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Medical Malpractice Verdicts, Settlements & Experts seeks to raise the standard of medical malpractice litigation in the United States by publishing relevant, timely information about trial court cases nationwide. Its purpose is to enhance the likelihood that victims of malpractice will receive adequate compensation for injuries and that health care providers will be protected from fruitless lawsuits brought by uninformed patients. **Medical Malpractice Verdicts, Settlements & Experts** is not affiliated with any professional organization of lawyers, hospitals, or health care providers. It is not affiliated with any insurance company or medico-legal consulting firm.

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A Message to Our Readers: The tardive dyskinesia special report is an example of a new feature we hope to incorporate in future issues. Please tell us how you like it and what you would like to see. We encourage readers to submit articles/reports on malpractice-related topics. Contact the managing editor.

SPECIAL REPORT:

A Lawyer's Guide to Tardive Dyskinesia: An Overview of Litigation and Medicine

PREFACE

The following article was written by attorney Jeffrey C. Anderson of the firm of Southers & Lyons, 126 Villita, San Antonio, Texas 78205. It is reprinted here with permission of the publishers and first appeared in Texas Personal Injury Law Reporter, November 1985 under the title "Preparing for the Tardive Dyskinesia Epidemic." (Butterworth Legal Publishers, 11004 Metric Boulevard, Austin, TX 78758.)

We are pleased to offer this comprehensive medico-legal discussion of a problem that has already been reported on a case-by-case basis in **Medical Malpractice Verdicts, Settlements & Experts** and we anticipate more articles of this type in future issues. Readers will remember our past reporting of the following tardive dyskinesia cases:

1. An Oklahoma jury verdict where a 65-year-old man took the drug Triavil for three years. The jury found him 50% at fault but awarded $295,000. Incomplete medical records apparently hampered the defense. **Fred Hamil v. Henry T. Wittenburg, D.O.,** United States District Court, Oklahoma No. 84-428. Jerry M. Melone, Tulsa, for plaintiff. Reported in MMVS&E, January 1986, p. 27.
2. A Washington settlement for a 44-year-old man who received Trilafon for a number of years. The amount is nondisclosable **Robert Timmel v. Ben Kuhner, M.D.,** United States District Court, Western District of Washington No. C84-92. W. David Allen, Washington, D.C., for plaintiff. Reported in MMVS&E, August 1985, p. 20.
3. An Indiana jury verdict for a man who took Navane from 1979-1981; the state patient's compensation fund paid the bulk of a $300,000 award. **Lela Headley v. Vincent Hanneken, M.D.,** Grant (IN) Superior No. ST-893-151. Stephen B. Caplin for plaintiff. Reported in MMVS&E, August 1985, p. 20.
4. A federal court in Minneapolis awarded a 36-year-old man $2 million for substantial disability incurred from 17-month use of Thorazine prescribed by a VA doctor; liability was admitted. **Larry Hedlin v. United States,** United States District Court, Minnesota No. _____ (July, 1985).

INTRODUCTION

Nancy began showing symptoms of schizo-affective disorder in her early twenties. As the suggestion of schizophrenia became more pronounced, her doctor undertook drug therapy to control the disorder by prescribing 400 mg. of Thorazine. Drug therapy was virtually the only alternative available to treat Nancy's condition, since her psychotic episodes were infrequent and nonviolent. When Nancy's condition did not readily improve with this initial treatment, the dosage of Thorazine was increased. Over the next several years, Nancy's psychotic episodes became more frequent and progressively worse. Her physician responded accordingly by increasing her daily intake of Thorazine, which at times during her treatment amounted to more than *1300 mg.* From time to time her physician would also prescribe Stelazine or Mellaril in addition to or as a substitution for Thorazine. For several years Nancy was continuously kept on Thorazine or alternate neuroleptic medications, with no breaks or prolonged drug-free periods. Subsequently, Nancy developed some minor involuntary repetitive movements of her orofacial, buccal, and lingual musculature, and one physician noted that she showed movements characteristic of the early stages of Parkinson's disease. In view of her continuing diagnosis as an undifferentiated schizophrenic, however, she was maintained on heavy dosages of antipsychotic medications. These Parkinsonian-like movements increased in severity and spread to her trunk and limbs. By this time, it was too late; Nancy had developed tardive dyskinesia. The real tragedy was that Nancy did not have a schizo-affective disorder, for which she was originally treated. Her condition was later accurately diagnosed as temporal lobe epilepsy; a condition for which neuroleptic/antipsychotic medication is not indicated. Despondent over her condition, Nancy committed suicide a year later by setting herself on fire.

