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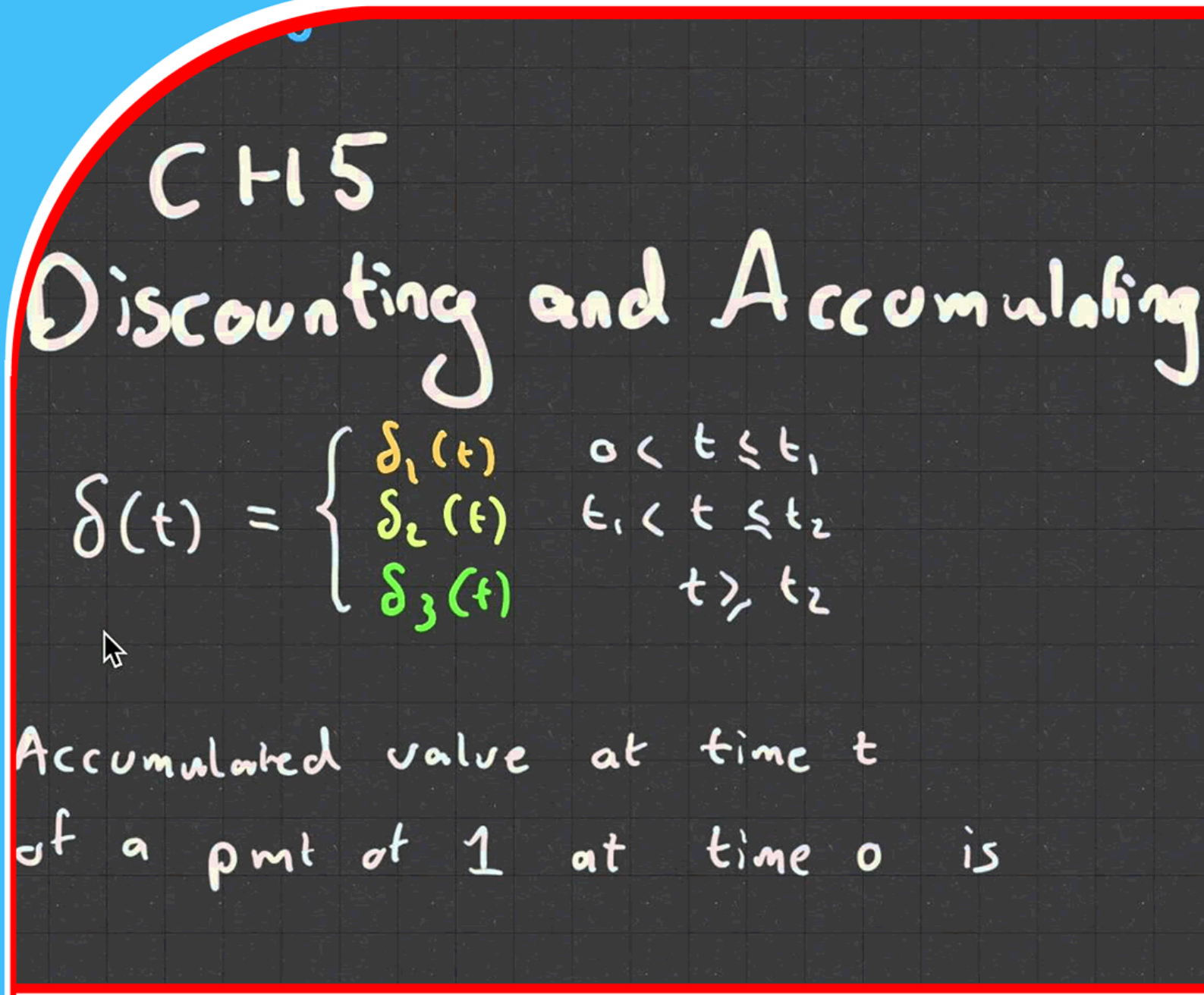

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Risk Management: Gaining Control of Medical Malpractice Litigation

