Adverse Medical Outcomes and Tort Reform

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Society has become increasingly litigious. To quote the Chief Justice of the Supreme Court, Warren Burger, "The public has an almost irrational focus—virtually a mania—on litigation as the way to solve all problems!" Personal misfortune is no longer personal; someone, anyone, no matter how remote or even tangential, has to pay. Our national motto is no longer "In God We Trust"; rather, we have adopted "See You in Court!"

This litigious mania is fueled to a significant extent by greed and gambling instincts. Unreasonable, eye-popping awards whet the appetites of ambitious lawyers and imaginative plaintiffs. The courtroom, where the emotions of the jury can be manipulated by the "theatrical performance" of the attorneys and a persuasive injury, is often not the site of justice but rather a pseudo-lottery where the name of the game is "Strike It Rich."

It is in this societal environment that medicine is practiced. On one hand, medicine is motivated by societal expectations to acquire a comprehensive understanding of the pathophysiology of disease and injury in human beings. This understanding is expected to result in more sophisticated diagnostic procedures, effective medications, and essential operative procedures. Society fails, however, to recognize and accept that as the effectiveness of medical care is enhanced, the potential for an adverse outcome is also greatly increased. This potential for an adverse outcome is to a large extent an inherent possibility of the pathophysiology of the disease or injury, the diagnostic studies, the surgical procedure, or the therapy prescribed. As an inherent possibility of effective medical diagnosis and therapy, adverse outcome is all intertwined with human error and infrequently with negligence on the part of the physician. Medical care with this potential for adverse outcome is therefore an ideal area for litigation.

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Professional liability, medical malpractice, as it relates to physicians is then a matter of sorting out the adverse outcome inherent in the pathophysiology of the disease or injury from the adverse outcome ascribable to human error or negligence on the part of the physician. Therein lies the problem. The present system of dispute resolution uses litigation or the threat of litigation as the primary method to establish fault and fix compensation for the patient-plaintiff.

Compensation of patient-plaintiffs who sustain an adverse outcome as a result of medical care depends upon the establishment of fault or "failed duty" by the physician-defendant. The process by which fault is established is often slow. For example, the weighted average number of months from incident to trial date for medical malpractice jury verdicts in Washington State from 1966 to 1985 was 57 months, or 4.75 years. The average number of months for 1984 was 77 and for 1985 was 54. Actuarial studies find that it will require 13 to 14 years, that is, until 2000 AD, before all the incidents involving medical malpractice arising out of the medical care for 1986 are resolved.

Not only is this legal process to establish fault inordinately slow; it is excessively costly. The cost of medical malpractice claims in Washington State for 1986 will ultimately approximate $90 million. Insurance carriers will charge $16.8 million as their expense costs. The remainder, $73.3 million, compensates the injured patient-plaintiffs and funds the legal process. The patient-plaintiffs will receive $27.9 million, or 38 percent, of the compensation dollars. The legal process, or transaction costs for attorneys' fees and litigation expenses, will consume $45.4 million, or 62 percent, of the compensation dollars. The plaintiff's attorneys alone will take $32.8 million, or 45 percent, of these funds.

In addition, defensive medicine in the form of extra tests and studies ordered by the physician to document protectively his or her management of the disease will cost an estimated 14 percent of the health care expenditures, or approximately $630 million in Washington State for 1986.

The legal process to establish fault and compensation in medical malpractice claims can be described as

inordinately slow, excessively costly, and unjust. Where is the justice? Is it just and equitable for an injured patient-plaintiff to be awarded $2,350,000 for general and specific damages only to have his or her attorney take $940,000 (40 percent) in fees plus $329,000 (14 percent) for litigation expenses, leaving the injured patient-plaintiff with only $1,081,000 (46 percent)? Is the intent of the jury to compensate fairly the injured patient-plaintiff compromised by this distribution of the award?

What are the causes of this crisis in medical malpractice? Why has our legal system become so slow, costly, and unjust?

The answer to the first question is clearly that there are more opportunities for adverse outcomes from the more sophisticated and complex medicine practiced today in a society with a primary focus on litigation as the solution for all personal misfortune.

What of the second question? In October 1985 the Attorney General established an interagency working group of representatives of ten government agencies and the White House. This working group, the Tort Policy Working Group, was directed to examine the rapidly expanding crisis in liability insurance availability and affordability. Its report was completed and published in February 1986 under the title, *Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability.*[1]

In the executive summary of that publication the authors summarize their answers to the second question as follows:

> [There is] a movement toward no-fault liability, which increasingly results in companies and individuals being found liable even in the absence of any wrongdoing on their part.
> [There is] an undermining of causation through a variety of questionable practices and doctrines which shift liability to "deep pocket" defendants even though they did not cause the underlying injury or had only a limited or tangential involvement.
> [There is] an explosive growth in the damages awarded in tort lawsuits, particularly with regard to noneconomic awards such as pain and suffering or punitive damages.
> [There] are excessive transaction costs of the tort system, in which virtually two-thirds of every dollar paid out through the system is lost to attorneys' fee and litigation expenses.

The objectives of any effort directed at tort reform should focus on changes that would reduce injuries to patients, provide reasonable compensation to injured patients, accelerate the resolution of claims, reduce the transaction costs of the legal process, and reduce the cost of professional liability insurance. In the Tort Policy Working Group's report they provide a list of tort reforms that are recommended to alleviate the present crisis in insurance availability and affordability:

1. Return to a fault-based standard for liability.
2. Base causation findings on credible scientific and medical evidence and opinions.
3. Eliminate joint and several liability in cases where the defendents have not acted in concert.
4. Limit noneconomic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount.
5. Provide for periodic (instead of lump sum) payments of damages for future medical care or lost income.
6. Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
7. Limit attorneys' contingency fees to reasonable amounts on a sliding scale.
8. Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

To this list should also be added those efforts that will reduce the instances of adverse outcomes from medical care, that is, a fair and effective medical disciplinary system that will exclude from practice those physicians whose practice behavior does not meet acceptable standards. Further, there should be regular participation of all physicians in effective risk management programs as a condition of licensure.

If these statutory changes can be fully implemented in the various states along with effective risk management and medical disciplinary programs, there is no doubt that the number of adverse outcomes to patients and the cost of compensation in those instances of physician fault can be substantially reduced.

Reference

1. Attorney General's Tort Policy Working Group: Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability. Government Printing Office, February 1986