Endurance

CONTRAST

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Welcome to our third edition of *Contrast*. Published quarterly for healthcare professionals, *Contrast* is just one way Endurance demonstrates its commitment to providing insight and analysis to our valued clients and associates.

About Us

Endurance's Healthcare Liability division, led by Judy Hart, focuses on Excess Medical Professional Liability for multi-hospital systems, integrated delivery networks, university teaching hospitals and large specialty hospitals. Our clients are typically sophisticated purchasers who practice strong clinical risk and claims management.

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Contrast welcomes your comments and suggestions. Please email us at jhart@endurance.bm, or contact our editor directly at 441-278-0441.

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Letter from the Editor

We are pleased to share with you our third installment of Contrast. The purpose of this publication continues to be discussion of current issues with respect to medical malpractice and other healthcare related litigation.

In this issue we offer the third installment of "20 Questions", our vehicle to mine the observations and opinions of leading trial consultants. John Gilleland of Browne DecisionQuest is our guest for this segment.

In the article entitled "Consumer Protection for Structured Settlements" Bill Hans of Legacy Settlements Group offers a timely assessment of the practice of selling structured settlements by plaintiffs and claimants. And last we submit Scott Crockett's article "Loss of Life Expectancy: A New Element of Damages?" which concerns a troubling new basis for damages in personal injury cases.

We invite your comments about Contrast and suggestions for future issues. Please feel free to email them to me at jhart@endurance.bm.

I also want to take this opportunity to thank you, our valued customers, partners and friends. Your support and confidence in us has allowed our Healthcare practice to become a significant part of the Endurance success story. As the Endurance name suggests, we look forward to lasting, meaningful and mutually beneficial relationships with organizations like yours.

Yours Truly,

Judy Hart
Executive Vice President,
Healthcare Liability
Endurance Specialty Insurance Ltd.

Loss of Life Expectancy

A New Element of Damages?

By Scott Crockett

Remember when the usual elements of damages in personal injury cases essentially were pain and suffering, loss of consortium, lost wages, and past and future medical? It's not quite so simple now.

In a ground breaking December, 2002 Illinois case, Townsend v. Little Company of Mary Hospital & Healthcare, the trial court allowed the plaintiff to recover money damages for a new and distinct element of damages: loss of life expectancy. You may be hearing about Townsend because it is now being widely discussed and touted within the plaintiff's bar as a "new remedy".

Townsend was a birth injury case filed 17 years after and tried 19 years after the child's birth. At age 19 Damen Townsend weighed 53 pounds, was wheelchair bound, suffered seizures and scoliosis and was unable to speak or care for himself. It is hardly surprising that life expectancy was an issue in the case. The jury awarded $20,250,000 broken down as follows: $9,000,000 loss of life expectancy; $5,000,000 past and future medical; $2,250,000 pain and suffering; $1,875,000 disability; $1,875,000 disfigurement; and $250,000 lost income.

The Defendant's Dilemma

One of the most difficult and delicate tasks faced by defense lawyers is talking to the jury about a plaintiff's reduced life expectancy. Whether to do it and how to do it are case by case decisions that bear on the defense attorney's skills and the circumstances of the case. Plaintiff attorneys, in turn, have complained for years, and with arguable justification, that a reduced life expectancy argument allows the defense to unjustly take advantage of the injury it inflicted on the plaintiff. Townsend has the potential to make the calculus even more difficult for both plaintiffs and defendants.

One of the most difficult and delicate tasks faced by defense lawyers is talking to the jury about a plaintiff's reduced life expectancy.

From my pro-defense perspective it seems that plaintiffs have often driven us to arguing life expectancy. After all, it is the plaintiff experts who say, despite of all the evidence and common sense to the contrary, that someone who has suffered massive and catastrophic injury will live as long or nearly as long as someone who hasn't. Defendants ignore such testimony at their peril, particularly when the plaintiff is going to be arguing for a million dollars or more for every year the plaintiff is alive and in need of medical care. So we must challenge it, carefully, thoughtfully, logically and with sensitivity.

The Townsend decision then presents the ultimate legal Catch 22: the plaintiff can argue normal life expectancy (no matter how outlandish that claim might be) but if the defendant has the audacity to challenge it, the plaintiff gets to recover for loss of life expectancy if the jurors believe life expectancy is reduced. Talk about having your cake and eating it too!

