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Medical Malpractice Symposium Foreword

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MEDICAL MALPRACTICE SYMPOSIUM

FOREWORD

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> Late, late yestreen I saw the new Moon, With the old Moon in her arms: And I fear, I fear, my Master dear! We shall have a deadly storm.
>
> "Ballad of Sir Patrick Spence"

Engendered by various social, economic, and professional crises, tort reform is becoming the *cause célèbre* of the mid-1980's. Not surprisingly, it arrives in a storm of controversy, and at the eye of the storm is that species of professional negligence known as medical malpractice.

The current issue of the *William Mitchell Law Review* offers four articles on various important medical malpractice topics. The timing of these articles is especially appropriate for it is the medical malpractice phenomenon that appears to be both the source of the tort "crisis" and the principal target of tort reform.

The first article, entitled *A Survey of Medical Malpractice Tort Reform*, is a useful review of various types of tort reform designed to resolve what author Shirley Qual refers to as a "crisis of affordability." She discusses possible causes of the crisis — historical and contemporary—critically evaluates legislative responses, and suggests some solutions of her own.

It is clear from Ms. Qual's article that blame for the crisis seems to depend on who is pointing the finger. Lawyers blame doctors and insurance carriers; doctors and insurers blame lawyers; and social critics blame the courts. An intriguing observation by some commentators, and one of doubtless validity, is the notion that high technology might be the real villain. As Ms. Qual notes:

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> Doctors no longer treat all the needs of their patients, but rather focus only on that aspect of the patient's care in which they specialize. This change in the role of doctors causes a breakdown in the doctor-patient relationship which alters the character of the relationship from one of a family confidant to that of an anonymous technician. As a result, suing your doctor has become much less of a personal affront than it was in the past. The medical profession seems to recognize this hi-tech relationship as problematic and at least some HMO's have begun to emphasize that patients can choose and retain their own personal physicians. A few such organizations have even begun to renew the tradition of the "house call."

Ms. Qual examines arbitration and pre-trial screening by medical panels as responses to burgeoning medical malpractice lawsuits. She rejects arbitration as a realistic solution because of its lack of success in finally resolving the cases involved. Her view seems accurate. This is not because arbitration is not worthwhile or potentially a solution to malpractice litigation. Rather, it is because arbitration usually is a nonbinding procedure, and as such, does not preclude full litigation in the courts if one or another of the parties is dissatisfied with the outcome. If we are going to solve the "crisis of affordability," we must avoid solutions that are likely to be duplicative of existing procedures.

One might raise a similar concern about medical panel screening. Although this sounds like tort reform, perhaps it is little more than what is already available through the device of summary judgment.

A traditional tort concept that has driven some persons to frenzy has been overhauled by Minnesota's 1976 tort reform law. The "collateral source" rule, which prohibits a set-off from tort damages for previously paid medical, wage loss, and similar benefits, has been changed. Now it is possible to obtain such set-offs after verdict. The legislation allows the parties to continue to litigate the issue of collateral benefits by submission of written evidence. Whether or not the new law will reduce the likelihood of double recovry of benefits remains to be seen. It is certain, however, that it will complicate and extend each case in which collateral sources are involved and will undoubtedly contribute to court delay.

Ms. Qual is particularly critical of using ceilings or caps on

damages awards as tort reform. She notes: "Damage caps typically affect only the severely injured person, since damages awarded to those with lesser injuries do not reach the ceiling amounts. Thus, the most helpless party among those involved in the medical malpractice lawsuit is forced to carry the burden of the cost of malpractice. This is fundamentally unfair." Not only is it unfair but, as Ms. Qual indicates, catastrophically injured persons whose medical and other costs exceed the ceiling will require public assistance. Thus, the taxpayer is forced to assume the financial burden of their care.

Artificial and arbitrary measures such as damages ceilings and narrow restrictions on expert witnesses will certainly result in tort reform, but it is unlikely that such reform ultimately will be accepted by society as fair.

The second article, by William Bradt and John Guthmann, deals with the "loss of the value of a chance" concept in tort law, a concept not formally recognized by Minnesota law. The primary focus of the article, however, is on the broader issue of causation in medical negligence actions in Minnesota. The authors suggest that Minnesota courts employ a double standard by requiring one type of proof of causation for medical negligence cases and another type for all other negligence actions.

Historically, as the authors note, the appellate courts have described the requisite standard of causation in negligence cases differently. In an early case, the Minnesota Supreme Court mixed its discussion of causation with that of foreseeability. As a result, the court gave little guidance as to precisely what standard of causation was to be applied in negligence actions. Other cases have employed "but for," "substantial factor," and "more probable than not" approaches to the issue of causation.

Although I agree with the authors that the courts have not always been precise and clear in discussing causation, I do not necessarily agree that a double standard of causation has emerged.

Much of the confusion derives form the failure to distinguish the quantum of proof required in order to prevail in any negligence action from the definition of causation. In order to prevail in a medical negligence action, the plaintiff must prove various elements, among which is that the allegedly negligent act or omission was a direct cause of the harm. The quantum

of proof required is the greater weight of the evidence, that is, whether it is more likely than not that the defendant's act or omission was a direct cause of the harm. We need a definition of direct cause in assessing this element. The correct definition is that a direct cause is anything which was a "substantial factor" in bringing about the harm. It must, of course, be proved by the greater weight of the evidence that the act or omission in issue was a substantial factor in bringing about the harm.

The term "substantial factor," which might seem nebulous in the abstract, should always be sufficiently clear in the context of concrete evidence. The medical expert for the plaintiff needs to identify the act or omission as a cause of the harm and to give his reasons for his opinion. The jury, considering all the evidence in the case, then determines whether it was more likely than not that the act or omission was a substantial factor in bringing about the harm in question.

