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Examining the Present Viability of Medical Malpractice Caps to Compensate Diminished Earnings for Patients and Workers

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Medical malpractice caps serve dual purposes, both enabling patients to receive remedy when physicians are negligent or perform malfeasance, and limit financial exposure for physicians that have been deemed at fault. From the early 1970's to the late 1990's, numerous state legislatures enacted caps, or limitations, related to both remedy and liability, often limited to $250,000 and $500,000 across several states. In the present article a primer is offered for the vocational rehabilitation counselor, nurse case manager, forensic consultant, and others. Legal and economic frameworks are offered as fodder to discuss the present medical malpractice caps. Ethical issues for vocational counselors, life care planners, and forensic economists are further addressed, particularly as diminished earnings may often be greater than present caps. It is suggested that legislators and additional government officials must currently re-examine medical malpractice caps, as most often present-day caps do not compensate diminished earnings for most patients and workers.

While health care reform has taken center stage on the American political and economic scene over the past two decades, considerable debate has surrounded reform of medical malpractice tort law. Much time and effort on the part of American legislators and policy makers, at both the federal and state level, has been devoted to this issue. Each year, an estimated 195,000 people die in hospitals due to medical negligence (Medical News Today, 2004). Patients who have been injured while receiving health care have a right to sue medical providers for medical malpractice under governing state tort law (U.S. General Accounting Office, 2003). While the laws governing medical malpractice vary for each jurisdictional venue, the goals of tort law include compensation to the victim and deterrence of malpractice. Compensation for damages is awarded through a variety of measures, either as a direct payout from the hospital or insurance company, settlement through mediation, settlement through binding arbitration, or jury award. At present, medical malpractice caps range from $500,000 (Louisiana) to $1 million (Colorado), while other states do not have a cap (Delaware). While the research has consistently sought to evaluate factors contributing to physician malpractice insurance rates, the literature is void of literature examining whether present-day caps adequately compensate diminished earnings for patients and workers that have been injured through medical malpractice. As such, the present article seeks to offer the vocational counselor, life care planner, and forensic economist an introduction to the legal, economic, and ethical framework related to this issue. Lastly, recommendations are presented to legislators and government officials to critically evaluate the viability of present medical malpractice caps.

Legal Framework for Medical Malpractice

Malpractice law is wholly the territory of state governments. It is largely a legal concept that is not aligned so much to the practice of medicine, as it is encompassed by the laws of torts, negligence and contracts. Tort law provides an avenue to litigate and recover damages for personal injury. In medical malpractice tort suits, the most common relief is payment of damages. The key issue in medical malprac-

tice is *negligence*. In general terms, the law says that a plaintiff has been negligently injured by a defendant only if the injury was preventable and if it was reasonable to take some action that would have prevented the injury. In a medical malpractice context, negligence may be defined as when a health care provider causes injury to a patient that could have reasonably been prevented. In order to "win" a medical malpractice case, the plaintiff must prove: 1) harm was done, and 2) the actions of the health care provider did not meet a "reasonable" standard of care. In the past, deviation from "local custom" was the standard used to establish medical negligence. This has given way to a "national" standard of care, as prescribed through medical journals, continuing education seminars and medical conferences, in which the latest information on diagnoses and treatments are presented.

The economic guidepost to judge negligence, and the economic concept applied thereto, was established by Learned Hand Rule. The Learned Hand Rule says that negligence has occurred if it would have been cheaper to prevent an injury than the expected costs when it occurs (the cost of an x probability of injury occurrence). In effect, this law puts a simple cost-benefit test on every activity that might prevent an injury. If the benefits exceed the costs, then the law says that the activity should be used commonly. If taken to a full economic analysis, the Learned Hand Rule would look at the extensive and intensive margins of use of an injury-preventing activity and ask (a) for which patients should it be used and (b) how often should it be used, while in both cases using an implicit cost-benefit test for the expanded utilization of the activity. The extensive margin refers to how the productivity of health care resources can vary with the total amount used. The intensive margin refers to an increase in the use of medical resources while holding the patient population constant.

Some economic issues involving medical malpractice economic damages include lost earning wages and benefits (past and future), lost household production, medical expenses, and life care expenses. Payment in this category is intended to restore the plaintiff to the same financial position he would have been in had the malpractice not occurred. Non-economic damages include pain and suffering, loss or consortium, and decreased quality of life. The dollar amount of such damages is usually left to the discretion of the jury, and is regarded as restitution to "make the plaintiff whole" (Kachalia, Choundhry, & Studdert, 2005).

There are two key goals of the medical malpractice system from a social and economic viewpoint. The two goals are to compensate injured persons and to provide incentives to avoid preventable negligent injuries. Malpractice insurance, as commonly administered, has mixed effects on these goals. By eliminating the risks of bankruptcy by individual providers (e.g., physicians) it probably enhances compensation. However, the premium pricing mechanism (charging by specialty but not by prior history of malpractice losses) creates a problem in that doctors to not face the full costs of their negligence, if any exists (Phelps, 2013).

