

Societal Responsibility for Malpractice

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The purposes of providing just compensation to victims of medical injury and assuring high quality medical care are not served by the tort system. The tinkering with the tort system following the 1975 malpractice crisis will not ease the constantly increasing cost burden on the health care delivery system. Costs will double every three to four years. The only answer is a social insurance approach. The costs of a compensation system for medical injury regardless of fault could be met by eliminating the friction costs of the tort system, and would be helped by establishing national health insurance. The system could be initiated gradually and would be accompanied by quality assurance measures.

The malpractice crisis, which has been gathering momentum for a decade, exploded in 1975.

During the period 1960 to 1972, the increase in the cost of malpractice insurance for the second-lowest-risk category for physicians nationally was shown in the report of the Secretary's Commission on Medical Malpractice (Department of Health, Education, and Welfare [DHEW], 1973:13) to have risen on a 1966 index of 100 from 71.9 to 498.3. For general surgeons, the index rose from 52.3 in 1960 to 526.2 in 1972. For hospitals, the index rose from 86.5 in 1960 to 461.3 in 1972.

For physicians in New York state, the average malpractice insurance premium for the lowest limits of liability currently available (\$100,000/300,000) rose from \$275 in metropolitan New York in 1965 to \$1,230 in 1970, \$1,628 in 1973, and \$3,150 in 1974 (New York . . . , 1976:243). In 1975, when the State Medical Society was forced to establish its own company because no commercial insurers were available, the average premium rose to \$4,700. This amount was for limits of \$1 million/\$3 million for 80 percent of the physicians who elected to take the higher coverage because of the higher amounts of settlements and awards.

For New York hospitals in 1975 the average cost for malpractice insurance rose per bed in one year (1974-75) from \$348 a bed to \$1,240 per bed, an average increase of 256 percent (New York . . . , 1976: 114).

Payments to patients (and their lawyers) in New York state

made by the company which carried the State Medical Society insurance rose from \$3.5 million in 1966 to \$6.3 million in 1971, and then jumped to over \$10 million in 1972, over \$14 million in 1973, and to almost \$22 million in 1974. During this period, the average payment per incident for which payment was made rose from \$10,772 to \$35,151. The number of incidents for which payment was made rose from 326 to 620 in the nine-year period (New York . . . , 1976: 246).

The New York experience is similar to that in other states. For example, in the state of Washington the premium for low-risk physicians rose from \$527 in 1972 to \$1,287 in 1976. High-risk-specialty premiums rose from \$3,192 to \$10,847 in the same period (University of Washington . . . , 1975: 6).

The future outlook is no less grim. The New York State Special Advisory Panel on Medical Malpractice reports (New York . . . , 1976: 19) "we find a widespread agreement among Government and industry experts on a predicted 'trend factor', i.e., a combined frequency and severity rate of increase of 20% annually." This means that, if the 20 percent annual rate is compounded the cost of malpractice insurance will double approximately every three and a half to four years.

In response to the crisis generated by these skyrocketing costs and doctor strikes to protest them in some areas, 42 states undertook formal study of their malpractice situations in 1975 (Georgetown University . . . , 1976: 4). More than 30 states took legislative action. For example, 19 states made changes in the statute of limitations, to shorten the time in which suits may be brought. It was hoped this measure would help to reduce malpractice costs. Seven states modified or eliminated the collateral source rule which prohibits consideration of other insurance income in determining the amount of an award to a patient for a medical injury.

Nine states placed limitations on the percentage of a malpractice award that an attorney can claim as a fee, on the assumption that this so-called contingency-fee arrangement tends to escalate costs and hence malpractice premiums. Eight states changed the law with regard to informed consent, to limit the disclosure requirements placed on a physician. This was designed to reduce suits started on the grounds that the physician had not made detailed disclosure of all conceivable risks and alternatives. Four states changed

their laws with regard to *res ipsa loquitur*, a legal doctrine which permits damages to be awarded on the grounds that "the thing speaks for itself." This doctrine shifts the burden of proof to the defendant when circumstantial evidence has been introduced of injury which ordinarily does not happen in the absence of negligence.

