# IN THE SUPREME COURT OF MISSOURI

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| **DEBORAH WATTS as Next Friend for NATHAN WATTS,** | ) | |
| **Appellants/Cross-Respondents,** | ) | **Supreme Court No. 91867** |
| **vs.** | ) | |
| **LESTER E. COX MEDICAL CENTERS, d/b/a FAMILY MEDICAL CARE CENTER, LESTER E. COX MEDICAL CENTERS, MELISSA R. HERRMAN, M.D., MATTHEW P. GREEN, D.O., WILLIAM S. KELLY, M.D.,** | ) | |
| **Respondents/Cross-Appellants.** | ) | |

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BRIEF OF PROFESSORS OF LAW AS
AMICI CURIAE IN SUPPORT OF APPELLANTS

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## INTEREST OF THE AMICUS CURIAE

This brief is filed on behalf of Professors Neil Vidmar, Tom Baker, Ralph L. Brill, Martha Chamallas, Stephen Daniels, Thomas A. Eaton, Marc Galanter, Valerie P. Hans, Edward J. Kionka, Herbert M. Kritzer, Joanne Martin, Frank M. McClellan, Deborah Jones Merritt, Ralph Peeples, James M. Richardson, Michael L. Rustad Charles M. Silver, and Richard W. Wright (collectively, the "Academic Amici") who are professors of law and/or social science at universities, law schools and research institutions throughout the United States. (Brief biographies of Amici are reported in Appendix A.)

The Amici are scholars who have devoted a significant portion of their time to researching medical malpractice litigation. Their work has assisted courts facing this issue in other states. *See Ferdon v. Wis. Patients Comp. Fund,* 701 N.W.2d 440, 667 n.229 (Wis. 2005) (striking down cap on non-economic damages in medical malpractice cases and noting Professor Vidmar's study reporting the absence of a factual basis for the assertion that "doctors were leaving the state [of Illinois] as a result of medical malpractice actions and a rise in liability insurance premiums"); *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1068 (Ill.1997) (stating that affidavits by Professors Vidmar, Galanter, Daniels, and Martin "clearly show[ed] that the legislative 'findings' listed in the [statute] do not provide a rational justification for the limitation of compensatory damages for non-economic injuries"). Many of the amici were also signatories on an amicus brief that played a significant part in oral arguments about a subsequent Illinois cap on "non-economic" damages in medical malpractice cases that was overturned by the

Illinois Supreme Court in 2010 in *LeBron v. Gotlieb Memorial Hospital* 930 N.E.2d 895 (Ill. 2010).

## CONSENT OF THE PARTIES

The amici has received written consent from all parties to file this brief. Therefore, the amici are filing this brief pursuant to Rule 84.05(f)(2) of the Missouri Rules of Civil Procedure.

## JURISDICTIONAL STATEMENT

The Supreme Court has jurisdiction over this appeal because it involves a constitutional challenge to a statute of the State of Missouri pursuant to Article V, Section 3 of the Missouri Constitution. Amici assert an interest in Appellant Deborah Watts', as Next Friend for Nathan Watts, appeal of the judgment of the Circuit Court of Greene County.

## ARGUMENT

## I. FACTUAL BACKGROUND

Amici adopt the factual background set forth in the Appellants/Cross-Respondents' brief.

## II. SUMMARY

Amici first address the issue of whether the cap on non-economic damages has a greater impact on certain classes of plaintiffs. We examine data verifying equal protection inequities as HB 393 is applied to different plaintiffs. Plaintiffs who are very young, very old, unemployed, stay-at-home parents, or suffer a previous disability may recover only a small fraction of their actual damages. Such discrimination occurs solely because of the particular plaintiff's age, gender, disability, race, status, or wealth.

Next, we examine whether the alleged "medical malpractice crisis" leading to the enactment in 2005 of House Bill 393 with its cap of $350,000 for "pain and suffering" is supported by contemporary data. Namely, amici examine and refute claims that doctors were leaving Missouri for states with an alleged better climate in which to practice. Our examination of official American Medical Association data reveals that the *per capita* number of patient treating physicians had been *steadily growing for decades* and continued through the alleged "crisis" and the passage of HB 393.

We then draw upon Missouri Department of Insurance data clearly showing rising malpractice premiums were *not* caused by an increase in either litigation or jury awards, but by a predictable business cycle affecting the profitability of medical liability insurance carriers. We further bolster the Missouri Department of Insurance's conclusion with additional research and data that corroborate the Missouri Department of Insurance's findings.

Finally, we look at data regarding jury awards compiled to determine if there is support for the proposition that juries are overly generous to sympathetic plaintiffs. Specifically, amici examine data provided by the Bureau for Justice Statistics and many empirical legal studies and surveys. The data show that jury awards are generally correlated with the severity of injuries involved. Furthermore, judges and doctors tend to come to the same conclusion as the jurors in a given case.

These factors, when considered together, show that non-economic damages have a disproportionate impact on certain classes of plaintiffs. Additionally, the Missouri Legislature could not have found a rational relationship between limiting non-economic damages and putting an end to the alleged medical malpractice crisis.

## III. LEGISLATIVE BACKGROUND

In 2005, the Missouri Legislature passed HB 393 which contained, among other provisions, a $350,000 cap on non-economic damages in medical negligence claims. Amici have been informed that there is no official record of the legislative hearings that

eventually led to the passage of HB 393. However, during the months preceding the legislative hearings the American Medical Association and similar state organizations publicly claimed that there was a nationwide crisis of increasing litigation and excess jury awards, especially regarding the "pain and suffering" component of the awards.

The AMA and allied organizations called for caps of $250,000 on the "pain and suffering" component of awards as a way to help stem the "crisis" (see for example: American Medical Association, *Medical Liability Reform – Now!*, (2005) (Reproduced in Appendix E)). Missouri was included among the "crisis" states, and several anecdotes in the report were devoted to Missouri (at page 16). In that document, and in many other reports by the AMA and their political allies, were claims that out of fear of litigation doctors were fleeing "highly litigious" states; closing their practices; reducing specialized services; and practicing "defensive medicine" by ordering unnecessary tests and procedures. The "crisis" was alleged to be especially acute among specialty areas of medicine, such as obstetrics and neurosurgery.

