“Double-Jeopardy” of New York State Medical Patients
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“A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.” 1 This is the number one principle of medical ethics adopted by the American Medical Association (AMA), which vicariously applies to all of its practicing professional members-physicians. In essence, the physician’s sole responsibility is to preserve human life to the best of his or her abilities. In the past decade, this is where some New York physicians have fallen short of complying with these ethical standards. As a result of the irresponsibility of a few physicians practicing within the State of New York, the New York State Insurance Department and the Medical Society of the State of New York (MSSNY) claim that New York is submerged in a medical malpractice “crisis.” 2

On July 2, 2007, State Insurance Superintendent Eric R. Dinallo for the State of New York announced that the Insurance Department was implementing a 14% increase to medical malpractice insurance premium rates. 3 As a result, then Governor Eliot Spitzer directed Insurance Department Superintendent Dinallo to form a task force consisting of medical, insurance, and legal experts to investigate the reasons behind high medical malpractice costs. 4 This article will explore the legislative bills that were introduced by legislators of the New York State Senate and Assembly in response to the “crisis,” as well as their impact on the civil justice system and on the supposed “crisis.” In addition, the analysis will compare New York’s proposed bills to the implementation of malpractice tort reforms in other states and their effectiveness in their respective forums.

First, this article gives an overview of what is entailed in a medical malpractice action in New York, as well as give a synopsis of previous medical liability reform in New York and the current statutes relevant to medical malpractice. Second, this article analyzes the proposed legislation that has been introduced in the New York State Assembly and Senate, which will affect a patient’s right to bring an action for malpractice, and will alter the litigation of such claims. Third, this article focuses on responding to the claims of organizations such as MSSNY about the adverse affect that medical malpractice litigation has had on the practice of medicine in the State of New York. Finally, this article summarizes the points previously addressed.

I. Background

Due to the complexity and uniqueness of medical malpractice law in New York, it is essential to discuss the procedural process of a medical malpractice action in the state judiciary system, and to put into context the effect of tort reform on the process.

A. Cause of Action for Medical Malpractice in New York

As in any tort action for damages, a lawsuit for medical malpractice first begins with an alleged injured person who obtains counsel to file a claim against one or more tortfeasors. In New York, a plaintiff’s complaint must have a Certificate of Merit declaring that the attorney for the plaintiff, after reviewing the facts and consulting with a physician who is licensed in the state and is knowledgeable of the relevant issues, has concluded that there is a “reasonable basis for the commencement of such action.” 5 The attorney does not need to disclose the identity of the consulting physician. 6 The justification for such a requirement is to serve as evidence in the event of an action against the plaintiff for filing a frivolous lawsuit.

The plaintiff bears the burden of presenting and proving a prima facie case of liability in such actions by proving: “(1) the standard of care in the locality where the treatment occurred, (2) that the defendant breached that standard of care, and (3) that the breach of the standard of care was the proximate cause of the injury.” 7 The locality standard of care has been upheld in New York case law for nearly a hundred years, from its inception in Pike v. Honsinger, 8 where the court ruled that a doctor should exercise the same reasonable degree of care practiced by physicians and surgeons in the locality where that doctor practices. 9 In other words, the plaintiff must prove that the defendant physician violated the standard of care in the geographic area of the practice, or in the specialty of the practice. As a result of the complexity revolving around proving this standard of care, courts require

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expert testimony at trial in order to clarify issues of professional or technical knowledge which is beyond the knowledge of the jury.\(^{10}\) Expert testimony is vital to the resolution of medical malpractice actions, and a plaintiff cannot prove its case without presenting such evidence, except in the rare instance where the issues are within the jury’s competence to evaluate. Furthermore, after discussing facts and information relied upon in their analysis, medical experts must conclude within a reasonable degree of medical certainty, that the defendant did or did not commit malpractice which was or was not a substantial factor in causing the plaintiff’s injury.\(^{11}\)

In terms of discovery, CPLR § 3101 is the governing statute for disclosure of documents, information, witnesses and experts. In medical malpractice actions, parties are not required to disclose the name of their medical expert witness. However, they must disclose all other information, including a summary of the basis for their opinions, the facts and data that they relied upon, and their qualifications.\(^{12}\) The thought behind such an exception is that the disclosure of the identity of medical experts may subject them to pressure and intimidation by their colleagues not to testify, since the expert is required to be from the same or similar locality as the defendant physician. Another possible purpose is to promote settlement, because the attorneys may not want to risk facing damaging expert testimony at trial. Notably, CPLR §§ 3101(d)(i) and (ii) are currently under consideration by the State Legislature to be amended.

With respect to presenting expert testimony at trial, there are instances where such testimony can be challenged by the opposing party through a Frye hearing.\(^{13}\) At a Frye hearing, which occurs during pre-trial motions in limine, the party offering the expert testimony has the burden of proving that the science and opinions relied upon by its expert is ‘generally accepted’ by the relevant scientific community.\(^{14}\) The proponent must prove three essential criteria: (1) the techniques generate results generally accepted as reliable within the scientific community; (2) the techniques satisfy a foundation inquiry on the evidence; and (3) the rate of error does not affect its trustworthiness, and is for the jury to decide.\(^{15}\) In essence, the court lets the jury decide on the soundness of the evidence after it rules that the science passes the standards of Frye. However, in medical malpractice cases, courts have begun to rely less on the use of Frye hearings because of the belief that the jurors should be allowed to weigh the credibility of expert medical opinions. Courts fear that strict application of Frye hearings will deter people from suing.\(^{16}\) Furthermore, if one takes into account the provisions in CPLR § 3101(d), it is difficult for an opposing party to challenge the opinions of an expert who has not given oral testimony prior to trial because a party is free to reject a request to have the expert deposed. See, CPLR § 3101(d)(ii).\(^{17}\)

In medical malpractice actions, plaintiffs can recover economic damages (past and future medical expenses, loss of earnings and reduced earning capacity), and non-economic damages (pain and suffering, mental anguish, loss of consortium).\(^{18}\) A plaintiff can also recover damages from a hospital where the physician responsible for the injury is an independent contractor if the hospital maintained control over the manner and means of the physician’s work and the plaintiff reasonably believed that the treating physician was acting on its behalf.\(^{19}\)

Complexity arises when multiple defendants are involved, which is quite common in medical malpractice cases. Issues arise as to a defendant’s joint and several liability for a damage award in favor of the plaintiff. If there are multiple defendants, then the percentage of their respective culpabilities (or liabilities) dictates their responsibility for non-economic damages, unless a defendant is more than 50% liable, in which case that defendant is responsible for all of the non-economic damages.\(^{20}\) In either case, the plaintiff can sue any of the liable defendants for the full amount of the economic damages.\(^{21}\) For example, assume that there are three defendants: A, B, and C, and their respective liabilities are 50%, 30%, and 20%. If non-economic damages are $100,000, then A pays $50,000, B pays $30,000 and C pays $20,000. But if A was 51% liable, then the plaintiff could go after A for the full $100,000 of non-economic damages. In addition, the plaintiff could seek the economic damages from any of the three defendants — usually the one with the deepest pocket. The problem arises when there is a non-party tortfeasor, who plaintiff could have but failed to sue. In that instance, the defendants who are parties to the action are allowed to decrease their percentage of liability by the percentage of culpability of the non-party tortfeasor.\(^{22}\) The status of joint and several liability is further discussed below regarding the proposed legislation. Currently, some of the statutes that are under consideration for amendment include CPLR §§ 3012-a, 3101(d)(i), 3101(d)(ii), and 1600-03.