Nancy is just one of the great number of persons who will contract tardive dyskinesia as a result of both the proper and improper use of neuroleptic/antipsychotic medications. Although at the present time there are very few reported medical malpractice cases involving tardive dyskinesia, there appears to be little doubt that these cases are just a trickle before the floodgates open. Dr. Paul S. Appelbaum, writing in the *American Journal of Psychiatry,* recently declared that the pending epidemic of tardive dyskinesia was possibly "our next mass accident," similar to the previous asbestosis, Agent Orange, diethylstilbestrol (DES), Dalkon Shield and swine flu/guillain barre syndrome man-made epidemics.[1] Since tardive dyskinesia is almost exclusively an iatrogenic disorder and since neuroleptic drug therapy is currently the only effective method of controlling the psychotic episodes of schizo-affective disorder, one author noted: "the impending flood of Tardive Dyskinesia litigation has begun. I think that there is an enormous backlog of cases that are going to plague us for years."[2] Articles have already been written by physicians urging that alternate compensation systems be set up to deal with the patients who become victims of tardive dyskinesia. Since the medical profession seems to be preparing for a flood of litigation involving this disorder, we need to understand more about its etiology.

ETIOLOGY

Neuroleptic drugs were first introduced into clinical psychology around 1952. Soon after their introduction, it became apparent that these drugs were capable of producing a variety of unexpected extrapyramidal side effects, including rigidity and acute dystonic reactions. These unexpected conditions were observed to occur primarily in early treatment, usually after days to weeks; to be transient, remitting spontaneously in some cases; and frequently to respond well to anticholinergic agents. These conditions were also reported to disappear after neuroleptic dosage reduction or discontinuation of the drug therapy.

Initial reports of tardive dyskinesia appeared in Europe in the 1950s. The first public description of the disorder is attributed to an article written by Dr. M. Schonecker in 1957 in a paper entitled "A Peculiar Syndrome in Oral Region as the Result of the Administration of Megaphen."[3] In the article, Dr. Schonecker described three patients who had developed involuntary movements similar to a Parkinsonian disorder after having been on a prolonged course of a neuroleptic medication. Although these movements occurred earlier in treatment than what generally became associated with the concept of tardive dyskinesia, the fact that they persisted following drug withdrawal suggested that the condition was a different phenomenon from the previously recognized "Parkinsonian" side effects.

Subsequent articles in the 1960s continued to report types of neuroleptic-induced dyskinesias, some of which persisted long after the discontinuation of the neuroleptic drug therapy.[4] At this time the term "tardive dyskinesia" was suggested to describe these Parkinsonian-type movements associated with neuroleptic withdrawal. By the early seventies the consequences of prolonged neuroleptic drug therapy were becoming evident as the number of patients with tardive dyskinesia increased dramatically. In 1980 a task force set up by the American Psychiatric Association published its findings formally recognizing a direct relationship between the prolonged use of neuroleptic drugs and the development of tardive dyskinesia.[5]

MANIFESTATIONS

Tardive dyskinesia is an abnormal, repetitive movement disorder that affects some individuals who have been treated for a prolonged period of time with antipsychotic/neuroleptic medications, such as Thorazine or Mellaril. The initial physical manifestations of the disease usually involve choreic movements of the face, which include movements of the mouth, tongue rolling, chewing or gnawing motions, lateral jaw movements, twitches, and repetitive tongue protrusions (a condition referred to as "serpent's tongue"). There may also be audible grunts, whistles, or swallowing sounds. As the disorder progresses, the dyskinetic movements commonly extend to the extremities, such as the arms, fingers and toes. There may be twitching or jerking of the fingers or toes or forceful constant choreic movements. The condition may also result in incapacitating dystonic posturing.

