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AND JUSTICE FOR WHOM?

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It would be difficult to find anyone who is satisfied with the current system of resolving medical liability disputes. In approaching this subject, I have first tried to look at the issues from the perspective of each of the major constituents.

Perspectives on medical liability

Physicians' perspective. Physicians take an allegation of malpractice as a personal affront to their professionalism. It is an attack on their character and dedication, as well as their skill. A claim becomes an emotionally exhausting event for many doctors, and they may end up obsessed with defending their honor. At the extreme, competent doctors have decided to "hang it up" rather than continue their practice in an environment that would allow such an unfair event to occur.

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For physicians, medical malpractice also means they must maintain costly liability insurance that is out of proportion to that of any other profession. This egregious expense is primarily needed to protect against unjustified claims resulting from recognized complications of treating difficult illnesses. The root of the problem is the legal morass that includes an overabundance of attorneys looking for any opportunity to make a buck and an out-of-control civil justice system that allows the pursuit of unmerited allegations. The pinnacle of the absurd is reached if a case ends up in civil court. Here, juries who are not prepared to make judgments about scientifically and technically complex issues are subjected to days of theater in which the attorney with the best acting skills is likely to prevail. This occasionally culminates in an overinflated multi-million dollar award, much of which is granted for noneconomic losses such as pain, suffering, and loss of consortium.

Finally, defensive medicine, a by-product of the threat of malpractice liability, wastes valuable resources to ensure one's backside is covered. The cost of this practice may be substantial.

Patients' perspective. Patients' views of the medical liability system differ considerably from those of the physician. What if a patient is injured while undergoing medical treatment and the injury was the result of a mistake? In such a case, a malpractice claim may be the only way the patient can recoup damages for the injury.

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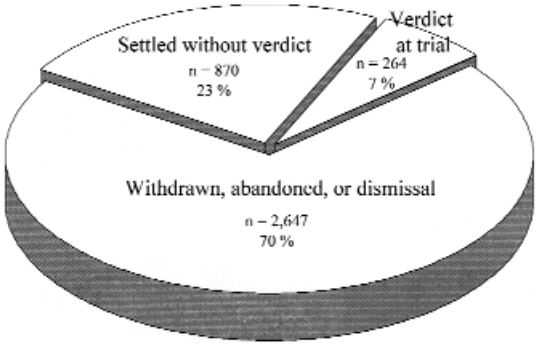

Fig 1. Natural history of malpractice claims against cardiothoracic surgeons, based on approximately 3800 closed claims in the PIAA database (1985-1997).

Funds may be needed to aid in the patient's recovery or, in the case of a permanent disability, for long-term care. There is also the issue of lost earnings.

Most patients who file a malpractice claim are angry and want to see their doctors punished for the uncaring, incompetent, and potentially dangerous individuals that they are. By suing, they may prevent the same thing from happening to others. The system is a way of getting bad doctors out in the open to be judged and "found out." While not an enjoyable process, somebody has to do it because the medical profession does a very poor job of policing itself. There is a widely held perception that physicians will not say anything negative about other physicians, particularly if there are potential liability issues involved. This "code of silence" necessitates the need for clever attorneys who can find the truth.

The legal perspective. Attorneys and the civil justice system look at medical malpractice in the same way they do any other situation in which a person is injured. That person may be entitled to damages. Why should the health care system be treated differently from others? Society had established rules and a method for deciding whether there is fault and how much payment should be made if a person is injured as a result of negligence. The civil justice system may be imperfect, but no one has put forward an alternative that "the people" believe would be more fair.

The legal perspective might also propose that the malpractice system helps to curtail bad care by highlighting incompetence. The threat of liability helps keep physicians and the system on its toes, and dangerous practice is quickly corrected.

