The Malpractice Controversy and the Quality of Patient Care

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The year 1975 was a landmark of sorts. In that year America was treated to its first exhibition of doctor strikes, most conspicuously in California and New York, where doctors withheld their services except for emergency cases, and hospitals were forced either to close their doors or sharply contract services. In some states physicians threatened more serious actions.

These uncommon actions were mainly triggered by disputes over malpractice insurance: extraordinary increases in premium rates demanded by insurance carriers and, in some areas, real or threatened withdrawal of carriers from the malpractice business, creating the possibility of no available coverage. The actions and the extraordinary publicity—much of it in the form of paid newspaper advertisements—were designed to press state legislatures into prompt remedial action as perceived by the medical organizations. They were, in the main, successful.

The strikes and threatened strikes were accompanied by high rancor and intemperate allegations and accusations on all sides. Doctors blasted their guns over a broad range. They alleged that lawyers were responsible for generating large numbers of malpractice suits; they attacked both the size of contingency fees and the practice of contingency fees itself. They attacked the judicial system, both judges and juries, for what they considered unfair decisions and awards. They excoriated state laws—said they were made by lawyers for lawyers—and thus also made targets of state legislatures.

Lawyers were not slow to respond, not only to deny the various accusations but to add their view that doctors were seeking to be relieved of all responsibility for their own torts, that the major cause for malpractice liability was incompetence or negligence, and the profession was seeking scapegoats for its own failure to undertake adequate self-policing and internal disciplinary action.

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Hospitals were facing their own malpractice problems as their premiums were also rising rapidly. In addition, doctors' strike actions victimized them by sharply reducing revenues and, in many cases, endangering the solvency of institutions. Hospital employees and their unions were angered by the layoffs and unemployment they suffered from the strikes. Only patients and consumer organizations were surprisingly mute. Few significant medical problems were reported.

One might easily get the impression from all this unpleasantness that the problem had come upon us suddenly. In fact, it had been growing for a long time but had been largely neglected until it reached critical proportions—somewhat like health care itself. Over sixteen years ago, Anne Somers and I tried to call attention to what even then we called "the vast increase in malpractice claims and suits." Our view of the underlying causes was quite different from most of the self-serving allegations that were contentiously filling the air in 1975. We called the malpractice "crisis" of that day "a symptom of deteriorating [doctor-patient] relationships" that "has been spreading ominously"(Somers and Somers, 1961).

Since that was written an important, comprehensive, and official survey was published, in 1973, by the Secretary's Commission on Medical Malpractice. The Commission assembled virtually all then existing knowledge of the subject and added special studies of its own. Its findings—which, among other important conclusions, emphasized that malpractice claims are actually rooted in medical injury and malpractice—and its recommendations, many directed at prevention, were ignored by the Administration which sponsored and financed it. As there was no apparent crisis in 1973, there was no pressure for action.

In 1975–76, there was enormous pressure. State legislatures moved with great haste to mitigate what was represented as a genuine health care crisis. The great outpouring of legislation was mainly aimed at strengthening the defense of physicians and hospitals against claims, reducing potential legal liability, and, most important, assuring the availability of insurance coverage to health care providers. There was, and remains, much to be corrected along these and other aspects of the wide-ranging and complex issues. But they do not reach out to the more fundamental causes of the magnitude of the problem. Many legislatures acknowledged the short-term nature of the new laws (including dubious con-

stitutionality in some cases) and established study commissions to weigh more considered and effective actions for the future.

It must be recognized that the legal and cost problems will probably never be eliminated so long as torts and tort liability remain facts of normal life. (Nor can they, in my opinion, be removed by "no fault" programs.) But, it is my thesis that they will not be satisfactorily or equitably alleviated until they are effectively related to problems of quality of care and the doctor-patient relationship in modern society. It is this aspect of the subject to which this paper is primarily addressed.

Commenting on the legislation passed in 1975, William J. Curran, professor of legal medicine at Harvard, noted that on the whole it "seems reasonably well designed to deal with the immediate crisis," but the atmosphere was "mainly technical . . . not involving the general public or most of the consumer-oriented medical-care groups [who] have taken little notice of these issues, considering them of much lower priority than increased medical benefits as such. This attitude may not continue in the future if the impact of these laws becomes overprotective of providers and insurance companies and forgets the patient in the bargain. I believe there is a danger in this eventuality, which must be watched for and avoided" (Curran, 1975).

Crises often have value. They eventually force real problems to the surface and offer unusual opportunities for constructive remedy. It is encouraging that there are a growing number of signs that, out of a variety of motives, such opportunities are beginning to be grasped. Fear, illumination, and dismay have already prodded many legislators and health care providers into facing up to the causes of the malpractice crisis rather than dealing with the expensive symptoms alone. History may yet record that out of all the travail a substantial net gain for the patient emerged.

Insurance Trends

Precise data on malpractice insurance are almost impossible to come by. State laws, regulations, and experience differ as does the experience of individual insurance companies. There is no agency responsible for central data collection, nor any uniform method for presenting such partial data as do exist. It is not surprising that dis-

cussions of the national experience are marked by wide-ranging estimates. Most states do not appear to have any usable data at all. The student, who must patch together the best bits and pieces he can muster, can readily understand the finding of the Secretary's Commission on Medical Malpractice (hereafter referred to as the Commission) that "inadequacies in the collection and analysis of appropriate data have precluded the development of sound actuarial practices and rates" and he will appreciate the importance of its recommendation for establishment of "a uniform statistical reporting system for medical malpractice insurance and that data be reported to a single data collection agent who will compile it, validate it and make it available . . ." (U.S. Dept. HEW, 1972). In 1975 the National Association of Insurance Commissioners (NAIC) and the industry's Insurance Services Office (ISO) at last got together to attempt uniform and central data collection. The situation should also be improved by the malpractice reform laws of 1974–76 whereby many states are for the first time requiring, in varying degrees, specific data on claims, settlements and/or closures. But there is still no national reporting system for all.

There is no doubt that the volume of claims filed, and the size of premiums and awards have all increased substantially, although there are frequent disputes regarding how much and what the data mean. Until 1974, with the exception of 1969 and 1970 when premiums jumped a total of 198 percent, the rise in malpractice insurance premiums was reasonably consistent with the rise in national health care expenditures and increases in annual malpractice claims and payments. The fragmentary available data suggest a fairly steady rate of increase of about 10–12 percent in the number of claims closed annually and about 10–20 percent in the value of the average settlement.[1]

But for 1974 and 1975, the ISO, which acts as actuarial advisor for insurors who underwrite about 75–80 percent of the nation's short-term hospitals and about half the country's doctors, recom-

[1]These figures are based on preliminary data from a comprehensive study being performed by Walter Cooper, vice president and actuary of Chubb and Son Insurance Company. The figures are similar to those reported by Congressman James Hastings in a background paper prepared for the National Conference on Medical Malpractice in 1975: an average annual increase of 11 percent in claims between 1970 and 1973. According to an article in *American Medical News*, November 4, 1974, claims filed had been increasing about 8–9 percent per year.

mended increases of 50 and 170 percent for hospitals and 53 and 170 percent for physicians and surgeons. What explains the wildly erratic movement of premium rates? For example, a recommended 1.4 percent increase in hospital premiums in 1973, and 50 percent and 170 percent in 1974 and 1975 respectively?

