

SHOULD WE REVIEW MALPRACTICE CASES FOR PLAINTIFF'S ATTORNEYS?

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In this issue we have pared the usual section entitled 'Departments,' to make room for five scientific articles rather than our usual four. In addition, we have omitted the usual column on medicolegal/ethical issues since my Editor's page addresses a topic in that category, as does the outstanding article on Needle Exchange for HIV/AIDS by Drs. O'Gurek and Kirchner.

BACKGROUND

Malpractice lawsuits remain a pervasive problem for even the most responsible and committed physicians. The recently passed health care reform bill (finally signed into law after a complex legislative process as the Patient Protection and Affordable Care Act—H.R. 3590) did not address the problem in any substantive way. A March 2003 study by the U.S. Department of Health and Human Services estimated the direct cost of medical malpractice to be 2 percent of the nation's health-care spending; defensive medical practices accounted for 5 to 9 percent. (The annual U.S. expenditure for health care is estimated to be about \$2.3 trillion.)

Most physicians feel certain that frivolous litigation, which includes claims that lack evidence of either injury or substandard care, or both, remains common and costly. A study from the Harvard School of Public Health in 2006 assessed this question by reviewing a random sample of 1452 closed malpractice claims from five liability insurers to determine whether a medical injury had occurred and, if so, whether it was due to medical error.¹ The authors analyzed the prevalence, characteristics, litigation outcomes, and costs of claims.

For 3 percent of the claims, there were no verifiable medical injuries, and 37 percent did not involve errors. Still, some compensation was made to the plaintiffs in 28% of the claims that were not associated with errors (145 of 515) and 16% that did not result in injuries (6 of 37), though these payments were significantly lower on average than were payments for claims involving errors (\$313,205 vs. \$521,560, $P=0.004$). Overall, *claims not involving errors accounted for 13 to 16 percent of*

the system's total monetary costs. For every dollar spent on compensation, 54 cents went to administrative expenses (including those involving lawyers, experts, and courts).

Even though the vast majority of expenditures in this sample went toward litigation and payment of claims that resulted from errors, the overhead costs of malpractice litigation are clearly exorbitant, and meritless lawsuits contribute substantially to this burden on the health care system.

I have no solutions to this complex problem, which stems in part from our cultural presumption that someone or something must be to blame for most of life's adverse events, plus the basic premise of our legal system that everyone is entitled to their day in court. Since I am no longer in clinical practice, I am not at risk of a malpractice suit, but because my specialty was cardiothoracic surgery, a specialty with a greater than ordinary risk of adverse outcomes, I was involved in the malpractice circus many times over the course of a long career. In three cases I was a defendant and in at least 10 others I was an expert witness for the defense.

THE PRACTICAL DILEMMA

Though all of the cases in which I was personally involved resulted in a defense verdict, plaintiff's attorneys (often attorneys for the same plaintiffs I had testified against!) occasionally contacted me later to ask if I would review a case for them. These requests indicated to me that they wanted an objective opinion, and I was confronted with having to consider whether a physician of conscience should review cases for a plaintiff's attorney. Many surgeons refuse even to talk to plaintiff's attorneys, and a debate on the ethics of such refusals was published in the *Annals of Thoracic Surgery*.² But aside from ethical considerations, I believe this refusal is a mistake for practical reasons. (In explaining these reasons, I will confine the discussion to surgery, the clinical discipline I know best, and the one that creates the most compelling grounds for dramatic lawsuits.)

There is considerable benefit from reviewing cases for a plaintiff honestly and objectively. Even the most rapacious attorneys do not wish to expend time and money on cases that have no merit, because such cases are unlikely to be successful or financially rewarding. Yet, they have no way to judge the merits of a complex case without the opinion of a surgeon. In my experience, one of the reasons that trial lawyers use "professional witnesses" from agencies is because it's hard for a trial lawyer to get a leading surgeon to review a case. However, if a respected surgeon reviews the case objectively and says there was no malpractice, it is likely that no lawsuit will be filed, and considerable harm will be prevented. In contrast, since professional witnesses derive considerable income from working with plaintiffs, they tend to see malpractice everywhere. ("To a man with a hammer everything looks like a nail.")

In my experience, plaintiff's attorneys have been grateful—albeit perhaps disappointed—when told there has been no apparent malpractice in a particular case and it would be unwise to proceed with a lawsuit. Rather, the dilemma arises for an objective reviewer when it seems there has been malpractice but the reviewer is uncomfortable about testifying for a plaintiff. Malpractice does occasionally occur, and if we don't acknowledge as much, we are not being honest. Even when the reviewer's unwillingness to testify has been communicated in advance, the reviewer has to make a choice if there appears to have been malpractice. On the one hand, one can offer one's opinion verbally and in confidence, but decline to provide a written opinion. In such cases, I believe the reviewer should make no charge for his or her time, which further emphasizes that the review was done without any subjectivity. However, if one feels that the plaintiff has

been severely wronged and deserves restitution, one may elect to go forward with testimony despite one's initial reluctance to do so.

In one case of egregious malpractice that involved surgeons well known to me personally, against whom I would not testify, I referred the attorneys to another potential expert witness. I sought him out, discussed the case with him, ascertained that he would be willing to testify if his own review also indicated that malpractice had occurred, and I withdrew from the case. In the end, because of the nature of most cases that came to me for review, I never testified for a plaintiff, though I saw many cases in which a lawsuit was being contemplated until I offered the opinion that there was no malpractice.

ALSO IN THIS ISSUE

Concluding our series of articles on obesity which has been a feature of the last two issues, we are fortunate to have an article on childhood obesity by a nationally recognized expert in the field, Sandra G. Hassink, MD, FAAP, who is Director of the Nemours Obesity Initiative at the A. I. DuPont Hospital for Children, our pediatric affiliate hospital. The other articles span a broad range of interesting topics.

Just as the summer insect season descends upon us, Dr. Joseph Kontra has provided an in-depth review of tick borne illnesses. Dr. Ketan Kulkarni teaches us about the latest endoscopic technology—ultrasound. Craig Gassman, CCP, describes the benefits and the local experience with autotransfusion, which is more important than ever in decreasing the risks of blood transfusion. Finally, as noted above, Drs. David O'Gourek and Jeffrey Kirchner describe the importance of needle exchange for HIV/AIDS.

REFERENCES

1. Studdert, DM, Mello, MM, Gawande, AA, et al. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. *N Eng J Med.* 2006; 354:2024-2033.
2. Watson, DC, Robicsek, F, Sade, RM. Are Thoracic Surgeons Ethically Obligated to Serve as Expert Witnesses for the Plaintiff? *Ann Thorac Surg* 2004;78:1137-1141