AAOS Now

Punitive damages against physicians in the healthcare reform era

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In the context of claims against healthcare providers, most states generally allow punitive damages only in cases involving gross misconduct, an egregious violation of the standard of care, or utter indifference to the well-being of the patient. The line between "mere negligence" and "malicious misconduct," however, is often blurry.

What are punitive damages?
Damages awarded in civil litigation serve two purposes: to compensate the injured party for losses incurred and to punish the offensive conduct. Although definitions vary from state to state, compensatory damages generally are available to any patient injured by another's negligence, and can include economic and noneconomic components.

"Economic damages" refers to objective, monetary losses, such as medical expenses, lost earnings, and lost employment or business opportunities. "Noneconomic damages" generally means compensation for subjective, non-monetary losses such as pain, suffering, inconvenience, emotional distress, and loss of society and companionship.

In a smaller subset of cases, additional damages may be imposed to punish the defendant's misconduct, rather than to compensate the patient for losses suffered, so as to deter similar transgressions in the future. These are "punitive damages."

When and why are punitive damages awarded?
The economic justification for punitive damages argues that exposure to damages in excess of the actual harm is a necessary deterrent to egregious behavior and that the occasional "premium" paid in punitive damages accounts for acts that go undetected, for which compensation was not paid. Some states justify punitive damages on the ground that, due to the aggravated circumstances, the "wrong" suffered by the patient exceeds the actual injuries, so the damages should exceed the actual losses.

For example, juries have been permitted to consider awarding punitive damages in the following cases:

- Implanting a different medical device than identified in presurgical consent forms, particularly where the device used is "investigational" or "not for human use"

- Performing a sterilization procedure following a C-section, without advising the patient that her newborn had been injured in utero
- Performing surgery when the patient presented only for a second opinion
- Performing one procedure when another, more effective or accepted procedure is available, particularly if the doctor stands to profit by performing the first procedure
- Continuing to use a particular treatment that is known to have had disastrous consequences in the past
- Declining to provide necessary follow-up care after surgery to disguise injuries caused by error during the procedure
- Altering (or refusing to supply) the patient's medical chart, particularly if motivated to "cover up" suggestion of error
- Performing surgery while impaired

Calculating punitive damages

The calculation of punitive damages remains a topic of debate, particularly in medical liability cases, for two principal reasons. Because they are rooted in punishment rather than compensation, punitive damages trigger due process protections under the Fourteenth Amendment. Further, the threat of punitive damages can inject a great deal of uncertainty into handling claims of medical negligence.

In two recent cases, the U.S. Supreme Court has addressed the calculation of punitive damages awarded by state trial courts. In 2003, the Court decided that an award for punitive damages must be proportional to the compensatory damages. Awards that exceed a "single-digit ratio" between punitive damages and compensatory damages likely will not satisfy due process, and a ratio of greater than 4:1 "might be close to the line of constitutional impropriety."

In 2007, the Court directed state trial courts to educate jurors about the proper standards for considering punitive damages. If the trial court fails to provide "proper standards that will cabin the jury's discretionary authority, its punitive damages system may deprive a defendant of fair notice of the severity of the penalty," resulting in "an arbitrary determination of an award's amount." This decision also prohibited the jury from punishing the defendant for injuries caused to third parties, limiting punitive damages to misconduct that caused or contributed to the plaintiff's injury.

A recent survey of the uniform jury instructions used in 36 states found that only 11 states had the required "proportionality" instructions. Only seven states had developed a standard instruction informing the jury that it may not award punitive damages for harm caused to other persons.

The nature of punitive damages makes them notoriously difficult to predict, a problem that is compounded by the absence of specific judicial instructions to aid juries. A claim for punitive damages can result in introduction of evidence that the jury would not be permitted to hear in a typical case. As a result, both uncertainty about when punitive damages are appropriate and inconsistency in the calculation of awards continue.

Tort reform and punitive damages

Punitive damage standards, which gained prominence in the 1980s, are one aspect of more comprehensive tort reform. According to a June 2004 study by the Congressional Budget Office (CBO) only seven states had statutory restrictions on punitive damages in 1985. Since then, however, 34 states have enacted one or more statutory restrictions on the recovery of punitive damages. These restrictions include an outright ban, a "cap" or maximum recovery of allowable punitive damages, an enhance burden of proof (generally "clear and convincing evidence") of malicious conduct, procedural hurdles, such as requiring a hearing prior to assertion of punitive damage claim, or trust funds that collect a percentage of punitive damages, reducing a plaintiff's financial incentive.

Proponents of tort reform also seek to legislate punitive damage issues at the federal level. Various tort reform amendments, including reform of punitive damages, have been introduced, but their enactment is, as of this writing, uncertain.

Recently, the CBO updated its analysis of the likely effects of tort reform measures, including restrictions on punitive damages. In October 2009, a CBO letter report determined that reform could reduce healthcare costs in two ways: "directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of diagnostic tests and other healthcare services when providers recommend those services principally to reduce their exposure to lawsuits."

The CBO concluded that direct costs to healthcare providers—malpractice insurance, settlements, defense and administrative costs—amount to approximately 2 percent of total healthcare expenditures. Comprehensive federal tort reform could reduce these costs by about 10 percent, resulting in an overall reduction of 0.2 percent in healthcare costs.

For indirect costs, the CBO concluded that federal tort reform could reduce total healthcare expenditures by 0.3 percent, savings that reflect reduced utilization of healthcare services and a decrease in defensive medicine.

The CBO also noted the lack of reliable data about the impact of tort reform on patient outcomes. One group of researchers concluded that a 10 percent reduction of direct costs related to medical liability could *increase* the country's mortality rate by 0.2 percent. Other research groups found that tort reform resulted in no significant adverse effect on patient outcomes.

Conclusion

General agreement exists on two points: everyone who receives healthcare services should be entitled to services that are at least equal to the "community standard of care," and patients injured by substandard care should be compensated for their losses, completely but not excessively.

While there is room for legitimate disagreement about how much compensation is required to "make whole" an injured patient, well-informed risk managers, lawyers, and mediators generally can evaluate these claims with reasonable accuracy. A claim for punitive damages, however, requires an entirely different analysis, which includes factors that are not directly related to the specific patient.

These damages should be limited to exceptional cases. Accordingly, mere medical negligence

alone ordinarily should not support an award of punitive damages. Rather, to warrant punishment, the physician's conduct must be intentional, malicious, or indicative of an extreme disregard for the health and safety of the patient.

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Additional links to the decisions cited in the article:

CBO Underestimates Benefits of Malpractice Reform

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State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408 (2003).

Phillip Morris USA v. Williams, 549 U.S. 346 (2007)

CBO studies: 2004 and 2009

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