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Abstract

The purpose of risk management is to anticipate a crisis, predict the most successful outcome for the crisis and prepare an actionable strategy to mitigate it. For doctors, a malpractice lawsuit is a crisis. It is completely predictable because it is always foreshadowed by a complication from a medical intervention. The complication can result from a medical error. However, it, also, can result from an error-of-nature. Both can lead to a lawsuit and they do so 50,000 times per year. CCC+C is a data-driven risk management tool that uses the scientific method to define, measure, analyze, improve, and control processes so that a medical error can be distinguished from an error-of-nature with 95% confidence. An error-of-nature is not preventable but a resulting frivolous lawsuit can be dismissed. Likewise, to err is human and a medical error results in a meritorious lawsuit. The lawsuit may not be preventable but it can be settled. Both outcomes depend on damage control. CCC+C is the damage control tool. When used by doctors as soon as a complication occurs, it manages all other obstacles presenting upstream from actuaries in medical malpractice insurance companies, plaintiff attorneys, defense attorneys and medical experts. In court, CCC+C is a forensic science designed to work in the same way as ACE+V, which is a forensic science that identifies fingerprints. Lastly, because CCC+C is transparent, it exposes unscrupulous tactics by any party on either side of litigation. It mitigates litigation by effectively protecting from, defending against and preventing unscrupulous tactics. Therefore, CCC+C is a game changer in the arena of medical malpractice litigation.

1.0 INTRODUCTION

Medical malpractice claims have been problematic for over half-a-century.[1] Health policy solutions prove futile; however, sometimes, the answer is in plain sight.

A complication from a medical intervention is in plain sight. Who better to recognize a complication than the doctor? Any complication, regardless of how trivial, is a medical malpractice lawsuit waiting to happen. If a claimant believes the complication is from a medical error, this suspicion of fault is enough to retain a medical malpractice attorney. The driving force for a potential lawsuit is not merit; rather, it is the settlement value of the complication.

This can change. It can change because of a risk-management tool, called CCC+C. ACE+V is the archetype for CCC+C. ACE+V is not a risk management tool; it is a forensic tool. Since the 1980s, it is regarded a game changer in criminal analysis. It uses the scientific method to determine if two fingerprints are the same or different with 95% confidence.[2] ACE+V is an acronym for Analyze, Compare, Evaluate and Verify.

CCC+C also uses the scientific method to analyze fingerprints. In this case, the fingerprints are found in medical liability. It is an acronym for Collate, Compare, Conclude and Certify. It determines if a medical intervention is the same as or different from the standard of care and does so with 95% confidence. [3]

As a rule of thumb, *a complication always results from a medical error until proven otherwise* and it is up to the doctor, responsible for the medical intervention from which the complication occurs, to prove or disprove it otherwise.

Once the complication is known, the next step expected of the doctor is to determine whether it is caused by an error-of-nature or an error-of-management, in other words, a medical error. This is the purpose of CCC+C.

Undoubtedly, medical errors occur during medical interventions.[4] The resulting mal-occurrence is indistinguishable from one caused by an error of nature.[5] However, medical errors have a distinct fingerprint. Because there is no medical error in a **standard of care**, this fingerprint is never found in **a medical intervention** that comports with the **standard of care**.[6] Any **medical intervention**, on which this fingerprint is found, is not the **standard of care**.[7] This is the fundamental principle behind CCC+C.

CCC+C is risk management. When used in medical malpractice litigation, risk management anticipates a lawsuit, predicts the most successful outcome and prepares an actionable strategy to realize this outcome.

2.0 METHODOLOGY

The 4 Steps of CCC+C:

"If the law has made you a witness, remain a man of science." These are the words of Dr. Paul Brouardel**,** a 19th-century French pathologist considered the father of forensic science. [8] This is true for any investigator of a complication from a medical intervention. For each, the starting point and everything that follows are the same. This is how the scientific method works and CCC+C reiterates the scientific method. Investigators, whether lawyers, medical experts, judges, doctors, risk managers or actuaries, are all schooled in the scientific method and, when used properly, outcomes of scientific inquiry are universal.

Step I - Collate:

This step and step 2 anticipate the lawsuit.

Divide the **standard of care**[9] and the **medical intervention**[10] into 10 corresponding phases:[11] 1) Presentation Phase, 2) Investigation Phase, 3) Interpretation Phase, 4) Diagnostic Phase, 5) Discrimination Phase, 6) Informed Consent Phase, 7) Selection Phase, 8) Technical Phase, 9) Resolution Phase and 10) Discharge Phase.