The industry explanation was essentially the same as for the spurt in 1969 and 1970: actuarial miscalculation of future losses to be covered by present premiums. The exceptionally long drag in disposition of malpractice cases, what actuaries call "the tail," makes the setting of rates primarily a game of intuition. The Commission reported that in 1971 only about one-third of claims were settled within three years after occurrence of the "accident"; the average case was settled in about five years; and even at the end of eight years some 12 percent remained unsettled.[2] So, in 1975, worried insurance carriers instituted new claims frequency and severity projection techniques which they believed would correct what they perceived to be serious underprediction of future trends. It is these alterations which were responsible for the bulk of the great rate increases requested in 1974 and 1975.[3]

The resulting variations in actuarial projections and rate-setting are enormous. In New York State, for example, where Argonaut Insurance Company was carrying most of the malpractice insurance (following the withdrawal of Employers Mutual of Wassau in 1973 which had been the insurers for eighteen previous years), the doctor rebellion was triggered when the company requested a 197 percent increase in premiums in 1975 which it said it needed in order to break even. (It had asked for 274 percent in California.)

[2]If the Commission's estimates were accurate, the situation has improved. The National Association of Insurance Commissioners' comprehensive survey covering the year ending June 30, 1976, showed that the time between an incident's occurrence and its reporting to the insurer, in cases in which the claimant was eventually paid, averaged 20 months for minors and 15 for adults. Disposing of such cases took an average of 22 months after they were reported.

[3]It should be noted that settlement inflation caused by passage of time is at least in part balanced by the earnings of reserves held by the insurance carriers. A prudent investment return of 7 percent would increase the value of the original premiums by 40 percent in five years and by 72 percent in eight years. Such company earnings are not taken into account when premium rates are calculated. When this question was raised at Dunne Committee hearings (New York State), an industry representative replied that investments are too speculative to be considered in advance and, he asserted, would be only a small percentage of the whole.

The Joint Underwriters Association,[4] which the legislature established in 1975, said a 100 percent increase would be sufficient. The State Insurance Department cut the request to 20 percent. The consulting actuary of the new doctor-owned mutual company, established by the state medical society under authority of 1975 legislation, claimed that Argonaut had been working with a "cushion" in 1974 and he recommended to the company an increase of only 10 percent for 1975 over the previous year's rates, despite an estimated 20 percent rise in malpractice settlement cost. The medical society company cautiously decided on 20 percent, later reduced to 15 percent. Many other states found the apparent lack of relationship between requested premium increases and actual claims experience a mystery apparently intelligible only to the insurors.[5]

It is now widely believed that the insurors' troubles were really primarily due to investment losses in their securities portfolios. The carriers were conspicuously reluctant to furnish information to investigative bodies.[6] Doctors began to compile evidence claiming that some companies that were demanding large rate increases had been making good profits on malpractice insurance.[7] In California, a

[4]A mandated consortium of all personal liability carriers in the state, legally required to provide a market for malpractice insurance.

[5]For example, in New Mexico, doctors had paid Travelers Insurance Company more than $3,600,000 in liability insurance premiums from 1971–74. Travelers had paid out only $70,000 on claims. But in 1975 the company asked for a 74 percent rate increase. Although the doctors thought the demand unwarranted, they reluctantly decided they had no option but to accept. Nonetheless, Travelers announced shortly thereafter that it planned to withdraw from the state (Lavin, 1975).

[6]Senator Kennedy stated that Congress had been "unable to produce a satisfactory explanation for the rapid increase in . . . premiums" in hearings before his subcommittee in 1975 (*Medical Economics*, Aug. 18, 1975, p. 49). The New Jersey Insurance Commissioners complained, "We can't get the necessary facts. . . . When we called [one company] to a hearing, they pulled out of the state rather than go to a hearing. They did the same thing in New York. You have this occurring all over the country" (*Sunday Times Advertiser*, Trenton, Aug. 31, 1975, pp. 1, 5).

[7]The Detroit-based Physicians Crisis Committee claimed to have turned up evidence that one of the country's major carriers, Medical Protective Company of Fort Wayne, Indiana, had grossly overcharged doctors for insurance. The Committee claimed the company had exploited the crisis to increase its after-tax profit from 11 percent in 1965 to nearly 32 percent in 1975. The company's officials refused to comment on the charges ("MDs Say Carrier Makes 32% After-Tax Profits," *Medical*

study by the Auditor General presented a mixed report—that the seven major insurors had paid out more than they collected from 1960 through 1974, but at the same time it concluded that their potential insolvency "has been brought about primarily by common and preferred stock investments."[8]

Doctors and hospitals had been reluctant to establish their own insurance companies but felt forced to do so. As the movement spread, they began to find they had uncovered a real means for containing premiums. The New Jersey Hospital Association, which was the first to establish a hospital owned insurance company, found that for an earlier year that Argonaut had projected a loss of $2,503,091, its own consulting actuaries, using the same data, came up with earnings of $1,525,989, a difference of over $4 million! The main reasons were that Argonaut had not considered the investment income that could be earned on "available funds" not used to pay claims and Argonaut had consistently overestimated its claim reserves, "2.68 times greater than necessary" (Donald F. Smith & Assoc., 1975).

It seems clear that the explosion of premium rate increases in the "year of the doctors' strikes" was caused less by any sudden or dramatic increase in actual malpractice claims and payments than by new pessimistic anticipations by insurance carriers of reserves needed to meet future claims and by bad experience in the securities markets. Additionally, many companies were signalling their interest in getting out of the malpractice business or sharply reducing their volume, mainly because of the exceptional volatility and uncertainties of the business. It was, in short, primarily a malpractice *insurance* crisis.

World News, May 3, 1976, pp. 21–22). In a separate study, the consulting actuary to the New York State Medical Society found that malpractice coverage over the last several years had not been unprofitable for the two private companies underwriting the coverage, as had been claimed ("State Malpractice Insurers Found to Be Profit-Making," *N.Y. Times*, June 11, 1975).

[8]*Medical World News*, Dec. 22, 1975, p. 12. At a hearing in California, former Argonaut officials attributed the financial plight of the company to a withdrawal of tax credits by its parent company, Teledyne, a conglomerate. Without this act of dubious propriety, Argonaut might have shown a profit on its old rates. It was also testified that the California Insurance Commissioner had not examined the affairs of the company nor inquired into the precise method used for establishing its reserves (*Medical World News*, July 14, 1975, pp. 23–25).

