Journal of
Medical Research and Surgery

Opinion Article

Pettingill BF, et al., J Med Res Surg 2022, 3:3

Proven Solution to Reducing Medical Malpractice Claims Nationwide

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Received date: May 16, 2022; **Accepted date:** May 26, 2022; **Published date:** June 02, 2022

Citation: Pettingill BF, Tewes FR (2022) Proven Solution to Reducing Medical Malpractice Claims Nationwide. J Med Res Surg 3(3): pp. 44-45. doi: 10.52916/jmrs224076

Introduction

Medical errors often lead to injury and sometimes death, as these serve as the basis for all medical malpractice claims in the United States. In 2021, over 250,000 deaths occurred as a direct result of medical errors [1]. However, one New England Journal of Medicine article reported that in 2016 a comprehensive study which analyzed 15 years of malpractice claims concluded: "Just one out of every 100 U.S. doctors is responsible for 32% of all malpractice claims that result in monetary payouts to patients" [2]. The majority of human errors that occur in medicine are unintentional. Consequently, the challenges in medical malpractice policymaking center on the interactions of three relevant systems, each with its own complex rules and regulations: health care, tort, and insurance [3].

The health care system focuses on policies that aim to protect and improve patient safety through the reduction of medical errors by imposing penalties against poorly performing providers whose medical errors serve as the basis of all medical malpractice claims. Policymaking that focuses on reducing medical errors can indirectly lead to a reduction in medical malpractice claims while improving access to medical malpractice insurance through the lowering of insurance (E and O) premiums. States and the federal government play an important role in reducing medical errors and improving patient safety. Although states have the primary authority to define the process for granting and renewing medical licenses and regulating the practice of medicine, the current regulatory environment has no uniformity across states regarding both medical licensure and the regulation of the practice of medicine. This lack of uniformity and rigorous regulatory standards can have an adverse effect on patient safety, as evidence of the practice of "defensive medicine". Essentially, doctor's concerns about medical liability and the potential negative outcomes associated with any malpractice claim may lead providers to administer unnecessary and overly cautious treatment to avoid high-risk services which reduces their liability risks.

In the United States, the tort system is the only mechanism through which a person suffering injury due to medical error is monetarily compensated when evidence is established that the doctor provided substandard health care. In the case of medical malpractice, critics of the current tort system allege the inefficiency to deter the errors that created the injury and the imbalanced compensation of those who suffer from an injury. This criticism is clear from the 2021 Medscape Malpractice Report that surveyed almost 4,400 physicians across 29 specialties [4] (Figure 1).

Additionally, 99 percent of physicians in high-risk specialties such as plastic surgery, general surgery, orthopedics, urology, and OB/GYN will face a lawsuit by age 65. In short, the current

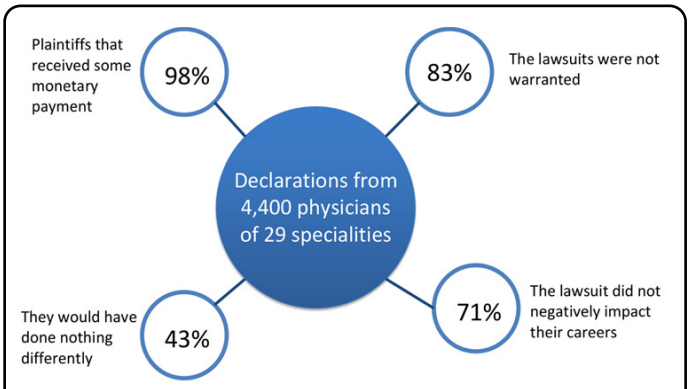

Figure 1: Four facts from the 2021 Medscape Malpractice Report.

tort system has served to transform medical malpractice lawsuits into a "lottery system". Like any lottery system, many valid claims are never filed, and many filed claims are not the result of medical negligence. Medical negligence can happen during the diagnosis, the treatment, or medical advice for treatment after an illness or injury. Similar to a lottery, no payouts were handed out in 78 percent of lawsuits brought to trial [1]. For a trial to result in a favorable verdict for the claimant, there are three burdens of proof that any medical malpractice case must meet. First, the plaintiff's attorney must show that there was a breach of duty causing a lack of proper medical care that another healthcare professional would have recommended. Second, there must be a physical or emotional injury caused by the medical professional, and third, there must be sufficient evidence that proves the medical professional caused the damage in the first place.