The lack of a full legislative record makes drawing a conclusion as to the purpose of HB 393 difficult. The assumption is that the changes in HB393 with respect to medical negligence claims in HB 393 were designed to address the problems put forward by the AMA among others. Amici worked under this assumption when evaluating the rationality of the $350,000 cap on non-economic damages in HB 393.

## IV. THE NON-ECONOMIC DAMAGES CAP IN HB 393 VIOLATES THE EQUAL PROTECTION CLAUSE OF THE US AND MISSOURI CONSTITUTIONS BECAUSE IT HAS A DISPROPORTIONATE EFFECT ON CERTAIN CLASSES OF PLAINTIFFS.

### A. Non-economic damages are an important part of compensation for injuries due to medical negligence.

There are some injuries that are very harmful to the patient but defy ordinary economic accounting. At a congressional hearing in 2003, Heather Lewinski, a seventeen-year-old teenager, courageously testified about her psychological pain as a result of egregious medical malpractice when she was eight years old that left her face permanently and horribly disfigured. Subcommittee on Oversight and Investigations of the Committee of Energy and Commerce, Hearing on "The Medical Liability Insurance Crisis: A Review of the Situation in Pennsylvania", 108th Cong. 60 (2003); *see*: Neil Vidmar, *Medical Malpractice Litigation in Pennsylvania*, Pennsylvania Bar Association, (May 2006). Among other side-effects, Heather constantly drools. She described how other children made fun of her as she advanced through her teenage years. She had one self-initiated date, and it was a disaster. She told about her belief that she will never marry, will never have children, and will have to concentrate on raising and training dogs because they do not discriminate on the basis of human appearances. Unfortunately, despite her apparent intelligence, warm personality, and the unfairness of her condition, Heather was probably right. Professor Vidmar, present at the Hearing, saw her face, as

did others who tearfully heard her testimony. If Heather lives to be seventy-eight years old, an award of $350,000 -- the limit for non-economic damages in Missouri -- would compensate her at the rate of $5,000 per annum for her shattered life. Heather's story is not the only example of patients' injuries defying economic accounting. When Professor Vidmar was conducting research in North Carolina, a young mother of two children was rendered permanently blind. (*see* Neil Vidmar & Valerie P. Hans, American Juries: The Verdict, at 327 (2007)). In other cases patients lost sexual or reproductive functions, injuries that were very real, though the losses could not be easily calculated like medical expenses or loss of income.

There is a widely held misconception that non-economic damages are the same thing as "pain and suffering." Indeed, pain and suffering is an important component of non-economic damages, which developed to compensate injured persons for their physical and emotional suffering. But non-economic damages include a lot more than just monetary compensation for physical and emotional suffering; they also include such matters as monetary compensation for disfigurement, loss of parental guidance, loss of parental companionship, loss of moral training from parents, loss of marriage prospects, loss of consortium (*e.g.*, companionship and sexual congress), emotional distress, and loss of enjoyment of life, see Ronald Eades, Jury Instruction on Damages in Tort Actions §6-18 to §6-20 (3d ed. 1993); Thomas H. Koenig & Michael L. Rustad, In Defense of Tort Law (2001).

Research by Lucinda Finley documented some of the non-economic damages suffered by women as a result of medical negligence. These included injuries such as pregnancy loss, infertility, and gynecological problems, each of which resulted in emotional distress, grief, social adjustment, an altered sense of self, impaired relationships, and impaired physical capacities such as reproduction and sexual gratification. In some cases, failure to diagnose breast cancer in its early stages resulted in the surgical removal of breasts, physical pain, and emotional fears of an untimely death. But such pain and suffering was not limited to females. In one case the misdiagnosis of a twenty-eight-year-old man's stomach pain resulted in partial removal of his bowel and scrotum, leaving him impotent and infertile. In another instance, a doctor used undiluted acid to treat a fifty-four-year-old man's genital warts resulting in severe burns to his scrotum and penis, permanent scarring, and severe pain during sexual intercourse. Lucinda M. Finley, The *Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 Emory L.J. 1263, 1281, 1308-12 (2004). Non-economic damages provide important compensation for these real and often tragic human losses that are not and cannot be encompassed in the category of economic damages.

**B. Caps on non-economic damages disproportionately affect traditionally disadvantaged groups such as women, children, people with disabilities, minorities and the elderly.**

As the Illinois Supreme court concluded in *Best v. Taylor Machine,* a cap "discriminates among types of injuries" because "the supposed difficulties of assessing

damages for non-economic injuries apply equally to all tort claims for pure non-economic loss, and not just those involving death, bodily injury or property damage," *Best*, 179 Ill.2d at 404, or just injuries caused solely by malpractice.

Numerous courts in other states, before and since *Best*, have echoed the *Best* court's views on the ways a cap discriminates and accordingly have struck down caps on special legislation or equal protection grounds. (*See e.g., Ferdon v. Wisc. Patients' Comp. Fund*, 701 N.W.2d 440, 465 (Wisc. 2005); *OATL v. Sheward*, 715 N .E.2d 1062, 1095 (Ohio 1999); *Trujillo v. City of Albuquerque*, 965 P.2d 305, 317 (N.M. 1998); *Hanvey v. Oconee Mem. Hosp.*, 416 S.E.2d 623, 625-26 (S.C.,1992); *Morris v. Savoy*, 576 N.E.2d 765, 769 (Ohio 1991); *Brannigan v. Usitalo*, 587 A.2d 1232, 1236 37 (N.H. 1991); *Moore v. Mobile Infirm. Ass'n*, 592 So. 2d 156, 169 (Ala. 1991); *Condemarin v. Univ. Hosp.*, 775 P.2d 348, 353 (Utah 1989); *Richardson v. Carnegie Lib. Rest., Inc.*, 763 P.2d 1153, 1163 64 (N.M. 1989); *Sofie v. Fibreboard Corp.*, 771 P.2d 711, 715-23 (Wash.,1989); *Lucas v. United States*, 757 S.W.2d 687, 691 (Tex.1988); *Sibley v. Bd. of Super.*, 477 So.2d 1094, 1108 09 (La. 1985); *Carson v. Maurer*, 424 A.2d 825, 830 31, 836 37 (N.H.,1980); *Arneson v. Olson*, 270 N.W.2d 125, 133, 135 36 (N.D.1979); *Park v. Detroit Free Press Co.*, 40 N.W. 731, 735 (Mich. 1888); *Arrington v. Galen-Med, Inc.*, No. 97-4329 (La., Calcasieu Parish Dist. Sept. 9, 2011).