To meet this problem some carriers have introduced "claims-made" policies. It is pay-as-you-go. Only claims reported within the policy year are covered by that year's policy. Next year's claims will be covered by next year's policy, and so forth. The conventional "occurrence" policy premium covers the risk of a claim which occurred in the policy year irrespective of when in the future it may be reported. The new device does not appear likely to reduce the long-term actual costs of malpractice, but the brief experience indicates that immediate costs can be reduced and it does help to alleviate pricing problems. One major company, St. Paul Fire and Marine Insurance Co., has discontinued all marketing of occurrence coverage in favor of claims-made, although some states do not authorize such policies.

Premium Costs

Estimates of total premiums paid by all health care providers differ widely, but are generally believed to have been around $1 billion in 1975.[9] This would represent less than 1 percent of all health care expenditures. It is a great deal of money, but hardly enough to upset the stability of the health care industry, as some have been led to believe.

Premiums vary greatly, of course, by geography and type of practice. A recent survey, based on reports from physicians, showed that the median premium in 1976 was $3,000, representing no more than 3 percent of gross receipts and about 8 percent of tax deductable professional expenses.[10] The highest risk categories, such as surgical specialties, in the highest risk states, paid much more. In California, the top risk class was charged $19,000 for a claims-made policy. In New York, premiums ranged from $470 (lowest risk category in upstate New York) to $19,880 (highest risk category in metropolitan area) with the physician-owned company, now the

[9]This does not include drug firms, which face increasingly complex products liability, a different issue.

[10]See Owens, 1976. Only one doctor in seventy paid as much as $25,000. See, also, *Medical Economics*, Oct. 18, 1976, pp. 146–148, and Nov. 1, 1976, pp. 81–91.

dominant carrier.[11] In the lowest rate states, like New Hampshire and South Carolina, premiums may run to about 10 percent of that level. Some individual physicians pay more due to penalty premiums resulting from a record of claims filed against them. But there is no parallel rate reduction for years of practice without claims.

Premium rates for hospitals differ greatly. They are usually "experience rated." Estimates of total premiums paid by private hospitals in 1975 range from $200 million to $700 million. Assuming a figure of $500 million, it would represent slightly more than 1 percent of hospital costs in that year. Hospitals pay for the coverage of their regular staff physicians, as do other institutions like health maintenance organizations. Increasingly, however, hospitals are also paying or sharing the costs for attending physicians.[12] There are indications that hospital premiums are rising more rapidly than physicians'. Hospitals are complaining that, for the most part, the increases have no relation to actual malpractice experience.

Claims, Awards, and Settlements

Contrary to impressions one might get from the press, most people who experience some injury in the course of medical treatment do not make malpractice claims and most doctors rarely, if ever, experience a malpractice case. In 1975, Dr. Roger Egeberg, special assistant to the Secretary of Health, Education, and Welfare, with responsibility for malpractice problems, publicly estimated that there are about two million medical injuries annually, of which some 700,000 appear to involve some form of negligent conduct (U.S.,

[11]American Medical Association, *State By State Report on the Professional Liability Issue*, October 1976. Of the New York State Medical Society's approximately 28,000 doctors only 384 pay the top rates. ("Malpractice Claims: Many are Filed but Few are Paid," *N.Y. Times*, June 1, 1975.)

[12]Where they do not, hospitals are insisting that attendings prove satisfactory insurance coverage, a requirement that is currently the subject of several court cases. Similarly, some of the new laws require doctors and hospitals to have insurance. This too is being contested.

Congress, 1975).[13] But the number of malpractice claims is estimated at about 20,000.

A survey prepared for the Commission showed that lawyers refused the majority of potential malpractice cases brought to them, usually because they saw no adequate basis for liability or because the potential award was too small. Among all lawyers the rejection rate was 88 percent; among a select sample of experienced trial attorneys the rate was 71 percent. This should not be surprising. Since most cases are handled on a contingency basis, lawyers cannot make a living from cases they are unlikely to win or which yield trivial awards. Defendants usually are represented by competent counsel, generally from law firms which on average are twice the size of those of plaintiffs' attorneys. A case that is not won may represent a substantial financial loss for the plaintiff attorney. Thus the contingency fee system, much maligned among physicians as a major cause of unwarranted claims, actually serves as a screen to inhibit cases that lawyers do not perceive as strong and substantial.

Similarly, the frequent allegation that cases are proliferating because patients have too high expectations of medical procedures, or merely because treatment achieves an unfortunate end result, overlooks the fact that a favorable verdict requires evidence of negligence on the part of the defendant and that there was a causal relation between the negligence and the injury to the patient. Thus the unsurprising finding of the survey was that 99 percent of plaintiffs' lawyers reported that they would not proceed with a case unless a medical evaluation from a consulted physician was supportive of both negligence and causal relation.[14]

According to Commission studies, since confirmed by the detailed 1975–76 study of the National Association of Insurance Commissioners (NAIC), most claim actions are resolved out of

[13]1975. By extrapolating the figures gathered by the Malpractice Commission, its executive director, Eli Bernzweig, arrives at a similar conclusion, about 770,000 such injuries. See "State Laws May Ease Malpractice Ills," *Patient Care*, Jan. 15, 1976, p. 34.

[14]The Commission asked malpractice insurers to indicate whether or not each claim filed was or was not "legally meritorious in terms of liability." The insurers judged 46 percent of the claims to be meritorious. The Commission concluded, "Viewed together, the number of claims judged to be meritorious by malpractice insurers and the number in which payment was made to the claimant would seem to indicate that the vast majority of malpractice claims are not 'entirely baseless' as often alleged."

court, i.e., settled by mutual agreement or dropped (NAIC, 1976). Fewer than 10 percent reach trial stage. Thus a jury is not usually involved, although anticipations of what juries are likely to decide undoubtedly influence the out-of-court resolutions. In fact, jury verdicts are far more frequently in favor of the defendant than the plaintiff. Of all claims filed, about 45 percent resulted in some kind of payment to the plaintiff. Of the cases which actually went to trial only 20 percent resulted in some payment to the plaintiff. More recent data indicate that plaintiffs are doing even more poorly than in the past. The NAIC survey showed that in 56 percent of all claims, the claimant received no indemnity. Of all cases settled by trial, the doctor won 80 percent of the time. Plaintiff lawyers do not appear to be nearly as powerful or persuasive as physicians seem to believe, and considering that more than half their cases result in no payment, their "cut" in winning cases—usually one-third—takes on a different dimension.

The Commission studies showed that among those who did receive payments in claims closed in 1970, three-fourths of the incidents were closed with less than $10,000 paid, and about half with less than $2,000. Awards in six figures were extremely rare, only 3 percent exceeded $100,000. The Commission concluded that less than one out of every 1,000 claims paid was for $1 million or more, "and there are probably not more than seven such payments each year." Considering the general economic inflation following 1970, it is striking that more recent data from ISO render so similar a general picture. In 1974, 43 percent of the claims paid were for less than $5,000, and over 56 percent received less than $10,000. Only 1 percent of all awards exceeded $500,000.[15] The large awards are, of course, a proportionately larger share of the dollar total than their ratio of the number of cases. The over $500,000 awards represented about 23 percent of money paid out. Since such cases are extremely rare, serious, and costly to pursue, they cannot be consigned to any category of frivolous undertakings of irresponsible lawyers.

