
The Ethicality of Capping Non-Economic Damages to Control Rising Healthcare Costs: Panacea or False and Misleading Practice?

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Abstract

Since the mid-70's, the healthcare industry has been plagued with three primary concerns: quality, costs and access. Several incremental measures have been taken by Congress to address these issues, most notably the passage of the Health Maintenance Organizational Act of 1973, and the Balanced Budget Act of 1997. Although neither legislative initiative was intended to be a panacea for controlling escalating healthcare costs, the acts gave impetus to the establishment of a variety of Managed Care Organizations (MCOs) and controlled governmental expenditures that seem to have had a positive impact on healthcare expenditures. Consequently, the health care industry experienced a stabilization of healthcare expenditures, partially attributed to both legislative initiatives. In the decade of the 90's, healthcare insurance premiums and healthcare costs experienced a period of decline. However, this period of economic euphoria did not last long. Toward the end of the 20th Century, healthcare expenditures and insurance premiums began to escalate again and increased concern was reflected among the industry's primary stakeholders.

Therefore, in an effort to address the next round of increasing costs, the focus shifted to another battle front, medical tort reform. Specifically, capping non-economic damages as an exclusive remedy to rising healthcare costs. This article explores the rationale for capping non-economic damages as an attempt to address rising healthcare costs and malpractice premiums. Specifically, it examines the ethicality of imposing caps as evaluated from a principle of justice perspective.

INTRODUCTION

Since the mid-70's, the healthcare industry has been plagued with three primary concerns: quality, costs and access. Several incremental measures have been taken by Congress to address these issues, most notably the passage of the Health Maintenance Organizational Act of 1973, and the Balanced Budget Act of 1997. Although neither legislative initiative was intended to be a panacea for controlling escalating healthcare costs, the acts gave impetus to the establishment of a variety of Managed Care Organizations (MCOs) and controlled governmental expenditures that seem to have had a positive impact on healthcare expenditures. Consequently, the healthcare industry experienced a stabilization of healthcare costs, partially attributed to both legislative initiatives. In the decade of the 90's, healthcare insurance premiums and healthcare costs experienced a period of decline (Barton, 1999). However, this period of economic euphoria did not last long. Toward the end of the 20th Century, healthcare expenditures and health insurance

premiums began to escalate again and increased concern was reflected among the industry's primary stakeholders.

Today, healthcare consumers, employers and other stakeholders have voiced concerns regarding the out of control costs of healthcare and the lack of accessibility. According to the Institute of Medicine, over 44 million Americans are without some form of health insurance. Rising costs, combined with the plight of the uninsured suggests that the industry is on the cusp of a national healthcare crisis. Consequently, the problems facing our healthcare system have become a topic of discussion at the local and national level. During the recent presidential campaign, addressing the affordability and access to healthcare was a primary issue addressed by both candidates. However, while many healthcare scholars will agree that escalating costs are a major problem, the consensus seems to end when one attempts to pin point the specific cause of the problem. The physician, insurance industry, and many Republicans seem to believe that the solution to rising

healthcare costs rests with tort reform (Glassman, 2004). During the campaign, President Bush often articulated a clear and definitive nexus between rising healthcare costs and medical malpractice lawsuits. During a recent speech, the President stated that high malpractice insurance premiums were causing physicians to practice defensive medicine, ultimately resulting in higher insurance costs for employers and overall higher healthcare costs (CNN, 2005). Consequently, the primary solution advocated for resolving the crisis of rising healthcare costs seem to be capping non economic damages (NEDs). Is this the most effective approach? Will caps have the impact those in favor articulate, or has the healthcare consumer been bamboozled and hoodwinked into supporting a policy initiative that primarily benefits physicians and insurance companies at their expense.

This paper explores the relationship between rising healthcare costs and the recommendation of capping non-economic damages as a solution to the nascent healthcare crises. More specifically, this paper evaluates the ethicality of imposing non economic caps from the perspective of various ethical paradigms.

