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Claims, Errors and Compensation Payments in Medical Malpractice Litigation

A recent report published in *The New England Journal of Medicine* analyzing claims, errors, and compensation payments in medical malpractice litigation has received much attention. Unfortunately, the review of claims' files was so insignificant as to render any empirical conclusions indefensible.

Reviews were conducted at an insurer's office which is very unlikely to have a complete file and certainly will not have any of the significant data utilized by those who bring claims. Even more astonishingly, reviews lasted only 1.6 hours per file on average and were conducted by one reviewer. In our office, for example, the average case is reviewed by a partner, a nurse and an outside physician reviewer spending approximately 10 hours total per file. That is for an initial review. In checking around the field, this is approximately average.

The study in question defined medical error as the medical industry does. That definition is, "The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." While this may be appropriate to determine if a particular course of action was carried out as originally contemplated, it has very little to do with carelessness or neglect. One may fail to carry out the action for a variety of reasons without being negligent. Likewise, carelessness may have nothing to do with the failure of a planned course of action or the failure to achieve an aim. For example, most diagnosis errors have nothing to do with failure to complete a plan or achieve an aim except in a very broad sense not utilized by the reviewers in the study.

The scale utilized by the reviewers was based upon "evidence." A close analysis of the reviews demonstrates that the reviewers did not know the difference between circumstantial as opposed to direct evidence. In the law, circumstantial evidence is just as good as direct evidence, and sometimes circumstantial evidence is the only kind which exists.

Further, there was no double-blind attempt to analyze the data. In other words, only people in the medical profession were utilized to do the reviews. This is the ultimate "fox guarding the henhouse" and, unfortunately, reflects poorly on this otherwise fine publication.

It is clear from the discussion contained in the article that the authors relied or were heavily influenced by prior medical industry studies. Their analysis demonstrates weaknesses in quantity of files looked at, reviewer background and a lack of understanding as to what medical negligence is and how evidence is utilized.

The article in the *New England Journal of Medicine* does demonstrate how difficult it is for plaintiffs and attorneys to discern what happened before initiation of a claim. The article notes that, "portraits of a malpractice system that is stricken with frivolous litigation are overblown." The findings lend support to the view that the system performs reasonably well in its function of separating claims without merit from those with merit and compensating the latter.

One of six claims involved errors and received no payment. The plaintiffs who bring such unrequited claims must shoulder substantial economic and noneconomic burdens that flow from preventable injury. This results in a vast underpayment of claims. This is not surprising given that the Patient Safety Authority in Pennsylvania received reports of 169,000 incidents and serious events in one year, with only 1,500 medical malpractice cases being filed in the state during the same year.

The study, in evaluating costs, claims that the system's overhead costs are exorbitant. The findings suggest, "that moves to curve frivolous litigation, if successful, will have a relatively limited effect on the caseload and costs of litigation. The vast majority of resources go toward resolving and paying claims that involve errors." What are those overhead costs then? They tend to encompass the tremendous hurdle that claimants have to overcome in bringing legitimate cases and the absurd ego-defenses that the medical industry frequently utilizes. It cost money to "fight

city hall" and lots of money is defending cases where there is no good defense.

The study skirts the fact that costs are exacerbated by the fact that doctors are very reluctant to work as expert reviewers for plaintiffs. The study does not mention that some specialty boards punish doctors who tell the truth about medical malpractice claims. The study does not examine the fact that most peer review is closed to the public, the patients, and to representatives of patients. This means that peer review has to be done twice; once by the hospital which is usually a whitewash, and second by a patient's representative. Sometimes a third peer review has to be done by state agencies. All of this adds to the tremendous administrative cost which is caused by an iron wall created by the medical profession separating truth from reality.

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