(A) Standard of care: Each phase in the **standard of care** is the benchmark for excellence. Because excellence is never a medical error,[12] an adverse outcome associated with the **standard of care** results from an error-of-nature.[13]

(B) Medical Intervention: Each phase in the **medical intervention** is the actual performance. Performance that departs from excellence is a medical error. [14]

Step II - Compare:

Contrast each phase in the **standard of care** to performance in its counterpart in the **medical intervention**. The variables used to make this comparison are:

(A) The Background Risk (μ): The Background Risk is the sine qua non of the **standard of care.** Adverse outcomes in the **standards of care** always result from errors-of-nature. Background Risk is the population mean for an error-of-nature. Background Risk is an independent variable unrelated to performance. An error-or-nature is unpreventable and happens randomly from all causes in the universe other than the medical error in question.[15] Attribution can be found in medical literature as the *background risk* for this particular complication.[16]

(B) The Observed Risk (≥ μ): An Observed risk that is greater than the Background Risk is the sine qua non, or fingerprint, for a medical error. Actual performance in any phase of the **medical intervention** produces an outcome having an Observed Risk.[17] Observed risk is a dependent variable. It has no random cause. The proximate cause is performance in the medical intervention. Observed Risk can be measured. When the Observed Risk in any phase of the **medical intervention** is statistically the same as the Background Risk, the adverse outcome is from an error-of-nature. When the Observed Risk is statistically greater than the Background Risk, the adverse outcome is from a medical error.

Attribution of Observed Risk is rarely found in medical literature; however, *relative risk* is often found.[18] Relative risk is usually reported as a relative increase in risk over normal, such as, 50% greater than normal.

(C) Risk of Harm (ROH): Any difference between the corresponding phases implies performance that has an inherent increase in risk as the proximate cause of an adverse outcome. [19] This is the *risk of harm*.[20] It is a dependent variable and can be measured.

The relative risk for the Observed Risk is the *risk of harm* or can be converted into the *risk of harm.* For instance, if relative risk is "50% greater than normal," the risk *of harm* is 1.5. Observed Risk = ROH x Background risk.

(D) <u>The Burden of Proof:</u> The comparison between the counterpart phases of the **standard of care** and the **medical intervention** to determine ROH requires a burden of proof called preponderance of evidence. This has 50% probability plus a *scintilla*.[21]

Scintilla is a critical variable.[22] Scintilla means just a "spark." For most observers, scintilla is a metaphor for any value. For all intent and purpose, any value added to the threshold of 50% probability, makes evidence more probable than not.

Scintilla can be measured and, for scientific investigators, like doctors and expert witnesses, scintilla is not a metaphor; it is 45%. A scintilla of 45% plus 50% probability equals 95%. Ninety-five percent confidence is standard in scientific inquiry.[23] In operation, this means that:

a. **If there is no difference**, the ROH is 1.0 and the Observed Risk in this phase of the **medical intervention** equals the Background Risk. This has 95% confidence.

b. **If there is a difference**, the ROH is greater than 1.0 and the Observed Risk in this phase of the **medical intervention** is greater than the Background Risk. This has 95% confidence.

c. **When repeated for each phase of the medical intervention,** there is a sample of 10 values for the Observed Risks. Some are equal to the Background Risk; others are greater than the Background Risk. This sample has 95% confidence.

Sometimes a difference makes no difference. This is the *respectable minority exception*. ROH is greater than 1.0 and the Observed Risk is greater than the Background Risk but the **medical intervention** still comports with the **standards of care**. This is because **standards of care** are duties to appropriately respond to certain hazards that are unique to a clinical presentation.[24] Even though an adverse outcome results from a particular phase, there is no medical error and the adverse outcome is caused by an error-of-nature.

Whether this circumstance is met in the **medical intervention** depends on the next step - hypothesis testing.

Step III - Conclude:

Basically, this step is hypothesis testing.[25] This step predicts the most successful outcome of a lawsuit.

(A) The Two Hypotheses:

a. **Null Hypothesis (H_0):** This is the "status quo." If there is no statistically significant difference between the Observed Risk of the adverse outcome in the **medical intervention** and the Background Risk, the **medical intervention** comports with **standards of care.**

b. **Alternate Hypothesis (H_a):** This is the "default position." If there is a statistically significant difference between the Observed Risk of the adverse outcome in the **medical intervention** and the Background Risk, the **medical intervention** departs from **standards of care**.