### B. Past Medical Malpractice Reform in the State of New York

In order to understand the current situation of medical malpractice law in New York, it is necessary to discuss past actions taken by the legislature in times of claimed “crisis,” and the effect of such laws over time.
In 1974, the state enacted its first medical malpractice reform act in response to a perceived crisis due to the state’s largest medical malpractice insurer withdrawing from the New York market. Between 1974 and 1985, legislation for reform came about in piecemeal fashion, and was not effective. Such shortcomings included the lack of appropriate governing bodies to conduct and control a system of medical peer reviews, and a disciplinary network.

One of the largest failures from the 1970’s reforms was the creation of medical malpractice panels, which had the purpose of reducing congested court calendars and fostering settlement. In 1980, the Ad Hoc Committee on Medical Malpractice Panels concluded, after an exhaustive study, that there was no real connection between panel findings and subsequent settlements.

On July 2, 1985, then Governor Mario Cuomo signed into law a medical malpractice reform bill (the “Reform Act”), which had three principle objectives: (1) curtail the cost of malpractice insurance; (2) quicken the litigation of malpractice claims; and (3) reduce the incidence of medical malpractice.

The Reform Act increased hospitals’ existing statutory duty to regulate the quality of medical care by implementing and installing a medical malpractice identification and prevention program. However, the Reform Act oddly stops short of setting forth sanctions in the event of a hospital’s failure to conduct such reviews or to implement the prevention program.

In terms of disclosing evidence during discovery, Section 4 of the Reform Act broadened disclosure by, among other things, requiring a party, upon request, to disclose “the substance of the facts and opinions on which each expert is expected to testify, the qualifications of each expert witness and a summary of the grounds for each expert’s opinion.” This turned into CPLR § 3101(d), which also includes the medical expert identity exception discussed above. The exception seems counterintuitive to the general purpose of Section 4 of the Reform Act, which was to quicken litigation of malpractice claims by broadening disclosure, and thus facilitate settlement.

The Reform Act also attacked ‘frivolous’ lawsuits through section 10, which imposes sanctions for bad faith filing of claims, defenses, cross-claims, and counter-claims. However, the courts have been wary to impose these sanctions under the belief that such penalties would severely inhibit the state’s strong public policy of open access to the courts.

The Reform Act tackled this issue in another way: by creating a downward sliding scale for contingency fees for plaintiffs’ attorneys. According to New York Judiciary Law § 474-a, a plaintiff’s attorney receives 30% of the first $250,000; 25% of the next $250,000; 20% of the next $500,000; 15% of the next $250,000; and 10% of any amount over $1,250,000. The rationale behind this law was that a plaintiff’s attorney would lose incentive to try to go after higher damage awards because of their decreasing fee percentage.

In further attempts to reduce judgments against defendants, the Reform Act introduced the Collateral Source Rule, which allows defendants to enter into evidence plaintiff’s receipt of compensation or benefit from a collateral source. In order for the courts to implement this properly, juries must itemize the damages into past and future damages. In addition, the Reform Act provided for the periodic payment of future damages rather than lump-sum payments for two reasons: it is arguably cheaper to make periodic payments, and it prevents alleged “windfall” awards to relatives if the plaintiff passes away before the period for which a particular award was intended to provide compensation expires.

There is the argument that such payments are unconstitutional and deprive the parties of their right to choose freely the use of the awards.

In examining the Reform Act of 1985, the legislature appeared to be ready to implement new reforms and laws concerning medical malpractice litigation; however, at the same time there is a sense of hesitation of not going too far. For instance, the Reform Act failed to set forth sanctions for those hospitals that did not comply with Public Health Law § 2803. In addition, the courts intervened in a few instances, such as by imposing sanctions for frivolous lawsuits and medical malpractice panels, in order to preserve the strong public policy of open and unimpeded access to the courts. As discussed below, some provisions of the Reform Act of 1985 have lost their initial purpose, such as the non-disclosure of the medical expert’s identity to prevent intimidation of potential testifying medical experts.

II. Analysis

Throughout 2007, the New York State Legislature was busy submitting and debating various bills concerning medical malpractice reform in order to respond to the supposed “crisis” in New York. The bills do not focus only on certain aspects of the litigation process but, instead, address the whole process from start to finish. The proposed legislation that is at the focal point of the current reform movement is Bill No.: A03139, which Assemblyman Robin Schimminger introduced on January 23, 2007. This bill is entitled the “Medical Liability Reform Act,” because it repeals...
and amends several provisions in the Reform Act of 1985. Other bills target the collateral source coverage for physicians, as well as improve the oversight by the Department of Health–Office of Professional Medical Conduct (OPMC).

A. Bringing a Cause of Action — Statute of Limitations, Certificate of Merit, and Court of Claims Jurisdiction

Unlike other civil tort actions, medical malpractice cases are governed by separate procedural statutes regarding the period of limitations to commence a lawsuit and the prerequisites to filing a complaint. Jurisdictional issues for Court of Claims actions in New York are also unique to malpractice suits.

i. CPLR § 214-a: Statute of Limitations for a Medical Malpractice Action

Medical malpractice actions have a special statute of limitations provision under CPLR § 214-a, which was one of the provisions brought about by the Reform Act of 1985. The statute states that an action for medical, dental, or podiatric malpractice must be commenced within two years and six months from the act or omission that caused the injury.38 In the case of a foreign object in the body, the statute runs either for a year from when the object is discovered or from when facts arise that would lead to discovery of the object.39 The statute of limitations for medical malpractice actions is rather restrictive and can lead to harsh results because it does not take into account those plaintiffs who are not in a position to perceive the connection between the injury and possible medical error within the prescribed period. The statute relies solely upon when the act or omission that is the cause of the injury occurred, and not when the plaintiff should have reasonably known of it. The issue here, then, becomes the lack of transparency in the medical profession, which inhibits a plaintiff’s ability to bring an action because the physician rarely communicates to the patient that a medical error occurred.40 One reason patients file lawsuits is because they are not provided sufficient information from the health care system and do not know if their injuries are due to malpractice; they may file lawsuits to find out the cause.41

Harvey Finkelstein, M.D. is a pain management physician in Long Island, New York who reused syringe needles, thus putting nearly 628 patients at risk for contracting HIV and/or hepatitis.42 Dr. Finkelstein did not disclose this practice and, the Department of Health, which investigated these incidents, did not direct Dr. Finkelstein to disclose this egregious conduct and the risk of infection to his patients until some three years after the fact.43 Since the statute of limitations is 30 months, if any patient were infected, they would be barred from filing a lawsuit by CPLR § 214-a. The patients had no way of knowing what caused their illness, if they became infected, because the health system failed to provide them with the necessary information in a timely fashion.