Today the initial diagnosis of tardive dyskinesia may not be a difficult one. Though there are no pathognomonic signs or symptoms, a presumptive diagnosis of tardive dyskinesia should be made for any patient with abnormal involuntary movements who has a history of taking neuroleptic medication for a period of at least three months. A physician should also be suspicious if a patient demonstrating dyskinetic movements has recently undergone a reduction in his neuroleptic drug dosage or a discontinuation of his medication prior to the onset of his involuntary movements.[6]

INCIDENCE, PREVALENCE, AND RISK FACTORS

Both the incidence (new cases occurring in a defined population during a given period of time) of tardive dyskinesia and its prevalence (the proportion of patients with tardive dyskinesia in a treatment facility during a given period of time) appear to be highly variable, ranging from a low of 1 percent to a high of 57 percent in chronic drug-treated patients.[7] The prognosis of patients with tardive dyskinesia is also highly variable.

There are a number of risk factors. Age appears to be the single most important of these. Generally, it is thought that younger patients who have not been chronically institutionalized and who have received low doses of antipsychotic medication over a short period of time are at less risk of developing tardive dyskinesia than elderly patients with prolonged exposure to antipsychotic drugs. Elderly patients are also more likely to develop irreversible tardive dyskinesia than are younger patients who have been taken off the medication upon demonstration of the first symptoms.

Being female is the second most frequently suggested risk factor. Tardive dyskinesia appears to be substantially more prevalent in women than in men, even after the age factor is discounted. It also appears from the studies that women are more likely than men to develop irreversible tardive dyskinesia, as well as the more severe forms of the disorder.[8]

Drug dosage and duration also seem to be major risk factors in developing tardive dyskinesia. It is generally considered that high dosages of neuroleptic drugs increase the risk of the disorder, as does prolonged administration of the drugs. The risk of tardive dyskinesia is directly related to the cumulative neuroleptic drug exposure, which is a combination of drug dosage and duration of drug administration. Generally, the higher the cumulative drug exposure, the greater the risk of developing tardive dyskinesia.[9]

Drug type does *not* appear to be an important risk factor in the development of tardive dyskinesia. The drugs implicated in etiology of tardive dyskinesia are numerous and include the following:

Generic Name	*Trade Name(s)*
Chlorpromazine	Thorazine
Promazine HCI	Sparine
Trifluprornazine	Vesprin
Fluphenazine	Permitil/Prolixin
Perphenazine	Triavil/Trilafon
Prochlorperazine	Compazine
Trifluoperazine	Stelazine
Thioridazine	Mellaril
Chlorprothixene	Taractan
Haloperidol	Haldol
Thiothixene	Navane
Molindone	Moban
Mesoridazine	Serentil
Lithium Carbonate	Cibalith-S/Eskalith/ Lithane/Lithobid/Lithotabs/Lithonate
Loxitane	Loxitane
Piperacetazine	Quide

None of the above-listed drugs appears to be more likely to produce tardive dyskinesia than the others; however, there does not appear to be sufficient research to completely rule out drug type as an important risk factor.

TREATMENT

There is no known cure for tardive dyskinesia. Some individuals recover spontaneously over a period of time after being taken off the medications. Dr. Norman M. Bacher reported some promising results in using a low dose of propranolol in an April 1980 issue of the *American Journal of Psychiatry,* but the treatment has been far from universally effective.[10] In some patients, lithium has been used to treat the symptoms, but there have been conflicting reports that lithium may actually aggravate the involuntary dyskinetic movements.[11] Other drugs investigated for use in the treatment of tardive dyskinesia include sinemet, tryptopan, morphine, haloperidol, atropine, and naxolone. Though many drugs have been tested, the overall value of all these treatments remains to be established.[12]

MEDICAL DILEMMA

The dilemma facing physicians regarding tardive dyskinesia is that there is no satisfactory alternative to the use of neuroleptic /antipsychotic medication in the treatment of schizo-affective disorders at the present time. Neuroleptic drugs are the mainstay of both acute and maintenance treatment of schizophrenia. In other words, physicians must use antipsychotic medication to prevent the psychotic aspects of schizophrenia, but in so doing, they unavoidably subject their patients to the very real risk of tardive dyskinesia. By attempting to control the psychotic manifestations of a schizophrenic patient, the physician may at the same time cause his patient to sustain a permanent incapacitating injury.