Malpractice insurance provides relief to the doctors from the financial risk they face. The malpractice legal system (not "insurance") is designed to provide relief to injured patients, and also to deter damage/ injury. The insurance provides relief for injured persons if and only if they win a suit and the doctor or hospital is otherwise unable to pay the legal damages. Malpractice insurance probably increases the rate of injury, particularly to the extent that the insurance is sold in ways that do not capture the intrinsic risk of the doctor in creating injuries. With insurance sold at the same price to all doctors (or all within a given specialty), the relatively bad doctors receive a subsidy from the good ones. If the bad doctors paid the full brunt of their expected costs, either they would be driven out of practice or their costs of practice would go up. Either would cause the amount of treatment by the bad doctors to decline, and thus the overall injury rate would decline.

A doctor's history of malpractice strongly predicts the chances that a future malpractice event will occur. In one study of doctors in Los Angeles, 46 (out of 8,000) doctors accounted for 10 percent of all malpractice verdicts and *30* percent of the damages awarded. Each of these doctors had lost four or more lawsuits in the period of study. Another study of insurance pricing showed that doctors' history of malpractice could predict malpractice awards in the future just as well as a doctor's specialty. Most insurance companies use doctors' specialty to set premiums, but few use past malpractice claims history (Rolph, 1981). The primary claim of value for the negligence system is that it *in concept* deters negligent injuries (malpractice). It does so by imposing a costly structure involving litigation (Phelps, 2013).

Legal Framework for Economic Remedy, Including Damages

The American legal system, in civil litigation, is concerned with restoring individuals to that position they would have occupied had the legal injury not occurred. An individual who has sustained a loss, whether that loss pertains to their property, their physical structure or function, or their personal reputation or dignity) has, under the law, the right to demand that the loss be restored to them by the party that caused the loss. The thing that is provided to restore the loss to the injured party, or plaintiff, by the liable party, or defendant, is referred to as the remedy.

Remedies may be divided into two categories: equitable remedies and legal remedies. Equitable remedies are always granted by a judge rather than by a jury, and consist of a court compelling a party to take some action, or to refrain from some action. Equitable remedies may require that a party, under threat of contempt of court, convey property to another party, or cease and desist from taking some action that injures or could potentially injure another party. Equitable remedies do not compel the payment of money from one party to another, although the cost and the negative consequences of the remedy are usually borne by the defendant. Equitable remedies are not favored by courts and are intended to be applied in certain circumstances; in fact, one basic principle of the equitable remedy is that it is not available provided that all the injury to the plaintiff can be restored through the second category of relief, the legal remedy.

Legal remedies are those that involve the payment of a monetary award to the plaintiff by the defendant as compensation for the injury. A person who has sustained a physical injury, for instance, may have sustained a number of different types of damage. There is damage to the physical structure of the body or mind which must be repaired to the extent possible. There is pain and suffering that has been sustained as well as mental anguish. There may be damage to the ability to perform work or sustain a career. There may be the loss of the ability to perform as a spouse or a parent. Finally, the defendant's actions that brought about the injury may be so egregious in nature that the court may choose to punish the defendant through the addition of additional damages.

All cases involving legal remedies will involve at least two specific categories of damages, or damage "heads." First, specific damages refer to those things for which a specific monetary value can be determined. Some examples of these types of damages are the cost of restoring or repairing damaged property, the expenses of medical treatment, and the cost of lost earnings or lost earning capacity. Some of these damages are relatively discrete in nature and easily determined (such as accumulated medical bills) while others are somewhat debatable (such as pre-injury and post-injury earning capacity). Nonetheless, these costs reflect restoration of monetary or property loss with monetary compensation in the amount of the lass; i.e., it is intended to be a dollar-for-dollar restoration of the plaintiff's loss. For this reason, these damages are sometimes referred to as pecuniary damages.

Secondly, legal damages include those things for which a monetary value cannot be calculated in an objective manner, but rather must be determined through a subjective determination by the finder of fact (usually the jury). These damages are referred to as general or nonpecuniary, damages, and include pain and suffering, mental anguish, and loss of enjoyment of life. A plaintiff's attorney usually asks for or suggests an amount be awarded for damages (both specific and general) in their complaint to the court (often called the "prayer for relief") or some other document, but also provides language allowing the finder of fact to award greater compensation if they feel this is appropriate.