Attorneys could point out that contrary to what physicians and the health care industry might lead the public to believe, the number of malpractice claims is not excessive. In fact, many more people are entitled to compensation than ever receive it. The primary platform for this argument comes from two widely quoted reports from the Harvard School of Public Health[1,2] that looked at malpractice claims and adverse events due to negligence. These retrospective reviews of randomly selected records of hospitalized patients from the state of New York initially screened more than 30,000 charts, and nearly 8000 were referred to a physician panel for review. From these charts 1100 adverse events were identified. These represented injuries resulting from the patient's medical care rather than from the primary illness. Among these adverse events, 280 were deemed to be due to negligence. By extrapolation, the authors concluded that about 1% of hospitalized patients had an adverse event resulting from negligence. During the same time period, the number of claims generated per hospital discharge was calculated to be 0.13%. Among the 280 study cases in which negligence was suspected, only 8 claims were actually filed (2.8% of potential claims). Not surprisingly, the authors of this study concluded that medical malpractice litigation infrequently compensated patients injured by negligence and rarely identified and held providers accountable for substandard care.

Overview of medical malpractice involving cardiothoracic surgeons

Little information exists on the number of malpractice claims filed against cardiothoracic surgeons, the nature and outcome of such cases, and the costs involved. While I was serving as chair of medical-legal affairs for The Society of Thoracic Surgeons (STS), our committee established a relationship with the Physician Insurers Association of America (PIAA). PIAA is a trade association of physician-owned and -operated medical malpractice insurance companies that has been collecting data on malpractice claims since 1985. The PIAA membership includes more than 60 carriers representing about 240,000 private practicing physicians in the United States and almost 500,000 practitioners abroad. There are currently more than 140,000 closed claims from the United States in the ongoing database, of which 3800 are attributed to cardiothoracic surgeons. The analysis described in this section comes from a review of these 3800 cases. The PIAA research department estimates that the data-sharing project captures approximately 25% of the claims against privately practicing physicians in the United States.

Malpractice claims against cardiothoracic surgeons. Cardiothoracic surgeons account for about 3% of the malpractice claims in the PIAA closed case file. They are responsible for a relatively smaller percentage, 2.2%, of all indemnity payments.

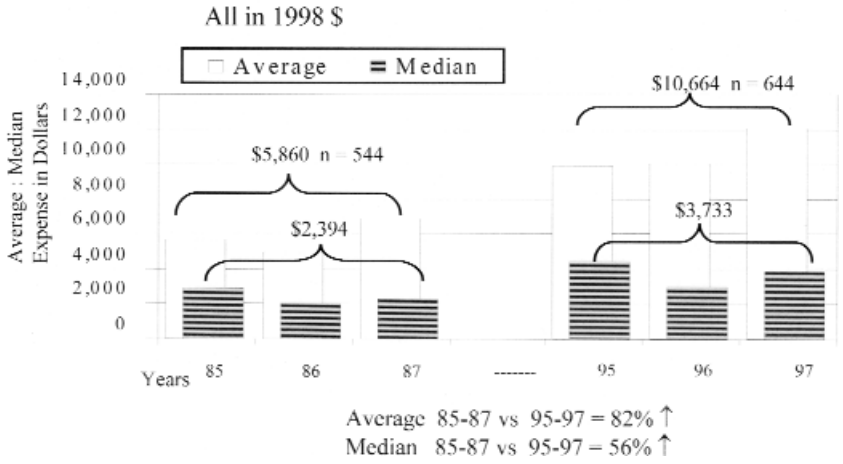

Fig 2. Claims that are withdrawn or dismissed (70% of all cases). Average and median expense for defense (in 1998 dollars).

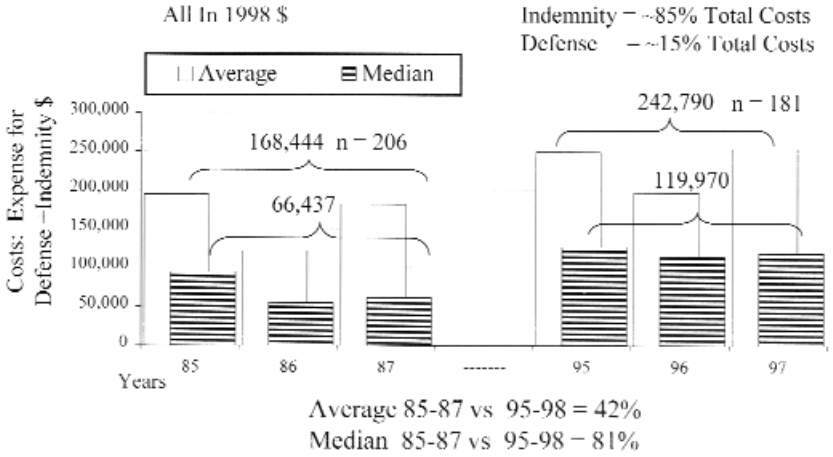

Fig 3. Claims that are settled (23% of all cases). Total costs: expense for defense plus indemnity (all in 1998 dollars).

