

Medical Malpractice in the 21st Century

By Bruce G. Fagel, MD, JD

It has been more than 35 years since the California Legislature passed the Medical Injury Compensation Reform Act (MICRA) in response to a perceived “crisis” in the availability and cost of medical liability insurance. A keystone of this legislation was the limit of \$250,000 on non-economic damages which has been cited by proponents of tort reform as the way to reduce medical malpractice claims. Since this cap on non-economic damages was not indexed to inflation, the practical effect is that \$250,000 today has the buying power of less than \$60,000 in 1975 dollars. If the MICRA cap had been indexed to inflation, it would now exceed \$1 million.

While there has been a reduction in the number of attorneys in California who are willing to pursue medical malpractice claims and certain types of claims are not being filed because of economic concerns to attorneys who are paid on a contingency basis, medical malpractice cases have not disappeared. In the meantime, the cost to litigate catastrophic injury cases



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has increased over the past 35 years, and will continue to increase in the future. This change has occurred as a result of a combination of public perceptions about medical malpractice, scientific and medical changes, and financial changes in the U.S. economy.

Public perceptions about Medical Malpractice

In the 1970s, health insurance became an important employee benefit, most people were satisfied with their own personal doctor, and most “community” hospitals were, in fact, part of the local community. Today, those who still have health insurance complain about both the cost and coverage. HMOs and PPOs require a primary care physician for referrals to a specialist and in many health plans, few patients

have a direct patient-physician relationship. Most “community” hospitals have been purchased by large hospital chains, and some hospitals have changed hands several times, with a significant number going through bankruptcy.

In 1999, the Institute of Medicine of the National Institutes of Health published a report claiming that 100,000 people die each year in the U.S. as a result of medical malpractice, and each year since then the public press has further reinforced these statistics with other studies and numerous anecdotal reports of medical negligence. As a result, in the last 10 years it is impossible to voir dire a prospective jury pool without having several prospective jurors who have either filed a medical malpractice claim or had a bad experience with a hospital or doctor and considered



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such a claim. Those prospective jurors who have experience with the defendant hospital will often have a negative opinion. While most medical malpractice cases (estimates as high as 70-80%) result in a defense verdict, this result is more likely due to the facts of the case rather than the reluctance of jurors to hold doctors and hospitals liable for injuries to patients. At the same time, most trial judges have a dim view of medical malpractice cases because they assume that any case with merit will settle before trial.

In addition to increased public awareness about medical malpractice, access to attorneys for the purpose of evaluating and filing medical malpractice claims has changed over the past 35 years. In the 1970s, victims of medical malpractice found an attorney through the Yellow Pages or word of mouth. Today, the Internet provides the public with a wealth of information about attorneys and information which allows research about a variety of medical problems, many of which have links to law firms. In 1975, the California Medical Association and California Hospital Association conducted a study to determine if a no-fault system similar to Worker's Compensation would be a less expensive alternative to the current tort recovery system. This study showed that less than 3% of potential negligence claims resulted in medical malpractice cases in court and it concluded that a no-fault system that compensated all individual victims of medical negligence, even with a low compensation for lost wages or medical expenses only, would be more costly than the current system requiring proof of fault. Several subsequent studies also confirmed that less than 10% of medical negligence cases end up as filings in court. While the number of cases of medical negligence that result in claims may not have increased over the past 35 years, increased access to attorneys together with improved screening of cases may result in an increase in the number of serious injury cases with clearer evidence of negligence and causation.

Medical and scientific changes

There have been many scientific and medical advances over the past 35 years which have raised the standard of care in many cases. The advent of evidence-based medicine has provided clearer

guidelines for the diagnosis and treatment of many medical conditions. In the area of hypoxic brain injuries in children, which forms the basis of many catastrophic injury cases, the use of brain cooling has become the standard of care since it has been shown to have no negative risk and it has significant positive benefit. Since such treatment must be started within 6 hours of delivery of a baby with presumed hypoxic-ischemic encephalopathy, the failure to provide such care, or the failure to transport the infant to a facility that provides such care, represents negligent care even if the underlying cause of the infant's HIE is not negligent. As a result

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of such brain cooling, many infants with mild to moderate HIE will show significant improvement in their outcome. While such an improvement may not result in a normal outcome for such children, it will likely increase their life expectancy and thus lead to a higher cost for future care. Also, while not reported in the literature, we have seen several cases of infants with severe HIE where recommendations were made for discontinuance of life support after brain cooling, but as a result of such brain cooling, these children survived with moderate to severe brain injury.

One area of medical care which will likely see an increase in claims, including catastrophic injuries, involves weight loss and cosmetic surgery. The typical case involves a morbidly obese patient who has a gastric bypass or lap band procedure and then undergoes a surgery to remove excess skin with so-called body sculpting. The length and complexity of some of these surgeries, together with the fact that many are performed in outpatient surgical centers or even in the doctor's office, increase the risk of an unwanted outcome, including catastrophic brain injury from anesthesia or excess bleeding. The fact that some of these surgeries take place on patients with significant co-morbidities related to obesity further increases the risk of a negligently-caused catastrophic outcome.