RATIONALE FOR CAPPING NON-ECONOMIC DAMAGES (NEDS)

The current medical malpractice crisis is not new. Medical malpractice concerns date back to the mid 70's and 80's, however the current reform movement seems to be gaining momentum for a variety of reasons. Physicians and hospitals in many states are experiencing a dramatic rise in malpractice insurance premiums. On average, premiums for all physicians nationwide rose by 15 percent between 2000 and 2002 (CBO Brief, 2004). This sharp rise is nearly twice as fast as total healthcare per individual. Consequently, many healthcare leaders and politicians have sounded alarms that patients may have difficulty accessing medical services, particularly in high-risk specialties such as obstetrics, physicians may be forced to retire or move to more favorable locations. According to the American Medical Association (AMA) many states are experiencing a medical insurance crisis which is threatening the availability of care. Moreover the crisis is caused by escalating jury awards and the high cost of defending against lawsuits (Glassman, 2004).

Those who advocate capping NEDs as a solution to resolving the malpractice crisis suggest that rising malpractice premiums and escalating healthcare costs are the result of extraordinary losses due to higher malpractice

verdicts, and excessive litigation causing physicians to practice defensive medicine (Herbert & Perkins; Florida's Medical Malpractice Insurance Crisis, 2003). The current crisis has stimulated calls for changes to the legal rules that govern medical malpractice. Many of these proposals attempt primarily to reduce malpractice insurance premiums. Some, however, see an opportunity to improve the overall performance of malpractice law, including far-reaching changes such as replacing the tort system with a no-fault or administrative approach to compensation (Mehlman, 2003; Health Coalition on Liability and Access, 2004).

A recent snapshot of medical malpractice reform proposals taken by the Health Insurance Association of America shows that 41 state legislatures debated medical malpractice reform in their 2003 sessions, but only 11 passed legislation (and Missouri's legislation was vetoed). Since 1975, 20 states have implemented caps at various levels ranging from 250,000.00 to \$1million. Texas being one of the most recent passed amended its Constitution in 2003 allowing for capping of non economic damages (Weiss, 2003). According to the National Governor's Association, in addition to caps, states also considered shortening their statute of limitations to file suits, reducing frivolous suits by reporting, and more stringent doctor discipline. (Spigal, 2003).

On the federal level, the Administration and members of Congress have proposed several types of restrictions on malpractice awards. Bills introduced in the House and Senate in 2003 would impose caps on awards for non-economic and economic damages, reduce the statute of limitation on claims, restrict attorneys' fees, and allow evidence of any benefits that plaintiffs collect from other sources (i.e., insurance) to be admitted at trial. Currently, President Bush has made capping non economic damages a primary goal of on his administration (CNN, 2005).

WHY IMPOSE CAPS?

The primary argument advanced by President Bush, the AMA and the legislative leaders who support capping NEDs is premised on the position that medical liability reforms are necessary to protect patients' access to care (Glassman, 2004). The proponents of capping NEDs argue vehemently that unlimited non-economic damages turn the justice system into a "lottery." They believe that jurors are often sympathetic to plaintiffs, and award them much more than is necessary because that is what the juror would want for themselves. Furthermore, supporters argue that economic damages, which compensate for actual medical costs and

lost earnings would not be capped, thus a limit on non-economic damages would ensure that plaintiffs received the compensation they deserved. Additionally, they believe that unlimited non-economic damages undermine the states' health-care system. Ultimately the system absorbs the cost of runaway verdicts. Supporters of capping contend that lawyers pursue medical malpractice cases in hopes of reaping large sums of money in emotional cases with jurors who may not understand the impact of multimillion-dollar awards on the entire health-care system. Proponents believe that non-economic damages for pain and suffering and disfigurement can be difficult to quantify precisely, unlike economic damages such as medical costs and lost earnings. Moreover, they believe that when premiums rise too high, doctors stop practicing, thereby threatening access to medical care for all U.S. citizens (Reforming the Medical Litigation System, HHS Study, 2003). Proponents contend that capping non-economic damages at reasonable limits would encourage insurers to do business in all states by ensuring that they would not incur massive losses because of large damage awards. Consequently, more insurers would join the market, and competition would reduce premiums (House Research Organization, 2003). Finally, proponents argue that the litigation system impedes efforts to improve quality. As a result of physician's fear of liability, they are discouraged from open discussion of medical errors and ways to reduce them (HHS Study, 2003.)

ARGUMENT AGAINST CAPPING NON-ECONOMIC DAMAGES

Evidence from states that have actually enacted some form of legislative malpractice tort reform indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise. However, even large savings in premiums can have only a small direct impact on health care spending, private or governmental. This is true because malpractice costs account for less than 2 percent of that spending. Although advocates cite other possible effects of limiting tort liability, such as reducing the extent to which physicians practice "defensive medicine" and preventing widespread problems of access to health care, the evidence of such is weak or inconclusive (CBO Brief, 2004).