Natural history of malpractice claims against cardiothoracic surgeons. The outcome of the 3800 closed claims against cardiothoracic surgeons documented in the PIAA database between 1985 and 1997 has been reviewed. For the purposes of this analysis, there are three potential outcomes: (1) A claim is abandoned, withdrawn, or dismissed (subsequently to be labeled as *dismissed*); (2) the claim is settled before a verdict at trial; or (3) the claim is resolved by a jury verdict. A few cases were resolved by arbitration, but the numbers were too small for a meaningful analysis.

Using the three criteria for outcome, 70% of the claims analyzed were dismissed, 23% were settled, and only 7% were resolved by a verdict at trial (Fig 1). Further, the percentage of claims that were resolved with compensation to the plaintiff over the period 1985-1997 showed no significant trend in either direction over time, with approximately 25% requiring payment. This outcome is similar to the results for the overall universe of all subspecialties covered by the PIAA data wherein 68% of claims are dismissed.

Expenditures associated with various outcomes of claims against cardiothoracic surgeons. In general, the expenditures related to a claim have been separated into the dollars spent on managing the defense (ie, attorneys' fees, fees for expert reviews, fees for depositions) and, if applicable, the dollars paid in indemnity. The expenditures for each of the three potential outcomes have been separately studied, and the trend in costs over a 10-year time period comparing the years

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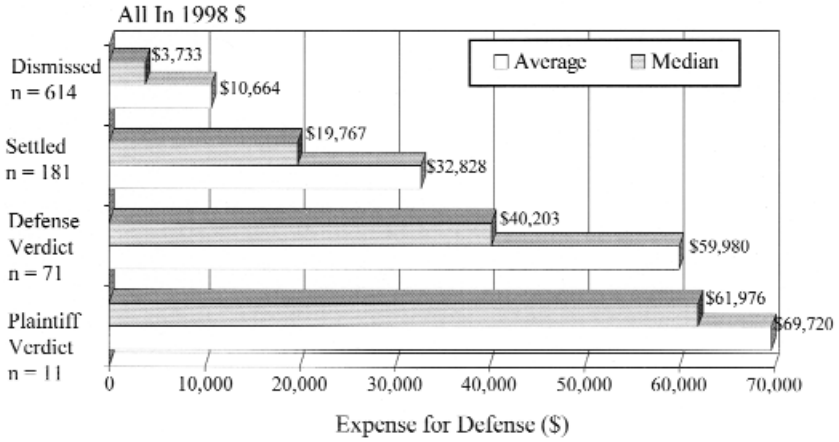

Fig 4. A comparison of expense for defense between cases that are dismissed, settled, or tried. Average and median for 1995-1997 (all in 1998 dollars).

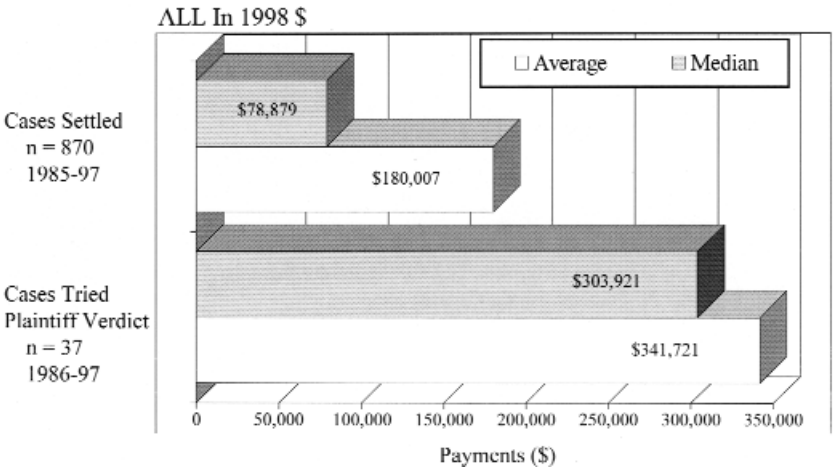

Fig 5. Indemnity payments. Cases settled versus plaintiff verdict (all in 1998 dollars).