(B) The Test: one sample t-test [26]

a. ***The sample:*** this is the 10 Observed Risks for 10 phases in the **medical intervention**.

b. ***Level of significance,*** *alpha* (α) = 0.05: this corresponds to threshold of confidence no lower than 95% (50% confidence plus a scintilla of 45%).

c. ***Population mean,*** (μ): this is the background risk.

(C) The Result – the p-value:

a. **If $p \geq \alpha$,** *retain the null hypothesis*

b. **If $p < \alpha$,** *reject the null hypothesis, which sustains the alternate hypothesis by default.*

Step IV - Certify:

This step begins the actionable strategy to realize the best possible outcome in the lawsuit.

A written statement is prepared which is notarized under oath that the medical intervention either comports with or departs from standards of care. The opinion satisfies the criteria for burden of proof, i.e., preponderance of evidence —50% probability plus a *scintilla.* It establishes the value of *scintilla,* be it 45% or some other value, such as 0.01%, for all to know. It confirms that the opinion is based on accepted science and is tested for validity with a given level of significance, whatever it may be, preferably, 0.05, the scientific standard and equivalent to a confidence interval of no less than 95%.

If the null hypothesis is retained, there a degree of confidence based on the level of significance that the null hypothesis is true. If the null hypothesis is rejected, the alternate hypothesis is sustained by default. However, there is still a risk that the null hypothesis is true and rejecting a true null hypothesis is an error, called a type-1 error.[27] The risk of that error is equivalent to the level of significance. For instance, a level of significance of 0.05 has a 5% risk of a type-1 error and a level of significance of 0.5 has a 50% risk.

The report fulfills all the criteria for objective valid evidence, including an expected error rate. These are all stipulated by the Supreme Court of the United States in the Daubert Decision.[28] Objectivity is not a hypothetical or a capricious obligation. Objectivity is a professional standard of the AMA and almost every other professional medical association. [29]

When prepared by the doctor as soon as a complication is realized the report serves as risk management in any investigation that may proceed. Later, when prepared by the medical experts retained by the attorney, the certified report of the doctor is verified in the affidavit of merit of the medical expert.

When there is an investigation of an adverse outcome without risk management, there is a tendency to arrange the wagons in a circle and subjectively justify things to cover-up a medical error. [30] By fulfilling the criteria of risk management, CCC+C dispels any such notion.[31] It anticipates an emerging lawsuit as a complication from a medical intervention as soon as it presents. It predicts the best possible outcome for the lawsuit by investigating the complication and diagnosing its cause as either a medical error or an error-of-nature. It prepares an actionable strategy to realize this outcome by being completely candid in a notarized report. Most importantly, the report is open to scrutiny by anyone including the claimant. [32]

Some can still assert that the report by the doctor is a cover-up for a medical error. However, it is due diligence. [33] If it does nothing else, the report establishes the statute of limitation for a potential lawsuit, which is pertinent when a lawsuit is filed because it cannot be filed beyond that time.[34]

3.0 DISCUSSION

Unlike everything already tried, CCC+C is not statutory. It needs no tort reform, no health policy, no legislation, no politician and no change to legal or judicial procedures. It is consistent with what is already expected of any physician, namely, due diligence. When doctors deploy it proactively, to the consternation of lawyers, risk managers actuaries and judges, who come thereafter, CCC+C cannot be undone.

Upstream, for whomever uses CCC+C, the burden of proof is always preponderance of evidence, i.e., 50% probability plus a "*scintilla." Scintilla* is always a metaphor and its qualitative value depends on the intuition of the user.

Evens so, *scintilla* is quantitative. When *scintilla* is 0.001%, burden of proof has 50.001% probability. When *scintilla* is 45%, burden of proof has 95% probability.

Even when left to intuition, for most observers, in particular jurors, it is only common sense that 95% probability is a stronger burden of proof than 50.001%. The higher the *scintilla*, the greater the chance that accepting the null hypothesis is a right decision and the lower the chance that rejecting the null hypothesis is a wrong one. Hence, the greater the *scintilla*, the greater the interval of confidence and the lower the risk of a *type-1 error* and vice versa.

CCC+C has immediate implications for malpractice insurance companies. Supplying a certified report to the insurance carrier by the doctor, even before a claim is made, is not required in the "conditions" of the reporting provision in the policy but it is, also, not discouraged. In fact, "conditions" are sometimes worded to imply an obligation for the insured to promptly notify the carrier in writing of an incident which has a *reasonable possibility* to result in a claim.[35] Neither does this report conflict with a consent to settle provision or the cooperation clause. It is simply due diligence. Once received, this report can impact the entire dynamic in "claims-made" policies.

