

The Medical Malpractice Insurance Crisis, Again

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The real crisis presented by the breakdown of our medical malpractice litigation and insurance system is that the wrong people are getting most of the money. Often, the people who sue have substantial injuries but dubious liability claims, while many people with legitimate claims can't even assert them. As a result, many doctors are angry and resentful toward patients who bring frivolous claims, and many patients with legitimate but unredressed grievances are disgusted by their lack of access to justice. The sad result is a breakdown in confidence and trust between doctor and patient. And that produces a perception of poor quality health care, as well as a dysfunctional community.

If you want to understand what this latest medical malpractice insurance crisis is about, a good way to start would be to dissect that phrase: "medical malpractice insurance crisis," because what we are dealing with is, in fact, three separate but related developments.

The medical component is entirely a function of expectations. In the last sixty years, the public's expectations of its health care system have risen dramatically, thanks to advances in medical science and the longer life expectancy and better quality of life they have delivered. But that expectation generates great anger when the medical profession fails to deliver. For example, forty years ago, virtually no one sued a neurosurgeon. If you were going to a neurosurgeon, you were almost certainly going to die, and if there was anything the neurosurgeon could do to defer that result, you were enormously grateful. As the technology and capability of neurosurgery developed, expectations of the specialty grew as well.

Neurosurgeons at least have the advantage of treating very sick patients, individuals who fully comprehend the gravity of their circumstances. Contrast this with the lot of the obstetrician, whose patients have the same expectation: a happy and healthy baby. They experience the physician's failure to meet that expectation with the greatest imaginable disappointment. It is the distance that the obstetric malpractice plaintiff travels from the "reasonable expectation" of a perfect outcome to the devastating fact of a neurologically impaired newborn that fuels the intensity of "brain damaged baby" lawsuits. In this regard, doctors are victims of their own success and their failure, or inability, to communicate to their patients that they can't guarantee a good outcome in every case.

The *malpractice* part of the malpractice insurance crisis is rooted in a flawed system for adjudicating medical negligence claims for which no one is currently held responsible. For any malpractice claim to move through the courts, be it meritorious or frivolous, the active support of three players is required. First, the potential medical malpractice plaintiff must find a lawyer. Because of the expense of prosecuting medical malpractice cases, the typical method for finding

a lawyer is the lure of the contingent fee system, whereby plaintiff's lawyers, who are professional gamblers, agree to prosecute an action on behalf of a plaintiff and charge no fee unless the action ends in a financial award. Say what you will about this system, without it no one other than the wealthiest members of our society could use the courts to adjudicate civil grievances.

Advocates of the current system argue that the contingent fee system helps discourage cases that lack merit. If plaintiffs' attorneys must invest substantial amounts of time and money in a case, they have a strong motivation to accept only meritorious cases likely to produce a significant recovery. But this is only partly true. Although rational self-interest filters out many potential legal actions, the criteria typically applied by the plaintiffs' counsel to case selection favor less meritorious cases with great economic value over more meritorious claims with limited compensable injury.

The second critical player in the medical malpractice litigation process is the plaintiff's medical expert. Medical malpractice cases are negligence actions in which the plaintiff alleges an injury that results from a breach of the standards of care accepted in the medical community. A breach of the standard of care can be proven only by the testimony of an expert licensed in the field of the defendant's practice. Historically, the need for a medical expert protected doctors from a great many frivolous lawsuits. Unfortunately, professional reluctance to offer testimony critical of a colleague also prevented a great many injured patients from proving very legitimate claims. This gatekeeping arrangement has been undermined by the development of a corps of professional physician witnesses, many of whom have never practiced in the particular medical specialty in which they profess to be expert, but are willing to testify in exchange for five-figure retainers. (It is, in fact, a very attractive career alternative for physicians who have become disenchanted with the practice of medicine due to the risk or reality of being sued for medical malpractice.)

