Limiting Damages for "Pain and Suffering" in Medical Malpractice

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MEDICAL MALPRACTICE IS once again in a state of crisis, the third such crisis in about the past three decades.[1] The most direct reason for the crisis is the recent substantial rise in medical malpractice premiums, after more than a decade during which premiums rose by relatively little. In contrast to prior instances of substantial increases in premiums, physicians and hospitals are now limited in their ability to raise prices for their services in the face of increased premiums. Their ability to set prices has been substantially reduced by current policies both in government and among private payers. Such financial pressures on physicians and hospitals may adversely affect the supply of care and thereby reduce patient access to care.

Although the premium increases have been quite sudden and sharp, the forces underlying the increases are longstanding. When medical malpractice is in one of its quiescent periods, it is rarely a major public policy issue. Political pressure for change occurs during crises. Thus, this is a particularly opportune moment to assess alternatives to the current system.

California's 1975 medical malpractice law has often been cited as a solution to the "medical malpractice problem." The most notable feature of this law was a ceiling on awards for nonpecuniary loss or a "cap on pain and suffering." Payments for nonpecuniary loss are part of compensatory damages, a general category which also includes payment for pecuniary losses, such as from medical care, lost earnings, and other services that are directly attributable to the injury. Punitive damages are distinct from nonpecuniary loss and have been much more important in other types of lawsuits, such as product liability, than they have been in medical malpractice.

Whether or not imposing caps on pain and suffering is good public policy and whether or not the caps are responsible for the "success" of California's law have been much-debated questions. My own research with others has indicated that caps did not decrease medical malpractice premiums during the first five years or so following enactment, but caps did decrease premiums in the longer run.[2-4] These findings are generally consistent with those from a study conducted by Patricia Danzon[5] and more recent research by Patricia Born and others.[6,7] This research evaluated the effects of limits on damages in medical malpractice cases in general and did not focus on California. Nor did this research—or, to my knowledge, research by others—assess the other policy changes that California has implemented that may account for the relative stability in premiums in that state. Some of my other research with colleagues has indicated that compensation in medical malpractice generally falls short of the underlying pecuniary losses, implying that awards from settlements and jury verdicts are not generally excessive—a finding that undercuts one rationale for curbing damages.[8]

As explained below, the system of awarding damages in medical malpractice in the US, and in tort litigation more generally, is seriously flawed. Whether or not awards are inadequate or excessive, it should be possible to do much better. The system can be criticized in its own terms, that is, as failing as a mechanism for providing proper incentives for exercise of due care and for providing an accurate and equitable mechanism for compensating injury victims. It is not necessary to appeal to the effects of the defective system, such as on access to care, effects that are not at all well documented.

Why is Reform of Damage Awards Needed?

The objective of compensatory damages is to make the injury victim "whole," but the law gives very little guidance as to how damage awards are to be calculated. For financial losses, there are prices and units of loss. For pain and suffering, by contrast, there are no markets. Values must be imputed, but the law provides no guidelines for valuation. In fact, whereas legal decisions are influenced by precedent, there is no role for precedent in computing compensatory loss. Each decision is independent and presumably highly individualized to fit the particular circumstances of the case. Not

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surprisingly, variability in compensatory damages is the consequence—in large part by design, since circumstances of individual cases are thought to be highly variable. Not only is there variability, but there is empirical evidence that patterns of awards reflect the income, racial, and ethnic composition of the area in which cases are tried [9] as well as the type of case being tried—factors that should have no bearing on the individual plaintiff's loss. Also, awards for the same injury appear to be higher in medical malpractice than in automobile liability cases,[10] suggesting that juries take into account "deep pockets" of defendants in medical malpractice cases. An alternative interpretation is that auto injury victims are even more under-compensated than are those with medical injuries.

High payment variability—especially at the upper end of award sizes—coupled with the prospect of even higher variability over time, may decrease the availability of liability insurance and, when insurance is available, create higher premiums. Payments in very few cases may account for a large share of an insurer's total loss. In general, insurers can diversify risk by pooling together large numbers of insurers. In any given period, some insured will incur losses, but others will pay premiums and not incur a loss. But the risk from large nonrandom fluctuations cannot be readily diversified away. To bear such risk, insurers demand higher premiums if they are willing to underwrite these risks at all. Since medical malpractice will be with us for a long time to come, it is in the public interest to facilitate a well-functioning market for medical malpractice insurance.