Furthermore, empirical research by neutral, well-regarded scholars not only corroborates these insights but clearly establishes that a cap discriminates against some tort plaintiffs and in favor of some tortfeasors in several other ways, too. The research

demonstrates that a ***cap disproportionately affects traditionally disadvantaged groups, such as women, children, people of color, the elderly, people with disabilities, and people of low income in general***, reducing the damages such people receive because their economic damages, such as lost wages, either are nonexistent or disproportionately low, *e.g.*, juries award such victims a greater proportion of their overall compensatory damages in the form of non-economic damages. For research and commentary see: S. Daniels & J. Martin, *Texas Two Step: Evidence on the Link Between Damage Caps and Access to the Civil Justice System*, 55 DePaul L. Rev. 635 (2006); E. Bublick, *Tort Suits Filed by Rape and Sexual Assault Victims*, 59 SMU L. Rev. 55 (2006). *See also* T. Koenig & M. Rustad, *In Defense of Tort Law* 114 (2001).

Studdert, *et al.* of the Harvard School of Public Health, studied California jury verdicts to assess the impact of that state's $250,000 cap on non-economic damages and concluded:

> Analysis of proportional reductions shows that the burden of caps falls on injuries that cause chronic pain and disfigurement but do not lead to declines in physical functioning that would generate lost work time or high health care costs… Notwithstanding their limited economic impact, the injuries involved are by no means trivial. (D. Studdert, *et al.*, *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 21 Health Affairs 54, 63 (2004)).

***A cap on non-economic damages exacerbates existing gender-based disparities in the tort system.*** L. Finley, *The Hidden Victims of Tort Reform: Women, Children and the Elderly*, 53 Emory L.J. 1263, 1280-81 (2004). This is so because men's overall jury awards tend to be higher than women's awards, due in part to men's higher wage-based economic damages. *Id.*, at 1281. Thus, because a cap operates to deprive women of a greater portion of an overall jury award, a cap effectively exacerbates the disparity between the average amounts that men recover for their injuries compared to the amounts that women recover. *Id.* at 1282-85, 1288-99.

***Caps disproportionately disadvantage the elderly* because juries also award elderly plaintiffs a much greater proportion of their overall damage awards as non-economic damages compared to non-elderly plaintiffs, especially when the elderly patient dies as a result of the tort,** see. Finley, *supra*, at 1286-88 & 1302-04. This is because 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. Despite these reduced areas of economic loss, elderly tort victims still suffer debilitating pain and reduced life activities. Non-economic damages become the principal way for the jury to assess and provide compensation for the severity and life-altering effects of the injury. Finley's research also showed that when the gender of plaintiff is combined with the age of plaintiff, juries tend to award elderly women an even greater proportion of their total compensatory award as non-economic damages than elderly men.

In addition, if an elderly plaintiff dies, juries allocate a substantial majority of the damages to non-economic damages. *Id.* As a result, elderly women experience particularly severe disparate impact from damages caps. Lastly, "[t]he impact of the cap in cases where an infant or child died as a result of malpractice was even more draconian than in the adult death cases." *Id.*

***Caps discriminate against members of racial and national minorities***, who are disproportionately unemployed and disproportionately employed in the lowest-paying occupations. *See* A. Edwards, *Medical Malpractice Non-Economic Damages Caps: Recent Developments*, 43 Harv. J. on Legis. 219, 219-21 (2006) (examining how such caps affect minority populations, and explaining how the data tables used to calculate economic damages project lower earnings for non-white workers, and this results in lower economic damages and more harm from non-economic damage caps); see also, J. Doroshow, *The Racial Implications of Tort Reform*, 25 Wash. U. J.L. & Pol'y 161, 169-70 & nn. 37-38 (2007).

There is another factor that is too often overlooked due to the false premise of tort reform, which focuses on verdict-size instead of the negligent actor's conduct and harm to the victim. Medical malpractice victims' damages may be primarily noneconomic due to permanent disfigurement or maiming. Moreover, an unknown number of medical negligence victims can no longer use the court system. Because noneconomic damage caps artificially and arbitrarily limit a victim's ability to recover her loss, the expenses of

litigation often outweigh the limited recovery arbitrarily permitted under the statute and the courthouse doors are effectively shut for a disparate number of victims. *See* Stephen Daniels & Joanne Martin, *Texas Two Step: Evidence on the Link Between Damage Caps and Access to the Civil Justice System*, 55 DePaul L. Rev. 635 (2006); Herbert M. Kritzer, *Risk, Reputations, and Rewards: Contingency fee Legal Practice in the United States* (Stanford Univ. Press, 2004).

Moreover, such inequitable treatment falls more squarely on already disadvantaged groups, including the elderly, the young, and the unemployed. Consider an example of a 15-year-old girl negligently treated by a medical professional resulting in severe facial disfigurement. She was not employed at the time of injury, so there are no damages for lost wages. There is nothing that could be done to repair the procedure, so there are no future medical expense damages. Yet, this young woman must live the next 50-70 years with severe facial disfigurement facing the daily challenges of a society that values appearance. She must face the reality that she may not ever experience dating, or marriage, or children. Yet tort reform could cap this young woman's damages at $350,000 (only $7,000 per year if she lived to age 65; and less than $5,400 per year if she lived to age 80). What's more, her recovery is eliminated entirely if the costs of pursuing her claim (written discovery, depositions, medical record review, experts, attorneys, etc.) approach or outweigh the arbitrary limit of her recovery.

The perverse result is that the negligent actor is effectively immunized while the innocent victim is denied access to the courts. In the process, the burden of the

negligence is often passed on to taxpayers through the form of welfare payments, Medicaid and Medicare for injured victims. See generally, Vidmar, N. *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries and Social Policy*. 38 Loyola Los Angeles Law Review 1252-62 (2005). The right of equal treatment under the law is fundamental. How can a damage cap that favors a special class of medical professionals by limiting or taking away the damages of an injured person be constitutional? What other person who negligently injures another is given this unconstitutional protection?