Cause of the Malpractice Insurance Crisis

The responses to this crisis are of course based on certain assumptions about the cause of the crisis.

These suggested causes can be grouped into the following categories: Legal, insurance, and sociological.

Suggested Legal Causes

Implementation of the *res ipsa loquitur* doctrine has been widely thought to be a cause of the problem (Department of Health, Education, and Welfare [DHEW], 1973: 28; University of Washington . . . , 1975: 13; New York . . . , 1976). In the view of the New York Panel (1976: 34, "the abolition of the [*res ipsa loquitur*] doctrine here will not produce more outcomes favorable to the health care provider. It would only require additional expert testimony in situations where they are not really needed, therefore increasing trial costs. In the Panel's view the abolition of the doctrine *res ipsa loquitur* would not contribute to insurance availability or reduce insurance cost."

The matter of informed consent has also been viewed as contributing to the malpractice problem. As noted above, changes were made in this area in 1975 legislation in eight states, including New York. The Secretary's Commission was concerned about this matter but noted that consent problems form the basis of malpractice action in a relatively small number of cases. In the report of the American Insurance Association (American Insurance Institute . . . , 1975:99), prepared by the Insurance Services Office, a sub-report was made on "Allegation and Suit Disposition." Allegations are often very extensive and frequently unsubstantiated in the final outcome, but the results showed that in response to three questions as to allegation versus suit disposition, the report found that in 2,720 closed claims, misdiagnosis was alleged, as against 6,165 in which it

was not, in 675 cases *res ipsa loquitur* was alleged, against 8,197 in which it was not. Lack of informed consent was alleged in 1,169 cases and not claimed in 7,716 cases.

These figures would appear to indicate a higher percentage of consent problems than reported elsewhere, but, as previously stated, inclusion of this allegation in a Bill of Particulars does not necessarily mean that it was actually a factor in the determination of a settlement or an award.

While the question of informed consent may not be the decisive factor in malpractice verdicts, it may, with the rise of consumerism, be a significant factor in the institution of claims and suits. Since a very large percentage of malpractice costs consists of claims and legal expenses, it may well be that attempts to limit the physician's responsibility for informed consent may in fact proliferate malpractice claims because the patient feels he was not informed of the risks and alternative treatments at the time of surgery.

It should be noted that according to a report by the Association of the Bar of the City of New York (1975: 349) there are few cases in New York which revolve around informed consent and no significant evidence that limitation on informed consent helps to reduce premiums. The New York Commission (New York . . . , 1976: 37-38) concurs in the view that the problem of informed consent, despite frequent statements to the contrary, did not play any significant role in generating the malpractice problem, nor will any laws to limit informed consent help with the solution of the problem.

The contingent-fee system has also been frequently cited as a cause of the malpractice crisis. The Secretary's Commission (Department of Health, Education, and Welfare [DHEW], 1973: 32, 33, 50) did not support this view and found that the average hourly costs for the plaintiff's attorneys were only slightly higher than those for defense attorneys. Of course the fact that defense and plaintiffs' hourly rates are comparable does not mean that the tort system, with or without contingency-fee arrangements, achieves the objective of compensating injury and achieving competent performance.

One argument in favor of contingent fees is that they enable poor people to bring cases they otherwise would not. This contention was accepted by the Secretary's Commission but is challenged by the New York State Panel (New York . . . , 1976:42) which found

that "a party with a good claim of under \$20,000 will have difficulty in finding an experienced malpractice attorney to take his case." Thus the size of the claim rather than the affluence or poverty of the claimant seems to be the determining factor. There will perhaps be some tendency to reduce large settlements by limiting contingent fees at the upper levels, and a number of states and judicial systems have adopted limitations on contingency fees that lower the percentage of the fee as the amount of the award or settlement rises. The theory behind this is that if the plaintiff's lawyer's fee does not rise proportionately with the size of the settlement, he will be less likely to hold out for larger amounts. Nine states enacted legislation along this line in 1975. It remains to be seen what effect this will have, but the New York Panel (1976) feels that, unlike most new legislation, this might have some slight effect on malpractice premiums, since large settlements do modify the average payment significantly.

