



Ethan Allen Institute

4836 Kirby Mountain Road
Concord VT 05824
Voice 802 695 1448, fax 802 695 1436
eai@ethanallen.org www.ethanallen.org

January 26, 2005

Reforming the Medical Malpractice System

Presented to the BISHCA working group on malpractice reform by
John McClaughry, President, Ethan Allen Institute.

Introduction: Medical malpractice liability has been a growing problem throughout the country. Although Vermont has not yet felt the brunt of dramatically higher premiums, it is only a matter of time before large jury awards drive up premium rates and perhaps more importantly, force medical providers to practice costly ultra-defensive medicine. Aggressive tort litigation causes a serious morale problem among providers, especially in ob-gyn and neurology, who feel that they have been targeted by plaintiff's trial attorneys not just for gross negligence, but for arguable errors of judgment or technique that led to unhappy patient outcomes.

Every patient deserves to have a remedy at law for the negligent actions of a provider that cause significant injury. But the system that affords that remedy must also be structured in a way that minimizes or excludes aggressive tort actions driven by the pecuniary dreams of patients and their attorneys. Striking a balance that most Vermonters would consider fair is not an easy task.

I am here today to suggest a number of possible changes to the present medical malpractice system. I do not pose as an expert. I am neither an attorney nor a medical professional, and I have never been involved in a malpractice case. My contribution, such as it may be, comes from my forty years as a public policy analyst, including considerable work over the past decade in the field of health care generally. What I hope to do is stimulate your thinking. Some of the proposals I present today may not be compatible with other proposals, and some may give rise to new problems that, with my lack of expertise, I have not foreseen.

Before I go down my list of ideas for consideration, let me address the leading issue of caps on compensatory damages. Such a cap - \$250,000 - has proven to be very effective under the California MICRA law in slowing the rise of premiums. It has also had the unfortunate effect of precluding some seriously injured plaintiffs from obtaining strong representation by qualified counsel. In effect, the California cap says that taking a malpractice case is not economically justified unless the defense can be presented for less than \$83,000. I am thus reluctant to advocate a general cap on compensatory damages, at least until other changes fail.

I am also reluctant to impose a ceiling on attorney's fees. As a long time friend of freedom to contract, and an opponent of price controls, I continue to believe that the arrangement made between lawyer and client should be their business, and not the government's.

That said, let me very quickly offer some concise and heuristic suggestions for your consideration.

1. Provider Tort Formulary

The purpose of this feature is to define, as far as possible, an “unsafe haven” of practice, where a provider is subject to summary judgment. The statute would define gross negligence as, inter alia, being drunk or on drugs while working, operating on wrong organ or limb, leaving tools in the patient; prescribing a drug not approved for the condition, etc. If the cause of the alleged tort is on the list, the prevailing plaintiff would get full economic and compensatory damages determined by jury, as at present.

If cause of the tort is not on the list (i.e. doctor’s erroneous judgment call), the plaintiff may sue to recover full economic damages, but pain and suffering damages would be capped at \$250,000.

A plaintiff may argue that an action of comparable seriousness ought to be on the gross negligence list, but wasn’t thought of by rulemakers. The judge would decide.

2. Practice Guidelines. This policy, implemented in Maine in 1992, is the inverse of the “provider tort formulary”. If the provider practiced according to medically approved guidelines, that would be a conclusive defense against the charge of negligence. Plaintiffs would have to prove that the provider unreasonably deviated from the guidelines, and if successful, they would be entitled to economic and compensatory damages.

3. Patient Negligence Formulary: If after being informed by the provider, the plaintiff patient gives materially false answers on medical history, neglects to take medication, takes the wrong medication, fails to follow doctor’s orders, etc. such negligence by the patient would either defeat the suit, or reduce the award.

4. Medical Malpractice Review Board: This board would be composed of retired judge and respected citizens with some medical knowledge. On defendant’s request, the Board would review demand letters and the suit. If it finds frivolity, and plaintiff takes case to trial anyway and loses, the plaintiff’s lawyer would become liable for defense costs and the finding of the frivolity and the case judgment would be reported to bar counsel for professional discipline of plaintiff’s lawyer. An extension of this proposal is the Health Court, which serves the review function and also adjudicates the case. Mandatory arbitration is another variation. If a party appealed an arbitration result to a court and lost, that party would be liable for the prevailing party’s legal costs.

5. Court Appointed Expert Review. The court would appoint a neutral expert to examine the merits of the case before trial and present the findings to both parties. If the case goes to trial, the court may ask the expert to present his/her views to jury. Fees to pay the expert would be assessed pro rata on parties based on the total non-economic damages sought, but the defendant’s share of pro rating is limited to \$250,000 (i.e., if plaintiff seeks a total of \$1,000,000 in non-economic damages, plaintiff would bear $1000/1250 = 4/5$ of assessment.)

6. Wrongdoing Exclusion: Pain and suffering damages should not be based on the provider’s wrongdoing, but only on jury-determined value of actual pain and suffering incurred. This rules out presentation of “guilt evidence” to inflate compensatory awards (and thus attorneys’ fees.).

7. Joint and several liability prohibited: Juries should apportion liability for the award among all the defendants, rather than allow the plaintiff to recover the entire judgment from one deep pocket defendant.

8. Collateral Source Offset: Courts should offset payments from collateral sources in determining awards due from medical malpractice insurers.

9. Liability Contract: The statute should allow informed patients and providers to agree in advance of treatment on limits of provider liability, using a state-approved contract form. This should be required for Medicaid-financed treatments. For instance, patient and doctor might agree that the doctor would only be liable for gross negligence under the provider tort formulary, and not subject to suit for deviation from practice guidelines.

10. Online MedMal Registry. There should be an online registry of plaintiffs and their lawyers and defendants and their lawyers, listing the plaintiffs' demands, review board opinions, chronology of the trial, judgments reported (but not amounts of pre-trial settlements), and results of appeals.

11. Jury Patriotism Act. This statute would impose an obligation on all citizens to serve with provisions for excusal, and would create a compensation pool (perhaps funded by punitive damages and small assessment on parties) to make it possible for working people to leave their jobs and serve.

12. State-sponsored Malpractice Insurance Company. In 2003 West Virginia, faced with severe malpractice premium increases and the disappearance of a competitive market, set up its own "West Virginia Physician's Insurance Company". The company was partly funded by a state note, partly by assessments on doctors and insurance companies, and partly by tobacco settlement funds.

The act also set a \$250,000 cap on noneconomic damages and \$500,000 per occurrence, eliminated joint and several liability, and provided for collateral source offset. The company is limited to 60% of the state market and cannot be privatized.

The dynamic for a state-sponsored company is that the state can set the liability rules that make the amount and number of awards more predictable, and the state's company can set its rates accordingly. In other words, the state could make it so difficult for plaintiffs to recover than the company could break even with low premiums. This involves a certain amount of moral hazard, where the pressure to avoid a state budgetary drain or a premium increase could trump justice for injured plaintiffs. Nonetheless the idea is worth exploring.

#####

No doubt much of the foregoing has already been the subject of expert discussion within this working group. Since all of you have much more expertise in the subject matter than I do, I submit these ideas only for their heuristic value, as you strive to find an appropriate balance that protects the right of injured Vermonters to be compensated for torts, but also frees Vermont's doctors and other providers from unreasonable demands and ultimately unaffordable insurance premiums.

Thank you for the opportunity to speak to you today.