In short, studies all tend to show that non-economic damages are a greater portion of the overall compensation for injured patients when those patients fall into one of the above categories. As a result, limits on the amount of non-economic damages will have a greater impact on the ability of these classes of plaintiffs to be fully compensated than it would on a high wage earner. For plaintiffs with large economic damages, the non-economic damages represent an additional category of compensation. For the classes of plaintiffs discussed above, non-economic damages may represent the majority of their judgment.

## V. THE LEGISLATURE DID NOT HAVE A RATIONAL BASIS FOR IMPOSING NON-ECONOMIC DAMAGE CAPS

### A. Missouri was not facing a shortage of medical professionals.

Statistics show the number of patient-doctors in Missouri has steadily increased over the past four decades. In its claims that doctors were leaving "litigious" states, the AMA reports mentioned above relied on anecdotes and methodologically flawed surveys of physicians asking them if they were thinking of leaving their practice because of the litigation climate in their state (*See e.g.* AMA 2005 at page 4.)

However, the AMA reports of a doctor exodus ignore its own official data collected for another purpose -- research published in the American Medical Association's authoritative annual compendium. The AMA has described this compendium as "the most complete and extensive source of physician-related information in the United States." *Physician Characteristics and Distribution in the U.S.*, App. 35 (2009 ed.,the "AMA Compendium"). These official data, conclusively demonstrate that the number of physicians engaged in patient care in Missouri steadily increased, even during periods of so-called "crisis." These data are summarized in tables and charts provided in Appendix B to this amicus brief.

In an early empirical study Patricia M. Danzon, *Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 Law & Contemp. Prob. 57, 79 (1986) cautioned against assuming caps would result in lower malpractice premiums. Similarly, a group of researchers reported that studies from across the country revealed malpractice insurance premium increases "had little effect on physician practice location or supply," Stephen Zuckerman et al., *Medical Malpractice: Can the Private Sector Find Relief?* 49 Law & Contemp. Probs. 85, 109 (1986). Professor V. N. Bhat's Medical Malpractice: A Comprehensive Analysis 172 (2001) reported a state-by-state study of the supply of physicians and OB-GYN specialists and concluded "the medical malpractice system is not a significant factor in this supply." The assumption that caps would increase the number of physicians is further undermined by a more recent study of the supply of OB-GYNs in all 50 states, which concluded:

Although the costs of malpractice insurance are substantial for OB/GYNs, they do not appear to be significantly associated with the supply of physicians in a state. Most practitioners in this specialty do not respond to liability risk by relocation or discontinuing their practice. Tony Yang et al., *A Longitudinal Analysis of the Impact of Liability Pressure on the Supply of Obstetrician-Gynecologists*, 5 J. Empirical Legal Studies 21, 53 (2008).

**In summary, official AMA statistics refute claims that doctors were leaving the state of Missouri. In fact just the opposite is true. The per capita number of patient-treating doctors, including the specialties of ob-gynecology and**

**neurosurgery had been steadily increasing for decades. The Missouri Legislature had no rational basis for attempting to encourage doctors to stay in Missouri since their numbers were holding steady or increasing during the preceding decade.**

**B. The Missouri Department of Insurance reports in 2003 and 2005 refute the assumption that non-economic damage payments impact the cost of medical liability insurance.**

Among the fifty states, Missouri ranks at or near the top for record keeping of medical liability claims and outcomes; and it produces annual reports. Two of these reports are particularly germane to the issues before this Court. In 2003 the Department produced a special report on malpractice: Scott B. Lakin, *Medical Malpractice insurance in Missouri: The current difficulties in perspective* (hereinafter "MDI 2003"). Its annual report for 2005: *Missouri Medical Malpractice Insurance Report, October 2005* (hereinafter "MDI 2005") corroborates the 2003 report. Both of these reports are produced in full in Appendix C.

The Missouri Department of Insurance explanation for the rise in liability premiums charged to doctors is a re-occurring business cycle, not an increase in malpractice litigation and jury awards. The MDI 2003 special report was written in response to concerns about a rise in medical malpractice insurance premiums starting shortly before the year 2000 and continuing at the time the special report was published. The Report attributed the rising premiums not to an increase in jury awards and

settlements, but rather to an underwriting cycle in the medical malpractice liability insurance industry. This cycle has occurred three times in the past four decades.

The underwriting cycle has been explained by leading insurance scholar, Professor Tom Baker, from the University of Pennsylvania Law School and formerly the Director of the Insurance Law Center at the University of Connecticut Law School, in an article in *DePaul Law Review* (2005) and in his book, The Medical Malpractice Myth (2005, chapter 3, pp 45-67). Professor Baker has explained that "the two most recent medical liability insurance crises [mid-1980s and early 2000s] did not result from sudden or dramatic increases in medical malpractice settlements or jury verdicts" but instead from the boom-and-bust insurance market. Tom Baker, The Medical Malpractice Myth 53-54 (2005). *See also* Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DePaul L. Rev. 393, 394 (2005) ("Litigation behavior and malpractice claim payments did not change ... between 1996 and 2001. What changed, instead, were insurance market conditions and the investment and cost projections."). The MDI 2003 report and its discussion is wholly consistent with Professor Baker's research.

In a nutshell, the cycle begins with aggressive competition among liability insurers for market share. As a result, premiums are underpriced to beat out competition. However, unlike many other insurance lines, such as car insurance, medical malpractice insurance has what is called a "long tail." This is because medical malpractice litigation is complicated and typically involves years of litigation between a medical incident and a resolution of the claim --whether it is eventually dropped by the plaintiff, results in a

settlement, is resolved at trial or is settled in post-trial proceedings (see Vidmar, Medical Malpractice and the American Jury, 1995; Vidmar, N. *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries and Social Policy.* 38 Loyola Los Angeles Law Review 1217 (2005)).