1985-1987 to the years 1995-1997 have been calculated. All expenditures have been converted to 1998 dollars by means of a coefficient based on the rate of inflation as measured by the Consumers Price Index.

Expenditures for claims that are dismissed (Fig 2). Although 70% of claims filed against cardiothoracic surgeons are eventually abandoned, withdrawn, or dismissed, there are still significant expenses incurred for defense. Among 644 claims that were dismissed in the time period 1995-1997, the average cost per claim was $10,664 and the median cost was $3733. Among 544 claims from 1985-1987, the average was $5860 and the median $2394. All costs have been converted to 1998 dollars. Thus, over a 10-year time period, the average cost to defend a claim that is eventually dismissed has risen 82% and the median cost, 56%. These figures do not account for the substantial time that the accused surgeon often spends on his or her own defense.

Expenditures for claims that are settled without a jury verdict (Fig 3). For cases that are settled there are two sources of cost: the expense of defending the claim and the indemnity payment for damages. Although the indemnity portion makes up 85% of the total expenditure, the cost of defense for these claims is much higher than for claims that are dismissed. Among 181 claims that were settled in the period 1995-1997, the average defense cost was $31,742 and the median was $19,081. The total cost of these claims was much higher, with the average among the 181 cases being $242,790, while the median was $119,970. The difference between the average and median costs suggests a skew toward several claims with very high indemnity payments.

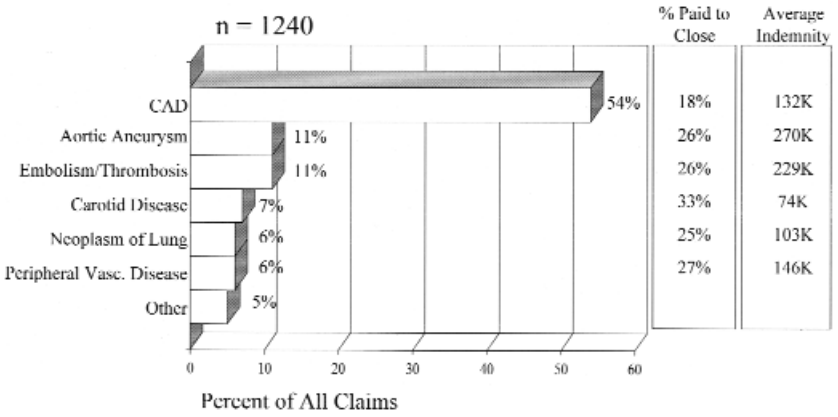

Fig 6. Conditions leading to claims against cardiothoracic surgeons with the percentage of each category where indemnity was paid, and the average payment in dollars. *CAD,* Coronary artery disease.

Table I. *Claims involving cardiothoracic surgeons by misadventure (1985-1997)*

Misadventure (n = 3560)	*Percent*	*Percent paid to close*	*Average indemnity*
Improper performance	36	28	$174,571
No misadventure	25	6	$197,458
Error in diagnosis	11	27	$161,073
Failure to monitor care	7	30	$181,869
Foreign body	5	45	$30,294
Not indicated	4	31	$164,596
Failure to diagnose complications	4	28	$182,309
Delay in performance	3	32	$212,209
Not performed	3	35	$183,090
Medication error	2	37	$267,612

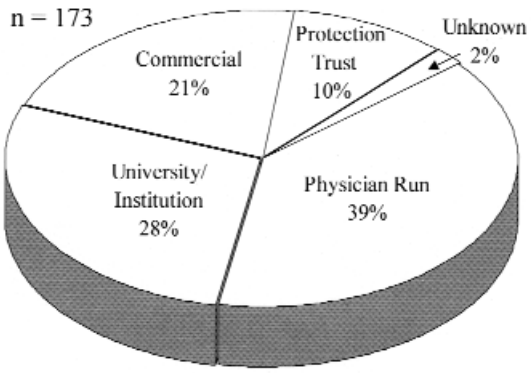

Fig 7. WTSA malpractice survey: type of coverage.