The available data do not support the view that the proportion of claims successfully pursued to an award has been going up and

[15]See ISO, 1976. These figures are higher than actual figures reported to ISO. Since cases closed in 1974 included occurrences spread over many preceeding years, the dollar amounts associated with each claim were, for purposes of comparability, adjusted to a common occurrence year, 1974, by a percentage amount equivalent to the average increase in claims costs over the period.

they indicate that the average size of awards has been increasing about 10–15 percent per year, which is generally consistent with the inflation of costs in the health care system as a whole. It is still fair to say that the bulk of malpractice compensation remains a small claims business.

The Commission's comprehensive survey of the insurance industry showed that most doctors had never had a malpractice suit filed against them. In 1970, 6.5 medical malpractice claims files were opened for every 100 active practitioners in the country. The Commission regarded this as a low figure that posed no great danger. Unfortunately, no recent national trend statistics are available. But is is interesting to note that in another major study of the state alleged to have experienced the most dramatic explosion of malpractice suits, California, it was found that claims against physicians increased by 40 percent from 1965 to the end of 1973 (Curran, 1976) an average rate of 4.3 percent a year. Considering the rapid rise of population in California and the increase in utilization of health services this is hardly a sensational figure. Figures from some insurance companies indicate far larger increases, but it is doubtful that they have exceeded 10 percent a year. The increases have, however, been cumulating over a number of years; there was no sudden leap in 1974 or 1975.

The risks of being sued are not equally shared among practitioners. The Insurance Services Office survey of cases closed in 1974 showed that 55 percent of all claims against doctors were against surgeons in the moderate or high risk classifications (commonly called classes IV and V), but concluded that the data showed "no apparent tendency for surgeons to be sued in a disproportionate number of cases" (Ins. Services Office, 1976:6–7). Other surveys indicate that aside from variations by specialty and geography, there are significant individual differences among practitioners. In a study of Maryland covering the decade 1960–70, the Commission found that only 17 of each 100 doctors had been sued for malpractice during their whole careers. Among those who had, most were shown to have one such episode in the decade, but some had four or more. The Commission cautiously advanced the hypothesis that some physicians, as well as hospitals, may be suit-prone—a view widely shared by students of the subject as well as insurance carriers.

Recent State Legislation

It is probably unnecessary to point out that the malpractice liability controversy is not an isolated storm in an otherwise tranquil sea. All fields of litigation have been burgeoning and awards increasing. Lawyers and other professions are being increasingly sued for malpractice, product liability suits are becoming common, "class action" suits are a growth industry, and doctors have also caught the litigious fever and are suing hospitals, medical schools, and other institutions in unprecedented volume (for example, Bernstein, 1974:83ff). The data seem to suggest that the medical malpractice debate has been marked by considerable hyperbole, undoubtedly encouraged by the unavailability of exact data. Nevertheless, the fact remains that the situation is serious, not only in its financial aspects, which is all one is likely to find in the daily press, but, ultimately more important, because of what it may reflect about patient care and the relationship of physician and patient as well as what it may do to that relationship.

State legislatures reacted energetically in the context of a perceived emergency. The volume of legislation in 1975–76 in this one field was torrential, probably unmatched in legislative history—a tribute to the political influence of medicine. Virtually all states had passed some type of new law by the end of 1976. The new laws were mainly designed to "get over the hump." It appears dubious that most will contribute very much to longer-term solutions, and questions of equity and constitutionality leave doubts as to how much of the new legislation will survive. Some were labeled temporary and set an expiration date. A large majority of states provided for special study commissions to make recommendations for future action.

The preponderant emphasis of the new laws has been to assure the availability of insurance and to contain costs.[16] There have been relatively few attempts to control or mitigate the actual occurrences of malpractice or the medical environment which may generate suits. In general, this is more true of the states that acted earliest in greatest haste; the later laws tend to show increasing concern with

[16]Brief summaries of the laws of every state have been assembled by the American Insurance Association (1976).

prevention, attempting to associate tort reform with quality control and professional discipline.

Two devices have been most commonly employed to make sure that insurance is available. The more frequent is the legislating of joint underwriting pools among all companies offering personal injury liability insurance in the state. They would share the risks for total liability or, in most cases, only for "umbrella" policies which cover losses above some large amount, say, $100,000. The latter are generally referred to as patient compensation or excess liability funds. They are generally self-financed by a surcharge on the premiums for basic coverage, usually 10 percent. In three states (Nevada, Rhode Island, and South Carolina) the Joint Underwriting Association has become the sole source for purchase of new insurance. More than half the states have enacted authorization for some type of pooling arrangement.

A second device is legalizing the establishment of physician-owned and/or hospital-owned mutual insurance associations, through state medical societies or state hospital associations (often referred to as "captive" companies). At least fifteen states have such legislation, including some of the largest like California, New York, and Ohio. The movement appears likely to spread as the associations report significant savings compared to commercial insurance. The American Hospital Association has officially authorized a "captive" reinsurance company for all member hospitals as well as for hospital-formed insurance companies. The American Medical Association has established an independent, but sponsored, company to aid with capital financing of state plans.

A variety of related devices toward the same end are exemplified by Oklahoma's authorization to its State Insurance Fund, which writes workmen's compensation insurance, to offer medical malpractice insurance to health care providers, and New Jersey's requirement that every firm that sells personal liability insurance in the state shall provide basic malpractice coverage.

The second most prominent group of state actions deals with legal system, mainly so-called "tort," reforms designed to reduce the number of claims, lessen liability, expedite settlements, and to improve the defendant's relative position in contested suits. The most common device intended to reduce the number of claims as well as to shorten the "long tail" was to curtail statutes of limitation. Most states enacted such a change. Most common are specific limitations on the time within which delayed discovery injuries could

be brought for action. The amendments differ substantially in their severity. At one extreme of contraction is the Indiana statute which sets a two-year limit from the date of *occurrence* of the incident, irrespective of the time of *discovery* of the damage. Children under six years of age have until age eight to file a claim. The Maryland statute is among the least restrictive, although tighter than in the past. Suit must be brought within five years from date of occurrence or three years from date of discovery, whichever is shorter. Minors are still able to sue until they attain the age of majority, now eighteen.

The most radical attempt to limit liability was the setting of arbitrary ceilings in a half dozen states on the amount of recovery that is permitted irrespective of the severity or extent of damages suffered by the patient. Indiana adopted an absolute recovery limit of $500,000. (It is interesting that the highest award ever achieved in Indiana to that time was $212,000.) Each health care provider must assume (via his insurance, as a rule) responsibility for awards up to $100,000 and a special state fund is created to finance larger awards, financed by a surcharge on all malpractice insurance premiums.