California is often cited as the model for tort reform. In 1975 California passed the Medical Injury Compensation Reform Act (MICRA). This legislation capped NEDs at \$250,000. Although there was an initial reduction in premium rates,

premiums continued to rise. "By 1988, twelve years after the passage of MICRA, California medical malpractice premiums had reached an all-time high- 450% higher than 1975, when MICRA was enacted." (Glassman, 2004, p. 17). In an effort to address the unabated problem of rising malpractice premiums, California enacted California Insurance Code 1861.01, Proposition 103. This piece of legislation required insurance premium rollbacks of up to 20%. Consequently malpractice rates began to fall immediately. Within 3 years total malpractice premiums had dropped by over 30.7% when adjusted for inflation (Glassman, 2004).

In Texas, voters attempted to resolve rising malpractice costs by passing similar legislation. In September 2003, the Texas Constitution was amended by a paltry 12% of the population. Proposition 12 established a \$250,000 cap on non-economic damages (Houston Chronicle, 2003). Texans were told that Proposition 12 was necessary to curb rising malpractice premiums, and control escalating healthcare costs. However, in 2004, one year after the legislation was passed, the Medical Protective Co., a large medical malpractice insurer filed for a 19% rate increase. The company stated that non-economic damages amount to less than 1% of its payouts (Modern Healthcare, 2005).

Those opposed to capping NEDs would argue that a policy of imposing caps is the least effective manner to address the issue of rising medical malpractice cost. This position is based on the following: (1) over 70% of malpractice lawsuits result in a defense verdict, (2) according to a bi-partisan Congressional Budget Office report, malpractice lawsuits account for less than 2% of healthcare costs, (3) according to the General Accounting Office, many of the claims regarding access to care are exaggerated or false, (4) finally, the primary reason for rising malpractice premiums rests with the insurance industry. The cyclical nature, lack of competition, mismanagement of reserves and a decline in investment income are factors capable of having a greater impact than capping non-economic damages (Weiss Report, 2003). Notwithstanding the fact that current evidence indicates that tort liability restrictions, specifically, caps on non-economic damages are insignificant, inconclusive and weak at best as a methods of lowering insurance premiums, many still advocate such policy. This leads one to ask the question, "Why are doctors, hospitals, and legislators going after malpractice litigants and their lawyers with such a vengeance through the use of non-economic damage capping proposals?"

The remainder of this paper explores the ethical arguments against capping NEDs focusing on the concepts of: (a) distributive justice, (b) procedural justice, (c) compensatory justice, (d) retributive justice, and (e) ethical egoism. Moreover, it will show how the capping of non-economic damages is in fact unethical and no more than a retributive justice and ethical egoistic response on behalf of conservative legislators, physicians, hospitals, and insurance companies.

PARADIGMS IMPACTING THE ETHICALITY OF IMPOSING CAPS ON NEDS

For purposes of this paper, ethics is defined as right and wrong behavior as determined by society (Carroll & Bucholtz, 2005). This definition of ethics however is somewhat problematic in that what is right to some may be wrong to others. However, there seems to be consistency among various schools of jurisprudential thought that efforts to mislead, deceive or misrepresent the truth rises to the level of wrong behavior; thus such behavior is considered unethical and in some cases illegal. Unfortunately the debate whether to cap or not to cap non-economic damages as a means of addressing the malpractice crisis is replete with false and misleading statements, lack of full disclosure and in many cases blatant disregard for what the empirical evidence establishes (Herbert & Perkins, 2003). The manner in which this argument has been presented to the healthcare consumer and voting public by the various stakeholders raise serious ethical questions.

In order to understand the ethical issues surrounding this debate, it is important to consider the various ethical paradigms to which an argument may be raised in opposition to imposing caps on NEDs. Typically, ethical behavior is analyzed from a teleological or deontological perspective (Bowen, 2002). A teleological perspective suggests that the consequences of one's conduct justify the action. A deontological perspective suggests the action is based on adhering to a duty or universal maxim (Carroll & Buchholts, 2005). However, for purposes of this paper, the argument against imposing caps on non economic damages is analyzed from a principle of justice ethical paradigm.