When these 1995-1997 figures are compared with the costs from 206 cases settled between 1985-1987, a significant increase in cost is apparent (even after accounting for inflation). Average costs increased 42% overall, with average defense expenses going up 98% and average indemnity payments increasing 38%. The same analysis for median costs showed an 81% increase overall and 70% and 83% rises for defense and indemnity payments, respectively.

Expenditures for claims that result in a jury verdict. This analysis has two arms with one related to cases in which there is a verdict for the defense and the other, those in which the plaintiff prevails. Among the 264 cases resolved at trial between 1985 and 1997, 86% resulted in a defense verdict and in 14% the plaintiff was awarded damages. As might be expected, the cost of defending a claim that goes to trial is considerably higher than for cases that are settled. The average is about twice as much and the median about three times the cost. Whether the case is defended or lost at trial, the cost for the defense is about the same. The average and median costs for defense for claims that are dismissed, settled, and resolved at trial in the period 1995-1997 are compared in Fig 4. The high costs of trial suggest the reason that insurance companies are often anxious to settle claims quickly for a figure that approaches the "cost of defense." This may be the case even if there is no evidence of practice that is below the standard. Although convenient and seemingly good business practice for the carrier, such settlements may encourage plaintiff's attorneys to pursue cases involving a maloccurrence, even if no negligence is apparent, in hopes of a quick pay day. Insurance companies confront a major dilemma in positioning themselves with such "nuisance suits," and some have elected to defend when expert review suggests no breach of the standard

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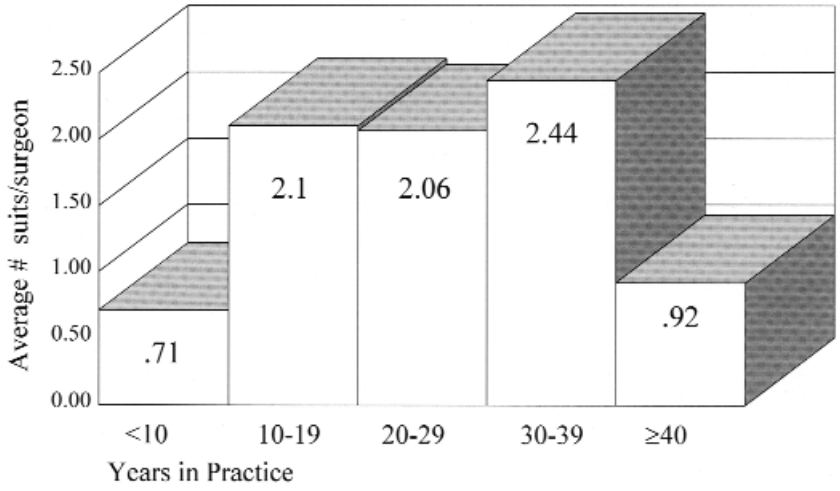

Fig 8. WTSA malpractice survey: frequency of suits/years in practice.

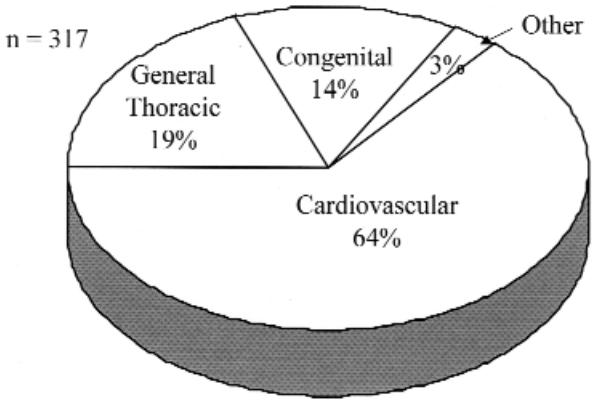

Fig 9. WTSA malpractice survey: malpractice claims by type of care.

of care. Although initially more costly, this strategy may be more cost effective in the long run.