Often the litigation process takes six years or longer. In the meantime, the reserves set aside by the liability insurer to pay for claims-- based largely on initially underpriced premiums-- are subject to losses from injury cost inflation (e.g., medical care and wage inflation) and to occasional downturns in the markets where the reserves are invested. The result is that eventually the liability insurers have to pay out more in claims than they are taking in through liability premiums charged to doctors. The companies then raise premiums to remain solvent. The increased premiums cause complaints among the insured doctors and, in consequence, the liability insurers falsely place the blame on an increase in medical malpractice litigation and, especially, jury awards. In short, as the Missouri Department of Insurance 2003 report concluded: "These difficulties [of increased premiums for doctors' liability insurance]… find their roots in the insurance underwriting cycle, not at the hands of victims [of medical negligence]." *Id.* (underline added)

The MDI 2003 report summarized findings from its comprehensive insurance files that are inconsistent with the claims of an upsurge in malpractice litigation and jury awards (see page 2 of that report):

1. Claims closed and filed have trended downward for both physicians and other types of health care providers;
2. In the past decade awards for malpractice damages actually lagged behind general inflation;
3. All increases in award sizes are accounted for by medical inflation, wage inflation (for lost earnings) and the increase in severity of the injury to the patients;
4. On average in 2003 physicians paid less for malpractice coverage than in 1990, even though 40 percent more doctors were licensed. All medical providers also paid less overall for coverage than in 1990.
5. Economic awards for increased medical costs and lost earnings accounted for a greater share of total damages than non-economic damages. (underline added for emphasis)
6. Missouri had few of the multimillion-dollar awards cited in the [nationwide] media and, when they did occur, most damages represented the medical costs to treat the injury and the income the victim could not earn.

Moreover, the MDI 2003 Report specifically asserted "These [insurance market] difficulties, however, find their root in the insurance underwriting cycle, not at the hands of the victims." (*Id.* at 2)

The MDI Annual Report for 2005 adds further facts consistent with its special report in 2003. The data on which it relied were for 2004, the year before HB 393 was enacted. The MDI findings included the following:

1. Profitability among the overall Missouri medical malpractice market posted positive underwriting results for the first time in five years. (This finding is consistent with the research on the underwriting cycle discussed *supra*).
2. Moreover, the reported malpractice claims against medical providers fell by 20 percent in 2004. This reduction followed an 11 percent decline in 2003.
3. While the number of reported claims in Missouri in 2004 increased for the third consecutive year, the number of paid claims had declined since 2002.
4. The average award for claims increased for the third consecutive year BUT it is critical to note that the Report concludes that this finding can be partially or wholly explained by the following facts:

    a. Average awards are highly sensitive to medical inflation, growth in real wages and average injury severity;

    b. The average severity of injuries increased in 2004 tying the historic high reached in 2002;

    c. The actual number of paid claims involving less serious injuries declined while the number of more serious injuries increased and the increase in severity of injury is part of a longer term trend. In short, plaintiffs were more likely to have suffered severe injuries such as

blindness, quadriplegia, brain damage or loss of limbs. The Report concluded that the increased seriousness of negligent medical injuries "undoubtedly plays a significant role in the increasing awards observed over the past several years."

d. Another factor in increasing awards is the fact that health care costs in Missouri increased by an average of 4.7% and average wages have increased by 3.2 percent between 1999 and 2004.

In summary, the increases in paid claims noted by the Missouri Department of Insurance were due to increases in economic, not non-economic, damages and an increase in severity of injuries suffered by patients. It is the understanding of the amici that the MDI 2003 report was provided to the Legislators while they were considering a solution to the perceived problem of high medical malpractice awards. In light of the findings published by its own Department of Insurance, the Legislature could not have rationally determined that a cap on non-economic damages would have an impact on the overall size of medical malpractice awards.

**C. Plaintiffs do not win the majority of claims that are decided by a jury.**

There is a widespread public belief that juries in medical malpractice cases are inclined to side with plaintiffs; but, in contrast to this perception, systematic research has shown that nationwide only about 7% of medical malpractice lawsuits are tried by juries and a 2001 survey involving data representative of the nation's seventy-five largest

counties undertaken by the U.S. Bureau of Justice Statistics (BJS) found that of 1100 malpractice trials plaintiffs won only 27 percent of the time, roughly one case in four, Thomas Cohen, Medical Malpractice Trials and Verdicts in Large Counties, 2001, U.S. Bureau of Justice Statistics,(2004) available at *bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=784.*

The BJS survey was repeated in 2008 with data from 2005, see L. Langton and T. Cohen, Civil Bench and Jury Trials in State Courts, 2005 (October 2008), available at *bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=554* . The raw data from the 2005 survey are stored in the archives of the Inter-university Consortium for Social and Political Research (ICPSR) at the University of Michigan. Specifically for this brief the present amici draw upon those data to report on jury verdicts in Missouri in 2005 (see Appendix D).

The survey's scope included not only St. Louis County but the Missouri counties of Boone, Buchanan, Dent, Greene, Harrison, Maries, Mercer, Phelps, and St. Charles. Note that cases in the dataset were filed before HB 393 was passed and were therefore exempt from the $350,000 cap on "pain and suffering." Altogether in those ten counties there were only 24 trials in the above counties in 2005, 16 in St. Louis, 1 in Boone, 3 in Buchanan and 4 in Greene. Plaintiffs prevailed in only 5 trials a win percentage of 20.8 percent, or in the obverse, doctors won 19 of 24, a win percentage of 79.2 percent.

According to the BJS coding, one of the plaintiffs was awarded $1,479,000 involving a lung infection (no breakdown of special and general damages provided); another received $36,894 for loss of sight (all for special damages); another was awarded $100,000 in a claim over a heart condition ($45,000 for general damages); another received $1 million for a heart issue ($400,000 for general damages) and in a final case, involving colon cancer, the jury awarded the plaintiff $162,000 in special damages and $500,000 in general damages but the final "adjusted" amount totaled only $185,360.

The U.S. Bureau of Justice Statistics did a broader survey which systematically sampled jury verdicts in 1992, 1996, 2001 and 2005 in courts representing the seventy-five most populous counties in the United States. Carol J. DeFrances *et al.*, Bureau of Justice Statistics, No. NCJ-154346, Civil Justice Survey of State Courts, *1992: Civil Jury Cases and Verdicts in Large Counties* (1995); Carol J. DeFrances & Marika F.X. Litras, Bureau of Justice Statistics, No. NCJ 173426, *Civil Justice Survey of State Courts, 1996: Civil Trial Cases and Verdicts in Large Counties, 1996* (1999). In the BJS survey for 2005, there were 2,397 cases involving claims of medical malpractice and plaintiffs prevailed only 22.7 percent of the time, See Langton and Cohen, Civil Bench and Jury Trials in State Courts, 2005 at Table 5,p 4 , available at *bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=554.*

To supplement the BJS data amici also searched Westlaw verdict reports for medical malpractice trials in Missouri for the years 2003 through 2005 (Also in Appendix

D). For those three years there were a total of 39 jury trials in Missouri State Courts and plaintiffs won only 6 cases -- a 15 percent plaintiff win rate.