LEGAL DILEMMA

Tardive dyskinesia also presents a dilemma for attorneys representing patients who have developed the condition as a result of drug therapy. At the present time, the treatment of choice for a schizophrenic patient in a psychotic state is the use of neuroleptic drug therapy. Uncontrolled schizophrenics in a psychotic state present an unreasonable danger to themselves and others. At the present time, this danger can be minimized only through the use of neuroleptic drug therapy, since the use of institutionalization and surgery is severely limited to chronically psychotic, highly dangerous individuals. What makes the tardive dyskinesia epidemic different from previous mass accidents caused by such man-made products as diethylstilbestol (DES), the Dalkon Shield, and the guillain barre-producing swine flu inoculation is that the physician has no choice in many instances but to place his patient at some risk of developing tardive dyskinesia in order to control his psychotic outbreaks. This lack of treatment alternatives, however, does not completely shield the physician from responsibility for causing his patient to suffer tardive dyskinesia as the result of neuroleptic drug therapy.

CAUSES OF ACTION

Informed Consent?

A great deal of attention has been focused in the medical literature upon informing prospective drug therapy patients of the possibility of developing tardive dyskinesia. The literature goes to great lengths to recommend that physicians disclose all risk factors and possible treatment alternatives to their patients before undertaking neuroleptic drug therapy.[13] This concern

regarding the legal consequences of failing to obtain a patient's informed consent before a drug treatment may be exaggerated in view of recent developments.

A cause of action based upon a physician's failure to obtain the patient's informed consent to administer neuroleptic medication may not exist in Texas under the present state of law. In *Barclay v. Campbell*, 683 S.W.2d 498 (Tex. App. — Dallas, 1984, writ granted), 2 Tex. Pers. Inj. L. Rep. 88 (1985), the Texas Court of Civil Appeals in Dallas affirmed a trial court's instructed verdict in favor of the defendant on the issue of informed consent. In *Barclay*, the plaintiff filed suit against the defendant physician, alleging that the doctor had negligently prescribed certain neuroleptic medications in connection with his psychiatric treatment of the plaintiff, and that the doctor negligently failed to disclose to the plaintiff the risks of tardive dyskinesia associated with the medications. During the course of his treatment, the plaintiff developed tardive dyskinesia. The evidence was undisputed that the defendant failed to warn the plaintiff of the risk of developing the disorder associated with the use of neuroleptic medication. During the trial various expert witnesses were called. Plaintiff's expert, a neurologist with a special interest in tardive dyskinesia, testified that the drugs administered by the defendant could cause the condition, but on cross-examination he stated that the risk was small. The defendant's expert witnesses also testified that although the drugs administered to the plaintiff could cause tardive dyskinesia, the risk was extremely small; furthermore, the plaintiff was suffering from a medical condition in which virtually the only treatment was drug therapy utilizing antipsychotic medication. A psychiatrist called by the defendant went further and testified that it would have been *poor* psychiatric practice to tell a patient like the plaintiff of the risk of the side effects of tardive dyskinesia because it would probably have kept him from taking the medication. The defendant himself testified that a possible consequence of informing the plaintiff of the risk of tardive dyskinesia was that it would have been more difficult for him to take the medication and the information "might very well have made him uncooperative." *Id.* at 501.