Limitation on damages for pain and suffering has also been proposed as a partial solution, and this would undoubtedly limit very large awards with a consequent reduction of the average payment.

The collateral source rule has also been suggested as increasing malpractice awards. According to this rule, the fact that the plaintiff is insured for many of the costs for which he has been damaged is inadmissible as court evidence. Hence, for example, Medicare, Social Security, Disability Payments, Workmen's Compensation Benefits, Veterans Benefits, Blue Cross, Blue Shield, and other health-plan income continue to go to the plaintiff so that he is paid doubly by being awarded damages covering the same costs for which he is insured. The American Insurance Association (New York . . . , 1976: 183) estimates that a dollar-for-dollar reduction of collateral sources could reduce premiums by 10 to 15 percent. Abolition of the Collateral source rule was advocated by the New York City Bar Association Report (Association of the Bar of the City of New York, 1975: 336, 350).

Large demands for damages, now often going over \$1 billion, have brought the suggestion that the *ad damnum* clause (the amount claimed for damages) should be eliminated. Since the media do not usually report the final results, the most frequent of which is no award, it has been stated that the elimination of the *ad damnum* clause would tend to discourage frivolous malpractice suits. While it

is dubious whether elimination of this clause would reduce premiums, there seems to be significant support for ending the irritant.

Suggested Insurance Causes

Because of the long time which elapses between the filing of the claim and the settlement, insurance companies have been able to charge low premiums, with the possibility of investing the premiums and earning considerable income before the actual payout was necessary. The Joint Legislative Audit Committee in California in 1975 concluded that doctors had paid inadequate premiums for the previous 15 years, while the California Insurance Commissioner stated that rates had been inadequate since 1957 (New York . . . , 1976: 222; Georgetown University . . . 1976: 27). With the collapse of the stock market of the sixties and early seventies into the recession of 1974–75, many insurance companies found themselves in financial difficulties. Some 30 insurers were reported to be insolvent. Furthermore, because of the long time between the payment of premium and the settlement of cases involved in malpractice insurance, the market became increasingly risky as the size of awards and settlements rose rapidly, along with the number of claims (the “long tail” effect). In Washington in 1971, there were 2.2 claims per 100 physicians covered, and this jumped to 4.4 in 1975 (University of Washington . . . , 1975: 7).

In 1973 the Secretary’s Commission (Department of Health, Education, and Welfare [DHEW], 1973: 38) found that “malpractice insurance is currently available to health care practitioners under group plans and the market for such insurance is competitive. Malpractice insurance is also available to individual health care practitioners although they appear to be having more difficulty—umbrella and excess coverage are also available, both to individuals and under group plans.” This finding was a very hollow one indeed by 1975 when no commercial malpractice insurance was available in New York and other states. Twenty-four states enacted or proceeded under previous legislation to establish the authority for pooling devices for medical malpractice insurance (Georgetown University . . . , 1976: 6). Umbrella insurance to cover the risk of the large awards was previously quite inexpensive. It became extremely expensive by the end of 1975.

According to the Peat Marwick Mitchell study of the New

York State Medical Society experience, 1959–1973 (New York . . . , 1976: 239), as of December 31, 1974, \$185 million of premium had been paid against \$292 million losses, including payments of \$95 million and reserves for the balance. General experience in the industry is that reserves have come close to final payments, so that the loss appears genuine.

Actually paid losses by Aetna, which covered the Washington State Medical Society, rose from \$40,000 in 1972 to \$120,000 in 1973 to \$482,000 in 1974, an increase of 200 percent from 1972 to 1973 and 300 percent on top of that from 1973 to 1974.