Nothing prevents doctors from sharing this certified report with the carrier. How a malpractice carrier responds depends upon how it regards the claim process.[36]

When actuaries for the carrier are placed on notice of a potential claim, they, too, have the duty of due diligence.[37] Based on this certified report, they could take it seriously; they could adjust claim guidelines; they could allocate resources or they could do nothing.

Upstream, CCC+C will impact defense attorneys. They have a conflict of interest between their obligations to an insurance carrier and their obligations to a doctor. Doctors have the right to protect themselves.

Ordinarily, the defense attorney is assigned by the malpractice carrier but not until a lawsuit is filed. However, once assigned, the certified report submitted by the doctor to the insurance company also puts defense counsel on notice. It can be ignored or can be taken seriously.

Defense attorneys typically have up to 90 days to respond to the charges in the complaint. They retain an expert witness to prepare a certificate of merit, aka, certificate of qualified expert, aka, affidavit of merit, upon which their response depends.[38]

If taken seriously, the opinions, which are expressed in the certificate of merit by this medical expert and, likewise, in the answers to charges by the defense counsel, should reflect the 95% confidence in the defendant's certified report. This largely depends on how proactive doctors are as soon as they are assigned a defense counsel. Ninety-five percent confidence stands in stark contrast to the generic 50% confidence plus a scintilla as, likely, will be expressed by the plaintiff

counsel and the plaintiff medical expert. This sets the tone for any ensuing litigation and can later lead to a dismissal of a frivolous claim or a negotiated settlement of a meritorious one as is warranted by the circumstances.

Upstream, CCC+C impacts a trial. It makes abundantly clear to everyone that, for the doctor, *scintilla* is 45% and, for the claimant, *scintilla* is just generic. Now, anyone hearing the evidence can rationally conclude the best proof of a case.[39]

CCC+C is in keeping with the oath jurors take to remain nonpartisan.[40] Scintilla is in the eyes of the beholder.[41] It is not partisan for a juror to understand that a threshold of 95% confidence is better than a threshold of 50% plus some ill-defined scintilla. Regardless of how they regard scintilla, jurors remain faithful to their oaths.

Upstream, CCC+C impacts legal strategies.

If there is no medical error, defense counsel has no problem with CCC+C because, when using a level of significance of 0.05, it retains the null hypothesis.

Not so for plaintiff attorneys. To prove their case, plaintiff counsels must use a level of significance that corresponds to 50% confidence plus a scintilla, or 0.5 plus a scintilla. Scintilla could be any value; even 0.00001 satisfies preponderance of evidence.

With hypothesis testing, there is technically no difference between a level of significance of 0.5 and a level of significance of 0.500001. Therefore, a level of significance, or alpha, of 0.5 serves a practical purpose.

Plaintiff counsel will argue that this is completely consistent with preponderance of evidence. According to the law, all that is required of any party, including the defense counsel, is no less than 50% confidence. The plaintiff counsel also knows that, when using a level of significance of 0.5, equivalent to a threshold of confidence no less than 50%, with hypothesis testing, the resulting p-value is less than 0.5, aka, alpha. When the p-value is less than alpha, the null hypothesis is rejected and the alternative hypothesis, which is consistent with negligence, is sustained by default. This is plaintiff counsel's job.

However, the defense counsel does not have to prove anything, but has to, merely, cast doubt on the plaintiff counsel's proof. The defense counsel knows that the plaintiff counsel's level of significance of 0.5 has a type-1 error of 50%. This makes the plaintiff counsel's proof of negligence no better than a coin toss. By contrast, defense counsel's level of significance of 0.05 is equivalent to a threshold of confidence no less than 95%. The p-value is greater than or equal to alpha. This retains the null hypothesis and has a type-1 error of 5%. Nothing casts doubt on the plaintiff counsel's proof of negligence better than this. This is defense counsel's job.

Alternatively, if there is a medical error, plaintiff counsel has no problem with CCC+C. Not so for defense attorneys

If the truth be told, when left to their own volition, neither plaintiff counsel nor defense counsel will use CCC+C for two reasons.