Idaho is even more restrictive. It limits liability in malpractice cases to $150,000 for an injury to any one person and, where more than one person is injured, to $300,000. In multiple person injuries involving hospital liability the limit is either $300,000, or $10,000 times the number of beds, whichever is greater.

The constitutionality of such restrictions is doubted by most authorities and is being challenged. That portion of the Illinois law (together with some other features) which had a $500,000 limit, similar to Indiana, has been declared unconstitutional by the state's Supreme Court on the grounds that it was arbitrary and conferred a special privilege; it established a classification for which there was no substantive basis and thus violated equal protection and due process clauses of the state constitution. The Idaho law suffered a similar fate in a state district court. However, the state Supreme Court has tentatively reversed that decision, stating that constitutionality would depend on the severity of the "medical malpractice insurance crisis" at the time the law was enacted, a matter that it has asked the lower court to determine.[17]

[17]In Nebraska the Attorney General delayed implementation of the law restricting recovery because "provisions of this act are sufficiently constitutionally suspect as to justify . . . nonimplementation . . . until such time as it can be evaluated by the courts . . ." (*American Medical News*, July 19, 1976, p.8).

Another device, among others, to limit liability, which a dozen or more states have adopted, is some modification of the "collateral source" rule. In varying degrees, these changes would restrict recovery from the defendant for economic losses for which the defendant was entitled to compensation from insurance or other sources.

A host of other legal process changes have been adopted among the varied laws. Many states eliminated the *ad damnum* clause (which permits specification of the amount claimed as damages) which doctors believe has operated to their disadvantage. Since the courts have been gradually moving away from the "locality rule" as the standard for medical care, attempts were made to get legislative sanction for a return to the old rule, but few legislatures responded. Arizona requires that expert witnesses must practice in that state; Alabama, Louisiana, Oregon, and Tennessee also adopted locality rules.[18] A number of states provided immunity in "good samaritan" cases. Washington and Kansas permit insurors to make structured payments over time, instead of lump sum payments, in malpractice awards. The definition and requirements for "informed consent" were clarified in many statutes.

Apparently to assuage the bitter feelings of physicians about contingent fee practices of lawyers (to which doctors often attribute the increase in claims), some states passed limiting laws. Most, like Ohio and Oregon, simply confirmed the general custom by establishing a limit of 33 1/3 percent on attorneys' fees. Idaho set 40 percent. Others introduced sliding scales of several sorts.[19] While it is doubtful whether any of these laws will have any effect on either the number of suits or the size of recoveries, they may in some cases result in larger net payouts to claimants.

One type of liability limitation which has a high priority in the American Medical Association's list of objectives was not enacted by any state; that is a "no-fault" system of recovery for all medical

[18]On the other hand, the highest court in Maryland recently lifted a century-old ban on bringing in out-of-state medical experts (*Medical World News*, November 3, 1975, p.7).

[19]A few years earlier, the New Jersey Supreme Court established a sliding scale without benefit of a statute, starting with 40 percent of the first $5,000 recovered and running to 10 percent of all amounts over $100,000.

injuries or what the AMA chose to call "workmen's compensation-type" legislation. Most legislators apparently failed to see any substantial parallel between the medical liability proposals and workman's compensation. They also have been disappointed by experience with the alleged cost savings and reductions in litigation that were supposed to be obtained from no-fault automobile insurance. Many perceived great inequities against patients in the specific proposals. But the AMA has indicated it will keep trying. In the meantime, several important studies have been initiated by organizations including the American Bar Association and the National Academy of Sciences' Institute of Medicine which will examine a variety of "automatic" compensation formulas.

About half the states have provided "screening panels" and/or arbitration procedures of various sorts to expedite claims handling and to try to settle them before they get to the trial stage. Where screening panels are established, the submission of the case to the panel is generally compulsory, but findings or recommendations are not binding on either party. In most cases the findings of the panel are admissable as evidence in court.

Generally, the panel is representative of various perspectives. For example, in New York, it will consist of one judge, one lawyer, and one member of the defendant's profession. The panel's determination of whether liability exists is submissible as evidence to the court only in such cases where the determination is unanimous; the panel member may be interrogated. The panel is not empowered to decide the level of damages to be awarded. Quite different is Indiana's medical review panel. It consists only of three physicians who make the determination, plus one non-voting lawyer. Its findings on both liability and amount can in all cases be submitted as evidence in court. In Massachusetts and Arizona, an appeal to the courts from the findings of the panel requires the appellant to place a $2,000 bond for court costs. Other states include various measures to encourage acceptance of panel findings.

Arbitration provisions generally permit parties, either before or after a claim, to enter voluntarily into agreement to accept binding arbitration. The tribunal is usually mutually selected or agreed to by the parties. Arbitration arrangements of various kinds have been operating on a small scale in various communities for a long time. A majority of states had recognized an award made under voluntary arbitration based on prior agreement as enforceable, and all states

accepted arbitration based on post-injury agreements, even before the various 1975–76 amendments. Under its new law, elaborating its existing arbitration statute, Michigan has gone farther than other states to promote arbitration. In order to qualify for any malpractice insurance, hospitals and doctors must offer each patient a voluntary arbitration agreement. By signing, a patient agrees to submit to arbitration any potential malpractice dispute. He has sixty days after discharge from the hospital to cancel the agreement. An agreement with a physician is also cancellable. Other states will be watching the Michigan experience carefully. At the end of 1976, ten states had voluntary binding arbitration laws applicable to medical malpractice; Puerto Rico has adopted a mandatory arbitration system, which is now facing court challenge.

Steps Towards Prevention and Control

This review of some of the more prominent features of the laws illustrates that they were primarily designed to alleviate the immediate insurance availability and cost problems and to assuage providers of care. In the course of doing so, existing rights of patients were significantly curtailed, although not as much as doctors had demanded. That may be temporary. In some instances, the courts intervened to remove or reduce such curtailments. Most of the legislatures officially acknowledged that they were acting in haste and under pressure. The study commissions which were formally authorized in almost every state have the task of examining more closely the economic and legal aspects of malpractice liability and insurance and to evaluate the equity and effectiveness of actions already taken, as well as to recommend remedial measures. Most have a specific reporting date. A minority of commissions were asked to look beyond economic and legal issues and to report on the effect certain enactments and proposals might have on the quality of medical care.