According to Costa (1998), ethics are the norms that a community defines and institutionalizes to prevent individuals from pursuing self-interest at the expense of others. Costa posits that the basic assumption of ethics is that people will not usually self-regulate. Without the opprobrium of society, and threatened punishment for non-

conformance, individuals will slide into behavior that maximizes personal advantage. Therefore, ethical norms create the basis for fair process (Costa, 1998). In other words, the impetus for our social policies ought to be based on societal fairness and not driven by ethical egoism. The ethical norm designed to ensure a fair process is the principle of justice. The principle of justice involves the fair treatment of each person, each situation on a case by case basis. It incorporates several kinds of justice, based on the ethical paradigms of distributive, procedural, retributive, and compensatory justice. The remainder of this paper evaluates the unfairness of capping non economic damages as a means of addressing the healthcare crisis through the ethical paradigm of the principle of justice. In addition, it explores how ethical egoism may be the primary motivation for those advocating the imposition of caps as a remedy to the malpractice crisis.

WHAT DOES FAIR PROCESS MEAN?

The term fairness is an elusive concept. In malpractice, what seems to count most is fairness to patients and potential patients. However, the relational aspect of healthcare implies that the system must also be fair to all the various healthcare stakeholders. Therefore, at a minimum a policy impacting healthcare and healthcare consumer rights must take in consideration the patient/healthcare consumer, physician, hospital, insurance company, and taxpayer. Fairness has two core components; outcome fairness or what social scientists call distributive justice and the psychology of the fair process or what social scientists refer to as procedural justice (Kim and Mauborgne, 1997; Mehlman, 2003).

DISTRIBUTIVE JUSTICE

Distributive justice is defined as the fair distribution of benefits and burdens (Carroll & Buchholtz, 2005). The psychology of outcome fairness or distributive justice is further described as follows: When people receive the compensation, resources, or reward that they believe they deserve, they feel satisfied with the outcome. Moreover, when people are satisfied with the outcome they will reciprocate by fulfilling their obligation to the legal system to the letter of the law (Kim and Mauborgne, 1997). Does capping NEDs provide a level of distributive justice or social fairness? The concept of fairness has long been at the center of controversy when people gather to debate the value of civil litigation. Without a doubt fairness is a critical attribute of a properly functioning system of medical liability. Fairness is both a legitimate outcome in itself and a process

of achieving important social goals, such as ensuring agents (physicians) function in the best interest of the principle (patient), and maintaining confidence in the courts and legislatures. If changes to the medical malpractice system are viewed as fair, then the changes will most likely be enacted and retained. Unfortunately, the healthcare consumer's perception of fairness is often created and influenced by those seeking to advance their on selfish interests. Those standing to gain the most from tort reform; insurance carriers, physicians and hospitals have been the primary proponents of such change (Glassman, 2004). By imposing caps on NEDs, the primary factors which have caused escalating healthcare costs and rising malpractice premiums are not addressed. Consequently, insurance company's mismanagement of resources and the burden of medical negligence will be born entirely by the healthcare consumer. In essence, the healthcare consumer gives up her right to have a jury of her peers determine a fair remedy for damages associated with pain and suffering for medical injuries.

Unfortunately, imposing caps on NEDs reduces all medical malpractice cases to the same outcome. Regardless of how egregious the harm, the most an injured party may receive for non-economic damage is the amount determined by the legislature. This pre-determined legislative amount is an attempt to remedy the problem of rising healthcare and malpractice costs. Requiring the injured party to accept the full responsibility for rising healthcare costs and more importantly the direct burden of the cost of medical negligence and insurance mismanagement violates the fundamental ethical principle of distributive justice (Mehlman, 2003).

PROCEDURAL JUSTICE

Procedural justice refers to fair decision-making procedures, practices, or agreements (Carroll & Buchholtz, 2005). Social scientists define this type of justice as the "fair process". The psychology of fair process or procedural justice builds trust and commitment. In turn trust and commitment produce voluntary cooperation and voluntary cooperation drives performance, leading people to trust in a legal system without being coerced into doing so (Kim and Mauborgne, 1997). Procedural justice is quite different from distributive justice. In the case of tort litigation, procedural justice is concerned with creating and sustaining a process that operates the system fairly. It gives credence that the goals (outcomes) of the system can be achieved by following the

process. By building trust and commitment, procedural justice produces voluntary cooperation and voluntary cooperation drives performance, leading people to trust in a legal system without being coerced into doing so. Procedural justice or fair process is based on three mutually reinforcing principles: engagement, expectation clarity, and accountability (Kim and Mauborgne, 1997; Mehlman, 2003).