Thus, while there may have been in the past high insurance company profits, inefficiencies in claims handling, and other defects, the increase in actual payments has been substantial and the very large increase in premiums that occurred in 1975 is a reflection of the trends described above and fears of the unknown, because of the “long tail.”

Sociological Causes

It has been suggested that the decline in prestige, status, and veneration of physicians has encouraged proliferation of malpractice suits. The Washington Study (University of Washington . . . , 1975: 12) lists as the first reason for the increase in the number and cause of malpractice actions as “the increasingly impersonal nature of the provider-patient relationship.” While the decline in the public image of the physician has been noted in various medical sociology studies, there are no studies available specifically tying this to the increase in suits, although the Secretary’s Report (Department of Health, Education, and Welfare [DHEW], 1973: appendix 678–693) has some suggestive material on this subject.

Another proposed explanation of the problem relates to increased patient expectations. Many physicians who have testified in connection with the crisis have referred to the “Marcus Welby Syndrome,” suggesting that television programs such as Dr. Kildare and many others have “encouraged the myth of the infallible all knowing, all powerful physician and have elevated public expectations” (University of Washington . . . , 1975: 12).

Increased malpractice publicity has also been suggested as heightening the public’s awareness of the possibility of obtaining large awards as reported in newspapers. Administrative experience

with malpractice problems for a group of hospitals in New York City shows that there was a sudden large increase in claims following the publicity about malpractice in 1975, and quite specifically, a rash of suits on retrolental fibroplasia following a large award in such a case which received much newspaper publicity.

Advances in technology have also undoubtedly contributed to the situation. Here again, while no studies are available, experience of New York hospitals shows a high frequency of cases relating to open-heart surgery, where the problems with the heart-lung pump can produce suits of considerable seriousness, obviously impossible before this device was introduced.

Issues in the Malpractice Crisis

What are the real issues in the malpractice crisis? In immediate terms the availability and cost of malpractice insurance and the proliferation of suits appear to be the problem, but the fundamental issue is how to guarantee high-quality medical care and to compensate patients for medical injuries.

Those who deal with the surface issue of premiums and increase in suits are caught in a dilemma of legislation that is unfair to patients when it limits their right to sue and the amount of damages they can collect, while costs escalate.

The Quality Issue

Let us start with the quality question, since the present system is supposed to assure quality; in any case it is the intended social goal of the system.

Present mechanisms for supervising and auditing the quality of medical care are clearly inadequate. Proposals to improve them through PSROs have been fought by providers (Gosfield, 1975). State licensing boards have been notoriously weak in coming to grips with clearly incompetent providers. The Federation of State Medical Boards estimates there are 16,000 doctors unworthy of their licenses, but an average of only 66 licenses are revoked annually (New York Times, 1976a: 1; 1976b: 1).

Fifteen states adopted legislation in 1975 affecting the health care licensing agency (Georgetown University . . . , 1976: 7). Six

states also adopted continuing professional education extended to a group not previously subjected to such provisions or added such education as a sanction available to health care licensing agencies.

The Secretary's Commission (Department of Health, and Welfare [DHEW], 1973: 24) found that patient injuries are prime factors in the malpractice problem. The Commission studied two hospitals and found that 7.5 percent of hospital admissions resulted in medical injury and that more than 20 percent of these injuries were due to negligence. Yet, instead of 500 claims which could have been made, only 31 malpractice claims were filed against the two hospitals in the study. The New York Commission projected this to illustrate that, instead of the 2,000 claims currently being filed annually in New York, 40,000 to 50,000 claims might be filed if all cases of negligence resulted in claims.