Young v. New York City Health & Hospitals Corp exemplifies the harshness of the statute of limitations doctrine.44 In Young, a female patient brought suit against her treating physicians and clinic for failure to diagnose breast cancer. The patient alleged that, in April 1990, she underwent a mammogram at the clinic which indicated a nodular density in the left breast; this result warranted a biopsy to rule out malignancy. However, these results were not communicated to the patient at that time. She received treatment at the clinic in June and September 1990 for unrelated conditions but was not told of the mammogram results. The patient first became aware of the results in November 1990, and underwent another mammogram in January 1991 that confirmed the diagnosis of cancer. She underwent a mastectomy and received postoperative care from the defendants until July 1991. The Court of Appeals affirmed the lower courts’ decision to grant the defendants’ motion to dismiss the plaintiff’s claim as time barred regarding any acts or omissions amounting to medical malpractice which occurred prior to the accrual of the cause of action in November 1990.45 The Court concluded that a course of treatment for the same condition which gave rise to the cause of action did not exist between April and November 1990.46 Furthermore, the Court ruled that the patient failed to show that further treatment for breast cancer was contemplated by both parties in April 1990.47

On March 7, 2007, New York Assembly members Peter Grannis and Helene Weinstein proposed a bill to amend CPLR § 214-a. The bill states that an action for medical malpractice must be commenced within two years and six months of the “accrual of any such action.”48 The bill defines the accrual event as when “one knows or should have known of the alleged negligent act or omission and knows or should have known that said negligent act has caused an injury.”49 The bill would relax the harsh effects of the statute of limitations because the statute would not begin to run until information and facts are made available for the patient to realize that their injury may have been caused by medical malpractice. This more equitable statute of limitations would, in effect, combat the rampant lack of communication between physicians, such as Dr. Finkelstein, and their patients concerning injuries from medical errors.
In addition, the proposed amendment to CPLR § 214-a would help support the courts’ public policy of open and uninhibited access to the judicial system. Under the original statute, the physician holds all the information that the patient needs in order to realize what occurred. Thus, the physician’s and the healthcare system’s failure to communicate information to patients inhibits the patient’s ability to file a malpractice lawsuit within the requisite period of time. This scenario could possibly be a due process violation as well, since the failure to communicate prevents the patient from utilizing the civil justice system for a meritorious claim.

ii. CPLR § 3012-a: Certificate of Merit

In order to successfully file a complaint for a medical malpractice action, a plaintiff’s attorneys must attach a Certificate of Merit to the complaint, as required by CPLR § 3012-a. Under the statute, a plaintiff’s attorneys must declare that they have concluded that there is a reasonable basis for the lawsuit based upon their review of the facts, and their consultation with a physician who practices in the State of New York and is knowledgeable of the relevant issues. The statute’s main purpose is to prevent plaintiffs from filing frivolous lawsuits. There are no sanctions for failure to comply with the statutory requirement, but case law indicates that courts will grant an extension of time to file the Certificate with the court. The plaintiff is not required to disclose the identity of the consulting physician, except in the case where the plaintiff consulted with three physicians who failed to provide the information required to certify the complaint and the opposing party requests the names of those physicians. The statute is a “bite with no teeth,” because there is no disclosure of the consulting physician’s identity, there are no sanctions or motions for dismissal allowed if the plaintiff fails to comply with the statute, and the requirements for the Certificate are somewhat general.

On January 23, 2007, an Assembly bill was proposed to amend, amongst other things, CPLR 3012-a. This bill requires a signed affidavit from the consulting physician, which concludes that “there is a reasonable basis for the commencement of an action.” In addition, the identity of the physician is disclosed, and an affidavit must address each cause of action where there are multiple defendants. As such, more than one physician affidavit must be submitted.

This amendment would strengthen the statute and place a greater burden on the plaintiff in bringing a lawsuit. The burden could lead to the creation of a rather harsh deterrence, especially in the instance of a claim against multiple defendants. In such a claim, the plaintiff would need to procure multiple physician affidavits for each defendant physician, since the defendants will have different specialties and claims against them. Not only does this appear to create an undue burden in terms of time and effort, but it also is a financial burden which may deter plaintiffs from even bringing such actions.

Plaintiffs may file lawsuits sometimes to find out what caused their injury because they received no information from the treating physicians or the healthcare system. As a result of this lack of information, plaintiffs will often enjoin multiple defendants until they determine through discovery which one was more likely to have caused the injury. This bill essentially infringes upon the plaintiff’s legal right to file a claim on a good faith basis and to pursue the action through the civil justice system. It inhibits the plaintiff’s access to the courts and places enormous burdens, including financial, in order to commence an action.

iii. New York Constitution, Article VI, § 9; Court of Claims Act § 8

In New York, whenever there is an action against the State, the action must be brought in the Court of Claims and not in any of the Supreme Courts. In the Court of Claims, only a bench trial is permitted, with no trial by jury. The State cannot be sued in any of the Supreme Courts of New York. An action cannot be brought against a state employee in the Court of Claims unless their alleged negligence occurred during their official capacity as an Officer of the State. A state agent or officer can be sued in the New York Supreme Court for tort damages because of a breached duty owed individually by them to the plaintiff; the State can be held secondarily liable under respondeat superior. In Morell, the Court of Appeals rejected a narrow interpretation of the Court of Claims Act that would bar actions against State agents in Supreme Court. The immunity of the State does not pass through to State employees in such actions merely because they are employed by the State. Thus, the separation between the State and its employees in tort actions helps to preserve the injured party’s constitutional right to trial by jury. In such a case, the injured party could have an
action against the physicians in the Supreme Court while also commencing an action against the State in the Court of Claims on the same matter. In a practical sense, the plaintiff’s attorney would want to resolve the action against the physicians first — either by settlement or a jury verdict in their favor. One possible tactic would be to receive a favorable jury verdict in Supreme Court, and then attempt to use that evidence against the State in the Court of Claims to show the physician’s percentage of culpability while alleging the doctrine of respondeat superior against the State.66 Court of Claims judges would not likely look favorably on such an attempt since the State was not a party to the Supreme Court action.

The issue of distribution of liability amongst the defendants exists in the Supreme Court action. Defendants might argue that the State’s liability should be factored into the judgment in order to lower the culpability percentages of the physicians. Plaintiffs cannot overcome this by proffering to the court that they are unable to obtain jurisdiction over the State in that Supreme Court. It is not an inability to obtain jurisdiction, but rather a result of a rule of substantive law based on sovereign immunity.67

On January 3, 2007, an Assembly bill was introduced to amend the jurisdiction of the Court of Claims. The bill amends the New York City Health and Hospitals Corporation (NYCHHC) Act Ch. 1016(1)(v)20 by extending the Court of Claims’ jurisdiction to the NYCHHC, its officers and employees for actions that arise during their employment with the NYCHHC.68 The first problem with this proposed amendment is that it would unconstitutionally deny the injured party his or her due process right to a trial by jury.69 The statute forces injured parties to bring their actions against state and city employed physicians into the Court of Claims, which does not offer jury trials. The second more subtle problem is that patients of state and city run hospitals and clinics are usually of middle or lower income. As these patients do not have the resources to go to private physicians or hospitals of their choosing, they lose their constitutional right to a jury trial if they are injured by a physician at a state- or city-run medical facility.

B. CPLR 3101(d): Medical Expert Disclosure

The Reform Act of 1985 fostered CPLR 3101(d), with the purpose of facilitating settlement by broadening disclosure and speeding up litigation.70 The courts struggled with the medical expert exception in subsection (ii) of the statute, which allows parties to exclude the identity of their medical experts, but requires the disclosure of their qualifications and summaries of their opinions, and the facts and data upon which they will testify.71 In Jasopersaud v. Rho,72 the court grappled with the idea of whether the proponent had a substantial right to withhold the identity of the expert. While discussing this issue, the court developed a ‘balancing test’ between broad disclosure and the risk that disclosed information would lead to the expert’s identity.73 In 2002, the Second Department stated that it was futile to try to conceal the identity of a medical expert due to the wealth of resources, especially the internet, which can identify the expert through the information disclosed.74 Nonetheless, the court ruled that the proponent could seek a protective order under CPLR 3103(a) to prevent disclosure of the expert’s qualifications which would lead to the disclosure of their identity.75 Other than the exception being weakened by modern technology, the probability that the expert will be effectively pressured not to testify if the identity is disclosed is offset by the relaxation of the locality standard of care since the Reform Act of 1985.76

In the bill submitted by Assemblymember Robin Schimminger, the provisions pertaining to medical malpractice actions in CPLR 3101(d) would be amended. The amended provisions discard the medical expert exception in subsection (i) that protects the identity of the medical expert, and require, under subsection (ii), that the parties conduct oral depositions of medical experts at the expense of the requesting party.77

In practical terms, the medical expert exception no longer served its purpose, since it is now very difficult to conceal the identity of the expert while disclosing the expert’s qualifications and other information. However, abandoning this exception means that the plaintiff no longer has the statutory or substantive right to seek a protective order under CPLR 3103(a). The exception still did serve a purpose in preserving the plaintiff’s right to seek such a protective order.