1. Engagement enables the parties involved to have a meaningful opportunity to be heard. The parties are adequately represented and the decisions are rational, based on evidence presented.
2. Clarity employs rules that are understandable and acceptable to all parties. Parties involved clearly understand what is expected of them and the consequences of the conduct.
3. Accountability involves holding the decision makers accountable, consistency of the decision and the system is proportional because it distinguishes among cases rationally.

Imposing a legislative cap on non-economic damages does not meet the procedural justice requirement of accountability. When state legislatures impose caps on NEDs, no distinction is made among the cases. Although an injured party may receive her day in court, a portion of her remedy is pre-determined without any regard for the serious or egregious nature of the injury. Thus there is no proportionality because there is no rational differentiation between the cases. Imposing caps on non-economic damages violates the ethical principle of procedural justice.

RETRIBUTIVE JUSTICE

Retributive justice refers to justice as a form of revenge. The psychology of retributive justice suggests that when individuals have been so angered by the denial of a fair process they may be driven to organized protest. Their demands often stretch well beyond their desire to not only restore fair process, but they may also seek to deliver punishment and vengeance upon those who have violated it in compensation for the disrespect the unfair process signals (Kim and Mauborgne, 1997).

Unfortunately, tort reform has become synonymous with the anti-lawyer movement. During the 2004 Presidential Campaign, President Bush often referred to trial lawyers as

the reason for the system being “out of control” (CNN, 2005). The President is quoted as saying “ It’s hard for some in Congress to stand up to the trial lawyers....” (CNN, 2005). Physician and the insurance industry consistently place the blame for the healthcare malpractice crisis on lawyers (Glassman, 2004). These attacks continue to be made notwithstanding the fact that the General Accounting Office concluded that claims of access problems due to escalating malpractice were inaccurate and the Congressional Budget Office report which stated that malpractice accounts for less than 1/2 of 1 percent of healthcare expenditures (CBO Report, 2004).

Notwithstanding these facts, those in favor of imposing caps do so with a visceral attack on trial lawyers as the culprit. The proponents of caps seem to base their argument from an ethical position of retributive justice. They seem to want to punish trial lawyers and unfortunately injured plaintiffs for what they perceive to be unfairness in the system of litigating medical malpractice claims. However, the research suggests that while capping damages may punish trial lawyers, it has the primary effect of rewarding insurance company mismanagement and increases insurance company profits at the expense of the healthcare consumer (Weiss Report, 2004). While retributive justice may be an appropriate ethical remedy, the vengeance must be sought against the proper culprit. The role of plaintiff lawyers in this crisis appears to be de minimus in comparison to the other contributors. This raises the question: Is vengeance being sought against the proper party(s)? In the case of malpractice reform, the primary contributors to escalating costs are in essence being given immunity. According to the University of North Florida’s report on Florida’s Medical Malpractice Insurance Crisis (2003), the real gains may be realized through regulation of the insurance industry, and physicians doing a more effective job of self policing versus imposing caps on NEDs.

COMPENSATORY JUSTICE

Compensatory justice involves compensating someone for a past injustice. Of all the various kinds of justice impacting the argument against capping NEDs, compensatory justice seems to be the most cogent. In Sept. of 2003, 12 percent of Texas voters amended the Texas Constitution and imposed a constitutional cap on the amount of non-economic damages an injured party could receive (Houston Chronicle, 2003). The amendment was necessary because the Texas Supreme Court has ruled that a similar statute violated the provision

of the Texas Constitution that gave each citizen a right to have her civil dispute decided by the Court. This Constitutional amendment takes away the right of every healthcare consumer in Texas to have their entire case evaluated and compensation granted on a case by case basis. As a result of promulgation of Proposition 12, an injured party is only entitled to receive a legislatively pre-determined remedy. The amount for non economic damages is not evaluated with regard to the seriousness, or egregiousness of the conduct. The remedy falls in the category of a “one size fits all” solution. The fairness of such a policy seems to be inconsistent with notions of compensatory justice.