Finally, there is the matter of indemnity payments for cases that result in a jury verdict for the plaintiff. The number of cases available for analysis is relatively small (n = 37) and the range of awards is large, making it difficult to assess whether there has been a significant upward trend in damages over the period 1985-1997. However, when compared with indemnity payments for cases that are settled, damages awarded by a jury are two to three times higher (Fig 5). There may well have been an attempt to settle these cases, but at a value deemed inadequate by the plaintiff. It should be remembered that the plaintiff's attorney does take a significant risk when going to trial, since according to the analysis of PIAA data, the chance of prevailing is only about 15%.

Cardiothoracic surgery versus other subspecialties: Indemnity payments. Overall experience from 1985 to 1997 shows that the average indemnity expenditure per file requiring payment was $162,584 for cardiothoracic surgery claims. Of the 27 specialties recognized by PIAA, cardiothoracic surgery ranked ninth, with specialties like neurosurgery, obstetrics-gynecology, cardiology, and anesthesia being higher. As an example, the average expenditure per paid file for neurosurgery was about $235,000.

Conditions that result in claims against cardiothoracic surgeons. The PIAA database has grouped claims into general categories by type of disease. Not surprisingly, the majority of cardiothoracic surgery claims, 54%, are related to coronary artery disease, which has been arbitrarily subdivided into coronary atherosclerosis, acute infarction, and chronic ischemia. Aortic aneurysm and peripheral vascular problems comprise other higher incidence conditions. Fig 6 summarizes the information on the conditions that most often lead to claims, including data on the percentage of such claims requiring indemnity payment and the average indemnity paid.

Type of misadventure resulting in claims against cardiothoracic surgeons. The Data Sharing Project has also arbitrarily catalogued the nature of the problems resulting in claims against our specialty. As might be expected, the most common alleged misadventure was "improper performance of a procedure," which accounted for 35% of closed claims. It is notable that in 25% the insurer could identify "no misadventure," yet a few of these cases had to be settled anyway. Table I tabulates the relative incidence of misadventures and

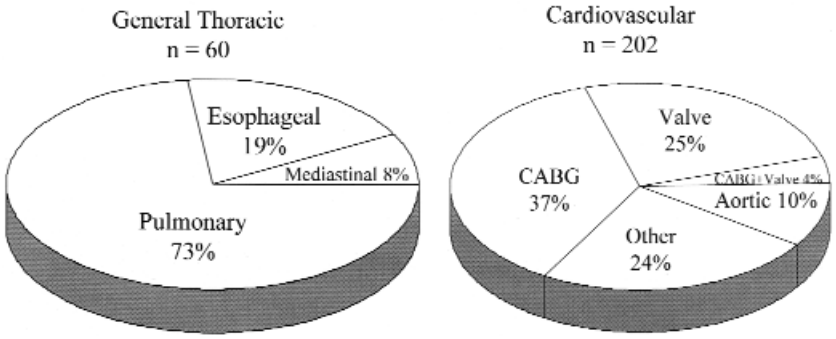

Fig 10. WTSA malpractice survey: malpractice claims by type of care. *CABG*, Coronary artery bypass grafting.

reports the percentage of such claims requiring indemnity payment, as well as the average cost.

Malpractice experience among members of The Western Thoracic Surgical Association (WTSA)

With the idea of obtaining a "snapshot" of medical malpractice in the western part of the United States and Canada, we have surveyed members of the WTSA to learn of their experience. Of 384 active and senior members surveyed, 173 responded (45%). There was proportionate representation from each of the states included in the WTSA's region, although a large number of the respondents were from California where the majority of our members practice.

The median respondent to our survey has been in practice between 20 and 29 years. Although the type of malpractice coverage spanned the options (as depicted in Fig 7), a significant number, 28%, were insured through the institution or university where they were employed. This is probably an aberration of the academic skew common to several of our societies. The median cost of malpractice coverage for all respondents was between $20,000 and $25,000, which reflects the relatively high proportion of respondents in academic practice and the fact that the majority were from California, where tort reform has helped reduce premiums.