The court of appeals, in affirming the trial court's instructed verdict in favor of the defendant on the issue of informed consent, stated that its decision was controlled by provisions of the Medical Liability and Insurance Improvement Act, Tex. Rev. Civ. Stat. Ann. art. 4590i (Vernon supp. 1984). That Act changed the common-law rule concerning a physician's duty of disclosure from that of a "reasonable medical practitioner" to that established by a panel of experts to determine and list which risks related to medical care should be disclosed. Provisions of section 6.07(a) of the Act created a rebuttable presumption of negligence when a physician failed to disclose one of the risks which the panel listed among those that must be disclosed. For some reason, tardive dyskinesia was not on the section 6.07(a) list of risks to be disclosed before undertaking neuroleptic drug therapy. In citing from the Act, the court stated that a physician's "failure to disclose may be found not to be negligent if there was an emergency or if for some other reason *it was not medically feasible* to make a disclosure of the kind that would otherwise have been negligent." (Emphasis added.) *Id.* at 501. The Dallas court affirmed the district court's instructed verdict on the issue of informed consent by finding, in effect, that it was not medically feasible to disclose the risk of developing tardive dyskinesia to the plaintiff because it could have caused him to become uncooperative in his drug therapy and to refuse to take the neuroleptic medication prescribed for him by the physician. *Id.* at 501-2. In other words, the trial court and the Dallas Court of Appeals determined that under certain circumstances the risk of developing tardive dyskinesia as a result of neuroleptic drug therapy is so small that it does not exist as a matter of law. It appears that the court of appeals created its own "benefit to risk ratio" in determining which risks related to medical care must be disclosed under the Act. Although the supreme court has granted a writ in this case, at the present time there may not be any cause of action for a physician's failure to warn of the risk of tardive dyskinesia when prescribing neuroleptic/antipsychotic drugs.

Misdiagnosis

If a physician at the present time has no duty to advise his patients of the possible risk of developing tardive dyskinesia incidental to neuroleptic drug therapy, he still must exercise reasonable medical care in screening those patients selected for administration of neuroleptic drugs. Neuroleptic medication must be limited to those patients diagnosed as suffering from a schizo-affective disorder of a moderate to severe nature. Its use must be limited to conditions which, in all reasonable medical probability, will result in severe aggression or self-abuse. *See Clites v. State*, 322 N.W.2d 917 (Iowa Ct. App. 1982). Neuroleptic medication must not be administered in the presence of any preexisting movement disorder or to patients in which such disorders may be masked by the use of other medications. In the case recited in the beginning of this article, Nancy had been erroneously diagnosed as suffering from a schizo-affective disorder for a number of years. Neuroleptic drug therapy was undertaken based upon this misdiagnosis. Even though the risk of tardive dyskinesia was never related to Nancy, that issue is not material, since Nancy's ultimate cause of action will be one based upon inadequate screening, misdiagnosis, and inappropriate medical treatment.

There is also a potential cause of action when the error in diagnosis relates to the failure of the defendant physician to timely recognize the initial physical manifestations of tardive dyskinesia or to confuse those manifestations with another disease process. In the case of *Fagenbaum v. Oakland Medical Center*, 373 N.W.2d 161 (Mich. App. 1985), the plaintiff filed suit on behalf of his minor daughter against the Clinton Valley Center and the doctors and staff of the Oakland Medical Center. He alleged that his daughter had been initially misdiagnosed as being mentally ill and that she was improperly admitted to the Clinton Valley Medical Center. *Id.* at 162. Shortly after the initial misdiagnosis, the plaintiff's daughter was begun on neuroleptic drug therapy with Thorazine and Mellaril. The prolonged use of these drugs subsequently cause her to develop

tardive dyskinesia, which was manifested by the classical movement disorders of her face, mouth and limbs. Although she demonstrated the classical symptoms, she was again misdiagnosed, this time as suffering from Huntington's Chorea, and was subsequently prescribed yet another neuroleptic drug, Haldol, to control the disorder. It was determined too late, after a prolonged course on Haldol, that she did not have Huntington's Chorea. The Haldol she received aggravated her condition and contributed greatly to the severity of her tardive dyskinesia, rendering the condition irreversible. *Id.* at 163.

The case was subsequently settled against some defendants for $378,000 and a verdict returned against the remainder in the total sum of $1,000,000. Although the case was reversed on the issue of governmental immunity under the Michigan Tort claims Act, it is one example of a cause of action that would be actionable under the Texas Medical Liability and Insurance Improvement Act.

Mistreatment

Even though physicians may be faced, unavoidably, with a risks-versus-benefit consideration when prescribing neuroleptic drug therapy, the dilemma posed by the risk of tardive dyskinesia will not excuse a physician from his obligation to follow accepted standards of medical care in the treatment of the condition. In the case of *Clites v. State,* 322 N.W.2d 917 (Iowa Ct. App. 1982), a twenty-eight-year-old retarded man who developed tardive dyskinesia as the result of prolonged treatment with major tranquilizers in a state hospital school was awarded a judgment in excess of $760,000.