Some states have taken substantial steps that indicate awareness that the malpracitce problem did not derive entirely from shortcomings in the legal system or insurance practices, that there remained the fact of malpractice itself and the medical environment which might induce malpractice claims. Mainly these steps fall into three general categories: (1) mandatory reporting of claims and/or financial recoveries to insurance companies and/or to a state

medical licensing or review board for investigation (the latter are designated by an astonishing variety of names); (2) strengthening and/or enlarging the disciplinary powers and mechanisms of existing or newly-created boards; (3) requiring periodic relicensing and/or continuing medical education. A few states have mandatory imposition of insurance surcharges on "repeater" physicians.[20]

An example of the first category is Indiana where all successful claims against health care providers must be reported to the state insurance commissioner who in turn must submit the particulars of the cases to the appropriate board of professional registration and examination for review of the fitness of the health care provider. The Rhode Island statute is broader. It requires the insurance companies to submit annual reports in depth to the Board of Medical Review and the state insurance commissioner. The Board is also charged with investigating all complaints against physicians in the state. At least five additional states have given their boards similar investigatory responsibilities. Georgia requires notification to the licensing authority when a physician's hospital privileges are revoked.

In the second category, the disciplinary powers of licensing boards were in some cases expanded to include professional incompetence as a new ground for suspension or revocation, and a stronger range of sanctions including limits on scope of practice. About twenty states passed some revision of the power or scope of health care licensing agencies.

New York provided some rather complicated arrangements in this area. It removed from the State Board of Medicine, in the Department of Education, responsibility for discipline, although it retains licensing authority. A state Board for Professional Medical Conduct is created consisting of not less than eighteen physicians and seven lay members. Two or more committees, consisting of four physicians and one lay member each, are to be appointed from among members of the Board. A committee is to investigate each complaint received and also conduct self-initiated investigations of suspected misconduct. After investigation and hearings, the committee's recommendations are to be transmitted to the Commissioner of Health, who shall make recommendations as to the com-

[20]In Florida a physician may elect to accept a deductible on his insurance policy in lieu of a surcharge.

mittee's findings and recommendations. The Commissioner must then transfer the entire record to the Board of Regents which must make a final decision after sixty days.

Oregon amended its Medical Practice Act and defined unprofessional and dishonorable conduct. It requires physicians and medical societies to report to the Board of Medical Examiners suspected medical malpractice, and authorizes competency examination by the Board of Medical Examiners. It permits temporary suspension of a physician's license where the board finds continuation in practice would constitute immediate danger to the public, and permits a physician to request limitation of his license.

California, in its statute, indicated a concern with the relationship of malpractice to quality. It changed the title of the licensing agency from the Board of Medical Examiners to the Board of Medical Quality Assurance. The Board's work was functionally divided into medical quality, licensing, and allied health professions. Among other changes, the medical quality review committee structure was revamped.

In addition, states took various measures to facilitate the work of these bodies. Almost every state now provides immunity in all good faith actions to members of peer review committees and boards. Kansas, Maine, Maryland, and Montana provide civil immunity to persons reporting information to review or disciplinary bodies. Oklahoma gave patients increased access to their medical records.

In the third category at least fifteen states have provisions for continuing professional education either on a mandatory basis or as a disciplinary action. Kansas and Ohio require triennial renewal of medical licenses including 150 hours of continuing medical education during the three years. Wisconsin requires fifteen hours every year. Florida and New York permit their boards to require retraining or continuing education as disciplinary measures. In addition, a number of laws provide for revocation of license, limiting practices, or rehabilitation of "impaired" physicians.

These were among evidences that many state officials were not prepared to overlook actual malpractice as one source of the problem or to victimize patients in the interest of conserving insurance premiums. They reflect a heightening sensitivity to the reality that the malpractice crisis cannot long be equitably or economically contained without basic preventive measures. Most

legislators recognized that there are limits to what legislatures alone could achieve. Encouragingly, it did begin to appear that the crisis itself, its costs, and the fear of additional legislative disciplinary acts might yet have the salutary effect of galvanizing health care institutions and professions into aggressive activities directed at risk control and prevention. Ultimately, results would depend more on professional responsibility than on any other force.

While prevention can never be 100 percent effective, there is much that can be done and surely a range of possibilities to be explored. To the extent that it is effective, it yields a double dividend. Its value for conserving costs is more than matched by its inherent value for reducing human suffering, disability, and waste.

Prevention, Quality, and Patient Relations

The contributing causes of the increase in malpractice claims are multifold. They all merit concern and remedy. Even if the cost problem could be disregarded, the situation should be worrisome to all concerned about the quality and effectiveness of health care. The plethora of claims and suits—even if some are without merit—do lend support to the growing acknowledgement of a deterioration in doctor-patient relationships, a failure in communication, and active or smoldering resentment between the parties.[21]

High technology and ever more refined specialization have increased emphasis on the mechanistic aspects of healing. They have contributed to disregard of the patient's need for information, for assistance in understanding his own condition and how to cope with it, for explanation of the advantages and disadvantages of differing procedures and therapeutic possibilities, and for assistance in developing a sense of responsibility for the management of his illness or disability.

The process has been in motion for a long time. Back in 1961, Anne Somers and I wrote:

> The growth in malpractice claims has been attributed to many causes, including the persistence of a small but increasingly

[21]The process can be circular. In eloquent testimony before the Commission, Dr. George Northrup declared, "It may be hard to believe, but we are a frightened profession. The doctor . . . really doesn't want to believe the hostility he feels" (U.S. Dept. HEW, 1972:196).

documented amount of genuine malpractice. Most recent studies of the problem, however, blame poor doctor-patient relations. A 1958 study made for the California Medical Association (Blum, 1958), which attracted nationwide attention, declares, "The malpractice suit is a symptom of the breakdown in the doctor-patient relationship" and "most suits grow from the interaction of suit-prone doctor and suit-prone patient."

The suit-prone patient, according to this study, . . . does not sue primarily for financial gains. He is generally angry at the doctor and sues to punish him. . . . The view that such suits are primarily stimulated by lawyers appears false. Most patients thought of taking action themselves. In only one-tenth of the cases did a lawyer advise suit. In just as many cases another doctor gave the advice.

The study also revealed that doctors who have been sued—especially those who have faced multiple suits—differ significantly in personality from doctors who have not. The suit-prone doctor wants patients to be dependent and grateful, he prefers not to call in consultants, is defensive. . . ."An astonishing 41 percent of the multiple-suit men seem to regard patients as backward children who are too stupid to make even common-sense decisions about health. . . ."

"Perhaps the most significant categories of replies . . . center on how—in the patient's view—the doctor could have prevented him from suing. . . .Very few patients actually want to sue. . . .In no case was a doctor sued who told the patient directly and honestly that he made a mistake and that he was sorry for it. . . .Two out of three suing patients said the doctor could have prevented their suing if the doctor had discussed the matter with them in a plain and candid manner. A third said that they would not have sued if the doctor had not merely sent the bill with no reference to the incident and no indication of concern for the patient."

If the study is correct—in spite of the furor the study caused in California medical circles no serious effort at refutation was attempted—it would appear that an underlying cause of the vast increase in malpractice claims and suits is the tension and conflict resulting from the effort to maintain an anachronistic nineteenth century form of human relations in the mid-twentieth century. . . .