Prior to the Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2011, jury verdicts reflected substantial variation occurring among states and among counties within states. This legislation provided somewhat federal uniformity within the tort system. There was a three-year statute of limitations for medical malpractice claims from the date of discovery of an injury; a cap of $250,000 for noneconomic damages was imposed; and a cap on awards for punitive damages the larger of $250,000 or twice the hard economic damages. Finally, replacement of joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury. A sliding-scale limit on the contingency fees that lawyers can charge was also considered in many states [5]. As of 2016, thirty-three states adhere to statutorily imposed damage caps when calculating damage awards and settlement amounts probable in a given medical malpractice lawsuit. Some thirty-three states adhere to a modified comparative at-fault rule, whereby a plaintiff cannot recover if he or she is found to be more responsible for the

injury than the defendants. Exactly how liable the plaintiff must be and how it affects recovery varies among the states. Medical expert testimony is required in thirty-two of these states, and the expert must meet minimum qualifications when testifying. All jurisdictions except Puerto Rico, New York, and New Mexico have provisions in place regarding medical and peer review panels. The remaining seventeen states do not adhere to the above damage caps [6].

Lastly, the insurance system greatly impacts medical malpractice policymaking overall. Liability insurance acts as a buffer between the actual award for malpractice determined under the tort system and the provider, who may have committed the malpractice. Although the huge majority of providers have liability insurance, there is increasing evidence of providers practicing medicine without any malpractice insurance. The increased volatility in premiums stems from an extended period of time that occurs on two fronts. First, the delay in recognizing that a claim might exist. Second, the delay in deliberations in the court system. Many times the losing party appeals the decision and prolongs the lawsuit even longer. Because insurance is based on estimating future claims and estimating the investment returns on premium payments from the time the premiums are paid until the time the claims are paid out, this longer period associated with liability losses increases the uncertainty in these estimations, both in terms of the frequency of claims and the dollar amount of awards [7]. According to the 2021 Medscape Malpractice Report mentioned above, 51 percent of respondents had been sued at least once, with 68 percent of the almost 4,400 doctors practicing medicine a minimum of 20 years. Table 1 below lists the medical malpractice payouts for noneconomic damages by state.

Table 1: Medical Malpractice Payouts for Noneconomic Damages by State [8].

State	Payout Limit	Comments
Texas	$250,000	$500,000 if against more than one party defendant (no exceptions)
California	$250,000	No cap on the amount of money the patient can receive for medical care required due to medical malpractice
Colorado	$250,000	-
Kansas	$250,000	-
Montana	$250,000	-
Ohio	$250,000	Three times the amount of economic damages with a maximum of $350,000
West Virginia	$250,000	Increases to $500,000 in the event of wrongful death, catastrophic injury, and disfigurement.

Texas has become the gold standard for medical malpractice tort reform after Governor Rick Perry became the first governor in the nation in 2003 to limit personal injury awards in medical malpractice cases to $250,000. As a result of this sweeping reform, litigation, paid claims, and premiums have been slashed in half in the state of Texas! Additionally, Texas applications for medical licenses have surged and the malpractice payout per capita is now the lowest in the country. Litigation in these states has decreased substantially over time, and medical liability premiums for physicians remains unusually low, by nationwide standards.

The authors conclude that despite the best efforts from policymakers to minimize medical error and maximize patient safety, “just one out of every 100 U.S. doctors is responsible for 32 percent of the malpractice claims that result in payments to patients.” Not all medical practitioners undertake the same levels of risk when treating patients, as the top five high-risk medical specializations of plastic surgery, general surgery, orthopedics, urology, and OB/GYN [4]. If policymakers want to effect change in the medical malpractice arena, then they must look at the clear evidence above. Lowering noneconomic payments must be the norm, plus additional incentives must be provided, such as lowering medical liability insurance premiums for practitioners who are rarely or never sued. Lower financial payouts for claims that served as a deterrent to filing frivolous cases or claims that are not the result of physician neglect. Those states that have enacted sweeping reforms to their medical malpractice tort reform have likewise experienced efficient changes to their medical liability environment, and a significant decrease overall in these three areas: litigation, paid claims, and medical liability premiums.

Conflict of Interest

The authors declare no competing financial interest.

Funding

No.

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