Townsend in Context

Townsend represents an extension of the ongoing debate about how to evaluate and compensate for personal injury. In the mid-eighties the concept of "hedonic" damages came into vogue. Hedonic damages were intended to compensate the plaintiff for his loss of enjoyment or pleasure of life. While the "hedonic" label was new, the concept was not. In reality judges and juries had been accounting for and awarding money damages for such losses for decades except they were categorized as pain and suffering or disability or loss of consortium damages. Given that, one of the principal arguments against hedonic damages as a separate element of damages was that it allowed the plaintiff to recover twice for the same type of loss, once as pain and suffering and once again as hedonic damages.

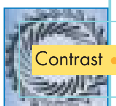
> *More recently courts have struggled with awarding separate damages for "loss of chance" and for "increased risk of harm".*

More recently courts have struggled with awarding separate damages for "loss of chance" and for "increased risk of harm". With both of these elements the jury is called on to speculate or at best make educated guesses about whether or not the plaintiff is more susceptible to complications or disease and future injury. Part and parcel to these elements of damages is the question of life expectancy. Arguably they both allow the jury to compensate the plaintiff for reduced life expectancy.

There are essentially four arguments against allowing loss of life expectancy to be a new and distinct element of damages: 1) life expectancy is unknowable and highly uncertain; 2) it compensates the plaintiff for harm not yet taken place; 3) the plaintiff may in fact die of causes wholly unrelated to the defendant's conduct and 4) it duplicates damages awarded for pain and suffering, disability or, where allowed, for loss of chance or increased risk of harm.

The first three arguments are similar in that they concern the speculative nature of "determining" life expectancy. But it is hard to credibly complain about such speculation because we engage in it as defendants all the time. In the abstract it is no more speculative for defendants to say a plaintiff's life expectancy is one year than it is for the plaintiff to say its twenty years.

It's the last argument about multiple recoveries that is the most compelling. Without impossibly clear cut definitions of what constitutes pain and suffering, or disability, or loss of chance, or increased risk of harm, or loss of life expectancy there is a very great risk that the plaintiff will get multiple awards for what amounts to the same general condition or outcome. In the end, plaintiffs are perfectly capable of asking juries for compensation for loss of life expectancy when they talk about pain, suffering, and so on. They do it all the time and jurors can and do act on it.



Townsend Going Forward?

It remains to be seen whether other courts will follow Townsend, or indeed if the Illinois Supreme Court would even allow loss of life expectancy to really become a new element of damages. The trial court's ruling on the issue was not appealed because the Townsend case was settled with a "high low" that capped the verdict at $19,000,000 to all defendants. As a part of that agreement the parties reportedly waived their right to appeal.

One also must wonder how much or if the loss of life expectancy damages increased the Townsend verdict. If the jury believed that Damen Townsend really had a normal life expectancy it is highly probable that the award for future medical would have been substantially higher that the $5,000,000 awarded for both past and future medical. In other words, the jury may have traded dollars, taking dollars out of the "future medical" bucket and putting them into the "loss of life expectancy" bucket. And this may be the best way for defendants to approach loss of life expectancy damages issue: make sure the jury realizes that if they believe life expectancy is reduced they must reduce the future medical award accordingly.

The problem defendants face, however, is that loss of life expectancy is a non-economic element of damages, not an economic one like future medical costs. With future medical there must be some evidence, however fanciful, on which jurors can base their future medical award. With loss of life expectancy damages, as with all non-economic damages, the sky is theoretically the limit if there is no cap. Townsend, in the end, may be yet another reason to fight for tort reform.

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Scott Crockett is the principal of Fortitude Litigation Services, Inc., which manages claims on behalf of Endurance Specialty Insurance Company's Healthcare business. He defended medical negligence and other cases in private practice and is a member of the Missouri and Kansas Bar Associations, the Federation of Defense and Corporate Counsel and the American Trial Lawyers Association.

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Consumer Protection for Structured Settlements

By Bill Hans

Studies show that somewhere in the neighborhood of 80% of all personal injury claimants have completely dissipated their personal injury settlement proceeds within 5 years of the date they receive their settlement check. For this reason, structured settlements have taken their place as in important part of the personal injury settlement process.