About 2.38 million needless operations were performed in the Medicaid program alone in 1974, resulting in 11,900 unnecessary deaths (House of Representatives, 1976). This was based on the Cornell University Medical College study of Dr. Eugene McCarthy (McCarthy and Widmer, 1974). The Director of the DHEW Secretary's Commission stated (New York Times, 1976a: 1): "The time has come for all parties seeking solutions to malpractice problems to recognize that the root cause of the current malpractice problem is the substantial number of injuries and other adverse results sustained by patients during the course of hospital and medical treatment."

In other words, a basic cause of the malpractice crisis is malpractice—i.e., poor medical care.

The DHEW studies, American College of Surgeons studies, and the Cornell study all undercut the argument of defenders of the tort system that it is the best way to provide compensation for those injured. It is clear from the numbers of injured involved that, despite the publicity concerning substantial awards, many patients are actually not compensated. Apart from claims never brought, studies of the allocation of the malpractice premium dollar indicate only a small portion goes to the patient (New York . . ., 1976: 250).

It will clearly be difficult to compromise all of the conflicting interests in the area of medical negligence, when the livelihood of lawyers, doctors, and insurance company managers and employees can be so seriously affected.

The lives and health of patients must, however, be the central concern of society.

The existing system does not protect the health of patients adequately.

The resistance of physicians to adequate controls and discipline means that poor care by physicians and hospitals continues. The tort system does not rectify poor care. The result of all this is rising patient dissatisfaction expressed in increasing numbers of malpractice suits.

The Organization and Financing Issue

Apart from the lack of quality controls in the existing system, its organization is inadequate so that in many parts of the country there are not enough physicians and/or specialists. Furthermore, the solo practice mechanism does not provide patients with adequate referrals to specialists when appropriate.

The way American health care is delivered also means that the poor and middle class receive inadequate care because of their inability to pay for good care. These defects in our health care delivery system have been frequently documented (Fuchs, 1974; Klaw, 1975).

All of these factors—poor quality control, poor organization, and inadequate financing combine to create a large number of angry patients who sue doctors and hospitals. Even in cases where the patient has coverage or can pay for medical care, if his costs increase because of a poor medical result, he is angry at having to pay the additional expense.

The growing number of malpractice suits is simply one manifestation of the dissatisfaction with the financing, organization, and quality controls of the whole medical care system.

Alternative Remedies

We shall now address ourselves to major proposals intended to help rectify the failure of the existing system to provide just compensation and high-quality care.

(1) *Changes in the Tort System:* The inadequacies of changes aimed at making the tort system better able to deal with the

problem have been indicated earlier. Some of the most extensive tort law changes were enacted in California (Georgetown University . . . , 1976: 31). Legislation established periodic payments for any award in which future damages exceeded \$50,000 to prevent windfalls to non-dependent heirs. The law tightened the statute of limitations to assure that claims were brought in a timely manner and theoretically to prevent the long tail. Also enacted was a provision to permit the introduction of collateral sources of recovery to preclude double recoveries. A limit was also established on damages for pain and suffering.

Despite these extensive tort law changes in California as of September 1975, malpractice premiums again jumped very sharply a few months later, and doctors' strikes broke out in Southern California in January 1976. Travelers Insurance Company raised rates in Southern California by 486 percent on January 1, 1976. This was reduced to a 327 percent raise by the State Insurance Commission (Wall Street Journal, 1976: 30).

Apart from the suggested tort law changes already dealt with, a number of other proposals should be mentioned. A demand by physicians for a legislative definition of medical malpractice was heavily pushed during the New York crisis. This would actually have no effect on the settlements or awards (New York . . . , 1976: 33) unless the legislative definition provided for compensation to be granted only in cases of gross negligence, as outlined in most good samaritan statutes. Such a gross negligence definition would, however, be clearly unfair to the patient. Most tort law changes are suggested as ways of cutting costs at the expense of equity for the patient.

For the society at large, as is pointed out in the New York report, the tort system increases the cost of health care as a result of the high insurance costs and the practice of defensive medicine. The tort system also delays introduction of improvements in the delivery of health care because of the threat of malpractice claims.

