plaintiffs over the age of 65 and under the age of 18 have far lower recoveries for lost income, and because juries therefore award elderly and minor plaintiffs a much greater portion of their overall awards as noneconomic damages.

Tragically, this disparity occurs despite the fact that injuries to members of these groups may cause a lifetime of debilitating pain and greatly reduce their life activities. For example, elderly plaintiffs, whose working days are behind them, do not incur the same extent of past or future wage loss as non-elderly plaintiffs. Moreover, given their shorter life expectancy, elderly plaintiffs will not incur as many years of projected future medical expenses. Yet, elderly tort victims often still suffer debilitating pain and greatly reduced life activities. (Finley, at 1288-91.) Noneconomic damages are the key way for juries to assess and provide

compensation for the severe and life-altering effects of these kinds of injuries.[21]

Among elderly plaintiffs who are nursing home residents, the predominance of noneconomic damages is even more striking. "Because few elderly nursing home residents have earnings that would be diminished by physical injury, noneconomic damages are essentially the only component of recoverable damages." (Rustad, 14 Elder L.J. at 344. See also RAND Study at xxiii [67 percent of the plaintiffs over 65 endured reduced damages].)

At the other end of the age spectrum, caps discriminate against children, who seldom have significant claims of lost earnings. Finley found a cap yields "even more draconian" effects when a tort causes a child's death, because a cap cuts the child's family median damages by 79 percent. (Finley, 53 Emory L. Rev. at 1292-93. See RAND Study, at xxiii [plaintiffs under a year old had their damages reduced 71 percent of the time].) The Wisconsin Supreme Court agreed, noting "[y]oung people are most affected

[21] Caps have an especially disparate impact on elderly women. (Finley, 53 Emory L. Rev. at 1291.) A $250,000 cap reduces noneconomic damages for elderly female patients by an average of 31.7 percent. (*Id.* at 1288-89.) The median recovery for elderly women, post-cap, was just 53.7 percent of the pre-capped amount; the comparable figure for elderly men was 72.8 percent. When the gender is combined with age, juries tend to award elderly women an even greater portion of their total compensation as noneconomic damages. (*Id*. at 1288-91.) In addition, if an elderly plaintiff dies, juries allocate a larger portion of an overall award to noneconomic damages. (*Id.* at 1291.)

by [a] cap . . . not only because they suffer a disproportionate share of serious injuries from medical malpractice, but also because many can expect to be affected by their injuries over a 60- or 70-year life expectancy." (*Ferdon*, 701 N.W.2d at 466.)

**c. <u>The cap disproportionately burdens minorities and the poor</u>**

Finally, the cap effectively discriminates against ethnic and racial minorities, who are disproportionately unemployed and disproportionately employed in the lowest-paying occupations. (See Doroshow and Widman, *The Racial Implications of Tort Reform* (2007) 25 Wash. U.J.L. and Pol'y 161, 169-70 & nn.37-38 (hereafter Doroshow); Edwards, *Medical Malpractice Non-economic Damages Caps* (2006) 43 Harv. J. on Legis. 213, 219-21 (hereafter Edwards).)[22]

Noneconomic damages also make up a greater portion of the damage awards received by racial and ethnic minorities. Thus, "limits on non-economic damages are disproportionately unfair to minorities." (Doroshow,

[22] (See also Orfield, *Segregation and Environmental Justice* (2005) 7 Minn. J.L. Sci. & Tech. 147, 151; Schulz, *et al.*, *Racial and Spatial Relations as Fundamental Determinants of Health in Detroit* (2002) 80 Milbank Q. 677, 683; Andrew Hacker, *Two Nations: Black and White, Separate, Hostile, and Unequal* (2003) 115-17.) Significantly, in 2007 median income for white households was $54,920 but only $33,916 for African-American or Hispanic ones, *i.e.* 38 percent less. (U.S. Dept. of Labor, *Population Survey* (2008) 1 <http://www.census.gov>.)

25 Wash. U.J.L. and Pol'y at 169; see also Edwards, 43 Harv. J. on Legis. at 219-21.)

**3.**

## THE CAP UNCONSTITUTIONALLY DISCRIMINATES AGAINST DISADVANTAGED GROUPS BY IMPEDING ACCESS TO JUSTICE

### A. Noneconomic Damages Play a Crucial Role In Ensuring That Malpractice Victims, Especially Those With Limited Incomes, Have Access to the Courts

MICRA's defenders assert that "[w]hile MICRA has reduced incentives to litigate the weakest claims, it has not affected access to the courts for individuals with justifiable claims." (CAPP, MICRA: Preserving Access to the Courts <http://www.micra. org/preserving-access/preserving-access.html>.) Thus, they pronounce, "[t]here is no evidence that MICRA's cap on non-economic damages has materially reduced access to the courts for those individuals with meritorious claims of medical liability." (Hamm-CAPP, at 15). Reliable empirical evidence proves this is just not so.