Flawed Public Policy Responses

One possible response is that we should do away with payment for nonpecuniary loss entirely. First, it has been argued that people cannot buy insurance for pain and suffering.[11] Given the lack of such markets, why should injury victims be compensated for such loss in tort? It is easy to understand why an insurer would not offer such coverage. Any insurance company offering this kind of coverage in addition to insurance for financial loss would potentially fall prey to "adverse selection." That is, people who are particularly pain-prone would demand such coverage in disproportionate numbers. Not only would nonpecuniary loss be high as a consequence of adverse selection, but the same persons who were attracted to the offering of insurance coverage for pain and suffering would be likely to be high users of medical care. There is also a potential problem of "moral hazard," since the insured would have an incentive to overstate their pain in order to obtain a higher payment from an insurance company. This moral hazard problem also plagues liability insurance.

Second, it may seem that such concepts as "pain and suffering," "loss of consortium," and "loss of enjoyment of life," elements of nonpecuniary loss, are somehow unreal and cannot be quantified. That these concepts are unreal is clearly contradicted by the fact that a substantial number of patients seek medical care for these conditions as well as pharmaceutical products that require a prescription from a physician and many over-the-counter drugs. That these conditions cannot be quantified is further contradicted by the fact that they *have* been quantified and the results have been published in refereed medical journals.[12] Techniques have been developed by specialists in the field of decision analysis and are being constantly being refined. Even if quantification were highly inexact, it is highly implausible that the true cost of pain and suffering and other nonpecuniary loss is zero.

But if such intangible loss is not zero on average, why not impose a flat cap on such loss, as California and other states have done? We can also do much better than imposing a single ceiling on payment for pain and suffering, fixed in nominal dollars until modified by legislative action. California's cap on pain and suffering is not a flat $250,000 but rather a $80,000 cap in today's dollars. Judged in terms of its effect on premiums, to the extent that an $80,000 cap is "effective," we can do still better with a $60,000 cap and so on. In the extreme, such logic implies that the "best" cap would be at $0. But this places no weight at all on the pain and suffering of injury victims who have suffered because of a physician's or a hospital's negligence.

A flat cap, expressed in nominal dollars, has the advantage of simplicity. But it is too simple and is a bad precedent. If this type of cap were a solution to excessive numbers of medical malpractice claims and payments, then it may become a precedent for applying the same policy to other areas, such as payment for particular medical or surgical procedures judged by a few experts to be in "excess supply."

One might argue that many states have imposed flat caps on payment for nonpecuniary loss for medical malpractice or more broadly to tort liability in general, without indexing for inflation. Why should states like North Carolina simply not follow the lead of the others? Following the lead would not negate the deficiencies of such caps and would only replicate the mistakes that others have made.

Better Ways to Reform Payment for Nonpecuniary Loss in Medical Malpractice

In this section, I outline three alternatives for reforming payment for nonpecuniary loss in medical malpractice. These alternative proposals are discussed in greater detail elsewhere.[13,14] No single method is perfect, but each is worthy of consideration.

An Award Matrix for Nonpecuniary Damages. Juries would be provided with a simple matrix of awards for damages, based on several factors, such as the plaintiff's age and severity of injury. Existing severity of injury scales may be used to classify injuries by severity. One classification system, which has been widely applied, uses a nine-point scale:

four categories for temporary and four categories for permanent injuries, with the ninth category for death. For temporary injuries, a younger person may recover more quickly from physical injury than would an older person. But for permanent injuries, a younger person would be expected to have to endure the nonpecuniary loss for a more extended time. The values in the matrix could be based on prior awards, past research valuing life and quality of life, and/or legislative determination. The matrix would be subject to judicial review and may be modified accordingly. Values would be inflated by a price index, such as the Consumer Price Index, which is used by the Social Security Administration to adjust payments for inflation.

Flexible Ranges in Lieu of Caps. A simpler variant of the award matrix which encompasses all awards is to regulate payment of the lowest and the highest payments for nonpecuniary loss. The state would designate payments in the lowest quartile and the top deciles of payments, for example. These values would be indexed by the Consumer Price Index. Payments for nonpecuniary loss at these extremes would be limited at both extremes—raised at the bottom and lowered at the top.

Valuation Scenarios to Assist Juries. Juries would be given a notebook containing descriptions of particular injuries and of the pain and suffering associated with each. Dollar values would be attached to each scenario.

A neutral scenario might read: "Permanent minor injury (level 5). Life expectancy 25 years. Mild persistent pain, usually controllable with aspirin. Unable to engage in more than light housework."

A more colorful scenario might read: "Plaintiff Peters has completely and permanently lost the use of her right arm. Her life expectancy is 25 years, according to standard life insurance tables. Her arm throbs with pain most of the time, but the pain usually can be controlled with aspirin. She cannot do more than light housework."

The scenarios could be more detailed than this. Each scenario might be delivered by video. The scenarios might characterize actual cases tried in the state in past years.