These charges may involve a great deal more than inconvenience, irritation, or legal battles. According to Dr. Ward Darley, former Director, Association of American Medical Colleges, "The time has come when illness as it may be caused or aggravated, and health as it may be perpetuated, by iatrogenic factors, should be subjected to careful and intensive study." This is a point long emphasized by psychiatrists and specialists in psychosomatic medicine. "We still are not sufficiently aware," says Dr. Flanders Dunbar, "that the physician

> himself is often pathogenic. . . ." He is so, according to this school of thought, when he permits the patient's craving for dependence and his own craving for admiration to dominate the diagnosis and the choice of therapy. By refusing to help or even force the patient to assume some responsibility for his own cure, he may, it is alleged, be contributing to a prolongation or "fixation" of the physiological symptoms and thus injure him physically as well as emotionally. "The risk of fixation is increased whenever treatment becomes very intensive, very elaborate, or very impersonal. . . ."
>
> This is a very serious indictment and it is, of course, deeply resented—just as was the charge made a hundred years ago by Doctors Semmelweis and Holmes that hospital obstetricians were often pathogenic. In that case the critics were correct and present-day aseptic childbirth is as much a tribute to their courageous and unpopular perspicacity as to the work of Pasteur and his followers (Somers and Somers, 1961).

The statement was, of course, concerned with only one aspect of the malpractice problem—medical care—the importance of which should not be obscured by the current preoccupation with the economic and insurance factors. The few serious studies of the subject since the above was written would generally support the central thesis.[22] With variations, the point was also made by the Report of the Commission in 1973, although its primary emphasis related to legal and financial issues. Among the Commission's many recommendations were:

> —Special programs should be developed to educate the public on health-care subjects about which patient knowledge is deficient, and which may contribute to later malpractice litigation;
>
> —Continuing programs of research and analysis should be aimed at increasing knowledge and understanding of patients' psychological and psychosocial needs and the findings of such research should be translated into specific action programs aimed at improving the physical design and methods of management of health care facilities and at improving the training of health care personnel in the human relations aspects of patient care;
>
> —Hospitals and other health care facilities should adopt and distribute statements of patients' rights in a manner which effectively

[22]For example, Henry A. Waxman (1975), chairman of the California Assembly Select Committee on Medical Malpractice, which made one of the most thorough studies, has attributed much of the increase in claims to a deterioration in doctor-patient relationships.

communicates these rights to all incoming patients;

—The patient should be told of any danger inherent in the proposed medical treatment. That right is consistent with the nature of the doctor-patient relationship and with fundamental fairness. "A much greater degree of communication between health-care providers and patients is really good, basic medical practice and should be encouraged."

—Adoption of uniform standards relating to the nature of the information which the provider must supply to obtain valid consent for treatment;

—Patients have a right to the information in their medical records. Such information should be made more easily accessible.

Encouraging Movement

It frequently does take a "crisis," or the appearance of one, to galvanize action. Recent years, particularly since the surge of malpractice publicity, have witnessed significant and salutary increases in willingness of the profession to acknowledge and face up to unnecessary shortcomings in quality of care and in doctor-patient relationships. Severe admonitions from leaders of the profession are now almost commonplace in the literature[23] and at such ceremonies as medical school commencement exercises.[24]

[23]For example, at a 1974 panel discussion among eleven of the nation's best known physicians, Dr. John Knowles, former director of Massachusetts General Hospital, asserted, "There are just too damned many examples of medicine's inability to police itself." He then cited five dramatic examples, including: "When I was in Massachusetts, the medical society was alerted to a guy doing about 80 disk operations a year. That was as many as Mass. General, with a stable of the finest orthopedic surgeons in the world, was doing! And every doctor in the guy's community knew he was doing it. Yet no one had complained." Nobody on the panel either disputed or qualified Dr. Knowles' generalization. It is unlikely that such criticisms would have been published in a medical magazine, say, fifteen years ago ("PSRO: Promise and Perils," *Medical World News*, May 3, 1974, p. 23).

[24]The 1975 graduating physicians and dentists at the College of Medicine and Dentistry of New Jersey were told by Dr. Lawrence Weed, "And while we continue to specialize, the distance between physicians and patients continues to grow" and warned against "equating knowledge with performance" ("Medical Graduates Urged to Return to Personal Level," *The Home News*, New Brunswick, N.J., June 3, 1975).

More important, fears of governmental intervention[25] have generated more individual and organized attempts to raise practicing standards and discipline than ever before. For example, about a half dozen state medical societies have voted to require members to participate in continuing education or be removed from the society. Moreover, medical societies supported, or did not oppose, the state laws that permit boards of medical examiners to compel all doctors to continue their education or lose their licenses or have them suspended. We are still a long way from the hopeful forecast of Dr. Robert Derbyshire, a leader in this movement, "The days of the lifelong license are coming to an end" (Med. World News, 1973). But acknowledgement of the problem is an important step.

There has also been a strong reaction against the lack of power or unwillingness of most licensing authorities to revoke licenses for demonstrated incompetence and the reluctance of medical societies to censure members, and this is reflected in some of the new laws as well as within the profession.[26] Invidious comparisons have been made with the much better record of bar associations in this respect, but this too is beginning to change.[27] Against considerable resistance, some doctors are pleading for professional self-policing to deal with doctors disabled by drug addiction, alcoholism, mental

[25]A leading federal physician, the administrator of the Food and Drug Administration, recently told the profession, "The greatest threat of increased intervention in medical practice comes not from a federal plot to nationalize medicine, but from congressional reaction to substandard performance by some doctors" (*Medical World News*, June 30, 1975, p. 72).

[26]Speaking of malpractice, the government's then top health officer said, ". . . We need to strengthen the sanctions against incompetence, and we haven't done a good job on that. State laws on licensure need to include specific provisions for the steps to be taken under which incompetence can be sanctioned, all the way up to fining and suspension. That's essential. Certainly we can't solve the problem by creating insurance pools . . ." (Theodore Cooper, M.D., in *Hospitals*, June 16, 1975, p. 55).

[27]According to Dr. Derbyshire, in the five years 1968–72, twenty states had taken no disciplinary action against any physician ("Medical Society Faces Discipline Issue," *New York Times*, February 25, 1973). But in the year ending in mid-1975, six Maryland physicians had their medical licenses revoked by the Maryland Commission of Medical Discipline, the largest number of revocations in any 12-month period since the board began in 1969 (*American Medical News*, Aug. 2, 1976, p. 2). Significant increases in disciplinary actions during 1975–76 have been reported for New York, California, and other states.

illness and the like,[28] as well as those who refuse to retire long after advanced age has caused them to lose their effectiveness.[29] The AMA gave formal recognition to this important problem in a resolution passed at its October 1976 clinical meeting.