The third critical player is, of course, the judge. There are several ways the judge can eliminate frivolous lawsuits and moderate the size of the awards jurors give. The judge's most important function in a medical malpractice trial is to rule on the qualifications of expert witnesses and thereby the admissibility of their testimony. As a matter of law, the judge is required to exclude evidence that is not scientifically supported and to preclude the introduction of expert testimony that lacks an appropriate factual foundation. When a judge fails to enforce meaningful limits on the type and quality of expert testimony that the plaintiff introduces, she increases the odds that the jury will make an unsupportable decision.

The judge can also affect the integrity of the medical malpractice litigation process through her rulings on cumulative evidence. Typically, each side is permitted to call only one expert witness to support its assertions about a particular claim or defense. Since the jury must decide what the accepted standards of practice are, the dispute between the plaintiff's expert and the defense expert often comes down to a contest over who can be more persuasive in describing their view of the generally accepted standard of care, rather than a true presentation of facts that establish standards in the medical community.

A vital role of the trial judge in a medical malpractice case is to determine what evidence from the experts actually gets presented to the jury. Sadly, most judges are very reluctant to decide what is appropriate expert testimony. They often permit anyone with a basic license to practice medicine to testify in any area of specialty or subspecialty, regardless of their training and experience in those areas. The judge's usual reaction to an objection to the qualifications of a medical expert is that those objections go not to the admissibility of the evidence but to its weight, which is a determination to be made by the jury.

Unfortunately, medical expert testimony, particularly for the plaintiff's expert, typically amounts to little more than a description of the individual's personal practice, or their training during medical school and residency, represented as the accepted standard of practice. The reason for this shallow exploration of medical standards is that judges are inclined to strictly enforce rules regarding cumulative evidence and hearsay. The hearsay rule prohibits introduction of statements, opinions, or medical literature to prove the truth of the matter contained in the statements unless the information is delivered in person before the jury. However, the cumulative evidence rule prevents multiple witnesses from testifying as to accepted standards of practice. The introduction of medical literature to document the range of acceptable practices is similarly barred on the grounds that it is hearsay. This makes for a true "Catch 22": you can only prove what a group of people believe to be true by proving what each of them individually believes is true, but you are barred from presenting multiple witnesses who all say the same thing. While these rules may provide efficiency and produce a just result in general liability litigation, they create an enormous obstacle to establishing "accepted" standards in the practice of medicine. It should be borne in mind that the plaintiff's medical expert has a significantly easier task than the defendant's expert. The plaintiff's expert has merely to assert that if the defendant had only followed the course of treatment advocated by the plaintiff's attorney, then in the opinion of the plaintiff's expert, the plaintiff's injury would not have occurred. But the defendant's expert must establish that how the physician rendered treatment was appropriate in spite of the always-present fact that the plaintiff did not obtain an optimal result.

Another obstacle presented to defendants by the medical malpractice litigation process is that judges are reluctant to permit bifurcated trials. Bifurcation, which is common in non-malpractice negligence actions, permits the jury to hear evidence about, and reach a verdict on, liability before hearing testimony concerning damages and deliberating on an appropriate award. The rationale for not bifurcating medical malpractice litigation is that in "med-mal" cases several of the plaintiff's goals—establishing departure from accepted standards of practice, establishing a causal connection between the malpractice and the injury, and determining the extent of the plaintiff's disability—require the same medical witnesses. By contrast, in a typical general liability case, the witnesses necessary to establish liability are non-medical, but the witnesses needed to establish causation and damages are medical experts. The problem this poses for medical malpractice defendants is that they must provide their liability defense to a jury whose sympathies are affected by testimony concerning the extent of the plaintiff's injury. Also, the med mal defendant has to wrestle with whether advancing a vigorous defense on damages, which reflect the extent of the plaintiff's injuries, will lead the jury to think that the defendant is conceding liability.