WHAT IS THE ETHICAL ARGUMENT FOR CAPPING NEDS?

The primary ethical argument for supporting capping non economic damages seems to be based on the paradigm of ethical egoism. An analysis of ethical egoism requires one to look at the motivation for each stakeholder proposing caps as a potential solution to the healthcare crisis and ask the question: What personal benefit does the proponent stand to gain?

ETHICAL EGOISM

Ethical egoism is often called materialism or brutal selfishness. It is not generally a normative school of moral philosophy, but an individual based rationale for one’s actions (Bowen, 2002). In this approach, the decision-maker engages in behavior that maximizes his self interest. Ethical egoism results in minimal ethical concern for others, however the decision-maker rationalizes his behavior based on the ancillary benefit others may receive. In the case of medical tort reform, the primary proponents stand to gain directly while the ancillary benefit to the healthcare consumer remains debatable. Moreover in some cases, the imposition of caps has resulted in a negative impact on the healthcare consumer. In Texas after caps were imposed, carriers raised rates 19 percent (Modern Healthcare, 2005). According to a filing by GE Medical Protective, the nation’s largest malpractice insurer, capping non-economic damages will show loss savings of only 1 percent (US Newswire, 2004). Implementation of caps in Missouri, Nevada, and West Virginia did not lead to premium reductions. In those states, just as in Texas, premiums increased (Herbert & Perkins, 2003).

Although the healthcare consumer’s benefit from imposing

caps is debatable, the benefit to the insurance carrier, physician and legislative proponents is less subject to debate. The imposition of caps has a direct benefit to insurance carriers. Lower claim payouts and increasing premiums result in higher profits for insurance carriers (Weiss Report, 2003). Physicians, also receive a direct benefit. Although they are paying higher premiums the argument is that “but for” the caps, the rate would have been even higher. Finally, legislators who voted for caps may have been influenced by the lobbying power of large powerful groups like the AMA, and insurance industry.

CONCLUSION

The healthcare industry is in a state of crisis. Escalating healthcare costs are forcing employers to change the way in which they have offered healthcare benefits to employees. Many employees are being forced to make decisions whether to purchase insurance or self-insure. One apparent easy target to place blame for the healthcare crisis is trial attorneys and malpractice litigation. The argument presented is that increasing malpractice litigation and insurance malpractice payouts have resulted in rising healthcare costs as a result of defensive medicine. In addition, the healthcare consumer has less access to care, and physicians experience increased malpractice insurance premiums. However in making the case for imposing caps on non-economic damages, the proponents seem to have ignored the empirical evidence that suggest capping damages may not yield the benefits being espoused by proponents of caps. An analysis of the research often reveals a converse effect of caps. Were the proponents motivated by selfish reasons? Did ethical egoism drive the proponents to push for change? Was the healthcare consumer sold a bill of bad goods?

While the majority of research supports other factors having a greater impact on rising malpractice costs, such as insurance company mismanagement, industry rate regulation, competition and the insurance cycle, proponents have focused on medical tort reform as the ultimate solution. Did the proponents of capping non-economic damages engage in misleading and deceptive practices to advance their position? Those questions remain open for further debate. However; what we do know and what is not debatable is the following: (1) caps are unfair to the patients with the most extensive injuries, (2) caps create a “one size fits all” mentality to resolving medical malpractice claims, (3) since caps limit an insurance companies' exposure, they are more likely to withhold claims payment as a negotiating

tactic and (4) caps can lead to a smaller percentage of insurance premiums going to pay victims and a larger percentage going to profit (Hebert & Perkins, 2003). Therefore, imposing caps on non economic damages as a remedy to the healthcare crises seems to be inconsistent with the ethical paradigm of the principle of justice. Ethical violations are evident not only in the policy, but also the unfair manner in which the position was presented to the healthcare consumer.

Finally, leaders in the healthcare profession must understand that there are inherent tensions between fair compensation and an economically viable healthcare system on one hand; and quality of care, and patient access on the other. There is no “one size fits all” or one dimensional remedy to this problem. Just as California discovered, tort reform alone will not be a viable solution and should not be presented as such. All healthcare stakeholders: legislators, judges, physicians, patients, insurance carriers and trial lawyers must work together to develop policy that is consistent with notions of fairness and provides real benefit to the primary stakeholder... the healthcare consumer.

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