

## Metro

# Tort Reform or Deform for D.C.?

Proposed malpractice caps would leave victims without fair compensation.

By Jack H. Olender

Robert Dixon received the call around midnight. They had found a kidney for him. After four years on the waiting list, Robert was weary of three-times-a-week dialysis. He wanted the energy to run his small business and to devote time to his wife, June, and their two teenage children. So Robert was excited as he drove to the hospital. The doctor had told him that he had a 98 percent chance of the transplant being successful. The D.C. streets were quiet, but still it seemed forever until he pulled into the hospital driveway.

Two kidney transplants were performed in the hospital that night. Robert had blood type O, and the other patient had blood type AB. The kidney to be implanted into Robert was brought to the operating room. It came in a box with a label stating "blood type AB." People with type O blood have antibodies that will attack type AB blood. But the surgeons did not look at the label. They also failed to look at the label on the other kidney.

Immediately before operating on Robert, the surgeons implanted the type O kidney in the other patient. Fortunately for that patient, people with type AB blood can successfully receive a transplant from any blood type.

Not so for Robert. The wrong kidney implant caused a hyperacute rejection and multiple organ failures. Robert's body attacked this foreign tissue in much the same way as the

body attacks any dangerous organism. The only way to save his life was to remove the kidney.

The worst, however, was yet to come. The ordeal with the wrong kidney had altered Robert's immune system such that it would attack *any* subsequent transplant. So Robert is back on thrice-weekly dialysis, and his condition has deteriorated so badly that he needs an oxygen tank. He will die soon.

This story is true; only the names have been changed. It occurred in the District of Columbia, and a lawsuit was filed by my firm against the hospital and the physicians responsible for the botched transplant.

## Personal Injury A Practice Focus

Now, D.C. Mayor Anthony Williams wants to change the law governing cases like Robert Dixon's. Legislation being prepared by the D.C. insurance commissioner, Lawrence Mirel, would cap medical malpractice damages in the District. The certain result of the Williams-Mirel bill: People whose lives had been forever harmed, if not destroyed, by bad health care would be denied their chance at fair compensation.

### CAPS STORY

Under current D.C. law, Robert Dixon is entitled to compensation for his medical expenses, lost earnings, and noneconomic losses, including pain and suffering, disability, inconvenience, etc. June Dixon is allowed to claim damages for the loss of consortium with her husband, including the loss of services, society, affection, etc. The trial judge has veto power

over any award deemed unreasonable under the facts of the case. The judge can either reduce the award or order a new trial. The D.C. Court of Appeals can also reject a judgment not supported by the evidence.

The case would be different if Robert Dixon's claims were governed by the law of neighboring jurisdictions. Both Maryland and Virginia have already enacted caps on medical malpractice damages.

In Maryland, Robert could claim damages for medical expenses and lost earnings. He could also claim for noneconomic losses, but these damages are capped at \$620,000.

In Robert's case, his medical expenses are not great (because no further surgeries are possible). His lost earnings are negligible because his business was very small and not very profitable. So the noneconomic loss—pain, anguish, disability—would be the greater part of the case were it not for the cap. June could claim loss of consortium, but her claim is included in the same \$620,000 cap.

Under Virginia law, Robert could claim damages for medical expenses, lost earnings, and noneconomic losses, but the *total* award would be capped at \$1.65 million. This is true regardless of the enormity of the injury, the enormity of the loss, or the enormity of the medical expenses. And June would have no claim for loss of consortium in Virginia.

## BAD HISTORY

Now the District is threatening to hop on this same misguided bandwagon. The proposed Medical Injury Compensation Reform Act of 2003 would drastically reduce damages available to Robert and June.

The history of the mayor's proposal goes back a quarter-century to California's enactment of a \$250,000 noneconomic loss cap. California's law, too, was called the Medical Injury Compensation Reform Act, popularly known as MICRA.

More recently, George W. Bush embraced the concept, first as governor of Texas, then as a candidate for the presidency. Bush highlighted it in his most recent State of the Union address and is pushing it in Congress. In March, the House of Representatives passed H.R. 5, the inaptly named Help Efficient, Accessible, Low-Cost, Timely Healthcare Act. The legislation is currently stalled in the Senate because Republican leaders lack the 60 votes needed to overcome a Democratic filibuster. They may not even have a majority because some Republican senators have declared the bill too extreme.

Though a Democrat, Mayor Williams has indicated that he admires many of President Bush's programs, including malpractice caps. As Williams was quoted in *Washington City Paper* earlier this month, "I like the president. . . . Many of the things he's doing I support strongly."

Under Williams' own MICRA bill, noneconomic malpractice damages would be capped at \$250,000, payable in yearly incre-

ments of \$50,000. This cap is "one size fits all." It doesn't matter if the patient has lost two kidneys, or had all four limbs amputated, or been rendered blind or deaf. It doesn't matter if all hope of a normal life is gone. Robert Dixon's claim for pain and suffering, his inability to survive another kidney transplant, his need to undergo dialysis, his anguish, and his shortened life, along with June's loss of consortium, would all be capped at total damages of \$250,000.