In summary, the only proposed tort law changes that seem likely to affect the size of awards and eventually of malpractice premiums would be elimination of the collateral source rule and establishment of a limitation on pain-and-suffering awards. Proposals to limit the total amount of damages appear to be of doubtful constitutionality besides being unfair to the patient. There is no reason why the malpractice crisis should be viewed solely as a problem of

reducing premium cost. The real problem is to see that the patient gets good treatment, or compensation if he doesn't. The Illinois and Idaho statutes placing a ceiling on damages were successfully challenged in the lower courts. It should be noted that very few of the proponents of tort law changes deal with the central issue of quality. In California and New York, however, 1975 tort law changes were combined with certain measures designed to improve quality.

(2) *Arbitration, Mediation and Screening Panels*: Screening panels and arbitration were recommended by the Secretary's Commission (Department of Health, Education, and Welfare [DHEW], 1973: 91). Voluntary binding arbitration has been in existence for some years in California under a variety of health plans. The evidence, while not conclusive, does not appear to demonstrate a significant effect on the problem (New York . . . , 1976: 47; Heintz, 1976).

Experimentation with screening and arbitration continues, with two states enacting, in 1975, voluntary pre-trial review and 11 states providing for mandatory pre-trial review (University of Georgetown, 1976: 8). In New York State, the Hospital Association and the Medical Society are both encouraging voluntary binding arbitration but no experience is yet available; the proposal seems to be moving slowly. The President of the Medical Society, who had been active in pushing arbitration, stated in a March 5, 1976, letter to members in a headline: "Voluntary Contractual Binding Arbitration is not a solution for the Malpractice Crisis."

Essentially, proposals to improve the tort system, to provide screening panels or to institute binding arbitration would diminish the protection that the system now gives those patients who are able to use it successfully. But such proposals would not help the large number of patients who now receive no compensation for medical injuries even though these are the result of negligence.

(3) *National Health Insurance*: Since the malpractice crisis derives from the defects in the basic health delivery system, it will not be solved without a major change in that system. The enactment of a system of national health insurance would remove a major portion of the causes of the malpractice problem.

Medical care for all conditions would be provided, regardless of the cause of the condition. There would be less inclination to sue in such a situation. The smaller number of suits in countries with

national health insurance or national health services is certainly causally related to the availability of those benefits. There would have to be no separate system to compensate those medically injured for their medical costs. The lack of itemized malpractice awards in most of our judicial system makes it difficult to assess what portion of the total national malpractice bill would be eliminated if medical costs were not included, and if only loss of earnings together with a limited amount for pain and suffering were to remain either in the tort/liability insurance system or alternative systems. In any case, subtracting medical costs from the total would be a substantial gain. Under national health insurance, the organization and quality control in the system would both be improved, since problems of distribution, referral systems, group practice, and other organizational defects of the present system could be remedied. Quality controls and disciplinary measures could be built into the system. Under the present system, quality controls, insofar as they exist, are mostly based on doctors controlling themselves, which in any other area would be unacceptable (Sidel, 1975; Gosfield, 1975). Even the Professional Service Review Organization system, which was scheduled to be initiated in January 1976, has been delayed by opposition from physicians. The effective date as a result has been postponed to January 1978. Only half of the PSRO services areas have planning or conditional contracts because of resistance from the professionals.

A national health insurance system and, even more, a national health service would thus be a major step toward resolving the compensation and quality issues.

(4) *Social Insurance (No Fault)*: A patient who suffers an adverse medical outcome should be compensated through a system of social insurance providing benefits for all losses due to medical injuries beyond those covered by national health insurance. The Workmen's Compensation system could be a partial model for such a system. It should not be necessary to spend five to 10 years under a tort system to prove that a doctor made a mistake in order for a patient to receive compensation.