First, CCC+C threatens incomes.

For plaintiff attorneys, income is based on the contingency fee. [42] They typically earn more than defense attorneys but they are paid only when they prevail. Excessive verdicts in meritorious cases and convenient settlements in factitious ones are how they prevail and CCC+C discourages both.

Income for defense attorneys is based on billable hours.[43] They are paid whether they prevail or not; however, when CCC+C expedites settlements of meritorious cases or dismissals of frivolous ones, less hours are billed.

Second, CCC+C threatens traditional legal practices.

Plaintiff attorneys accept cases, not for merit, but for return on investment - a settlement value. The nature of their practices selects for clientele, whose suspicion of fault arises from an unfortunate outcome, sometimes caused by a medical error but other times caused by an error-of-nature.

When caused by an error-of-nature, the case may have a settlement value, but has no merit. To distract from this, plaintiff attorneys litigate such cases according to the "rules of the road" technique.[44]

They underestimate the ability of jurors to understand the science and appeal to their emotions. This strategy repeatedly attacks defense experts and ignores valid science.

Proceedings are protracted. The longer a case continues, the more likely an overzealous verdict will be rendered. An overzealous verdict makes a factitious settlement, even of a frivolous claim, more acceptable to the defense team, which includes the malpractice carrier.

"Rules of the road" technique is the antithesis to CCC+C. For this reason, it is not a fit in the traditional legal practice of plaintiff attorneys.

CCC+C is not a fit in the traditional legal practice of defense attorneys for a similar reason. Their strategy is to "postpone and adjourn." [45] This, too is the antithesis to CCC+C.

The strategy of "postpone and adjourn" produces more billable hours. Because of the nature of their practices, defense attorneys have 2 clients: the doctor, who is the defendant, and the malpractice carrier, who is a de facto client that pays the bills.

Cooperation clauses in malpractice policies, ostensibly, weave a tangled web making the malpractice carrier a partner in the defense strategy. Doctors become unwitting subjects of a defense strategy, over which the lawyer and the carrier confer.

This is especially pertinent when defense attorneys know a claim is meritorious. They acknowledge that, ultimately, damages will be awarded but, by protracting the case until they negotiate favorable settlement terms, they protect their de facto client, the insurance company.[46] The doctor still loses the case; however, the malpractice carrier loses less money.

There is an even greater conflict of interest when the doctor is an employee of a health system. Health systems are joint ventures of medical practices and hospitals.

Ordinarily, doctors, as participating providers, are paid by health insurance according to a discounted assignment for every service they render to an insured patient.[47]

This is not how they are paid as employees in health systems. Health systems negotiate a prospective capitated reimbursement with health insurance companies based on the numbers of *insured lives* for whom doctors render services when they join the health system.[48] Rather than

insurance companies paying physicians according to the quantity of care, now employers pay physicians according to the quality of care.

To do so, the health system, adopts resource-based *best-practices.*[49] These guidelines have less to do with quality than they have to do with healthcare costs. According to employers, doctors, who adhere to guidelines, practice quality care and are paid accordingly. Patients never know that medical interventions are determined by *best practices.*

Why would physicians accept such a model of practice? Oddly enough, it is because of the threat of medical malpractice litigation. When doctors are employees of a health system, they no longer pay malpractice insurance premiums and are covered under the malpractice insurance of the health system. Oftentimes, the health system is self-insured and has a proprietary interest in a medical malpractice insurance company. Like it or not, this is our modern healthcare system.

When litigation results, the employer's guidelines mean more to plaintiff counsel than do the standards of care. In accordance with the principle of *respondeat superior,* [50] plaintiff counsel makes it appear that doctors are incentivized to place the interests of their employer above the interests of their patient. Hence, the employer is a co-defendant in a medical malpractice lawsuit.

The defense attorney, now, has 3 clients: the doctor, the malpractice carrier, and the employer. With self-insurance the malpractice carrier and the employer are the same.

Despite this tangled web, CCC+C gives doctors more power over attorneys in medical malpractice claims than employers and malpractice carriers, despite self-insurance. There are 6 reasons for this:

1. Doctors are entitled to the best defense possible.
2. Defense attorneys owe doctors, who are their principal defendants, an overriding professional obligation of zealous advocacy.
3. The doctor has an overriding professional obligation to comport with applicable standards of care regardless of guidelines.
4. The employment contract between doctors and employers acknowledges that doctors are accountable to professional standards.[51]
5. Medical malpractice insurance covers breaches of the standards of care, not breach of warranty or fraud, which are different tort.
6. As long as the doctor remains in compliance with conditions in their policies, the malpractice carrier, self-insurance or otherwise, must fulfill all terms of coverage.