The plaintiff was admitted to the Glenwood School, a state-owned hospital school, in early 1963. Upon admission, he showed no signs of abnormality other than mental retardation. He was completely ambulatory upon admission, had sufficient manual dexterity to care for himself, and could interact with his peers. Although the plaintiff had a poor speech pattern, he could make himself understood. In 1970, he was placed on Mellaril, a neuroleptic, after unsubstantiated reports of sexual misconduct and aggression. Over the next several years, the plaintiff continued to receive this drug therapy in ever-increasing dosage levels. In 1975, he developed hyperkinetic, involuntary movements of his mouth, face, and limbs. At that time he was diagnosed as suffering from tardive dyskinesia.

The plaintiff filed suit under the Iowa Tort Claims Act, alleging negligence in the improper use of drugs and the failure to moderate the dosage levels. He also alleged that he was given this treatment merely for the convenience of the staff and not as the result of any medical necessity.

In its decision, the trial court found that the long-term use of neuroleptic medication, under the facts of this case, was medically unwarranted, that the plaintiff was improperly monitored and restrained, and that the staff was medically negligent in failing to discontinue the drug therapy upon the development of the tardive dyskinesia manifestations. In arriving at these conclusions, the trial court set out the basic medical standards to be followed when utilizing neuroleptic/antipsychotic drugs:

1. Limiting the use of neuroleptics or major tranquilizers to situations in which the patient has demonstrated severe aggression or self-abuse.
2. Regularly monitoring patients under neuroleptic drug therapy through the use of regular visits to a physician and regular physical examinations, including the use of the appropriate laboratory tests.
3. Temporarily interrupting drug therapy, i.e., drug holidays to monitor a patient's progress while he is not under the effect of major drugs. Though the court noted that there was some disagreement in regard to the use of "drug holidays," their use as part of a treatment regimen should be considered.
4. Consulting periodically with drug therapy specialists or periodically using peer review.
5. Altering or timely halting drug therapy when the manifestation of tardive dyskinesia first develops.
6. Restricting the concurrent use of major tranquilizers and neuroleptics to only those circumstances where the use of multiple drugs is the least intrusive means of treatment.

Id. at 920-21.

The decision of the trial court was affirmed by the Iowa Court of Appeals on June 29, 1982. *See Clites v. State,* 322 N.W.2d 917 (Iowa Ct. App. 1982). Although there are no reported cases involving the treatment standard applicable to patients suffering tardive dyskinesia in Texas at the present time, the standard set out by the Iowa court certainly comports with the recommendations contained in the current medical literature and should certainly apply to physicians in Texas and elsewhere.[14]

CONCLUSION

Although there are few reported medical malpractice cases dealing with tardive dyskinesia as a consequence of drug therapy, many cases should be appearing in the Reporter system very soon. The medical community has recognized the problem and has been gearing up for the tardive dyskinesia epidemic for several years. Although the condition is a necessary risk of an equally necessary procedure, the medical community recognizes that the risks can be minimized and probably the prevalence of the disorder reduced. The legal profession must be equally prepared to deal with the pending tardive dyskinesia epidemic. We must be thoroughly familiar with the disorder in order to fulfill our duty of distinguishing the victims of an unavoidable medical consequence from the victims of avoidable medical mismangement.

NOTES

[1]Appelbaum, Schaffner, & Meisel, *Responsibility and Compensation for Tardive Dyskinesia,* 142 Am. J. Psychiatry 807 (July 1985).

[2]Baker, *Expect a Flood of Tardive Dyskinesia Malpractice Suits.* Clin. Psychiatry News, Jan. 1984, at 3.

[3]Schonecker, *Ein Eigentumliches im Oralen Bereich bei Megaphen Applikation,* 28 Nervenarzt 35 (1957).

[4]Uhrbrand & Faurluye, *Reversible and Irreversible Dyskinesia after Treatment with Perphenazine, Chlorpromazine, Reserpine and Electroconvulsive Therapy.* 1 Psychopharmacologia 408-18 (1960).