As a structured settlement consultant I often hear myself saying to personal injury claimants, "The best thing about a structured settlement is that the payments are fixed and guaranteed, so you cannot change the payment schedule once you have selected a particular structured plan." Unfortunately, this feature of structured settlements is all too often viewed retrospectively by structure claimants as the worst feature of structures, rather than the best.

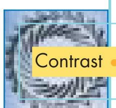
...in 1998 Illinois became the first state to regulate the practice of the sale of structured settlements to third parties.

Circumstances change. Life invariably throws curveballs. Claimants who thought that structured settlements were a great idea at the time of the settlement may not think so 15 years down the road. So what options does a claimant have when they no longer want to be locked into a structure?

There are a variety of so called "gray market" companies that will purchase structured settlement annuities for a fraction of the present value of those structured settlement annuities. Unfotunately, the proliferation of these structured settlement purchasers has led to numerous instances in which structured settlement claimants desperate for a lump sum of cash have been convinced to sell their structured settlements for a scant percentage of their actual value.

Recognizing the danger inherent in this practice, in 1998 Illinois became the first state to regulate the practice of the sale of structured settlements to third parties. There are now 35 states that have adopted consumer protection legislation governing the sale of structured settlement annuities. These statutes protect individuals from being taken advantage of by businesses that purchase structured settlements. The statutes primarily achieve this goal by permitting the sale of a structured settlement only if the structure owner and purchasing company demonstrate to a court that it is in the "best interest" of the structure owner to do so.

Legislation passed at the federal level applies if one of the remaining 15 states is involved. This legislation, now codified at section 5891 of the Internal Revenue Code, is part of the Structured Settlement Protection Act. The legislation specifically requires individuals seeking to sell their structured settlements to obtain court approval prior to doing so. Section 5891 requires simply that the sale must be in the "best interest" of the payee.
Two recent court cases provide insight as to how courts will apply the "best interest" standard: Davis v. Travelers Casualty & Surety, No. CV 02-0815609 (Ct. Sup. 2002) and In re Spinelli, 803 A.2d 172 (N.J. Super. 2002). These two cases were based on state statutes with language



essentially mirroring the newer federal legislation. It is not surprising that the courts will make the "best interest" decision on a case-by-case basis.

In Davis, the court rejected an individual's request to sell the remaining portion of his structured settlement. Davis, the applicant, was scheduled to receive two lump sum payments totaling approximately $50,000—the first in 2006 and the second in 2011. He wanted to sell these remaining structure payments for just under $16,500. Davis wanted to make the sale because his car was in need of significant repair. In its unreported opinion, the court concluded the sale was not in Davis' best interest. The court cited a number of factors as the basis for its decision including: (1) the discount rate used by the purchasing company to calculate the $16,500 purchase price was approximately 20%, a rate well above the prevailing prime, mortgage and credit card interest rates; (2) the purpose of the sale was for a car; (3) the applicant did not even have a basic understanding of financial and economic matters; and (4) the applicant had not sought professional advice regarding the sale.

The Spinelli court reached a different conclusion, stating that a proposed transfer was in the applicant's best interest. Like the applicant in Davis, Spinelli asserted that he needed the money now. He was $20,000 in debt due to a bout with cancer. Also, the discount rate applied by the purchasing entity was steep, according to the court (17% to 18% per year).

There are a few important differences between Davis and Spinelli that explain the different conclusions. First, the applicant in Spinelli was a fully licensed financial adviser, having worked at two well-known investment firms. He also had received advice regarding the sale from investment advisers and a business attorney. The court also stated that Spinelli had "shopped around" for price quotes for his structured settlement. By doing so, he had confirmed that the purchase price offered by the proposed purchaser was competitive. Furthermore, the court emphasized that Spinelli was not selling the structure's entire future income stream. Specifically, the terms of the proposed sale did not affect Spinelli's right to his final structure installment of $113,000 in the year 2019.

It is clear that structured settlement claimants now have the option to sell their structured settlements in the event that a serious need arises and a court of competent jurisdiction determines that such a sale would be in the structure holder's best interest. While the ubiquitous daytime and late-night commercials for factoring companies seeking to buy structured settlements likely will not go away anytime soon, it does appear that unsupervised bad deals transacted for no other reason than to relieve a structured settlement claimant from his periodic payments will cease.