For example, some medical injuries occur because of high-risk procedures. A young attorney concerned with health law recently suggested to me that such procedures should be prohibited or severely limited, since they impose on the insurance system unneces-

sary burdens, even if the doctor is willing to risk his professional reputation and the patient knowingly consents to the high risk of medical injury.

The value of the human lives saved through attempting (and therefore often improving) high-risk procedures such as open-heart surgery in my view outweighs such arguments. Society does gain and has mechanisms for dealing with those experiments which do not succeed (e.g., the dramatic drop in heart-transplant attempts).

It is obviously desirable to develop a detailed plan for the implementation of a compensation/social insurance approach to medical injury. It should be noted that such an approach was adopted into law in New Zealand on April 1, 1974. As a result, any personal injury from accident, under any circumstances, is covered. During the first year of operation, income was \$81 million and expenditures \$49 million (New Zealand . . ., 1975: 19).

An excellent analysis of possible medical injury compensation systems not based on fault was prepared by Edwin W. Roth and Paul Rosenthal of the Calspan Corporation for the Secretary's Commission on Malpractice (Department of Health, Education, and Welfare [DHEW], 1973: appendix 450-493).

One of the criticisms of a social insurance approach to medical injury is the assumption that it would involve an enormous cost. Claims of high cost for social insurance are based on the assumption, however, that all medical injuries would be immediately subsumed under the system, together with all of the faults of the fault system. Furthermore, there has been no study of the total social cost of the existing system, including the costs of the judicial system. Malpractice premium expenses are by no means the only cost item in the tort system.

The DHEW study points out that such a system might deal solely with compensation limited to special damages (costs incurred, future costs, and loss of income) or that it could also include general damages (pain and suffering, loss of consortium). In fact the study indicates there are a total of 432 modes in the models it examines. It further points out that while predictability is almost non-existent within the tort approach, the outcome of a social insurance system can be predicted within statistical limits such that feedback mechanisms which have not been available within the tort/liability approach, could be installed in a social insurance system.

Among the disadvantages of the fault system which would be

remedied by a system not based on fault, the DHEW report indicates the following:

1. Difficulty in uncovering medical evidence to prove provider negligence
2. High cost of pursuing claims through legal channels
3. Difficulty in obtaining competent legal assistance for relatively minor claims
4. Ambivalence in subjecting health care providers to the stigma of adverse publicity
5. Large disparity of awards and settlements for comparable injuries and circumstances
6. Inducement to exaggeration and fraud on the part of the claimant

The above are all disadvantages to the patient which would be remedied.

The health care provider, in a non-fault system, would benefit from elimination of the following disadvantages of the tort system:

1. Long delays and anxiety as to outcome of claims
2. Negative reflection on professional status
3. Barrier to willingness to apply new techniques
4. Degradation of the relationship with the patient by introducing suspicion and hostility
5. Defensive medicine
6. Loss of time from practice in preparing for defense

On the insurance-carrier side, large administrative costs are part of the tort system. There are major difficulties as well in setting sound rates because of low predictability.

In assessing the easy charge that a social insurance or Workmen's Compensation and/or no-fault system would be enormously expensive, one should look at the experience with existing similar systems. The New York Panel (1976) found that compared to estimates as low as 16 percent of premiums paid out to the injured patient (and his lawyer) in the tort/liability medical malpractice system that 54 to 70 percent of the Workmen's Compensation premium dollar was paid to the injured worker: and that the Social Security (OASI) provided 98.5 percent to the recipient, Medicare part A 96.8 percent, Unemployment Insurance 91.5 percent, and Public Assistance 82.4 percent.

It should be noted that the estimates of payouts to the patients in the malpractice tort system represent a percentage of premiums only and not a percentage of the total social cost, including the costs of the judicial system.

In the pioneering paper of Havighurst and Tancredi (1973: 125) a possibility of high premium costs in a no-fault insurance scheme is thought likely, but felt to be compensated by reduced social costs. While the actual cost remains to be seen when the system is implemented, my own view is that no great risk need be assumed: a social insurance system could be initiated step by step, starting in with a specific list of compensable injuries as suggested by Havighurst and Tancredi and broadening out as experience is gained.