[5]R.J. Baldessarini, J.O. Cole, J.M. Davis et al., *Tardive Dyskinesia: A Task Force Report of the American Psychiatric Association (1980).*

[6]Gardos, Cole, & LaBrie, *The Assessment of Tardive Dyskinesia,* 34 Arch. Gen. Psychiatry 1206-12, (1977).

[7]Gardos & Cole, *Overview: Public Health Issues in Tardive Dyskinesia,* 137 Am. J. Psychiatry, no. 7 (July 1980).

[8]J.M. Kane, M. Woerner, J. Lieberman, B. Kinon, *Tardive Dyskinesia Neuropsychiatric Movement Disorders* 98.

[9]Kane & Smith, *Tardive Dyskinesia: Prevalence and Risk Factors, 1959-1979,* 39 Arch. Gen. Psychiatry 473-81 (1982).

[10]Bacher & Louis, *Low-Dose Propranolol in Tardive Dyskinesia,* 137 Am. J. Psychiatry, no. 4 (April 1980).

[11]Bacher, *supra at 495.*

[12]Kane, Rifkin, Woerner et al., *Low-Dose Neuroleptic Treatment of Outpatient Schizophrenics,* 40 Arch Gen. Psychiatry 893-96 (1983); Gardos, Perenyi, & Cole, *Tardive Dyskinesia: Changes after Three Years,* 3 J. Clin. Psychopharmacol. 315-18 (1983).

[13]Tuardy, *The Issue of Malpractice in Psychiatry,* 1979 Med. Trial Tech. Q. 161; J.M. Kane, M. Woerner, J. Lieberman, B. Kinon; *Tardive Dyskinesia Neuropsychiatric Movement Disorders* 98.

[14]Kane et al., *supra at 98.*

MALPRACTICE LITIGATION NEWS

Independent Study of Malpractice Insurance in Pennsylvania Funds Current "Crisis" Not Based on Increased Claims or Excessive Profits — Joint Lawyer-Doctor Supported Study Finds Fault in Several Places and Attacks "Myths" — One Percent of Doctors Account for 25 Percent of Payments — Some Lawyers Have "Propensity" To File Claims That Result in Zero Payment — Study Suggests Mechanism for Settling Claims Within 90 Days. In the nation's first joint study of medical malpractice insurance, the Pennsylvania Medical Society and the Pennsylvania Trial Lawyers Association supported an independent study which explodes some "myths" of malpractice litigation/insurance but totally exhonerates no one involved in malpractice litigation, whether doctor, lawyer, hospital, or insurer. But the study, conducted by UCLA insurance professor Alfred E. Hofflander and consultant Blaine F. Nye is sure to become a model for similar investigations. While much of the focus was on the state's Catastrophe Fund, a statutorily-created excess carrier, the study explored broadly the issues of malpractice insurance premiums, litigation cost and suggested reforms. Highlights of its findings are these:

1. When compared to the growth rate of health care cost (Medical Care Index) and the Consumer Price Index, the current "crisis" is neither based on increased malpractice claims, nor excessive insurance company profits.
2. Only since 1983 have premiums climbed steeply, that in part to the insurance "cycle" whereby ease of carrier entry in 1975-76 set premiums too low and then climbed due to "tacit collusion" once carriers became aware that they had set them too low. This happened about 1982.
3. Premiums are set unfairly because they are not experience based, only class rating based. This is because there is no comprehensive database containing the malpractice experience of individual health care providers.
4. One percent of all doctors who pay Catastrophe Fund premiums are responsible for over 25% of loss payments.
5. Some hospitals have far worse records than others and exercise poor risk management given the high-risk procedures performed.
6. The physician licensing scheme needs strengthening.
7. No support was found for the alleged harmful consequences of "defensive" medicine either medically or economically.
8. No support was found for abolishing the contingency fee although a large percentage of cases were closed without payment, yet these resulted in 40% of all "loss adjustment expenses."
9. Some lawyers have a propensity to file claims that result in zero payment.
10. The law needs to create incentives to resolve suits quickly and the study suggested a mechanism whereby the carrier must take some action such as rejecting the claim or offering to settle within 90 days. Another suggestion was that companies have the right to settle without the insured's approval.