In short, the BJS and Westlaw data are consistent with the Missouri Department of Insurance report concluding that jury awards are not a noteworthy factor in the cost of malpractice liability insurance.

**D. Jury awards are justified by actual losses and injury severity. Large jury awards, while rare, are reduced in post-judgment motions and settlements.**

An important study of medical malpractice litigation by Mark Taragin and his colleagues compared jury verdicts with the judgments of doctors hired by an insurance company to review the medical records to provide a neutral assessment of whether they believed medical personnel had acted negligently. Mark I. Taragin *et al.*, *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 Annals Internal Med. 780 (1992). These decisions were confidential and could not be obtained by the plaintiff or used at trial. The Taragin et al research team compared the doctors' ratings with jury verdicts. The jury verdicts tended to be consistent with these expert assessments. The results, therefore, are inconsistent with the claim that juries decide for the plaintiff out of sympathy rather than by applying the legal standard of negligence.

Other studies have asked trial judges to make independent assessments of who should have prevailed in civil cases over which they presided. The judgments were made

while the jury was still deliberating and therefore were not contaminated by knowledge of the outcome. The judge's decision was then compared to the jury verdict in that case. Although the research did not specifically focus on malpractice juries, the findings indicate that there was high agreement between judges and juries. Moreover, in instances where the judge would have decided differently than the jury, the judge usually indicated that, nevertheless, the jury could reasonably have come to a different conclusion from the trial evidence. Harry Kalven, Jr. & Hans Zeisel, The American Jury (1966); Larry Heuer & Steven Penrod, *Trial Complexity: A Field Investigation of Its Meaning and Its Effects*, 18 Law & Hum. Behav. 29 (1994).

Bovbjerg, Sloan, and Blumstein found that the magnitude of jury awards in a sample of medical malpractice tort cases positively correlated with the severity of the plaintiffs' injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia. Randall R. Bovbjerg *et al.*, *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 Nw. U. L. Rev. 908 (1989). While the Bovbjerg study acknowledged that there was considerable variability within categories of injury severity, later research by Sloan and van Wert provided a plausible explanation for this variability, namely that economic losses vary considerably within each level of injury severity, Frank A. Sloan et al., Suing for Medical Malpractice 123, 139-40 (1993) The economic loss for a quadriplegic who is forty years old with a yearly income of $200,000 and a family of three young children would ordinarily be much greater than an identical quadriplegic who

is retired, widowed, seventy-five years old, has no dependents, and whose annual income never exceeded $35,000.

More than a decade ago Frank Sloan and Stephen van Wert, two economists, conducted systematic assessments of economic losses (medical costs, income losses, and other expenses) in Florida cases involving claims of medical negligence occurring as a result of birth-related incidents. Even though those researchers offered the caution that their assessment procedures probably underestimated losses, they concluded that severely injured children's economic losses were, on average, between $1.4 and $1.6 million in 1989 dollars. Frank A. Sloan & Stephen S. van Wert, *Cost of Injuries*, in Frank A. Sloan *et al.*, Suing for Medical Malpractice (1993), at 123. Adjusted for inflation, those average figures would have exceeded $2 million in 2005 dollars at the time the Missouri legislature enacted its most recent medical liability reform law. In the same study, the losses of persons who survived an emergency room incident were estimated at $1.3 million, or just over $2 million in 2005 dollars. For persons who died in an emergency room incident the loss to their survivors was estimated at $0.5 million, or $0.79 million in 2005 dollars. Moreover, it is important to note that Sloan and van Wert's estimates did not consider non-economic losses, such as pain and suffering, disfigurement, or loss of enjoyment of life's amenities.

Another study of malpractice verdicts in New York, Florida, and California also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury. Neil Vidmar *et al.*, *Jury Awards for Medical Malpractice and*

*Post-Verdict Adjustments of Those Awards*, 48 DePaul L. Rev. 265, 287 (1998). Daniels and Martin found a similar pattern, Stephen Daniels & Joanne Martin, Civil Juries and the Politics of Reform 127-37(1995).

An examination of medical malpractice verdicts in New York, Florida, and California found that the general damages portion of awards was positively related to severity of plaintiff injury, Neil Vidmar *et al.*, *Jury Awards for Medical Malpractice and Post-verdict Adjustment of those awards,* 48 DePaul L. Rev. at 281-99. Neil Vidmar, Medical Malpractice and the American Jury (2005), describes several experiments in which jury-eligible citizens awaiting jury duty in North Carolina courts were provided detailed facts about injuries and were then asked to award damages for pain and suffering and disfigurement. Senior lawyers, including retired North Carolina judges, were independently presented with the same facts and asked to indicate their professional judgment about the appropriate award. The data showed jurors tended to render awards similar to those of legal professionals. The data also showed jurors' reasoning on damages was similar to that of the professionals.

Despite the substantial evidence indicating that juries are ordinarily conservative in deciding damages in malpractice cases, there are exceptions resulting in what are commonly labeled "outlier awards." There are a number of reasons for outlier awards. One is that doctors might contest the case solely on liability and not contest damages at all. The plaintiff, on the other hand, presents the losses through experts who give a high-end version of the plaintiff's losses. The judge instructs the jury to decide damages solely

on the evidence but the jurors have only the plaintiff's figures to work with. Despite reservations, the jurors follow the judge's instructions and accept the plaintiff's suggested award, because that is the only evidence they have. In other instances, the defense may call an economist who offers an alternative to the plaintiff's damages estimate; the level of damages may be quite high due to the seriousness of the injury, and the jury might use this as a floor from which damages are estimated. Additionally, in some jurisdictions juries are presented with the gross amount of a loss or of a life care plan that is not reduced to present value. While outlier awards unquestionably do occur, they are not nearly as frequent as portrayed in the mass media. Nevertheless, research evidence indicates that these verdicts seldom withstand post-verdict proceedings. Vidmar *et al.*, *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DePaul L. Rev. 265 (1998) examined malpractice verdicts in New York, Florida, and California to determine what happened to the outlier awards. They observed there are four main processes by which awards can be reduced. Two of these invoke the "trial by judge and jury" explanation: the judge reduces the award verdict through the legal mechanism of remittitur, or the case is appealed and a higher court reduces the award. Sometimes the sides agree there was negligence but disagree about the amount of damages and set a high-low agreement prior to trial. Most common of all, the plaintiff and the defendant negotiate a post-trial settlement that is less than the jury verdict.