The purpose of the proposed broader disclosure is to take CPLR 3101(d) a step further than the Reform Act of 1985 and try to achieve its goal of expediting litigation and facilitating settlement negotiations. Once again, this amendment places a harsh burden on the plaintiff. In practice, an oral deposition of an expert is very costly because experts are paid for their time. In addition, during discovery and pre-trial preparation, parties will identify numerous experts to finalize and strengthen their theory of the case before finally settling on one or more experts for trial. During discovery, a plaintiff will not know which of the defendant’s experts will testify at trial and therefore is forced to choose which experts to depose. Depositions are very costly to a plaintiff and to the attorneys working on a contingency fee basis; they may hesitate to depose numerous experts. If the plaintiff chooses to depose only some of the defendant’s experts, then the defendant can opt to bring one of the non-deposed experts to testify at trial.78

The amended provision also is counterproductive to the grand scheme of the bill, which is to lower costs to malpractice insurers and physicians. Litigation will also be expensive for the defendants if they choose to depose their co-defendant’s experts and/or the plaintiff’s experts. That very well may be the point of the amended statute — to get both sides to avoid high litigation costs by resolving the matter early on in the litigation process. At the same time, the provision acts as an inhibitor for the plaintiff to reach a jury trial because the plaintiff or the attorney cannot afford the high litigation costs associated with deposing experts.

C. CPLR 1601: Joint and Several Liability

One of the compromises in the Reform Act of 1985 is Article 16 of the CPLR, the joint and several liability provisions. Specifically, CPLR § 1601 affects the liability of defendants for non-economic damages, in that each defendant is liable for the percentage of non-economic damages in relation to their share of culpability. For economic damages, the plaintiff can recover 100% of the economic damages from any defendant found liable.79 In addition, if a defendant’s culpability exceeds 50%, then the plaintiff can recover 100% of the non-economic damages from that defendant.80 For economic damages, the plaintiff usually seeks the deepest pocket, such as a hospital rather than a physician. Article 16 modified the common law rule of joint and several liability, based on the premise that the full compensation of a relatively innocent victim is more important than a balancing of fault.81

Schimminger’s proposed bill amends CPLR § 1601 by removing the clause referring to a defendant who is more than 50% culpable who then

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could be held responsible for 100% of all non-economic damages. The bill also states that a defendant is liable to the plaintiff for non-economic and economic damages not exceeding that defendant’s share of liability. Defendants would only be at risk for paying that portion of the economic damages commensurate with their percentage of fault. Under the bill, the defendant’s share of the culpability dictates the percentage of both economic and non-economic damages that that defendant is liable to the plaintiff.

This amendment to CPLR §1601 undermines the common law purpose of joint and several liability, which is to compensate plaintiffs fully and allow them to recover from the deep pocket (i.e., the hospital instead of the physician) in actions for medical malpractice. Under the current statute, in an action where the plaintiff sued and received a favorable judgment against a hospital and physician, the plaintiff would usually try to recover the economic damages from the hospital, the physician runs the risk that the physician would not have sufficient insurance coverage or enough assets to fully compensate the plaintiff. By recovering all economic damages from the hospital, the plaintiff has a better chance of full compensation. The burden is on the ‘deep pocket’ to indemnify itself against the physician.

The amendment of CPLR §1601 flips the burden and forces the plaintiff to deal with recovering economic damages from all the defendants. Thus, the plaintiff might not receive full compensation because a defendant may not have sufficient coverage or assets to cover its percentage of damages. In essence, the amendment protects the hospitals over the injured party.

D. Article 50-C: Limitation on Non-Economic Damages

Putting a cap on non-economic damages is very controversial in medical malpractice tort reform actions. The majority of states that enacted some form of malpractice reform include statutes capping non-economic damage awards. The theory behind such a cap is that reducing the amount of judgments in medical malpractice claims will reduce malpractice premiums for physicians.

Schiimminger’s proposed bill includes the enactment of a new article to the CPLR, Article 50-C, which places a cap of $250,000 on non-economic damages, regardless of how many defendants are in the action. Caps on damages do not reduce malpractice insurance premiums, and only hurt the severely injured plaintiffs. Other states that have imposed caps on non-economic damages did not experience a correlation between reduced judgments and reduced premiums. In 2002, Nevada passed caps on damages and within days, its two largest insurance companies announced that they had no intention of lowering their rates. When Mississippi considered damages caps in the summer of 2002, physicians were told by their insurers that they would face a 45% increase in premium rates regardless of whether the state implemented damage caps. The Nations’ largest medical malpractice insurer, GE Medical Protective, tried to raise premiums by 19%, claiming that non-economic damage caps are nominal and will only create loss savings of one percent. This occurred six months after Texas passed its caps on non-economic damages. Lastly, the 2003 Farmers Insurance Group demonstrated that caps do not result in affordable insurance for physicians — the Group pulled out of five states, including California, which has had caps and tort reform for decades.

Insurance companies respond to the state of the economy and the cyclical effects of the industry’s investment market. A study explicitly concluded that between 1991 and 2002, the states with caps on non-economic damages saw median physician premiums rise 48%, while in states without caps, physicians’ median premiums rose only 36%. Experiences in other states and studies done on the connection between premium rates and damages caps demonstrate that there is in fact no correlation. Some would argue that it would make more sense for the statutes imposing caps on damages to include a provision that reduces premiums as well — an option that New York has not considered. Tort reform supporters point to the fact that in California, where there are caps on non-economic damages of $250,000 (not adjusted for inflation), malpractice insurance premiums stabilized and declined. However, the decline in malpractice insurance premiums was not due to the damages caps but, rather, because California passed Proposition 103 in 1988, which required insurers to open their books to justify their rate increases.

The real downside to imposing damage caps, especially on non-economic awards, is that the greatest negative effects from such caps are those plaintiffs who suffer severe injuries without substantial economic loss. In essence, plaintiffs would be facing “double-jeopardy,” first hurt by the health care provider, and then penalized by the law. In addition, damage caps nullify claims for decrease in quality of life. Disfigurement, deafness, blindness, and other injuries may have minimal economic damages, but have large non-economic damages because of the person’s reduced quality and enjoyment of life. Women are especially adversely affected by non-economic damage caps. Women who bring gynecological malpractice suits can lose their awards because their...
injuries, which include impaired fertility, impaired sexual functioning, miscarriage and scarring, do not carry large economic losses, even though they account for serious emotional suffering, lost sense of self, and reduced quality and enjoyment of life. These women would be deprived of their legal rights to bring such lawsuits because the role of the jury is abrogated by the damage caps in actions for gynecological malpractice. Thus, the injured women are not fully compensated for their injuries. Instead, Californian women are subject to an arbitrary flat cap on damages that is not adjusted for inflation. If the cap were adjusted for inflation, the cap level would have been set at $779,000 in 1999.7

Non-economic damage caps do not affect insurance premium rates or healthcare costs in general, because premiums account for less than two percent of total health costs.8 In the end, the caps deprive plaintiffs of their legal rights to having a jury determine the full extent of their damages, while plaintiffs lawyers operating on contingent fees likely will decide not to pursue non-economic damage-oriented claims.