A third type of damages, punitive damages, may also be requested by the plaintiff, but is only appropriate when the defendant's state of mind at the time the injury was committed more than mere negligence or carelessness. Circumstances such as intentionally causing injury to another, recklessness (i.e., engaging in an action despite the knowledge that a person could be harmed although harm to the person was not specifically intended), or gross negligence (carelessness so inexcusable that it is deserving of liability in and of itself) are those which can lead to a prayer for the granting of relief in the form of punitive damages. Punitive damages, as the name implies, are intended to punish a defendant for their behavior by imposing a monetary sanction to be paid to the plaintiff, the rationale being to deter future occurrences of the behavior by that plaintiff or by other plaintiffs.

Two other types of damages may be discussed in the present context that differ from the damages discussed above because they are awarded to third parties, rather than to the party who sustained the direct injury caused by the defendant's action. First, wrongful death may be applicable in those situations in which the injuries to a party are fatal. Wrongful death is usually a separate cause of action in civil litigation. The action is governed by state statutes and is often brought by the executor or administrator of the estate of the deceased, or by a close relative. The statutory scheme, which differs from state to state, is necessary because, at common law, the cause of action of a plaintiff in a tort action died when the plaintiff died, relieving the defendant of potential damages. Wrongful death statutes permit the estate to recover for the actions of the defendant when the plaintiff is deceased, and can provide proper compensation to a surviving spouse or children for their sustenance, or to an estate of the deceased to permit such uses of the funds recovered as paying debts of the deceased which would otherwise deplete the bounty of the estate. Likewise, a third party (usually a spouse) can also bring actions for loss of consortium. Loss of consortium typically refers to those duties performed in sustaining a familial relationship, such as marriage, and is a cause of action by the spouse of an injured party for the loss of such things as affection, companionship, or sexual relations brought about by the injury.

Because most trials are jury trials rather than bench trials, the jury will determine both the liability of the defendant and the damages to be paid to the plaintiff. Juries have great latitude in determining damages,

especially those damages categorized as general or punitive in nature. In theory, these damages could be unlimited, but are usually tempered to some degree, as courts will strike down awards which are so large as to "shock the conscience" or are clearly based on prejudice against a party or undue passion of the trier of fact for the parties or issues surrounding the case. Courts have the ability to reduce a jury award through the process known as remittitur. In remittitur, the court may demand that a plaintiff accept an amount less than that awarded by a jury, lest the judge dismiss the decision of the jury as unreasonable and call for a new trial on the merits of the case. Remittitur is a common procedure in federal and state courts. The opposite of remittitur, additur (the addition of damages by a judge) is not permitted in federal courts as it is seen as a violation of the Seventh Amendment rights of the defendant to trial by jury, but is allowed in some state courts (in which the Seventh Amendment right has been deemed to be inapplicable). Generally, however, it can be said that the outer limits of a damage award is determined by a jury, with the court having the capacity to lower the amount of the award.

Medical Malpractice Insurance and Liability Reduction

Professional liability insurance is purchased by medical practitioners in order to reduce the risks and costs associated with medical malpractice. Such coverage is mandatory in nearly all states, but in the few states that do not require such coverage, it is still needed for medical staff privileges at hospitals. In order to reduce risk of liability, many physicians practice "defensive" medicine which includes the "assurance" or the "avoidance" approaches towards treatment of their patients. The" assurance" approach involves ordering and obtaining multiple tests and treatments that are arguably not absolutely necessary. This quantity versus quality practice creates patient confidence that proper management is being performed, as well as providing the physician with a credible defense argument, in the event of a claim of negligence, that all possibly helpful investigations and treatments were considered and implemented.

The "avoidance" approach involves physician refusal to treat high risk patients, minimizing or discontinuing performance of high risk procedures, or referring such patients elsewhere so as to lower their risk of adverse outcomes. It is held that if proper informed consent has been given for the additional tests and treatments associated with assurance behaviors and these tests and treatments do not breach the standard of care, and that avoidance behaviors do not involve abandonment of patients, physicians practicing defensive medicine are likely not violating ethical responsibility to the individual patient (Phelps, 2013).

Damage Limitations (popularly known as Caps)

In a medical malpractice lawsuit, payment for non-economic damages consists of compensation for loss of enjoyment or value of life (hedonic damages). Although the jury determines the dollar figure of this award, it is the judge who limits the maximum amount that can be recovered. Recovery of economic damages, as noted above, may also be subject to the cap. The assessment of such damages often cannot be objectively determined. For example, how does one measure and quantify a dollar figure for these complaints? How is the "worth" of the work by homemakers measured? What should be the dollar level of the cap? Should the dollar level of the cap be indexed for inflation? What if there are multiple defendants? Should the cap include non-economic damages, total damages or both? What about a state's equal protection guarantee? (Kelly, 2005).