The research empirically explored the fate of many of the outlier awards. Some of the largest malpractice awards in New York ultimately resulted in settlements between

five and ten percent of the original jury verdict *Id.* at 287-88. A study of medical malpractice awards in Pennsylvania found a similar reduction as did still another study of closed claims in Florida, Vidmar, et al. *Million Dollar Medical Malpractice Cases in Florida: Post-verdict and Pre-suit Settlements,* 59 Vanderbilt Law Review 1343 (2006). These findings are consistent with earlier research by Broeder, by researchers at the RAND Corporation, and by researchers at The National Center for State Courts; *See* Ivy E. Broder, *Characteristics of Million Dollar Awards: Jury Verdicts and Final Disbursements*, 11 Just. Sys. J. 349 (1986); Michael G. Shanley & Mark A. Peterson, RAND: The Institute for Civil Justice, *Posttrial Adjustments to Jury Awards* (1987); Brian Ostrom *et al., So the Verdict Is In--What Happens Next?: The Continuing Story of Tort Awards in the State Courts*, 16 Just. Sys. J. 97 (1993). Similarly, Merritt and Barry conducted a detailed examination of jury awards in Franklin County (Columbus) Ohio that documented a number of post-trial reductions in jury awards. Deborah Jones Merritt & Kathryn Ann Barry, *Is the Tort System in Crisis? New Empirical Evidence*, 60 Ohio St. L.J. 315, 353-55 (1999). Finally, Hyman, et al. Do Defendants Pay What Juries Award? Post-verdict Haircuts in Texas Medical Malpractice Cases, 1988-2003, 4 J. Empirical Legal Studies 3 (2007) found a similar pattern in Texas.

Plaintiffs are willing to negotiate lesser amounts for three main reasons. First, many plaintiffs would rather have a smaller settlement immediately than wait the years it would take to get the full amount of compensation due if the case were appealed. Second, there is always a risk that an appeals court will reduce the award or even

overturn the verdict. Third, most of these outlier awards greatly exceed the medical provider's insurance coverage. While plaintiffs and their lawyers could attempt to foreclose on the defendant's assets, they are very reluctant to do so. Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 Law & Soc'y Rev. 275, 284-85 (2001). Therefore, the plaintiff negotiates a settlement around the limit of the defendant's insurance coverage.

Research by Ralph Peeples *et al.*, The *Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 Wake Forest L. Rev. 877 (2002), on a sample of insurers' medical malpractice files indicated insurers tend to settle cases primarily based on whether their own internal reviews by medical experts indicate the provider violated the standard of care. If they decide the standard was violated, they attempt to settle. Those authors concluded claims proceed to trial only when the plaintiff cannot be convinced there was no violation of the standard and cannot extract a reasonable offer from the insurer. An earlier study by Roger A. Rosenblatt & Andy Hurst, *An Analysis of Closed Obstetric Malpractice Claims*, 74 Obstetrics & Gynecology 710 (1989), reached similar conclusions. Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made, there was general consensus among insurance company staff, medical experts, and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the forty-two percent of cases in which these various reviewers decided there was no lapse in the standard of care.

Overall, the research points to the fact that juries tend to award amounts that are directly related to the severity of the injury. The high cost of medical care and wages or the extensive nature of the injury are the most apparent explanation for the calculation of the jury. Even when awards appear to be higher than justified, the post-trial procedures of remittitur, settlement negotiations and the appellate process bring the award back in-line with general expectations.

**E. Plaintiffs are not inclined to sue medical professionals when they have a bad result after medical treatment.**

Sometimes explicitly, but more often tacitly, debates about medical malpractice contain the arguments that medical negligence is relatively infrequent and injuries, and the consequent financial losses of patients, are exaggerated. However, empirical research shows that both of these arguments are without foundation.

A pioneering and highly regarded Harvard study of medical negligence examined hospital records of 31,000 patients and concluded one out of every 100 patients admitted to a hospital had an actionable legal claim based on medical negligence. *See, e.g.*, Paul C. Weiler et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation (1993) at 124-29. Some of these patients' injuries were minor or transient, but fourteen percent of the time the adverse event resulted in death; ten percent of the time the incident resulted in hospitalization for more than six months; and seven of

those ten persons suffered a permanent disability. *Id.* at 44. Generally, the more serious the injury the more likely it was caused by negligence. *Id.* at 44, Table 3.2.

Subsequent research involving Utah and Colorado found rates of negligent adverse events that were similar to the Harvard findings. Eric J. Thomas *et al.*, *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 Med. Care 261, 261 (2000). These findings are consistent with earlier research reported by Patricia Danzon who estimated that on average one in twenty hospital patients incurred an injury due to medical error. Patricia M. Danzon, Medical Malpractice: Theory, Evidence and Public Policy(1985) at 20. A still earlier study in California estimated that compensable injuries due to negligence occurred in one in 125 hospitalizations. California Medical Association, Medical Insurance Feasibility Study (Donald Mills, ed., 1977).

In 2000, The Institute of Medicine produced a report that relied on these studies and other data. It concluded that each year 98,000 persons die due to medical negligence and that many other patients sustain serious injuries. Inst. of Med., To Err Is Human: Building a Safer Health Care System (Linda Kohn *et al.* eds., 2000) (http://books.nap.edu/catalog/9728.html?onpi_ newsdoc112999); *see also* Lucian L. Leape, *Institute of Medicine Medical Error Figures Are Not Exaggerated*, 284 J. Am. Med. Ass'n 95 (2000).