The District's proposed version of MICRA would also abolish joint and several liability for malpractice defendants. In other words, if one of several defendants is bankrupt or otherwise can't pay damages, the injured person loses again.

## WRONG AGAIN

The mayor, the insurance commissioner, the insurance industry, the D.C. Hospital Association, and the Medical Society of D.C. seem to rely on four major arguments to justify the imposition of caps on malpractice victims and their survivors.

**Point 1:** There are too many malpractice lawsuits, and too many of those are frivolous.

**Counterpoint 1:** In the last 10 years, the number of medical malpractice suits filed in D.C. courts has declined by 24 percent: from 209 suits in 1992 to 158 in 2002. Compare that with the situation in Baltimore, a demographically similar city with damages caps. In 2002, Baltimore had a considerably higher rate of medical malpractice suits filed per capita and up to four times as many lawsuits per doctor. (These and other statistics are taken from an April 2003 report, "Medical Misdiagnosis in Washington, D.C.: Evidence About Proposals to Restrict Compensation to Malpractice Victims," prepared by Public Citizen's Congress Watch ([www.citizen.org](http://www.citizen.org)).)

"Frivolous" malpractice lawsuits are a figment of some public relations genius's imagination. Plaintiffs and their attorneys receive compensation only if they win in court or if they settle a case that is winnable in court. The investment of time, emotion, and money is too great for anybody but a fool to bring a frivolous case.

The problem in the District and across the United States is not frivolous malpractice suits; the problem is bad medicine. The Institute of Medicine, a National Academy of Sciences-affiliated organization, reports that up to 98,000 Americans a year die because of preventable medical errors committed in hospitals. A landmark Harvard study found that only one lawsuit or claim is filed for every eight incidents of preventable medical error as determined by physician review of hospital records.

Doctors get away with a great deal. The District ranks at or near the bottom of all states in five of the last 10 years when it comes to physician discipline. If the organized medical industry would devote its lobbying efforts to beefing up medical board staff and putting teeth into doctor discipline, some of the bad apples responsible for much of the malpractice could be restrained. According to the National Practitioners Data Bank,

5 percent of physicians make 54 percent of the malpractice payments to injured patients.

**Point 2:** Malpractice insurance premiums are too high in the District.

**Counterpoint 2:** Proponents of a cap warn that D.C. doctors might otherwise flee to Virginia, with its \$1.65 million cap. Yet, according to the April 15 issue of *Ob.Gyn. News*, malpractice insurance premiums in Virginia (for ob-gyns, at least) have increased in one year by more than 74 percent, to \$83,254. That does not sound very enticing.

Maryland, also with caps, is also supposedly a potential haven for D.C. physicians. But, again, look at the numbers: Although D.C.'s cost of living is 39 percent higher than Baltimore's, and Baltimore's median household income is 25 percent lower than the District's, malpractice insurance premiums for the largest carriers in each market are virtually the same in three specialties for which data were available—internal medicine, general surgery, and obstetrics and gynecology.

In Los Angeles, the largest city in the birthplace of MICRA, general surgeons and internal medicine specialists covered by the state's leading insurer pay higher premiums than D.C. doctors insured by the District's leading company.

American Insurance Association and the American Tort Reform Association admit that such proposals will have little, if any, effect on premiums.

**Point 4:** Physicians are fleeing the District because of lack of tort "reform."

**Counterpoint 4:** D.C.'s physician/citizen ratio has increased nearly 1 percent per year and the number of doctors has increased by 17 per year for the last 21 years. The District has more physicians per 100,000 citizens than any state in the country. The number of doctors per capita is 60 percent higher than in Massachusetts, the state with the highest proportion of doctors.

## NO GOOD SERVED

In short, current data on the state of D.C. doctors provide no valid reason for capping malpractice damages and other tort "reforms." The D.C. Control Board reached the same conclusion a few years ago when it was directed by Republican members of Congress, as part of the D.C. budget package, to investigate malpractice in the city. After an extensive investigation and a hearing in 1998, the control board found no cause for any tort "reform." It recommended, instead, that the medical disci-

“Current data on the situation facing doctors in Washington, D.C., provide no valid reason for capping medical malpractice damages or other tort ‘reforms.’”

**Point 3:** Caps will reduce premiums on malpractice insurance.

**Counterpoint 3:** As shown in Counterpoint 2, states and cities with caps do not necessarily have lower premiums than the District. The business cycle, mismanagement, and greed are what cause premiums for professional liability to rise. Over the last three years, as the stock market and interest rates fell, insurance companies' investment income dropped. So the companies raised their premiums.

Bear in mind that insurance and professional baseball are the only two industries exempt from antitrust laws. Active insurance regulation in the District is *de minimus*. Malpractice insurance premiums in California did not stabilize until after there was significant regulatory reform.

Responsible insurance executives and lobbyists have never claimed that caps will diminish premiums. In fact, the

plinary system in the District be improved. The board came to the same conclusions in its 1999 report.

MICRA—whether we're talking about California in 1975, or Texas in the 1990s, or the District today—does not reduce the incidence of malpractice or expand access to good medical care. What it does is effectively destroy significant legal rights for innocent malpractice victims like Robert and June Dixon to obtain fair compensation. And no public good is served by destroying that.

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