The authors have correctly pointed out the confusion that results when courts attempt alternative definitions of cause in order to justify the results of cases. For example, if a court on appeal states that an unbroken sequence of events occurred from origin to conclusion, is the court providing an empirical definition of causation or merely describing what happened in that case? It would seem that the court is merely being descriptive, that it is, simply attempting to demonstrate why it believes that causation was proved, and is not at all trying to formulate a definition of causation.

Whether or not the reader agrees with Mr. Bradt and Mr. Guthmann, it is apparent that they have identified a significant problem which deserves eternal vigilance by the courts; namely, the problem of being scrupulous in the use of language so as to achieve clarity and historical consistency among cases.

A controversy as acrimonious as that regarding the collateral source rule is the dispute about the "honest error in judgment" instruction in professional negligence cases. In the third article, Peter Plunkett examines the background, purpose, and limitations of the "honest error" concept.

Some jurisdictions have rejected the concept but, as Mr. Plunkett notes, the "rule" has been recently reaffirmed in Minnesota, with a strong admonition that it is reversible error for a

trial court to fail to give the honest error instruction in the appropriate case.

Mr. Plunkett aptly identifies the problem with the rule: ". . . honesty and dishonesty are not elements of negligence." By employing the rule, we interject a new element into the case. If the physician's motives were pure and if he acted in good faith, then he should be exonerated. This, of course, is not the law and never has been. Mr. Plunkett wonders, and so should we all, what the "honest error" instruction adds to a case other than confusion and a new element to litigate.

One would not be so concerned were the honest error language just harmless surplusage. But it becomes a pernicuous instrument of confusion in the case in which the physician's credibility is virtually critical to a determination of whether or not he was negligent. Suppose, for example, a Minnesota physician is presented with three young children for examination. Their father first tells the physician that they are visitors from Africa and then he describes certain symptoms. The doctor recognzes the symptoms as classic indicia of ear infection and, after the requisite examination, he treats the children accordingly. The symptoms increase in severity over the next few days and, continuing to believe that the children are suffering from ear infections, the physician prescribes stronger medication for such condition. The children do not improve, are hospitalized in severe condition, and are diagnosed by an emergency physician at the hospital as having malaria. One child dies and the others recover.

In the malpractice action against the initial treating physician, the allegation is that he negligently failed to diagnose the possibility of malaria and have appropriate tests performed. It is further alleged that at the first visit the children's father told the doctor that each child recently had bouts of malaria in Africa. The doctor denies that the father gave any such information, and admits that had such information been given, he would have been obligated immediately to suspect malaria and to order appropriate tests.

It should be clear that the doctor's credibility is central to the case. To give the honest error instruction with the standard credibility of witnesses instruction not only would be confusing, but it would likely lead to a distortion of the case's result as well.

Mr. Plunkett also points out that the application of the honest error rule is limited to the situation in which the doctor is required to choose among equally available and reasonable modalities of treatment. This will not be the situation in all cases and courts must be careful to recognize the limitation.

To paraphrase Mr. Plunkett, "honest error" is inherently dishonest because it does not accurately express the concept it is intended to define, but instead, provides a subterfuge by which a negligent physician can achieve exoneration by showing merely that he is a decent, honest person who acted in good faith.

The final article, a student Note entitled *Consent to Medical Treatment: Informed or Misinformed?*, analyzes the informed consent rule. Just as the honest error rule is frustrating to the plaintiffs' bar, this rule must be frustrating to the medical profession and lawyers who defend malpractice claims.

As with many of the rules examined in all the articles, informed consent seems conceptually sound, just, and necessary. When we try to define it and identify its boundaries, however, it becomes confusing.

This Note brings us back to a discussion of causation and its standards. The authors state: "To prevail in an informed consent case, the plaintiff must prove that the undisclosed risk resulted in harm. The plaintiff must also show that disclosure of the risk would have resulted in a decision not to undergo the proposed medical treatment. The second component of causation presents a difficult question." The authors then explain that the standard of causation has either been objective, subjective, or a hybrid.

The objective standard is a "reasonable patient" approach. The subjective standard focuses on this particular patient. Minnesota has adopted a modified objective standard and has delineated precise elements for assessing informed consent. The authors suggest that in formulating a standard, the focus must be broad enough to encompass the entire decision-making process, to take account of the needs of the patient, the concerns of the physician, and the ability of the courts to implement a clear rule. The authors point out: "Minnesota's position, a modified objective standard of disclosure, addresses the goals of the three parties in the informed consent arena. The Minnesota courts have repeatedly affirmed their commit-

ment to patient autonomy. Additionally, the courts have recognized the legitimate needs of physicians." A significant problem with this hybrid standard, according to the the authors, is that it is unnecessarily confusing; a purely objective standard would be far more effective in satisfying the concerns of patient, physician and court.

Although only the lead article is overtly focused on tort reform, all the issues presented in the other articles are necessarily parts of the reform effort. In addition to alerting us to significant contemporary tort issues and providing much valuable information, all the articles compel us to engage in some degree of critical self-assessment. Are our present rules and traditions principally vehicles to satisfy our avarice, or are they essentially fair and equitable protections of our rights? Are tort reform laws necessary and desirable limitations on unacceptable legal practices, or are they arbitrary, unreasonable obstacles to the vindication of wrongs committed by a certain segment of society? Have the courts created lamentable confusion in the law by careless and imprecise use of language and by straining legal concepts in order to justify results of cases? The articles in this issue do not give definitive answers to these questions, and perhaps there are no definitive answers. But, the concerns have been raised and the issues presented — that is the beginning of any meaningful reform.