The medical malpractice litigation system has also been criticized for the lack of guidance it gives jurors about what constitutes fair and adequate compensation for an injury. For all practical purposes, jurors are told simply that the amount of money they award should only compensate the plaintiff for injury, not reward for misfortune. Very often, juries will ask the judge whether there are standards or tables to use in arriving at a dollar amount for an award. They are told that no such guidance exists, and that they should use their judgment.

The third leg of the medical malpractice crisis, the dysfunction of the insurance system, is rooted in two basic economic facts. First, the money available to pay the judgments and settlements incurred by the insured is no longer subsidized by the substantial earnings on investments that insurance companies obtained prior to the current economic downturn. This means there are fewer dollars available to pay for doctors' malpractice settlements and judgments. Second, while physicians are obligated to obtain their insurance policies from a market-driven insurance industry, they practice medicine in a highly regulated system that does not permit them to freely pass along to their customers, the patients, the increased cost of their malpractice insurance.

For the dozen or so years since the last medical malpractice crisis, insurance companies have benefited from investment income from doctors' premiums. That income gave the companies additional resources to pay settlements and judgments. In those rich days, insurance companies would often settle claims strictly for business reasons, without regard to the impact of the settlement on the doctor's reputation or the long-term inflationary effect of paying quick and easy settlements to plaintiff's lawyers. The clear, and clearly unanticipated, effect was a dramatic increase in the economic expectations of plaintiffs. In recent years, insurance companies have lost much of that revenue stream while also confronting dramatic growth in the size of jury awards. For while it is true that the number of medical malpractice lawsuits has dropped in recent years, the number of dollars paid out has been steadily and dramatically increasing. What this tells us is that plaintiff's lawyers are taking a smaller number of cases, each of which has yielded a higher payout. This phenomenon is not due exclusively to a reduction in the rate of medical error and iatrogenic injury. It also represents a simple, reasonable business judgment on the part of plaintiff's attorneys to take on a smaller number of more lucrative cases. And that decision in turn reflects the growing cost of prosecuting a malpractice action. Even a relatively simple medical malpractice action can cost a plaintiff's attorney thirty to forty thousand dollars to bring to trial. Plaintiff's attorneys are less likely to bring a case worth seventy-five to one hundred thousand dollars, no matter how strong the likelihood of success, than they are to bring a multi-million dollar case with a questionable liability claim.

Not only do malpractice premiums no longer pay for settlements as well as they once did, but in our heavily regulated and economically unbalanced health care delivery system, doctors, and to a lesser extent hospitals, are unable to pass along the cost of higher premiums. In a true market model, the increasing costs of malpractice insurance would not create a serious problem. All providers would be affected more or less equally, and those whose quality of care was deficient would be forced out of business by higher premiums. But with market forces encouraging plaintiff's attorneys to favor "big dollar cases" over "strong liability cases," the invisible hand of the market is moving us in the wrong direction. It is the significant number of claims with major

damages and weak liability claims that are siphoning off money from the insurance pool, inflaming the medical profession, and leaving the truly deserving without recourse. This is producing intense animosity in physicians toward plaintiff's lawyers, government, the insurance industry, and even their own health care institutions. Worse yet: enormous numbers of people who have legitimate grievances against the medical profession and health care delivery system cannot find lawyers willing to take on their cases.

So there you have it. Doctors are frustrated about frivolous lawsuits for good reason. Patients are frustrated about the lack of a forum to seek redress because they cannot find a qualified attorney who will take the case, due to the high cost of prosecuting a malpractice lawsuit. And a significant segment of the patient population is disappointed with, or disgusted by, both the medical and legal professions. They also feel victimized by their government's lack of ability to provide an effective means to redress their grievances.