When doctors are proactive and insist on CCC+C as their best defense, they emphasize the ethical obligation of advocacy and they put defense attorneys on notice to whom their loyalty in a medical malpractice case belongs.

Defense attorneys must argue that, although respondeat *superior* makes the doctor, as an employee, a servant of the employer, the doctor is not responsible for and does not necessarily endorse the policies and practices set by the employer. This is contrary to what is contended by the plaintiff attorney.

Furthermore, the employment contract makes it clear that the doctor is expected to professionally perform according to the standards of care. When doctors comply with their employment contract, they necessarily comport with standards of care. By adhering to standards of care, any resulting

complication is caused by an error-of-nature and not a medical error. When doctors use CCC+C in the certified reports to prove that the standard of care, not a guideline, governs their performance, they vindicate themselves.

At the same time, when plaintiff counsels assert that a guideline caused the complication, they implicate the employer more than the doctor, especially when the guideline departs from the standard of care. Even though the guideline plays no role in performance and does not implicate the doctor in liability, it does implicate the employer in fraud, breach of contract and breach of warranty.

When realizing that best practices of the employer are misaligned with the interest of the doctor, the malpractice carrier, self-insurance notwithstanding, has no other choice than to provide the doctor separate legal representation from the employer.

The doctor has no culpability. The doctor's defense counsel, who only represents the doctor, can move to dismiss the doctor with prejudice. With the doctor dismissed, medical liability no longer exists. The suit continues against the employer but not for medical negligence because the doctor is dismissed.

The remaining charges, such as fraud and breach of t, are, technically, beyond the scope of coverage by a medical malpractice insurance policy, although they may be covered under an employer's general liability insurance.[52] Also, fraud, breach of warranty, etc. fall into a different category of torts than medical liability and require a more robust burden of proof. Fraud, for instance, requires clear and convincing evidence.

Because of CCC+C, this medical malpractice case enters an entirely different dimension. Plaintiff attorneys are caught off guard. To avoid litigation that requires a more robust burden of proof, they must salvage their medical malpractice case. They move for the presiding judge to disqualify CCC+C, arguing that CCC+C is inadmissible, untried and without legal precedent.[53]

How any judge decides is unpredictable. Judges know that CCC+C tends to make evidence more probable than the evidence would otherwise be and, therefore, it is relevant.[54] They, also, know there are no countervailing factors. CCC+C is not unfair, prejudicial, confusing, wasteful, hearsay or confidential. Asserting CCC+C is inadmissible is, at best, a specious argument and CCC+C should be admitted.[55]

Furthermore, in adversarial procedures, either plaintiff attorneys can prove these other charges against the employer or they cannot. In any event, it is left to the plaintiff counsel to impeach CCC+C, or those who use it, rather than leaving it to the judge to disqualify it.

If, perchance, the motion to disqualify CCC+C is sustained, judges, also, know that there is the right to an appeal.[56]

4.0 CONCLUSION AND RECOMMENDATIONS

The moment a report is prepared and certified by the doctor, risk management begins and the cat is out of the bag. Nothing changes this.

As in the above example, CCC+C empowers doctors in frivolous claims. The carrier is informed, prepared and committed to defend the case should litigation follow. Defense counsel moves to dismiss the doctor with prejudice.

What if, rather than the plaintiff counsel refusing to dismiss the doctor in the hope that the judge will decide that CCC+C is inadmissible, the claimant refuses to dismiss the doctor in the hope of securing a generous jury verdict? Because of CCC+C, settlement is not an option. Under these circumstances, the jury rightly, returns a verdict in favor of the doctor.

Continuing a frivolous lawsuit in the expectation of a generous verdict may be legal but it is an unscrupulous tactic by the claimant and plaintiff counsel. Until now, they are not held accountable.