More than 75% of those responding to our survey had been sued, and the average number of suits per surgeon was two. When we compared the average number of suits with the number of decades in practice (Fig 8), we found no significant difference except that among those practicing for 40 years or more, the incidence was lower. We were unsure whether these more senior respondents had practiced, at least in part, in a "kinder" era, or whether they had just forgotten some of their earlier experience. Fig 9 shows the incidence of malpractice claims by type of operation and is roughly proportional to the incidence of cases done in our subspecialty. A further breakdown of claims generated by specific types of patients in the general thoracic and cardiovascular categories is seen in Fig 10.

When the outcomes of cases from this WTSA survey are compared with those reported by the PIAA, which has a more national scope, the results are less favorable. One half of cases reported in the WTSA survey were dismissed or abandoned, whereas in the PIAA experience 70% had that outcome. Only 7% of PIAA cases went to trial, as compared with 17% in the WTSA experience. It is difficult to know whether this means that plaintiff's attorneys in the WTSA region are more discriminating in selecting cases or more effective in their pursuit.

The WTSA survey also showed that among 149 cases that were dismissed, only about one third involved significant discovery, suggesting the overall cost for these claims should have been relatively low. Likewise, in 40% of the cases that were settled, the settlement cost was less than $30,000, which has traditionally been a threshold for getting rid of nuisance cases that might otherwise involve significant defense costs. These findings are shown in Fig 11. Finally, although the number of cases lost at trial was small (n = 19), only 5 (~25%) involved payment of more then $250,000. This may be a reflection of the Medical Injury Compensation Reform Act (MICRA) tort reform legislation, which has been in place in California since 1976. Among other provisions, MICRA limits noneconomic damages (eg, those for pain, suffering, and loss of consortium) to a maximum of $250,000.

The expert witness issue

A surprisingly large number of respondents to the WTSA survey had served as an expert witness. It could be argued that the responses were biased toward those interested in medical-legal issues, but the fact remains

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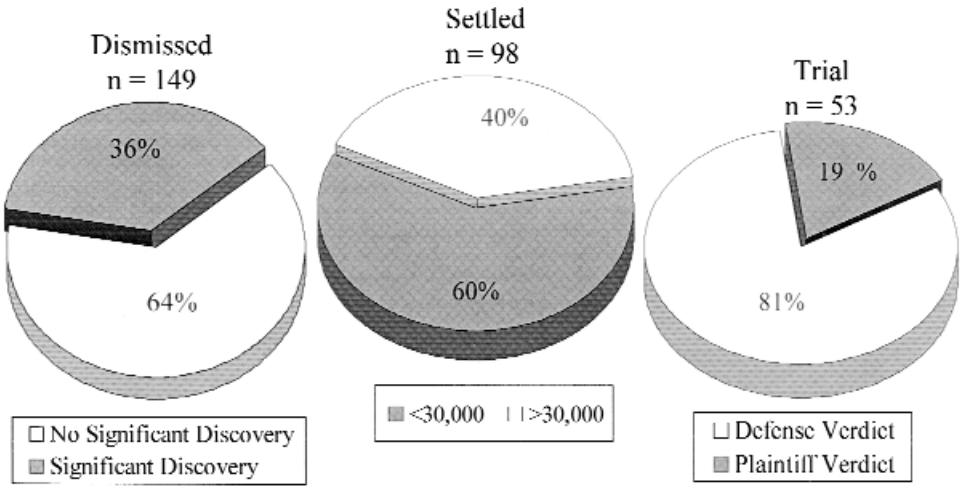

Fig 11. WTSA malpractice survey: outcome of malpractice claims.

that the percentage was high. In an effort to keep the survey short, we did not get information on how frequently opinions had been given for the defense versus the plaintiff.