ABOUT THE AUTHOR

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20 Questions

Installment Number 3 with John D. Gilleland, PhD, of Browne DecisionQuest, Chicago, Illinois

Question: How have juror perceptions/attitudes about healthcare defendants changed over the last few years?

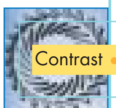
Answer: Jurors, and society in general, have become more savvy about healthcare. They are now better informed about their own medical problems and relentless in their pursuit of information. The tremendous growth of the internet has contributed directly to this "thirst" for understanding medical issues, and doctors regularly tell us that patients now come to them having completed their own research into medical problems as well as possible treatments and procedures that doctors might be recommending.

On the defendant side this has translated into jurors who have a better appreciation of the healthcare industry in general. They have more information about options and procedures people undergo, they better appreciate the risks involved, and they tend to realize that doctors and caregivers of all types are mere mortals. These "medical consumerists" are also much more likely to seek second opinions and to place the onus on the patient to understand and appreciate the risks inherent to their own medical care. Although these individuals won't tolerate obvious negligence, they do understand that most medical procedures involve risk, and that sometimes "stuff happens." For plaintiff-oriented individuals more information generally just means they have higher expectations for success and less tolerance if something goes wrong.

There have also been changes over the last decade in terms of the respect paid to doctors and to the medical profession. Although doctors are no longer put on such high pedestals, and are held to high standards of professional care, they are still not viewed as on an equal footing with the everyday person (i.e., there is still somewhat of an aura around the label "doctor"). Psychologically it would be too threatening to put the medical treatment of yourself or your loved ones in the hands of someone you didn't respect – at least for their training and ability.

We have also seen a change in doctors towards their patients. Doctors have, for the most part, become more accessible to the patient (i.e., doctors seem to have a greater appreciation for the development of a good bedside manner, both in terms of patient retention and in the event of medical complications down the road). Jurors anecdotally tell us how their doctors now spend more time with them and how their doctors seem more willing to explain the steps in medical procedures. And jurors appreciate these changes; even though they often go on to hypothesize the change is due to a fear of litigation.

Finally, the ever increasing cost of healthcare has not gone unnoticed by jurors. Although jurors have always complained about the relative high cost of healthcare (at least they have in my 15 years of jury research on medical malpractice cases), jurors now seem to consistently raise the issue of the role litigation plays in these rising costs. They've read (and have taken to heart) that the cost



of malpractice insurance has caused some physician's to curtail their involvement in riskier procedures, and right or wrong, they believe that the escalating premiums paid by physicians just come back to the consumer in the form of larger medical bills. Although this logic rarely makes an overt impact on the jury deliberation process, it works behind the scenes, maybe even subconsciously, to affect the individual juror's decision making processes.

All in all, these changes have led to our present state of affairs – today's healthcare defendants are faced with jurors who recognize what constitutes good care, and then demand good care, but jurors who are also willing to listen to explanations of why things went wrong. Doctors have responded by stepping up their education of consumers about risks involved with procedures so there are no surprises. When the patient's options – and risks – are explained more fully up front, jurors are less likely to punish doctors when problems do occur.

Question: What did you learn from focus groups and actual trials in 2003 about juror perceptions re: medical malpractice lawsuits?

Answer: One response we've seen consistently in medical malpractice cases regards juror perceptions of the need for tort reform. Although these perceptions are at an all time high, our research shows that such perceptions do not necessarily have an impact on the liability decisions reached by jurors in medical malpractice cases.

During the voir dire portion of both our research exercises and actual trials, jurors tell us there is "too much litigation" and that "jury awards have gotten out of hand." But although as many as 90% of jurors today agree with such statements (up considerably from the more evenhanded figures of 40%-50% in the late 1980's) these more general attitudinal responses are routinely overwhelmed by the specifics of any particular medical malpractice lawsuit.

Medical malpractice cases always have an element of human drama and a "loss" factor with which jurors can empathize – someone has been severely injured or lost their life. This is not frivolous litigation, which is what jurors are thinking of when they readily agree to the more general tort reform statements. Faced with a grieving family or an injured individual – and recognizing that the patient has little control over either their condition or the medical procedure that was completed – jurors tend to presume that the medical provider must have made a mistake or could have done more in the care of the patient.

On the "good news" side of things, the current corporate ethics crisis that our research shows has had a tremendous impact on commercial litigation does not seem to have had as large of an effect on medical malpractice lawsuits against individual doctors. There is still a basic presumption that doctors intend to do good, and that when it comes right down to it, the individual physician does not put profit over the care of their patient.