Moreover, there are reasons to believe that these studies may have underestimated the incidence of medical negligence. The Harvard study, for example, was based on data

from hospital records. A number of studies suggest that medical errors are often not recorded in such records. *See, e.g.,* Lori B. Andrews, Medical Error and Patient Claiming In a Hospital Setting (Am. Bar Found., Working Paper No. 9316, 1993); Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DePaul L. Rev. 357 (2005) (at a large Chicago hospital, many injuries were not recorded on the hospital records as required, especially when the main person responsible for the error was a senior physician); *see also* Leape, *supra*, at 97 (citing R.W. DuBois and R. Brook, *Preventable Deaths: Who, How Often and Why?* 109 Annals Internal Med. 582 (1988)); Kathryn B. Kirkland *et al.*, *The Impact of Surgical-Site Infections in the 1990s: Attributable Mortality, Excess Length of Hospitalization, and Extra Costs*, 20 Infection Control & Hosp. Epidemiology 725 (1999); Thomas M. Julian *et al.*, *Investigation of Obstetric Malpractice Closed Claims: Profile of Event*, 2 Am. J. Perinatology 320 (1985) (concluding that "common obstetrical risks were often not recognized or not recorded in medical records").

Similarly, in 2004, Healthgrades, Inc., a company that rates hospitals on health care for insurance companies and health plans, studied Medicare records in all fifty states for the years 2000 to 2002. Healthgrades concluded that the Institute of Medicine's figure of 98,000 deaths was too low and that a better estimate was 195,000 annual deaths. Healthgrades estimated that there were 1.14 million "patient safety incidents" among thirty-seven million hospitalizations in those two years. A total of 323,993 Medicare patients involved in one or more patient-safety incidents died and 81 percent of those

deaths were directly attributable to the incidents. "One in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died," Health Grades, Patient Safety in American Hospitals (2004) available at *www.**healthgrades**.com/media/english/.../HG_Patient_Safety_Study_Final.pdf.*

Still other scholars who have examined empirical data from the years leading up to the rate hikes of 2001-02 have observed that the number of medical malpractice claims and the severity of claims rose little, if at all, when adjusted for population growth and inflation. *See, e.g.,* Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children and the Elderly*, 53 Emory L.J. 1263, 1268-70 (2004) (noting that "most of the available empirical research refutes the criticisms" that medical malpractice claims drove insurance costs up); Arthur R. Miller, *The Pretrial Rush to Judgment: Are the "Litigation Explosion," "Liability Crisis," and Efficiency Clichés Eroding Our Day in Court and Jury Trial Commitments?*, 78 N.Y.U. L. Rev. 982, 992-95 (2003): "[C]laims of the alleged 'litigation explosion' are exaggerated; indeed, [the] evidence casts doubt on the very existence of a significant increase." (citing, among other empirical research: Marc Galanter, *The Day After the Litigation Explosion*, 46 Md. L. Rev. 3 (1986)); David Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 Vand. L. Rev. 1085, 1086 (2006), the latter concluding that these kinds of attacks on the civil justice system are "facially implausible". **In short, there is no serious question that medical negligence not only occurs, but that it occurs at a substantial rate.**

Despite the high rate of injury caused by medical negligence discussed above, few potential medical malpractice plaintiffs actually file malpractice claims. One of the most striking findings of the Harvard medical negligence study was that seven times as many patients suffered from a medical negligence injury as filed a claim. Weiler *et al.*, *supra*, at 1a, pp 69-76. Put in different words, for every seven patients who suffered a negligent injury, just one claim was filed.

Other studies have also found that relatively few victims of medical negligence file malpractice claims. Earlier research by Danzon, using a database from California, concluded that "at most 1 in 10 negligent injuries resulted in a claim." Danzon, *supra*, 1a at 24. Even more telling is the finding of the Andrews' study that, of 1,047 patients who experienced a medical error, only thirteen patients made a claim. Andrews, *supra 1a*, at 12.

A specific example of cases where potential plaintiffs chose not to file suit can be found in a 1995 study looking at 220 childbirths in Florida in 1987 that involved death or permanent injury to the child (Frank A. Sloan & Chee Ruey Hsieh, *Injury, Liability, and the Decision to File a Medical Malpractice Claim*, 29 Law & Soc'y Rev. 413 (1995)). The families of the children were interviewed, and the data were supplemented by an independent medical review of the records by physicians. Of the 220 cases, twenty-three parents sought legal advice. These tended to be cases in which the child suffered very serious injuries and the independent reviewing physicians concluded that negligence was probably involved. Yet, not a single suit was filed in any of the 220 cases. Sloan and

Hsieh note that "[t]he lack of claimants among the 220 women whose babies had serious birth-related injuries and the failure of 23 women to obtain [legal] representation runs counter to the 'conventional wisdom' that patients sue when they obtain less than a 'perfect result.'"

One of the reasons for the failure of injured patients to file a medical malpractice claim is that the injured party does not discover that medical negligence was the cause of the injury. Andrews found that some physicians did not include errors in the hospital records because they wanted to avoid litigation. Andrews, *supra*, 1a, at 7. Since patients have an illness that caused them to seek treatment in the first place, it is easy for them to believe that an additional illness or injury is a natural outcome of the treatment. There are other reasons as well for the failure to file malpractice claims. Many people are reluctant to sue because of widely shared beliefs that it is not proper to do so. *See, e.g.*, David M. Engel, *The Oven Bird's Song: Insiders, Outsiders, and Personal Injuries in an American Community*, 18 Law & Soc'y Rev. 551 (1984).

## VI. CONCLUSION

Plaintiffs with a medical negligence claim who are female, members of a minority group, have a pre-existing handicap, are children, or are elderly typically have low or nonexistent economic damages. Caps on non-economic damages constitute a form of discrimination that limits a higher percentage of total compensation for similar injuries merely because of the plaintiff's age, gender, disability, race, status, or wealth. Moreover,

the inequity is especially pronounced when it is considered that those same plaintiffs would not be so disadvantaged by a cap if the cause of their injury was being struck by a bus or exposure to a dangerous chemical. This inequity violates the equal protection rights of plaintiffs in these disadvantaged classes. The empirical studies conducted in the years leading up to the passage of HB 393 in Missouri and Nationwide show no rational relation between a limit on non-economic damages and lower medical liability insurance premiums or medical professional retention. The information put forward in this brief was available to the Missouri Legislature during the debate and passage of HB 393, and it tends to show that the Missouri Legislature could not have had a rational basis to believe a cap on non-economic damages would serve any legitimate state interest.

**Respectfully submitted**

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**CERTIFICATE OF SERVICE**

I hereby certify that on this 20th day of October, 2011, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent notification of such filing to following, and further that I sent a electronic copy hereof by email to :

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