MICRA's cap does more than just generally deny *full* compensation to seriously injured malpractice victims and particularly deny *complete* compensation to female, elderly, young, or minority victims. It also closes

the courthouse door to many of these malpractice victims, effectively denying them *any* compensation whatsoever. In fact, the ABA recently reiterated its "longstanding policy opposing caps" exactly because such malpractice "reforms" unfairly limit the compensation owed to "patients who have been most severely injured by the negligence of others." (Letter from Thomas M. Susman, Director, Governmental Affairs Office, American Bar Association, to the Obama-Biden Presidential Transition Office, at 2 (Jan. 13, 2009) <http://www.abanet.org/poladv/transition/2009jan13_accesstohealth_l.pdf> (hereafter ABA Letter).)[23]

Our Constitution, art. I, section 7, subd. (a), guarantees the fundamental right to have a remedy for an injury to person or property by due course of law. (*Payne v. Superior Court of Los Angeles County* (1976) 17 Cal.3d 908, 914.)[24] This substantive right is empty without the

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[23] The ABA "reiterat[ed its] longstanding policy opposing caps" just last year. (ABA Letter, at 2 (citing <http://www.abanet.org/poladv/priorities/mpl/lebron_amicus_brief.pdf>, which found caps "undermine the ability of a significant number of injured plaintiffs with meritorious cases to seek redress for their injuries in the courts" deprive tort victims of access to the courts and "for malpractice victims who cannot find lawyers to take their cases, caps do not merely limit damages; they eliminate damages altogether.").

[24] An individual's right of access to the courts to secure justice "whenever he receives an injury" is "[t]he very essence of civil liberty." (*Marbury v. Madison* (1803) 5 U.S. (1 Cranch) 137, 163 (citing 3 W. Blackstone (1768) *Commentaries on the Laws of England* 23). See *Chambers v. Baltimore & Ohio R.R. Co*. (1907) 207 U.S. 142, 148 [the "right to sue and defend in the courts is the alternative of force. In an

procedural right of access to the courts. Thus, "[t]he right to petition [the courts] for redress of grievances is a basic right guaranteed by" Cal. Const., art. I, § 3. (*Pacific Gas & Elec. Co. v. Bear Stearns & Co*. (1990) 50 Cal.3d 1118, 1133 fn. 15.)[25] That procedural right is itself hollow without the ability to retain competent legal representation; without competent counsel, the right of access to the courts is like "a promise to the ear to be broken to the hope, a teasing illusion like a munificent bequest in a pauper's will." (*Edwards v. California* (1941) 314 U.S. 160, 186 (Jackson, J., concurring).) Thus, an individual's right to be represented by counsel also "is among the most fundamental of rights," as "it is through counsel that all other rights," including access to the courts for redress, are secured. (*Penson v. Ohio* (1988) 488 U.S. 75, 84.)

Malpractice actions involving serious injury require a plaintiff's attorney to devote considerable time to investigating a claim and researching the law, and to expend considerable sums out-of-pocket for

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organized society it is the right conservative of all other rights, and lies at the foundation of orderly government."].)

[25] Access to the courts for redress is so fundamental that it is secured not just by one or two but by five overlapping provisions of the U.S. Constitution. (*Christopher v. Harbury* (2002) 536 U.S. 403, 415 fn.12.)

experts and other case preparation. (Shandell, *et al.*, *The Preparation and Trial of Medical Malpractice Cases* (2002) § 2.02 (hereafter Shandell).)[26]

Because many potential plaintiffs cannot afford to hire a qualified malpractice attorney on an hourly or fixed-fee basis, most qualified malpractice attorneys are retained on a contingency-fee basis. This means (and has been true for years) that the availability of such attorneys may well depend on whether the size and prospects of the potential damages yield is sufficient to prompt an attorney to agree to take the case on a contingency fee basis. (Shandell, at § 2.02; Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries, and Social Policy* (2005) 38 Loy L.A. L. Rev. 1217, 1233. See generally Kritzer, *Risks, Reputations, and Rewards: Contingency Fee Legal Practice in the United States* (2004).)

Malpractice lawyers' contingency fee "agreements are the 'poor man's key to the courthouse door': they enable persons who cannot afford to retain an attorney on an hourly or fixed-fee basis to pursue their claims with competent counsel," and often are the only practical way to bring

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[26] See Lawrence S. Charfoos, *The Medical Malpractice Case: A Complete Handbook* (1974) 24 ["Malpractice cases . . . have high direct and indirect costs. The direct costs result from the necessity of extensive pre-trial discovery, . . . travel . . . , and always the need to spend substantial sums for medical consultations as well as for medical testimony for trial, if the case cannot be settled. An additional cost is the disproportionate amount of time that an attorney must spend working on the file compared to most other personal injury cases."].

justice within reach of most Americans. (*Leonard C. Arnold, Ltd. v. Northern Trust Co*. (Ill. 1987) 506 N.E.2d 1279, 1281, citation omitted.) Unlike many federal torts, which often allow prevailing plaintiffs to recover attorney fees and costs, tort actions in California generally proceed under the unrealistic theory that preparing a case is cost-free and a plaintiff is made whole by an award of medical expenses, lost income, and noneconomic damages. But this theory is unrealistic precisely because contingency fee contracts typically require a plaintiff to rebate roughly a third of a total award "to cover legal fees, the costs of experts, and related expenses." (Viscusi, *Pain and Suffering: Damages in Search of a Sounder Rationale* (1996) 1 Mich. L. and Pol'y Rev. 141, 157-58 (hereafter Viscusi).)