What should we do, and what can we do, to improve the system? President Bush says that liability reform is “a national issue requiring a national solution,” and that he wants to curb the “proliferation of baseless lawsuits.” He also says that he can accomplish this by legislating a hard “cap” of \$250,000 for non-economic awards and by eliminating joint and several liability, which requires co-defendants to pay more than their apportioned share of the jury award. Sadly, each of the president's contentions and solutions is wrong. In fact, his remedies might exacerbate an already bad and fragile situation.

Liability reform is not a national issue, and it does not lend itself to a uniform, national solution. Here is why: When the President talks about a \$250,000 cap on non-economic damages, he refers to the component of a jury's award commonly known as “pain and suffering.” But that is a dated and inaccurate characterization of non-economic damages, one that obscures the reason some plaintiffs deserve significant compensation for their injuries, and in amounts that vary depending upon where they live. Non-economic damage awards are really awards for loss of enjoyment of life. They represent the cost of restoring the plaintiff as nearly as possible to the quality of life that he enjoyed before the injury. Some of that money surely represents compensation for the physical pain during and following an injury, but a more significant portion represents the actual cost of adapting the plaintiff to pursue whatever profession or avocation gave the plaintiff's life meaning before the injury. If, for example, the plaintiff was an avid cyclist before losing his vision, the cost of restoring him to his former quality of life as a cyclist might involve adaptive equipment or employing a cycling guide. That is not a pain and suffering expense, but neither is it an economic harm like loss of income or the cost of medical treatment.

The cost of such accommodations is an inherently regional issue because the availability of other forms of recreation or fulfillment and the availability of organizations and support groups varies from place to place. Even the cost of employing a guide will be tied to the local wage scale. Likewise, the cost of real estate can profoundly affect the expense of any accommodations for an individual's injuries. If as a result of harm the plaintiff is confined to a wheelchair, the cost of facilitating that individual's mobility might be limited to the cost of building a ramp—if he lives in a rural environment in a ranch style house. The cost will be quite different if he lives in an

urban fifth floor walk-up and must relocate to a place with suitable accommodations. In short, both a cap on pain and suffering and a uniform dollar amount for the entire nation are inherently unfair and unequal.

The problem with eliminating the joint and several liability rule is that doing so will only enrich insurance companies, which will be called upon to sell ever-larger insurance policies to individual practitioners who want to do business with or practice at institutions. This is because the institutions will become targets of opportunity for direct claims of negligence. Plaintiff's attorneys are constantly making strategic decisions as to which claims to pursue in any given situation. More often than not, they can focus their attack depending on the perceived availability of a cash recovery. Changing the joint and several liability rule will simply motivate plaintiffs to shift their focus to direct liability claims against the deepest pocket, namely, the institution. The net effect is that everyone needs more insurance.

The president's proposals are no solution. But neither are the Democratic proposals offered during the 2004 presidential campaign. Requiring certificates of merit for lawsuits has been tried and has done nothing to eliminate frivolous suits. The Democrats' proposal, which is current law in New York, requires an affidavit not from the medical expert, but from the plaintiff's lawyer. The lawyer merely has to represent that, after consulting with a physician, he has concluded that the claim is meritorious. Lawyers who are inclined to bring frivolous claim can get around this requirement by limiting the information provided to the physician, thereby ensuring that the physician will find the claim to be valid.

Non-binding mediation has been and will remain available, but it rarely resolves major claims. Plaintiffs rarely agree to mediation of frivolous claims because the leverage that gets a large settlement is the fear that the jury won't understand a medically complicated defense. A meeting of the minds based on an informed, rational analysis is therefore not the plaintiff's objective. Since mediation is voluntary, it can work only if both sides are sincere and open-minded.

Finally, the concept of "three strikes and you're out" for lawyers who bring frivolous suits sounds good, but someone has to make the determination that the suit is frivolous. Any peer-review system capable of making that determination could much more easily just dispose of the lawsuit in the first place.