Financial changes in the U.S. economy

One part of the MICRA legislation was designed to shift the cost of medical malpractice damages by an abrogation of the collateral source rule (Civ. Code § 3333.1) which allowed a jury to consider payments by collateral sources to offset past and future medical care costs. These collateral sources included both private health insurance and public benefits. The changes in private health insurance include the fact that many people who work for large employers are now insured through self-funded insurance plans that, under ERISA, are exempted from state law and thus able to assert a lien for recovery of benefits paid. Even for those who have traditional health insurance, there has been an erosion of benefits as well as a substantial increase in premium costs, which are an offset to any benefits. In the arena of public benefits, the budget problems in California, and many other states, has resulted in many public source benefits such as CCS or Regional Center, now asserting liens against any recovery, which then exempt such benefits in the same way as MediCal is exempted from Civil Code § 3333.1. MediCare has also adopted a requirement for MediCare set aside trusts (MSA) which requires payment by the MediCare beneficiary from any proceeds of a settlement or judgment before MediCare will pay for any care. Even the school systems which are required to provide educational benefits for disabled children are having substantial budget cuts such that few jurors will be willing to shift the cost of care to such public entities.

The largest and most significant change that has affected medical malpractice claims over the past 35 years has been the financial changes in the U.S. economy. While the \$250,000 cap on non-economic damages has lost value since 1975, economic damages have increased with both wage increases and increased cost of health care. A present cash value of \$250,000 for future wage loss in 1975 is now valued at over \$1 million. But the greatest increase has occurred in health care costs, which have gone up over 700% since 1975. This means that a present cash value for future health care costs that had a value of \$1 million in 1975, now has a value of over \$7 million. Taken together, a claim that had a present cash value of \$1.5 million in 1975



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(assuming \$250,000 for non-economic damages, \$250,000 for the present cash value of future loss of earnings, and \$1 million for the present cash value of future health care costs) now has a present cash value of over \$7 million. While \$1 million in liability insurance coverage in 1975 would be considered sufficient for most claims, today such coverage is woefully inadequate.

On an individual level, unexpected health care costs not covered by health insurance are the largest single reason for personal bankruptcy.

The other significant financial change has occurred more recently in the annuity market. Traditionally, tort claim damages required juries to determine and award the present cash value of future damages for loss of earnings and health care costs, and the plaintiff could then invest the money to pay for future needs. With the enactment of periodic payments law (Code Civ. Proc. § 667.7) the use of an annuity has become the standard for settlement of any medical malpractice case with substantial future damages. The use of an annuity served an important function for both plaintiffs and defendants in medical malpractice cases. For the plaintiff a life annuity would provide benefits for as long as the plaintiff lived, even if that was longer than a life expectancy finding by a jury. For defendants, an annuity company would shift the risk for such payments to a large insurance company that would "bet" that the plaintiff would not live as long as the finding on life expectancy by a jury. In some cases, the cost of an annuity could be half of the present cash value or even less.

Two developments have occurred which have dramatically changed the annuity marketplace. First, the money earned on investment by annuity companies has decreased with the drop in long-term interest rates. Annuity companies can no longer assume an internal rate of return in excess of 6% when the interest rates on 30-year government bonds are barely above 4%. Second, and probably of greater significance, is the fact that the annuity companies are no longer willing to take

the risk that an injured plaintiff will not survive for a longer time. Despite the opinions and supportive "data" by some defense experts on life expectancy, the annuity marketplace will no longer provide age ratings that correlate to the life expectancy opinions of these "experts." At the same time, annuity companies that were previously willing to take the entire risk of a specific case, now restrict the amount of a policy they will take to \$2.5 million or less. As a result, providing an annuity in excess of \$2.5 million for future damages will require at least two or more annuity companies, which further increases the cost since the second or third company has a higher cost than the first company.

For any plaintiff who has a long-term debilitating injury that requires care for as long as they live, a life annuity is required to provide the protection that such a plaintiff needs to be able to settle their case. When the cost of that annuity is less than the present cash value based on a specific life expectancy, there is a benefit to the defendant in a settlement. But as a result of this change in the annuity marketplace, the actual cost of the annuity, or a combination of annuities, will be significantly higher, and in some cases it may exceed the present cash value determination by a jury. Thus, much of the benefit that medical defendants' liability insurance carriers got as a result of periodic payments through MICRA has been eliminated as a result of current financial marketplace condition, and that financial reality is likely to continue into the future.

Over the past 35 years, healthcare has come to dominate more and more of American life. Expenditures for Medicare and Medicaid are responsible for much of the increasing debt owed by the federal government. On an individual level, unexpected health care costs not covered by health insurance are the largest single reason for personal bankruptcy. At the same time, an aging population and an ever-increasingly complex system of providing health care will continue to dominate the debate over healthcare funding. It is thus no great leap to understand why, in the absence of the elimination of medical errors, the personal and professional cost of medical negligence will continue to increase. In the end, payment of liability claims are part of the cost of doing business for healthcare providers, and that cost will continue to increase in all sectors of healthcare in the U.S. ■



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