This benefit of the doubt obviously does not hold true where the evidence specifically allows the plaintiff to argue a "volume business" is being conducted by a single doctor (dozens of patients or multiple procedures in a single day) or when a physician group or hospital is the target defendant. As in other corporate enterprises, when a medical "entity" exists, jurors in today's climate are much more likely to believe that conduct is driven by profit margins then by altruistic behavior – even though individuals as care givers are still the ones involved and being blamed.

Question: What techniques/strategies have healthcare defendants been using that have worked/not worked over the past year?

Answer: Educating jurors as to the science behind the events that occurred and medical decisions that were made is the single most important aspect of a medical defendant's case. We have found that when jurors do not understand an illness, or a procedure comes across as being too complicated, they will assume the doctor or nurse had this same lack of communication with the patient/family.

Medical testimony of experts in a particular field must be simplified and pared down to the basics, so jurors can truly understand the conduct of the healthcare professionals, and the impact that conduct did or did not have on the patient's health. Good visuals are a part of any medical malpractice case, as without demonstratives it may be very difficult for the jury to follow the testimony.

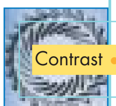
The true science behind any given medical condition or procedure may be very technical – and the battle of the experts at trial can get technical – but defense counsel must always come full circle with the expert and bring the discussion back up to a level that jurors can understand and that is consistent with the general case themes.

Jurors also react poorly to defendants who try to hide behind a given procedure's statistical "success rate." If there is only a 70/30 chance of surviving a particular procedure, jurors will pick up on the fact, and they will realize that the patient may have just been one of the unlucky who falls into the 30% category. But you have to let the jurors bring up how individual differences may have been a factor in the patient's ability to survive. A defendant in this situation is much better off explaining and focusing on what they did right rather than overtly relying on the "stuff happens" defense.

Defendants also have more success when they can effectively focus on the patient's own levels of knowledge and control. Like the old adage "follow the money," jurors routinely focus on these two dimensions when making liability decisions; who knew what (knowledge), and who had the ability to change the outcome (control).

Unfortunately, it is usually the physician who has the most knowledge and who ultimately controls the events that transpire during any particular medical procedure. When the situation allows, showing that the patient knew the risks and made the informed decision to proceed is an effective strategy, and it goes a long ways towards getting jurors to properly concentrate on the risks inherent in medicine. When patients have knowledge and the potential to control their own destiny, jurors tend to blame them for their lack of actions (e.g., the pregnant women with a history of miscarriages who fails to go to the doctor after being in a car accident – then later blames the doctor for another miscarriage).

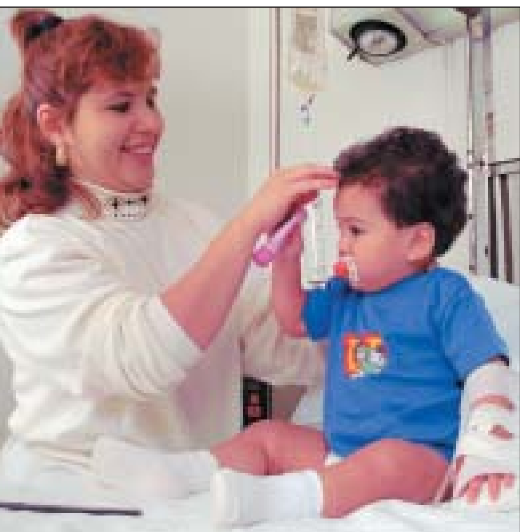
Finally, one of the best bets for improving a medical defendant's case is humanizing that defendant. We see the most success in cases where the trial team focuses the jurors on the doctor as an individual and not on her "practice." Doctors are used to being "in charge" which can easily carry with it an air of arrogance.



The doctor accused of malpractice is one of the only witnesses who will essentially testify as both fact and expert witness. The doctor who appears concerned and understanding, while simultaneously delivering her rationale explanation of events, goes over much better than one who testifies with a chip on her shoulder. This takes practice, as it is not an easy thing to remain calm and rational when you are accused of causing a severe injury or even a death.

Question: What techniques/strategies have you seen medical malpractice plaintiff attorneys successfully use over the past year?