Once the doctor prevails in this frivolous lawsuit, there is the specter of a malicious prosecution lawsuit against all those, who initiate and continue the frivolous lawsuit. Not all frivolous lawsuits are malicious but all malicious lawsuits are frivolous. Not only does CCC+C prove this case frivolous but, it, also, satisfies all 4 criteria of a malicious lawsuit.[57]

Because the malpractice carrier incurred unnecessary costs defending a frivolous malpractice suit through to trial, it, too, may be a plaintiff in the malicious prosecution lawsuit and pays all the legal cost arising therefrom, relieving the doctor of this burden.

During litigation the defendants, including the claimant, the plaintiff attorney and even the expert witness, will, likely, turn on each other. If the jury renders a favorable verdict, the defendants not only incur legal costs; they pay damages. These consequences should discourage willfully refusing to dismiss a frivolous malpractice lawsuit, which can be considered as a malicious lawsuit once the doctor prevails.

There are also meritorious lawsuits in which CCC+C plays a role in promoting the most favorable outcome possible.

What if CCC+C is used by the doctor as intended but rather than proving the lawsuit frivolous, it proves, with 95% confidence, that a resulting lawsuit is meritorious? The carrier is informed, prepared and consents to settle if a lawsuit follows. When filed, defense counsel makes a good faith offer of a fair and equitable settlement. Then, what if the claimant and/or the plaintiff counsel stubbornly reject it in the hope of securing a more lucrative jury award including punitive damages? Under these circumstances, the jury, rightly, decides in favor of the claimant.

Willfully refusing a good faith settlement in leu of the expectation of an excessive jury verdict that includes punitive damages may be legal but it is immoral. Until now, the claimant and plaintiff counsel are not held accountable.

Not all jury verdicts will be excessive or will award punitive damages but, under circumstances described above, any award greater than the settlement offer can be regarded excessive. The remedy for an excessive verdict is remittitur.[58]

If the award is excessive, regardless of merit, the doctor has the right, if not the obligation, to ask for a new trial or move to set the verdict aside.[59]

Under this circumstance, the malpractice carrier, which consents to the settlement, may also be an appellant. It pays all legal costs relieving other appellants of the burden. Appellees bear all legal costs and can lose everything. These consequences should discourage the willful refusal of a justifiable, fair and equitable settlement offer in the hope of a more generous jury verdict.

What if CCC+C is used by plaintiff experts as intended and proves, with 95% confidence, that the lawsuit is meritorious? Now, the plaintiff offers an equitable settlement. The malpractice carrier

agrees. Then, what if, the doctor, in defiance of this negotiated settlement, stubbornly rejects it hoping to be totally exonerated? The jury, rightly, decides in favor of the claimant.

Knowingly embarking on a futile defense at the expense of the malpractice carrier may be legal but it is unethical. Because of *consent to settle provisions* in the policy, the doctor is accountable for damages in excess of the settlement and possibly for legal transaction costs incurred after rejecting the settlement offer.

Moreover, when the doctor defies the malpractice carrier's consent to settle, the doctor breaches the cooperation clause and forfeits all coverage. While these should be enough to dissuade a doctor from embarking on a futile defense in a known meritorious claim in the false hope of deceiving the jury and being exonerated, there is still more.

CCC+C opens the door for the claimant and even the malpractice carrier to press charges of perjury and seek other civil penalties applicable to the rules of civil procedure that are violated by the doctor.[60]

There is one last scenario. What if CCC+C is used and the medical malpractice lawsuit is frivolous. Yet, to remedy charges of fraud, breach of warranty, etc. the malpractice carrier and/or the employer determines to settle the lawsuit. They should be able to; however, first, the doctor must be dismissed with prejudice, which completely exonerates the doctor of all charges. CCC+C makes this possible.

Admittedly, these scenarios are "what ifs." However, the purpose of risk management is to anticipate "what ifs," to predict possible outcomes and to prepare an actionable strategy that successfully mitigates the "what ifs." Each of these above scenarios serve as an example of a "what if" when CCC+C is used.

To know what happens when CCC+C is not used requires looking at what plagues our modern healthcare system, namely, a medical malpractice crisis that lasts half-a-century, a parade of failed legislative initiatives, the emergence of a medical liability litigation cartel, an average of 50,000 malpractice lawsuit each year, 70% of which are frivolous, a 5% risk for every doctor in the country to be sued for malpractice per-year, and $56-billion-per-year in medical liability costs (awards and transactional).[61] It is undeniable that medical malpractice litigation is badly in need of risk management?

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[61] See endnote 11