E. Medical Malpractice Insurance Reform

When the New York State Insurance Department announced that it approved an increase of 14% in medical malpractice insurance rates, the Department cited the misappropriation of funds as one of the chief causes of this “crisis.”99 Specifically, the State previously appropriated $691 million of the medical malpractice insurance reserve funds from the Medical Malpractice Insurance Association (MMIA) to meet other budgetary needs.100 The MMIA fund was created to provide insurance for those physicians who could not get regular commercial coverage because of their high risk status. The Insurance Department admits that if “MMIA’s reserves had been preserved and allowed to grow by collecting interest over the years . . . medical malpractice insurers would be in a much stronger financial position today.”101 The Medical Malpractice Insurance Plan (MMIP) replaced the MMIA but, according to the Insurance Department, it has a deficit of $525 million, which by law must be shouldered by the malpractice insurers in the State.102

In January 2007, State Senator Liz Krueger proposed a bill to amend § 6524(11) of the Education Law to require that every practicing physician in the State of New York procure a policy of at least one million U.S. dollars.103 In that same month, another bill was proposed which would establish a separate state fund to compensate neurologically impaired infants as a result of the acts or omissions of obstetricians-gynecologists (OB/GYN) and midwives.104 Two months later, another insurance bill was proposed which would provide excess insurance to physicians who are unable to obtain commercial insurance because they are considered “high-risk.”105 The fourth proposed insurance bill of 2007 dealt with requiring the medical liability insurance association to replace the insurance pool which the State drained of all of its funds.106

The MMIP has a deficit of $525 million because it subsidized high-risk physicians who could not obtain commercial insurance. Seven percent of physicians are responsible for two-thirds of all medical malpractice payouts.107 This small number of physicians is responsible for draining the fund, thus forcing the insurers to cover the losses. These physicians, who are so high-risk they cannot even obtain commercial insurance, are still allowed to continue their practice without disciplinary actions and are guaranteed by the State to receive insurance.

Bills S0973 and S7038 both require practicing medical professionals to obtain insurance of one million U.S. dollars. However, in order to qualify for excess insurance of one million U.S. dollars from the medical liability insurance fund, a physician must have $1.3 million in insurance coverage.108 Instead of requiring these physicians to obtain the extra $300,000, the bill proposes further subsidies for the physicians by providing them with the $300,000 from a state-operated hospital fund that is under the control of the Superintendent of the Insurance Department.109 On top of providing subsidized insurance to high-risk physicians through the medical liability insurance plan, the State further subsidizes all physicians from a hospital fund in order to qualify for excess insurance. Bill S7038 does not differentiate between good and bad doctors; nor does it differentiate between specialties. Instead the proposed bill provides a subsidy across the board to all physicians.

Instead of disciplining high-risk physicians, the State is guaranteeing insurance for these physicians under the Medical Liability Insurance Association. A study shows that, if New York stopped physicians who committed three malpractice acts or more from harming more patients, malpractice cases would decline by one-third.110 Instead, the State is subsidizing insurance for physicians like Dr. Finkelstein,111 while ethical
physicians, who are the overwhelming majority, bear the burden of paying higher premiums.

The other shortcoming of the rise in medical malpractice insurance premiums is that insurance rates are not based on experience. Premium rates are not adjusted individually to reflect the physician’s performance history, such as with auto insurance. On the contrary, malpractice premiums are the same across the board based on the specialty rather than the performance of individual physicians. Thus, the large percentage of medical errors caused by that seven percent of New York physicians negatively affects all physicians’ access to affordable insurance, rather than just themselves.

The neurologically impaired infant fund also is not necessary based on statistics available on OB/GYN malpractice actions. The purpose of the fund is to protect OB/GYN physicians by capping their liability, based on the presumption that these specialists will leave and are leaving the State due to high health insurance costs. In fact, New York ranks third in the nation with 39 OB/GYNs per thousand, while California — the national ‘model’ for reform — ranks, 17th. Additionally, Florida and Virginia both attempted to implement the same program; however, it failed in both states. No other state has implemented such a program. One reason for its failure is that the program is funded by fixed assessments from doctors and hospitals, so the administrators have a strong resolve for solvency of these funds versus making compensation available.

There is no evidence that these types of lawsuit are so rampant that they should be removed from the courthouse and subject to the whims of a state fund. In reality, neurologically impaired infants are part of a group that does not comprise a major part of medical malpractice costs. Instead, under such a fund, plaintiffs would be barred from receiving redress from the courts, thus encroaching on their constitutional rights. The proposed bill also bars the plaintiff from seeking non-economic damages on behalf of the infant who will undoubtedly suffer pain and suffering, mental anguish, and reduced quality of life. The only group that has an option to enter or leave the fund is the OB/GYN, not the infant. In short, the fund’s main purpose is to isolate and protect OB/GYNs from paying out malpractice awards to the detriment of the legal rights of injured infants and their families. The injured infant endures a ‘double-jeopardy’ through the health care system, both injured from medical errors and deprived of their legal rights.

These funds and insurance pools are initially what drove New York State and the insurance companies into this “crisis.” Controls need to be imposed in order to prevent another misappropriation of funds, such as what happened with the $691 million that was in the insurance pool. Administrators for the subsidized insurance coverage should conduct physician screening to weed out those physicians who pose not only a risk to the funds in the pool, but also a risk to patients. Due to the absence of experience rating — adjusting rates based on how safe or not safe individuals conducts themselves — in medical malpractice insurance, medical professionals cannot control their premiums by improving their quality of care. Thus, there is no incentive to avoid liability. The main dilemma, and error, is that good physicians suffer just because they are in a certain specialty.

F. Malpractice Prevention and Medical Peer Review

Attacking the root of medical malpractice, such as physician errors, neglect and carelessness through oversight and prevention programs could curtail rising medical malpractice costs and payouts. For instance, anesthesiologists had the highest premium rates as compared to most other specialists in the 1980s, until anesthesiologists began implementing safer practices.

Similar safety initiatives have occurred as a response to mounting litigation in a particular specialty or area of medicine. In Connecticut, an investigative journalist used records from a pending malpractice lawsuit to uncover an epidemic of hospital-borne infections. It was not until the lawsuit commenced and bad publicity ensued that the hospital adopted safety measures which reduced infection rates from 22% to nearly zero. The Harvard Medical Practice Study shows that litigation drives safety as the experience of being sued makes physicians twice as likely to take the time to explain risks and communicate with patients.

In New York, a major problem is oversight and discipline by the OPMC. According to the National Practitioner Data Bank (NPDB), only 28% of the physicians who made ten or more payouts were disciplined by the OPMC. Instances such as Dr. Finkelstein’s case are commonplace. In a sense, it is a breakdown of the health system in New York, because hospitals fail to investigate their physicians, and the OPMC fails to investigate individuals who have a number of payouts or who are known to be high risks.

In January 2007, a bill was proposed to amend Public Health Law § 230(12-a) by requiring the commissioner
to inform the OPMC immediately of a physician who is the subject of a medical malpractice lawsuit. In February 2007, a bill was submitted in the Assembly to amend Public Health Law § 230 (9-b) by providing that the OPMC conduct a thorough investigation into the conduct of a physician when the office accrues three reports relating to separate incidents within a five-year period, or five reports within any two-year period for more severe penalties.