Administrative costs in the social insurance system, predicted to be high by its opponents, would in fact be much lower than those in the tort law/liability system (Department of Health, Education, and Welfare [DHEW], 1973: appendix 471). The tort law/liability system costs are high because of the fragmented nature of the system and because of the need on the part of the insurance companies to anticipate claims whose tails are long.

A social insurance system could be adopted in the United States on a state-wide or national basis. It would be initiated by payment by physicians and hospitals of a fixed premium which would be later subjected to merit rating as in Workmen's Compensation. In this way, those providers who had a higher incidence of claims would pay the highest fee.

Administration would be by a commission including physicians, attorneys, and laymen. Examiners would screen claims, hold hearings, and report to a referee for a decision in accordance with a compensation schedule. Appeals could be taken to a review panel, with a final decision resting with the commission. Thus, the Medical Injury Compensation Commission would function like any administrative tribunal with mechanisms similar to the Securities and Exchange Commission, the Federal Communications Commission, the National Labor Relations Board, or the Workmen's Compensation Commission. Resort to the legal system would be permitted only on procedural matters, not amount of awards. The compensation schedule would provide for a limitation on awards for pain and suffering.

Eventually, the system would be expanded to encompass automobile accidents and Workmen's Compensation and the entire program could be made part of the Social Security system.

We have seen that the tort/liability system does not serve either of its two main purposes: providing compensation to injured patients or assuring the high quality of medical care. The mechanisms for providing proper compensation to victims under a social insurance system have been outlined above. We have also given some indication of an approach to ensuring high quality of medical care. Some element of the responsibility contained in the tort system would be carried forward by establishing premiums subject to merit rating based on experience. This would fix monetary rewards for good experience and penalties for bad experience.

In addition to this, since we would be dealing with a social insurance system established by statute, there would be no difficulty in building-in requirements for audit and tight hospital-staff organization, which have a demonstrable relationship with lower malpractice incidence. Delineation of privileges, so that physicians operate only within their spheres of competence, would be part of the system.

Continued review of competence could also be included in the system, which would make possible more complete reporting of claims and awards than we now have under the tort system. Based on the information that would be available in a social insurance system, measures to deal with physicians found to be of lower competence could involve as a first step a requirement that certain educational courses be taken and appropriate examinations passed; for more serious cases, licenses could be suspended with a requirement of performance under close supervision in a hospital or other structured setting. Cancellation of license would be reserved for the most severe cases.

Conclusion

The next step is the initiation of a social insurance system for medical injuries on either a state or national basis. We believe this is practical fiscally. It would eliminate the friction costs in the present tort system and convert them to benefits in the compensation system. We also believe that the plan could be developed gradually,

by starting out with a specific list of compensable injuries which could later be expanded as the necessary experience was developed. We need to start now to gain this experience rather than to continue studies and arguments about what the costs might be.

Finally it should be pointed out that while such a compensation system for medical injuries could move forward without the adoption of national health insurance, many of the costs of a compensation system are picked up in countries like England and Canada, where all medical costs are covered whether caused by negligence or not. Furthermore, under the English system, there are stringent, built-in controls on practice which assure quality. This would clearly strengthen the compensation system. The present wide disparity in malpractice premiums between Canada and the United States (\$100 a year in Canada against an average current premium in New York State of \$4,000) is clearly not caused by the absence of contingency fees or jury trials but by the coverage of medical costs under national health insurance.

In sum, while we believe a social insurance system for medical injuries could move forward successfully without national health insurance, it is clear that if the compensation system was relieved of the burden of covering medical costs, it could provide better benefits for more types of injuries than would be possible if it had to bear the burden of compensation for both medical and non-medical costs.

Let us start down the road toward acceptance of social responsibility for malpractice.

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