Hence, for plaintiffs with low economic damages, noneconomic damages play an indispensable "practical role . . . in facilitating the payment of legal fees." (Viscusi, at 158.) That fees are limited by law simply renders these meritorious cases economically unviable. There is wide recognition of "the crucial practical role that pain and suffering damages play in the current tort regime in generating the funds to pay for the fees charged by the plaintiff's attorney," which "not only secures monetary redress for victims but also provides actors and enterprises with significant financial incentives to adopt precautions that protect all of us." (ALI Reporter's Study, at 215.)

### B. The Cap's Disproportionate Impact on the Disadvantaged also Disproportionately Diminishes Their Chances to Obtain Legal Assistance

Because noneconomic damages play such a "crucial practical role," (ALI Reporter's Study, at 215) in convincing an attorney to take on a case, statutory "limits on [such] awards may affect access to the civil justice system by making cases financially unattractive to plaintiffs' lawyers working on a contingency fee basis." (Daniels & Martin, *The Texas Two-Step: Evidence on the Link Between Damage Caps and Access to the Civil Justice System* (2006) 55 DePaul L. Rev. 635, 645 (hereafter Daniels & Martin).) And by undermining the ability and willingness of attorneys to take on malpractice cases, caps effectively deprive many tort victims of any legal redress at all because "the only way for most people to afford representation, especially in a substantial matter like medical malpractice, is to hire a lawyer who will handle it on a contingency fee basis." (*Id*. at 645-46, footnote omitted. See ABA Letter.)

The impact is especially acute for women, the elderly, children, minorities, and the poor, who may be left "[w]ithout meaningful legal representation" or a "realistic remedy for their injuries." (Daniels & Martin, at 669.) Caps "creat[e] two tiers of malpractice victims," because "lawyers are turning away cases involving victims that don't represent big economic

losses—most notably retired people, children and housewives." (Zimmerman, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, Wall Street J. (Oct. 8, 2004) A1. See Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps* (2005) 80 N.Y.U. L. Rev. 391, 489-90.) Texas' $250,000 cap, authorized by a constitutional amendment,[27] has "slammed the courthouse doors shut on those who can least afford it—children, stay-at-home moms and the elderly." (Daniels & Martin, at 645 [quoting Donald, *Access Denied: Does Tort Reform Close Courthouse Doors to Those Who Can Least Afford It?* Tex. Law., (Jan. 10, 2005) at 1].) California's cap, which is not the subject of a specific constitutional authorization, cannot stand in the fact of our Constitution's guarantees.

## CONCLUSION

In the final analysis, even if this Court were to accept the unsubstantiated notion that limiting jury awards in malpractice cases reduced doctors' liability premiums and thereby reversed (or prevents) a physician exodus and healthcare crisis, that exodus and crisis no longer exists. But the cap most definitely did and still does discriminate against

[27] Tex. Const. art. III, § 66.

the most grievously injured malpractice victims, as well as women, children, the elderly, minorities, and the poor, depriving them of full justice and access to the courts. It is manifestly arbitrary, unfair, and irrational to impose the costs of reducing the insurance premiums charged to members of the wealthiest profession and safeguarding the profits of private insurance companies on the backs of the most seriously harmed victims of medical malpractice and on the backs of the elderly, children, women, minorities, and the poor.

John Adams, one of colonial America's most eminent trial lawyers, once told a Massachusetts court: "'[f]acts are stubborn things; and whatever may be our wishes, our inclinations, or the dictums of our passions, they cannot alter the state of facts and evidence.'" (John Adams, *Argument in Defense of the [British] Soldiers in the Boston Massacre Trials* (1770), *in John Adams*, 3 *Legal Papers of John Adams* (Wroth., ed., 1965) 269. See McCullough, *John Adams* (2001) 68.) Here, because the facts stubbornly show the cap is not rationally related to the public interest (*Young*, 41

Cal.3d at 899) this Court should hold that the cap violates the California's Constitution's guarantee of equal protection.

Dated: October 15, 2010

Respectfully submitted,

THE ARKIN LAW FIRM

CENTER FOR CONSTITUTIONAL LITIGATION

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## CERTIFICATE OF LENGTH OF BRIEF

I, Sharon J. Arkin, declare under penalty of perjury under the laws of the State of California that the word count for this Brief, excluding Tables of Contents, Tables of Authority, Proof of Service and this Certification is 10,869 words as calculated utilizing the word count feature of the Word for Mac software used to create this document.

Dated: October 13, 2010

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SHARON J. ARKIN

# APPENDIX