The goal and purpose of these amended statutes is to compel the OPMC to regulate the conduct of medical professionals within the State of New York to curtail rising medical malpractice costs and prevent further harm to patients. As of now, litigation is the catalyst for such safety measures. When errors occur on a frequent basis, then lawsuits will mount and place costs upon providers until a balance is met and it becomes less costly for the provider to implement measures to improve quality. The tort system is the only means of gaining insight into serious misconduct that endangers patients, especially since the New York Patient Occurrence Reporting and Tracking System (NYPORTS) denies access to injured patients who wish to see data and peer reviewed records.

These proposed laws existed in the guidelines for the OPMC; however, they did not live up to their standard of review and oversight. The agency failed to investigate doctors with payments for malpractice that would usually trigger an investigation. In addition, there was a chronic recurrence of inexcusable errors, including surgery on the wrong limb and leaving foreign bodies in the patients. These acts amounted to at least 550 deaths per year in New York. The fact that these inexcusable errors occur on such a frequent basis is an indication of poor patient safety and OPMC laxity in its oversight of negligent and unethical doctors.

Public Citizen reported on the recommendation that the State’s licensing board investigate those physicians who are unable to obtain commercial insurance coverage to see if they are suited to continue practicing medicine. Elimination of such ‘bad’ doctors will protect the safety of patients and will remove their adverse effects on insurance funds due to multiple malpractice payouts.

Reducing medical malpractice litigation against healthcare providers starts with the conduct of the doctors and the safety measures they implement to ensure the well-being of their patients.

III. Diagnosing the “Crisis” in New York

There are several misconceived notions and allegations made by groups such as MSSNY pertaining to the cause of the current “crisis” situation in New York. The primary cause of this insurance problem is a failure by the State to manage properly the funds in the insurance pool for high-risk physicians, and a failure of the OPMC to monitor and oversee their professionals properly. The State also failed to regulate medical malpractice insurance rates properly. From 1991-2007, the rates increased at a stagnant average of 3.5% annually, with virtually no increase in insurance rates until 2003. The average rate hike in the United States in that same time period was nearly double at 6.5%. Thus, with premiums lower than the national average and declining revenues, the only way for the insurance companies to rebound was to hike rates dramatically. However, the Insurance Department would not grant a 30% raise request in 2007 and instead raised premiums by 14%.

Nearly 100,000 people die in the United States each year from medical mistakes, which exceeds the number of individuals who die in automobile or workplace accidents. Emphasizing the poor regulation of physicians by the OPMC, it is important to note that approximately 6,189 doctors made two or more malpractice claim payouts. Of that group, only 8.5% received some disciplinary action, and only 11% of the 3,057 doctors that made three or more payments were disciplined. Under the OPMC regulations and the proposed bills, reports of three separate payments automatically trigger an immediate investigation by the OPMC as to that physician’s conduct.

MSSNY claims that, as a result of the hostile litigation climate of New York and the recent increase in premium rates, there are shortages in several medical specialties. In contrast, New York’s physician pool actually is flourishing. The physician population has increased by 20.5% from 1995–2007, an increase of 15.8% in the number of physicians per 100,000 residents. If physicians are fleeing New York for friendlier environments (i.e., states that have less medical malpractice litigation) then why does New York boast a greater amount of practicing physicians and specialists per capita and nearly double the residents and fellows on duty than both California and Texas, which are considered tort reform states?

MSSNY, the New York Chapter of the American College of Surgeons, and New York State Society of Orthopaedic Surgeons contend that, during “crisis” periods, physicians flee those areas, and most specialties restrict their scope. As to the first contention, a report by the Government Accountability Office (GAO), clearly states that physicians did not flee perceived medical malpractice “crisis” states, contrary to the contentions of the AMA. Another study also clearly contradicts the medical societies’ contention that specialists limit the scope of their practices during “crisis.” Connecticut has the highest percentage of orthopedic surgeons even though general surgeons pay thousands of dollars more in premiums than general surgeons in New York.

The Orthopaedic Society asserts in its submissions to the Task Force that there is a scarcity of specialists, as evidenced by certain counties having two or fewer orthopedic surgeons. However, the counties that the Orthopaedic Society referred to are rural counties and are in regions with the lowest premiums, thus contradicting its argument. The surgeons are actually leaving cheaper premium regions to work in New York City or Connecticut where the premiums are much more expensive. This demonstrates that premiums have little to no effect on where a physician practices. In addition, there has not been an increase in medical malpractice claims. According to the Insurance Information Institute, one in eight patients who suffer an injury from an adverse event will file a malpractice lawsuit and one out of 15 will receive compensation. The amount of malpractice payouts has remained steady from 1991 to 2006, with a slight decline in the average between 2002–06. Further, the number of payments made by physicians has also steadily declined in recent years. Furthermore, the number of Request for Judicial Intervention in medical malpractice actions has stayed around 4,300 per year.

Medical malpractice premiums only account for two percent of healthcare costs. Lawsuits are one of the smallest factors driving up health costs, at least than one percent of total healthcare spending. Malpractice cases could be cut by one-third if the OPMC disciplined doctors who committed three or more malpractice payments. Lastly, limiting medical malpractice
liability will undermine any incentives for safety because there will be one
less check on the conduct of physicians in the treatment of patients. This
will make it more difficult for those patients with legitimate but difficult
claims to find legal representation, especially with reforms driving up
litigation costs.15

IV. Conclusion

There is a crisis in the State of New York, but it has little if anything to do
with litigation of malpractice claims. The crisis is the unsafe environment
that patients in New York deal with when undergoing treatment — whether
it is within a physician’s office or in a hospital. As long as unethical doctors
like Dr. Harvey Finkelstein are allowed to continue their practice and
receive subsidized malpractice insurance, patients will be at a great risk of
injury. The unchecked and unmonitored subsidizing of high-risk physicians
guarantees the continuation of inexcusable medical errors. Good doctors
should not be penalized simply because they practice a particular specialty.
Neither they nor their insurer should be forced to subsidize physicians who
are not able to obtain commercial insurance.

Tort reform is not the solution — all it will do is subject the malpractice
victims to further hardships and deprive them of their legal rights to
due process and a trial by jury. Funds like the Neurologically Impaired
Infant Fund forces this remedy upon plaintiffs and encroaches upon
their constitutional right to a jury trial. Caps on non-economic damages
only subject the severely injured plaintiff to the further harm of “double-
jeopardy.” The caps do not correlate with a reduction in premium rates;
however, they do reduce the claims brought by women, children and the
elderly. If the bill for the subsidized insurance for high-risk physicians
is allowed to pass, then the bill should be named “Harvey’s Law,” because
it will only benefit doctors like Dr. Harvey Finkelstein, and subject the public
to further harm and injury.