Answer: Plaintiff attorneys still direct their efforts at attempts to generate anger about the defendant's actions. For several years now, plaintiffs' attorneys who concentrate in medical malpractice cases have moved away from relying on sympathy as a pressure point with juries (and our research efforts support the notion that jurors do not respond to a case built too heavily on sympathy).



True outrage is driven by anger, and as mentioned above, empathy exists wherever suffering exists. Plaintiff's attorneys now recognize that if anger exists, sympathy will follow (better yet, if anger exists, you don't need sympathy).

But anger is generally characterized by plaintiffs' lawyers as a component of punitive damages. And that leads one to consider the recent Campbell decision, which appears to limit the size of punitive damage awards, or at a minimum implies that punitive damages should bear some relationship to the size of the compensatory damages.

Because of Campbell, plaintiff's attorneys now seem to be focusing more attention on the non-economic damages of their cases; trying to increase awards for pain and suffering, which in turn will increase the "allowable" size of any punitive award that is also given by the jury.

In some instances plaintiff attorneys have also found success in focusing on the positive in their client's life rather than the negative – things their client cannot do. Although at first it seems counter intuitive to point out the strides the plaintiff has made in his or her recovery, our research has shown that jurors today are receptive to an injured party who has overcome adversity, and they respect a person who has "made the best of a bad situation."

Given the same set of facts, the plaintiff who has tried to "move on" will almost always draw a bigger jury award than the one who remains bitter and withdrawn. Jurors will perceive the bitter plaintiff as sitting back, waiting to see what a jury will give him.

Question: If you were a medical malpractice litigation defense decision maker, how would you undertake to obtain better trial results in 2004?

Answer: Actively engage in witness preparation workshops with both the defendant doctor(s) and the expert witnesses.

Although we all like to think the facts will win out in the end, a poor portrayal of those facts can sink even the most winnable of fact patterns. Doctors accused of malpractice need to experience first hand the tough cross examination they might see at trial in order to understand how the way in which they approach this attack on their integrity and behavior can help decide the case.

The trial team should videotape the experience so the doctor can objectively review his own performance (it is easier to spot indifference, arrogance, etc., when it is played over and over for appraisal by the trial team). Experts need to be shown just how esoteric (and confusing) their language can be to a lay person. These same experts will need to practice various ways of getting complicated concepts to fit with both the actual facts and the trial themes, and supportive demonstratives need to be started well in advance of trial so they can be refined right along side the trial themes.

Practice is key. Once doctors are comfortable with what they are going to say, they can begin to hone how they are going to say it. This allows doctors to present their best story, while allowing jurors to focus on the content of the defendant's case – instead of the personality of the defendant.

Test out your theories about what jurors will and will not do with a particular set of facts.

Decision makers also sometimes forget that jury research is not just for when you're outright trying to win the case. Can a significant portion of the blame be shifted to another party? Will a jury even think punitives are necessary? These are testable issues, and may be key to your decisions to move forward with the litigation or to push for settlement.

We recently worked on a case where the issue was whether or not a jury would hold a second defendant accountable, and if so, at what percentage of the total negligence? When the trial team uncovered a very real desire to assign the additional party a significant percentage of negligence, along with an equally strong desire not to award punitive damages against anyone, it gave them the will to actually try the case. Their subsequent strong position during final settlement negotiations, just prior to trial, worked to drive a much more attractive structured settlement package for both defendants.

Finally, better trial results can mean not taking the truly bad case to trial – but instead settling it at the "proper" value for the venue.

Insurance carriers, corporate entities and trial teams are regularly asked to assess whether or not cases are winnable, and then if the determination is "no," what the potential exposure might be; it's part of the job. Yet these entities might have disagreements about what is the true value of a case that everyone agrees should not be taken to trial.

What is the likely range of a pain and suffering award in a particular venue and for this type of conduct? What about the range of those punitives (if the jury thinks they are necessary)? You don't want to settle the case for the plaintiff's requested $15 million if a typical jury in the venue would only give something in the $5-$7 million range.

When debating the exposure of the case with truly bad facts it seems self evident that valuation research should be utilized. The investment is probably well worth it for the comfort of knowing you've structured a settlement that comports with what an actual jury might have given. Again, just knowing you have your finger on the pulse of the community can lend conviction to the trial team, and push a settlement through that might otherwise have been much higher.

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