Whereas physicians who read cases for the defense draw little attention from their colleagues, case review for a plaintiff's attorney triggers animosity from one's peers. This became acutely apparent to me when, as chair of medical-legal affairs for the STS, our committee attempted to establish a national registry of cardiothoracic surgery experts. We elicited an amazingly large response from STS members who were willing to have their names made available. A preliminary registry, which was regionalized and categorized by area of expertise (ie, general thoracic, adult cardiac, congenital), was formed. From the outset the committee believed it was critical that the registry be open to any attorney, whether representing the defense or the plaintiff. The individual registry experts would determine the acceptability of cases, as well as the fee schedule.

When the proposal to implement the registry was put before the STS Council, a small but vocal group defeated the proposal by arguing that allowing plaintiff's attorneys access to registry experts would in essence "aid the enemy." This seemed a shortsighted and unfortunate outcome, because there is no doubt in my mind that there is more benefit than risk in reviewing cases for the plaintiff. This opinion is based on several observations:

1. Plaintiff's attorneys have a difficult time obtaining qualified experts in cardiothoracic surgery. Because of the stigmata associated with working for the plaintiff, there is often difficulty in finding a reputable, experienced, unbiased surgeon to review a matter. Instead, the plaintiff often ends up with a "hired gun" who finds a way to support even the weakest argument for practice below the standard. That is, after all, in the best interest of a professional witness. It is likely that such an expert encourages the continuation of a legal action that might otherwise have been turned down had the plaintiff's attorney had the benefit of a reputable opinion. This phenomenon may also account for the low percentage of plaintiff's verdicts at trial.

2. An experienced plaintiff's attorney does not want to pursue a case without merit. If a reputable unbiased expert reviews a case and finds practice that meets the standard, the vast majority of skilled plaintiff's attorneys will drop the matter. We know that a very high percentage of malpractice cases are dismissed, abandoned, or withdrawn, and it is highly probable that such cases might not have been filed had the plaintiff had access to a reliable expert. It must be conceded that not all attorneys representing the plaintiff are capable and experienced, but as a rule the capable attorneys get the major cases.

3. If a case is below the standard it should be settled quickly. There is the perception that physicians conspire to protect each other under a "code of silence" even if practice is substandard. This is clearly unacceptable, and we as surgeons must not provide the ammunition for such an argument by denying plaintiffs access to experts in our subspecialty. In the majority of instances in which a case is reviewed by a reputable, experienced, unbiased expert and care below the standard is found, settlement discussions begin rapidly. This is as it should be. Valuable resources should not be wasted because the plaintiff cannot find a qualified surgeon to consider a case.

4. Credibility. Finally, it is difficult to accept a med-

ical expert as unbiased if he or she has only read cases for the defense. In sworn testimony all experts will be asked about their history regarding cases reviewed for the defense versus the plaintiff. A reasonable balance is required to be viewed as impartial.

In summary, those involved in medical-legal review should consider plaintiffs' cases. This will help to build the credibility of our profession and on balance be beneficial to our colleagues.

Avoiding malpractice suits. In closing, I would like to reflect on the issue of avoiding malpractice suits. The message, like most things that are true, is one that you have heard repeatedly: develop a close, caring relationship with your patients. Patients do not sue physicians if they trust them, believe that they care, and believe that everything possible has been done in their best interest. Physicians who have avoided lawsuits are not necessarily the most technically gifted, diagnostically astute, or even the most respected among their peers. They are instead the ones who take the extra time to listen and who organize their practice to show respect for their patients' time and dignity. The manifestations of such a practice have been articulated by a group of experienced, suit-free physicians from Texas who made the following suggestions[3]:

1. Listen patiently.
2. Respect the patient's dignity and privacy.
3. Return phone calls promptly.
4. Be polite.
5. Be on time.
6. Have the patient join in decision making.
7. Keep patients' expectations in line with reality (prepare them for all eventualities).
8. Be honest about a misadventure (*never* cover up or try to blame others).
9. Avoid high-risk situations such as cases you are not fully equipped to handle or cases in which there is a personality clash with a patient or family.
10. Treat the patient as you would like to be treated.

We would all be well served to remember and follow this sage advice.

I gratefully acknowledge the contribution of Ms Lori Bartholomew in collecting and analyzing data from the PIAA database.

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