1 American Medical Association (AMA), Principles of Medical Ethics,
Adopted by the AMA’s House of Delegates on June 17, 2001, available at
2 New York State Insurance Department, Rate Increase Staves off Looming
Insurance Industry Crisis as New Task Force Confirms Medical Malpractice
yu.us/press/2007/p0707021.htm; Medical Society of the State of New York
(MSSNY), AIS Medical Society Says Rate Increase Bodes Ill for New York
3 See, NYS Insurance Department, Press Release July 2, 2007 (reasoning
that the raise in premium rates was deter the financial deterioration
of medical malpractice insurance companies).
4 Id.
5 New York Civil Practice Law and Rules (N.Y. C.P.L.R.) Section 3012-a(1)
(Consol. 2008).
8 155 N.Y. 201 (1898).
9 Pike, 155 N.Y. at 209.
10 Boland v. Montefiore Medical Center, et al., 2005 NY Slip Op 50289U
*6 (1st Dept. 2005) (holding that “unless the alleged malpractice falls within
the competence of the jury to evaluate,” the plaintiff is required to present
expert testimony to support its claims and establish a prima facie case); see
also Hoagland v. Ira Kemp, et al., 155 A.D.2d 148, 150 (allowing an expert
to testify as to the minimum standard of care required of all dentists in
the State of New York, even though the expert could not testify as to the locality
standard of care where the defendant practiced).
12 N.Y. C.P.L.R. § 3101(d)(ii) (Consol. 2008); see also N.Y. C.P.L.R. § 3101
(d)(ii) (Consol. 2008) (oral depositions of medical experts are optional).
13 Frye v. United States, 293 F. 1013 (D.C. Cir. 1923); see People v. Wesley,
14 Wesley, 83 N.Y.2d at 423 (ruling that general acceptance does not have to
be unanimous acceptance).
15 Id. at 436; compare with Daubert v. Merrell Dow Pharmaceuticals, Inc.,
509 U.S. 579 (1993) (relaxing the standard for a Frye hearing by weighing
the evidence, and considering margin of error and peer reviews along with
general acceptance).
16 Jeffrey M. Kimmel, ‘Frye’s’ Applicability to Medical Malpractice Cases,
307, 311-312 (1st Dept. 2004) (holding that expert testimony which opines
the causation of the injury to be the defendant’s conduct is not novel as per
the Frye test, but rather is exactly what is the “primary point of contention
in a personal injury action.”).
17 N.Y. C.P.L.R. § 3101(d)(ii) (Consol. 2008) (all parties to the action must
consent to oral depositions of medical experts in order for such disclosure
to take place during discovery).
18 N.Y. C.P.L.R. § 1600 (Consol. 2008).
19 See, Torns, 305 A.D.2d at 966-67 (held a hospital vicariously liable for
conduct of an independent contractor because plaintiff could reasonably
believe that the physician was provided by that hospital and acting on its
behalf).
21 Id.
22 Id. (allowing the plaintiff to not consider the liability of a non-party if
they show even after due diligence they were unable to obtain jurisdiction
over that person).
York State Legislature Responds to the Medical Malpractice Crisis with a
Prescription for Comprehensive Reform, 52 Brook. L. Rev. 135, 139 (1986).
24 Id. at 145.
25 Id. at 161 (discussing how some courts found panels to be
unconstitutional, unworkable, and inequitable to litigants).
26 Gagliardi, Report of the Ad Hoc Committee on Medical Malpractice
Panels to the Chief Administrative Judge of the State of New York on the
Operation of Medical Malpractice Panels, 159-64 (1980) (concluding that
panels do not facilitate settlements and in many instances actually reinforce a
party’s resolve to go to trial).
27 Rosen, supra note 23, at 135.
30 Rosen, supra note 23, at 158.
(Justice Lazer reversed the imposition of such sanctions on the basis that they
were beyond the “inherent powers” of the court, and stated that “an action
or motion which may appear frivolous . . . may in fact be the beginning of a
new development in the law.”).
33 Rosen, supra note 23, at 164-65; see also CPLR § 4545(a).
34 CPLR § 4111(d) (Consol. 2008) (juries shall award the full amount of
future damages without reductions).
35 Rosen, supra note 23, at 170-711.
36 Id.
Assemblymember Robin Schimminger (amending CPLR. §§ 3012-a,
1600, 1601, 3101(d)(i), 3101(d)(ii), and adding Article 50-C to the CPLR.).
38 N.Y. C.P.L.R. § 214-a (Consol. 2008) (in the case of continuous
treatment for the same illness, the statute runs from the first treatment for
that illness).
39 Id.
40 Tom Baker, The Medical Malpractice Myth, 92, 157 (University of
Chicago Press, 2005) (discussing how physicians should be open with their
patients and disclose to them when a medical error takes place).
41 Id. at 157.
42 Kathleen Lucadamo. State’s slow bust pricks needle suits, N.Y. Daily
43 Id. (Instead of notifying all of his patients immediately, Dr. Finkelstein decided to hire a lawyer in order to negotiate with the Department of Health. He has not been disciplined, but OPMC states that he has been “re-educated.”).
45 Id. at 296 (citing that the “continuous treatment doctrine” does not toll the Statute of Limitations unless the action is filed within the limitations period after the last treatment where there is continuous treatment for the same illness or condition which gave rise to the cause of action); citing Borgia v. City of New York, 12 N.Y.2d 151, 155 (1962) (stating that the rationale behind the continuous treatment doctrine is that it would be absurd to require an individual to interrupt corrective treatment to commence a lawsuit and thus undermine the confidence and trust in the treating physician).
46 Young, 91 N.Y.2d at 296 (stating that a general physician-patient relationship for routine and periodic examinations will not satisfy as continuous course of treatment, which is what occurred between April and November 1990).
47 Id. at 296-97 (citing the rule that a course of treatment does not necessarily end on the last date of treatment if the patient and physician affirmatively contemplate further treatment for the condition through regularly scheduled appointments).
49 Id.
50 N.Y. C.P.L.R. § 3012-a (Consol. 2008).
51 Laws 1986, Chapter 266, § 1 (the legislative intent behind certificates of merit is to “improve the quality of medical malpractice adjudications and deter the commencement of frivolous suits.”).
52 Bowles v. State, 208 A.D.2d 440 (1st Dept. 1994) (ruling that the proper sanction was dismissal, but to grant the plaintiff an extension of 30 days to comply with the statute).
53 N.Y. C.P.L.R. § 3012-a(a)(3) (Consol. 2008) (defendant may move for disclosure when notified that three physicians refused to certify).
54 A. 3139, supra note 37, at page 1, lns. 14-17.
55 Id. at page 2 (failure to comply with the filing of the certificate and affidavit will result in dismissal of the complaint).
56 Baker, supra note 40, at 157.
57 Id. at 91-92 (the large number of suits that are closed without payments are not “frivolous claims,” but rather is the plaintiff realizing that one of the doctors did not contribute to the injury so they therefore dismiss that claim).
58 Court of Claims Act § 8 (plaintiff must file a Notice of Claim one year after commencement of the action).
59 Id.
60 For purposes of this article, it is important to note the hierarchy of the New York State Courts. In New York State, the trial courts for each county are called Supreme Courts. Appeals from the Supreme Courts are heard in the Appellate Divisions which is divided into four Departments. Each of the four Departments have jurisdiction over several New York counties. For example, the First Department has jurisdiction over the lower courts in New York and Bronx Counties. The First and Second Departments have jurisdiction over appeals originating in the New York City and Long Island areas, while the Third and Fourth Departments have jurisdiction over appeals from Upstate New York. The top appellate court in the State is the Court of Appeals. Available at http://www.courts.state.ny.us/courts/structure.shtml. 61 Id.; see Public Officers Law § 17.