In order to control the widely varying and sometimes excessive awards granted in malpractice, many states have enacted tort reform measures. For instance, in 1975, California enacted the Medical Injury Compensation Reform Act (MICRA), whereby a flat cap of $250,000 for non-economic damages was set by the state legislature. Thirty-seven years later (2012) it is still being debated by legislators, advocates, insurance regulators, and state Supreme Courts. Many states have already passed legislation or amended their constitutions to create such caps in order to limit the maximum amounts plaintiffs can recover in medical malpractice and personal injury cases. While state-to-state damage limitations vary, typical damage caps in most states range from $500,000 to $2 million.

Ethical Guidelines in the Context of Medical Malpractice

When a vocational or economic expert estimates occupational opportunities, wage losses, or additional factors, it is important that the professional maintain the same method of estimating losses regardless of the size of a "cap." For instance, it is accepted practice for an economist to use the method of discounted present value. In addition, often case law and /or standards set by professional associations (e.g., National Association of Forensic Economics) will dictate methods to be used. If an expert veers from accepted methods, the professional may be subject to court challenges of expert qualifications and penalties from the professional association.

With relation to medical malpractice award caps, an expert should never "adjust" losses to the size of the cap. If, for example, Louisiana has a cap of $500,000 and California has a cap of $2 million, the expert should not "lower" losses to meet a $500,000 cap or

"raise" losses to meet a $2 million cap. By doing so, the expert risks incurring loss of professional reputation and credibility.

Pending Research Questions

With respect to the above-stated issues, comparatively little research has been conducted on the effects of the *caps* themselves. The true nature of the relation between state-specific medical malpractice damage caps and physician malpractice insurance rates are presently unexamined in the literature. A detailed variance analysis must be conducted to verify if such a relationship exits (e.g., states with medical malpractice caps also offer lower medical malpractice insurance rates to physicians). Second, it must be examined whether or not damage limits (i.e. caps) adequately compensate a low-skilled worker for economic damages incurred as a result of malpractice. Third and fourth respectively, the same question must be analyzed for semi-skilled and skilled workers. Fifth, it must be examined whether damage caps adequately compensate for the economic losses of an individual with long-term disabilities, such as head injury, spinal cord injury, or tardive dyskinesia. Examination of these issues may enable not only rehabilitation and economic professionals, but also state legislators, and other government officials to strategically evaluate the viability of present caps.

Recommendations for Legislators and Other Government Officials

It is not the purpose of the present article to offer or refute a solitary position on the issue of medical malpractice and diminished earnings. One side of the argument may suggest that all medical malpractice caps must be eliminated. If medical malpractice caps were eliminated, then, theoretically, all plaintiffs would receive full remedy, for both economic and non-economic damages. While patients and injured workers do deserve remedies based on their claim, it is important to recognize that not all claims have merit. In circumstances, wherein, plaintiffs are awarded benefits without merit, society, particularly physicians, suffer. As such, the other side of the argument posits that medical malpractice caps must be initiated, and furthermore set at low limits, to avoid litigation, wherein, frivolous suits are avoided. With low caps, perhaps, attorney and plaintiffs would be hesitant to pursue malpractice claims, considering that legal expenses, including expert witness fees, in consideration of the potential reward—a limited settlement based on medical malpractice caps.

Albeit, the present paper does not seek to support either side of the above stances, several recommendations are given to address this contemporary issue. First, the issue should be examined as a contemporary issue. Many states have not examined their present caps in over two decades, or even longer. Considering the importance to both plaintiffs and physicians of this issue, this issue should be examined every 2-3 years. Second, caps must be considered in the context of whether the respective injury is catastrophic or non-catastrophic. For example, medication error with minimal medical consequences should not be considered in the same context as a medication errors resulting in permanent disability or death. Third, caps must be considered in the context of inflation and Consumer Price Index. Indeed, $250,000 in 1993 does not translate to the same amount in 2013. Moreover, in most of the states that have present caps, such economic allowances are not in place for these timely variances. Fourth, medical malpractice caps may be considered not only in the context of economic and catastrophic variables, but also individual features. Theoretically, a multiple regression equation may be developed to numerically equate age, catastrophic level, geographic region, or additional variable that "contribute" to the disability, with the settlement amount as the "dependent" variable. In this circumstance, features may be "entered" into the equation, resulting in an identified cap. However, at present, according to the authors' knowledge, such an equation does not exist. In the interim, conversations, and accompanying research, must begin to address this contemporary issue.

Conclusion

Within the present article, admittedly, more questions were presented, than answered related to medical malpractice and diminished earnings. Medical and economic frameworks for this present-day issue were offered, giving rehabilitation and economic professionals fodder for additional discussion. When given a medical malpractice case, the forensic consultant must evaluate employability and wage losses in the framework of the case, independent of prescribed medical malpractice caps. Issues related to legislator and governmental officials were discussed, suggesting that while immediate solutions are not available, greater understanding of this issue must be sought. Further examination of these issues will assure not only that diminished earnings for patients and workers are recovered, but also physicians are protected from unsubstantiated suits.

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