The real solution to our current predicament is to ensure fairness to both the practitioners and the patients, thereby re-directing the dollars from those with significant injuries but frivolous claims to those who have truly suffered harm and need a cost-effective means of getting compensation. To do that, we have to start by clearly defining accepted standards of medical practice so that both physicians and injured patients can respect the determination that a departure has or has not occurred. And to define those standards, we need to take the job of evaluating compliance with standards of care out of the hands of judges and jurors.

Judges are very good at making procedural and evidentiary decisions that relate to protection of individual rights and privileges. Juries are very good at ascertaining simple facts about, for example, who is telling the truth about what actually happened on a given day in a particular location. Neither judges nor jurors are particularly well equipped to gauge the capabilities of

modern medicine and whether an individual physician's conduct conforms with accepted standards of practice.

Moving the responsibility for making determinations of standard of care out of the courts will yield an additional benefit for adjudication of medical questions. We will be able, once and for all, to stop using the tort system, the “battle of the experts,” as a surrogate for professional discipline and quality assurance. Standard-of-care questions should be resolved by objective panels of disinterested experts, either through a court appointment process or through private arbitration.

It is outrageous that a physician who settles a medical malpractice lawsuit, be it for business reasons, because medical records are lost, or because a witness is not available, can end up losing her right to participate in a managed care plan, effectively ending her career. Florida's recently adopted “three strikes and you're out” statute for physicians is a particularly grotesque manifestation of this approach. It will only manufacture more lawsuits and force more settlements, and therefore further alienate doctors and increase insurance costs. Rest assured that some plaintiffs' attorneys will seize the situation for tactical advantage and target doctors who have already taken a single case to verdict unsuccessfully, knowing that no physician would risk a second adverse adjudication.

If adjudication of standard of care questions by an independent, perhaps court-appointed panel of doctors, lawyers, and health care consumers is not an appropriate vehicle in a particular community, then we need to substantially bolster the intellectual integrity of our current system of “trial by medical expert.” First, we should enforce legitimate standards for minimum qualifications for expert witnesses. In our current age of medical specialization and sophistication, it will not do for an orthopedist to testify as an expert in an obstetrical malpractice action. Second, if we continue to use juries to decide standard of care questions, we must allow a full and detailed presentation of all scientific evidence, including consensus statements from the medical boards, that will enable the jury to do more than just choose between two experts' conflicting opinions. There is a very good reason that accepted standards of practice are not published in textbooks or issued in government regulation. Standards of practice are continually evolving and embrace multiple, sometimes competing approaches.

Since the burden of proof in civil litigation rests with the plaintiff, the plaintiff's expert should have the burden of demonstrating not only that his assertion of accepted standard of care is valid, but also that it is widely acknowledged by the medical community that the defense expert's position is not. To accomplish this, it is necessary that we either eliminate or modify the qualified immunity given to medical experts when they testify in court. Physicians who decide to ply their skills as courthouse medical experts should not be permitted to testify with complete impunity. They should be held accountable for their statements and the consequences of their actions. Historically, the close-knit nature of the medical profession served as a regulator of courtroom behavior, but the introduction of the business model to medical practice has disabled that mechanism. It must be replaced. If medical experts were held accountable, were subject to suit, and had to buy malpractice insurance themselves, the marketplace would quickly eliminate the charlatans from the ranks.

Finally, some system must be created, whether it is a private mediation/arbitration forum or a government-administered medical small claims court, to meet the needs of those whose claims are not economically interesting enough to attract a qualified lawyer. A place must be found where these minor cases can be aired, claims validated or put to rest, and appropriate compensation sought.

The crisis we now confront is not complicated, and the solutions are simple. But at the same time, the solutions are not easy. It is incumbent upon all stakeholders in the health care delivery system to insist not simply that the number of lawsuits be reduced or that insurance premiums be mitigated, but that the system of malpractice litigation be made more serious and more scientific. Only then can we hope to achieve the goal of openness and honesty in our effort to reduce medical errors, and rebuild trust between doctors and patients.