As part of their deliberations, juries would determine which scenario or scenarios most closely resembles the case being tried. The process could be made voluntary rather than mandatory, which means that the scenarios would be a factor in setting awards, but juries would not be bound by the scenarios. However, the process might make it more difficult for juries to arrive at an award far in excess of the scenarios included in the notebook. Values of the scenarios would be set by the state legislature and be updated annually using the Consumer Price Index. Even if the system were not mandatory, large discrepancies between the valuation scenarios and the jury award may be subject to review on appeal.

Service Contracts. Some plaintiffs who seek compensation through tort have suffered permanent, serious injuries, which will require life-long care. It is compensation in such cases, rather than for more minor and temporary injuries, that leads to volatility of loss. Currently, awards are not well synchronized with the outlays that such injury victims incur. Imprudent victims may squander their awards and later require public subsidies or rely on uncompensated care subsidies. Furthermore, even if awards are not excessive on average, they are likely to be either insufficient or excessive in many cases. Substantial lawyers' fees reduce appreciably any payment that plaintiffs receive, leading to the likelihood that net compensation after fees is insufficient to cover injury cost.

Under the service contract proposal, rather than award damages, juries would specify features of an insurance contract. Such features would include duration of coverage and services to be covered, typically specified in considerable detail. The court would then solicit bids from insurers or providers willing to integrate provision of care and insurance functions or to contract with an insurer. Proposals from prospective contractors would specify details of services they would provide and their associated prices. The court would then select a contractor. Potential contractors would include medical centers, hospitals, and large physician group practices as well as HMOs and other insurers. This would be a business opportunity for providers who could specialize in particular types of injuries, such as care for the severely and permanently impaired, neurologically impaired children, or persons with cancer that became more advanced because of a misdiagnosis. This alternative is more complex than the above proposals, and resolution of various details of implementation would be critical to its success.

Under a service contracting system, services to help persons cope with nonpecuniary loss could be part of the contract and could substitute for much or all of the payment for such loss. Since injury victims would receive more comprehensive, specialized care tailored to each individual's circumstances, including psychiatric needs, they would receive something in return for eliminating or substantially reducing compensation for nonpecuniary loss.

Discussion

Each of these proposals preserves the jury system and none redistributes income from injury victims.

One by-product of any system of limiting compensation for nonpecuniary loss is that compensation for financial losses may increase to the extent that juries seek a particular target for the total award. This in fact is a defect of flat caps as well, unless the caps are so low as to make it practically impossible to compensate for the limitation by increasing other compensation. Thus, it would be important to implement guidelines for calculating such other compensation, including guidelines for measuring losses for medical care, other care, special adaptations to home and vehicles, and so

on, at the same time imposing limits on payments for nonpecuniary loss.

A deficiency common to all of the proposals is lack of information about medical malpractice claims and their resolutions, and the costs that injury victims actually incur. One criticism of the service contract proposal I heard on a visit to a major insurer is that actuarial data are lacking. This was about 15 years ago, and there are no better actuarial data today than there were then. Critics of the award matrix proposal might argue that the requisite data from settlements and awards are lacking. This criticism lacks the force it might have had previously, given the data collection effort of the National Practitioner Data Bank (NPDB).[15] But these data may not be adequately detailed, valid, or reliable for purposes of developing a value matrix or scenarios, and they are certainly insufficiently detailed to serve as the basis for service contract bids. Some states, such as Florida,[16] maintain their own data collection effort separate from the NPDB's. Particularly given the size of the awards and the importance of this public policy issue, a role for the state in data collection is clearly warranted.

Settlements, which are far more frequent than jury verdicts, do not distinguish between payments for nonpecuniary loss from other payments. Thus, we have no statistical basis for determining what the payments for nonpecuniary loss are currently. With settlements, to separate payments for nonpecuniary loss from other payments, it would be necessary to have information on financial losses incurred by plaintiffs. The state could require reporting for cases involving total payment beyond a certain level and/or for cases of particular severity. These claims would probably be in the minority but accounting for the most dollars.

Also, it will be difficult to build public support for a major change in payment method without having more conclusive evidence that North Carolinians really face a problem. Although there are statements that our citizens currently face, or will face, access barriers due to medical malpractice in the future, no rigorous study supports this claim. In fact, one can read similar accounts in other states. For example, in Pennsylvania, it is claimed that physicians are leaving that state for points south.[17,18] We have no careful analysis of supply or of access barriers attributable to medical malpractice or how barriers from this source compare to other access barriers, such as lack of insurance and geographic distance from facilities. Collecting such information logically requires a partnership among hospitals and physicians, the state, private foundations, and researchers. We are fortunate to have the intellectual resources in this state to exert leadership. The challenge is ours.

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