62 Morett v. Balasubramanian, 70 N.Y.2d 297, 301 (1987) (allowing an action against State-contracted physicians to be brought into Supreme Court).
63 Id.
64 Id. at 302 (rejecting the narrow interpretation because it would deprive an injured party of an action since only the State can be brought into the Court of Claims).
65 Id.
66 Court of Claims Act §8; N.Y. C.P.L.R. 1601 (Consol. 2008).
67 Id. (a non-party’s culpability will not be factored in with the defendants’ culpability if the plaintiff can show that through due diligence they were unable to obtain jurisdiction over that non-party tortfeasor); see Rezucha v. Garlock Mechanical Packing Co., 159 Misc.2d 855 (1997) (permitting defendants to prove State’s share of culpability in order to reduce their own liability towards the plaintiff).
70 Rosen, supra note 23, at 135.
73 Id. at 701.
74 Thomas v. Allexey, 752 N.Y.S.2d 362, 368 (2nd Dept. 2002).
75 Id. at 371 (granting a protective order if the proponent can show that disclosing the expert’s qualifications and other information, would reasonably lead to disclosure of the expert’s identity and there would be a reasonable probability that the expert would suffer abuse, harassment, expense or embarrassment).
76 Shilton, supra note 71, at 2078 (experts no longer have to be from the exact locality as the defendant physician, but rather they must be knowledgeable of the standard of care for their specialty and for State requirements); see Hoagland, 155 A.D.2d at 150.
77 A. 3139, supra note 37, at 4-5.
78 Id. (The amended provision does not require that every retained expert must be deposed. It only requires that the party produce the expert when they receive notice for deposition of an specific expert).
80 Id.
81 N.Y. C.P.L.R. § 1601, C1601.5 (McKinney 2008) (if a plaintiff is slightly comparatively negligent, the court usually will err on the side of the plaintiff, as per the common law purpose of the statute, and remove the plaintiff culpability from the equation so the plaintiff can recover 100 percent of the damages from the defendants).
82 A. 3139, supra note 37, at 3.
83 Id. at 3, lns. 22-24.
84 A. 3139, supra note 37 available at http://assembly.state.ny.us/leg/?a=A03139 (capping non-economic damages at $250,000).
85 A. 3139, supra note 37, at 3-4 (also allowing contributory negligence and the collateral source rule to be used against the recover of damages).
87 Mississippi Tort Reform Effort Falls Short, Commercial Appeal, February 18, 2003.
92 The Assoc. of the Bar of NYC, supra note 90, at 4.
93 Harvey Rosenfield, California’s MICRA: Profile of a Failed Experiment in Tort Law Restrictions, June 1993 (in fact, 12 years after the enactment of the caps the physician premiums nearly tripled before Proposition 103).
94 David M. Studdert, Y. Tony Yang & Michelle M. Mello, Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California, The Harvard School of Public Health, Health Affairs, July/August 2004, Vol. 23, Issue 4, page 54 (discussing how gravely injured plaintiffs are poorly compensated as a result of the reductions imposed by damage caps in California); see also Pace, Nicholas M., Daniela Golinnelli & Laura Zakaras, Capping Non-Economic Awards in Medical Malpractice Trials, California Jury Verdicts Under MICRA, Prepared for by the Rand Institute for Civil Justice, July 2004.
95 Id. (suggesting that the cap should be on a sliding scale in proportion with the severity of the injury rather than a flat cap).
96 Lucinda M. Finley, The Hidden Victims of Tort Reform: Women, Children and the Elderly, paper delivered to Thrower Symposium, Emory Law School, February 19, 2004 (concluding that the greatest loss will be the loss of deterrence, dependency on societal funds, and lost opportunity to bring these problems to the public notice and regulatory attention).
97 Assoc. Bar of NYC, supra note 90, at 1.
98 David Morris, Malpractice Stats Aren't What Needs Fixing Here, Minneapolis Star Tribune, available at http://www.ilsr.org/columns/2005/011005.html (limiting liability, according to the Congressional Budget Office (CBO), will undermine incentives for safety and make it difficult for those with legitimate claims).
99 NYS Insurance Department, supra note 2.
100 Id. (the funds were used by the state to fix other budget deficits).
101 Id.
102 Id. (the debt shouldered by the carriers is one of the reasons for the approval of a 14% increase in rates).
105 S. 7038, 2007 Sen., 231st Sess., at 1 (N.Y. 2008) (proposed by Senator Flanagan). (the bill passed the Senate on April 15, 2008 and is now up for vote in the Assembly).
108 S. 7038, supra Note 105.
109 Id. at 2.
111 Lucadamo, supra note 42 (Dr. Finkelstein was not disciplined after potentially infecting 628 patients with HIV and Hepatitis because he reused syringes).
114 Public Citizen, supra note 110, at 11-13 (both Florida and Virginia implemented these programs because there was a threat of withdrawal of liability coverage for physicians who delivered babies, which is not the case in New York).
115 Id.
116 Id. at 11 (these injuries rank 5th out of ten categories of injuries, right below minor permanent injury).
117 S. 157, supra note 104, at 3 (the fund also limits what future damages the plaintiff can claim and collect from the fund).
118 Id. (the physician is only liable for $250,000 of the award, and anything in excess is covered by the fund).
119 Public Citizen, supra note 110.
120 Mark Geilsfeld, Malpractice Insurance and (Il)legitimate Interests of the Medical Profession in Tort Reform, 54 DePaul Law Review 439.
121 Dr. Ellisom Pierce, Jr., ASA Monitoring Guidelines: Their Origin and Development, 66:9 ASA Newsletter, September, 2002 (presently, death rates from anesthesia related injuries 1 out of 250,000, compared to 1 out of 5,000 in the 1980's).
122 Baker, supra note 40, at 98; G. Annas, The Patients Right to Safety—Improving the Quality of Care through Litigation against Hospitals, New England Journal of Medicine, May 11, 2006 (focusing on litigation provides a strong resolve to hospitals and to make them safer).
125 Public Citizen, supra note 110 (only 7% of doctors account for 68% of all malpractice payments).
128 Hyma & Silver, supra note 124, at 28 (as quality rises and errors subside, consumers will litigate less).
131 Id.
132 Id. (negligent oversight of bad doctors allowed these errors to occur).
133 Self-Inflicted “Crisis,” supra note 112, at 37 (even though only 1 percent of doctors cannot obtain commercial insurance, it is this group of doctors that caused the insurance pool to go $500 million into the red).
135 Self-Inflicted “Crisis,” supra note 112, at 14; NYS Insurance Dept., supra note 2 (discussing how as a result of artificially low rates, the insurance companies face a difficult road to regain profits).
136 NYS Insurance Dept., supra note 2.
137 Baker, supra note 40, at 1-14 (citing a report by the Institute of Medicine of the National Academy of Science).
140 Self-Inflicted “Crisis,” supra note 112, at 28 (steady and consistent increase in physician population yearly).
141 Id. at 32; First Do No Harm: A Consumer Response to the Medical Lobby’s Campaign to Limit the Legal Rights of Injured Patients, page 9.
143 Michelle M. Mello, Change in Physician Supply and Scope of Practice During a Malpractice Crisis: Evidence from Pennsylvania, Health Affairs, April 24, 2007.
144 Joseph Awad, Letter to Eric R. Dinallo, Superintendent of the New York State Department of Insurance, and Richard F. Daines, M.D., Commissioner of the New York State Department of Health, October 15, 2007, available at http://www.nystla.com (Connecticut premiums for general surgeons range from $65,000 to $118,000, while premiums for New York General surgeons ranges from $18,000 to $85,000).
146 Awad, supra note 144, at 2.
149 Id.
150 First Do No Harm, supra note 141, at 6.
151 Assoc. of the Bar of NYC, supra note 90, at 6.
152 Id. at 8; see also Congressional Budget Office Report, 1992.
153 Public Citizen, supra note 110.
154 Morris, supra note 98.