Refusal to testify for plaintiffs and failure to report the observed malfeasance of other physicians—the so-called "conspiracy of silence"—are diminishing and are no longer quietly accepted as appropriate professional conduct. For example, it was surely the changed environment that encouraged the revelation, after years of delay, that a mortality survey committee of the Philadelphia County Medical Society spent eight years reviewing hospital deaths caused by alleged medical malpractice, but kept no records and took no disciplinary action. The city medical examiners presented cases of "serious breaches of medical practice that had resulted in the death of the patient, including failures to diagnose head injuries, inaccurately placed hip pins that severed arteries, and arteries punctured during other surgery." The physician who chaired the committee for four years acknowledged that the findings were never passed along to the state Board of Medical Education and Licensure nor were victims' relatives informed of the inquiries. He said that the records had not been kept because of the fear of malpractice suits and fear by his own colleagues of being subjected to suits. The city medical examiners finally exposed the entire matter in October 1976, two years after the committee had disbanded.[30]

[28]See " 'Disabled' Doctors: Ignored by Peers," *Medical World News*, June 2, 1975. The AMA recently announced that twenty state medical societies have started programs to identify and rehabilitate physicians who are mentally ill or who have alcohol or drug dependence. At least four states—Utah, New Mexico, Nebraska, and Kansas—enacted "disabled physician" laws patterned after the AMA's model statute which responded to a House of Delegates resolution in December 1975 urging legislative action on rehabilitation of disabled physicians (*American Medical News*, May 31, 1976).

[29]See Curtis, 1975. A survey of Illinois physicians by the state medical society produced an "alarming estimate" that one in nine physicians is addicted to alcohol or other drugs (*Medical World News*, May 16, 1977, p.5.). Nonetheless, many doctors still firmly disagree with professional self-policing. For example, Dr. Ray McIntyre wrote to *Medical Economics* (October 15, 1973), "Why, indeed, should the medical profession provide judge, jury, and hangman for an advocatary proceeding against its own guild members?"

[30]"A Study of Malpractice Deaths Reported Ended Without Action," *New York Times*, October 5, 1976. In 1974 the state legislature passed a law that says that any

Specialty boards have become increasingly sensitive to their responsibilities for quality performance. The certifying Board for Family Practice is requiring periodic reexamination, to be centered on observation and evaluation of actual clinical performance. The American Society of Internal Medicine has approved the idea of relicensure and would make it entirely dependent on performance testing rather than written examinations or continuing education. Several other specialty boards and societies are seriously considering similar actions. The American Board of Medical Specialties and twenty-two member boards have endorsed the principle of periodic voluntary recertification.

As the initial anger at the sudden spurt in premium costs subsided, leaders of the medical profession and of hospitals began to urge that the providers of care examine their own contributions to the problem. Addressing the American College of Surgeons, Dr. H. William Scott, Jr., its president, stated that the "gut issue of medical professional liability is far more than an insurance program." He soberly noted that the first element of malpractice is injury to a patient as a result of care administered, and called upon physicians and hospitals to determine the kind of injuries taking place and why, how to prevent as many as possible, and to place blame on the shoulders of those truly responsible. "If the frequency of claims and suits is to be reduced, it is vital to obtain facts concerning the medical injuries that initiate them," he said (Health Lawyers News Report, 1975).

The American College of Hospital Administrators has moved to impress on its members the relationship of the conduct and care of hospitals to malpractice vulnerability. For example, it is distributing a cassette whose purpose is "to demonstrate how the quality of medical care delivery can be improved by identifying and correcting specific and potential sources of hospital malpractice common to the various medical specialties and to the hospital" (Hersch, 1976).

In 1976 medical magazines increasingly featured articles which departed from the earlier mode of berating lawyers and juries and concentrated on advising doctors on elements of their own behavior, their relations and communications with patients that might stimulate malpractice suits. Traditional public postures were being

person providing information to peer review committees that investigate health care cannot be held civilly liable or found to have violated any criminal law.

abandoned and it was no longer "it just isn't done" for professional organizations to acknowledge publicly the reality of incompetence and negligence and even to urge public officials to assume more disciplinary authority over the profession. For example, in a remarkable official statement, which probably could not have happened even five years earlier, the prestigious American Surgical Association (1976) proclaimed:

> Physicians who have been found incompetent, negligent or careless should be appropriately identified and disciplined. Findings arising within the system of professional liability claims should be reported to the appropriate state licensing board, local hospital authorities and regional or national professional organizations. Discipline should involve the withdrawal of the license to practice in some cases, withdrawal of specialty credentials or staff privileges in others. In still others, psychiatric or medical care is needed. For some, upon re-engaging in practice, there should be the requirement of continuing education with mandatory supervision.

It is noteworthy that in a 1976 questionnaire survey of all state medical societies, the AMA asked some unprecedented questions under a heading, "Risk Prevention and Control Activities." It asked whether the society had an educational program in this field, whether it had an audit or assessment program, whether risk control was on the society meeting agenda, and what activities county societies were undertaking. In addition, the state societies were asked to report on "Activities to Identify and Treat Impaired Physicians" (AMA, 1976).

Numerous other encouraging examples could be cited.[31] They still represent only promising beginnings, a base to work on, but they are significant. Such movements to improve quality and patient-doctor communications are important for their own ends irrespective of the malpractice insurance problem.[32] But there can be

[31]As the malpractice crisis was approaching a boil in the closing months of 1974, a striking change of mood was evidenced when the American Medical Association Board of Trustees endorsed making studies of the "most effective methods for incorporating measures of *patient satisfaction* into the systems by which physician performance is evaluated" (*American Medical News*, November 4, 1976).

[32]A physician authority on malpractice stated, "Discussions of the malpractice problem in the press . . . suggest that the central purpose of the liablility system is to compensate the injured party. That ignores a second major impact of

little doubt that this new trend was spurred and accelerated by the insurance crisis to which, in historical perspective, society may yet feel indebted. The signs are now that the insurance crunch will ease substantially, but it is essential that its salutary side-effects not be permitted to wither and that the new candor and aggressive initiatives in respect to quality and human relations in health care be maintained and nurtüred.

Concluding Observations

The very early responses to the dramatically advertised "crisis" were in the main distressing. The first legislatures acted in an atmosphere of semi-hysteria and a mood that action of some kind was immediately imperative, with no time for analysis. They lacked information; much of the data they had proved wrong or inconclusive. They concentrated on reducing the liability of defendants. Much of their actions resulted in special privileged protections for health care tortfeasors not available to other classes of citizens, a form of class legislation of dubious constitutionality. Gradually, the temper changed to considered sobriety and later legislation proved far more balanced and constructive. The results of the many state study commissions, who have yet to report, augur well for reappraisal and correction of earlier mistakes.

Even now, it seems probable that the net effect of the farrago of activity will be a subsiding of insurance pressures. The contraction of time periods within statutes of limitations will be helpful. Normally the nearer a case decision is to the medical event, the fairer the medical determination is likely to be. Although legal authorities agree that dilatory tactics of lawyers on both sides have contributed as much to delayed decisions as statutes of limitation, these curtailments should help make insurance premiums more predictable by

compensation—its effect on the physician. When I make the rounds at the hospital . . . and look at each record, I am far more sensitive to the quality of the care than I was five years ago. . . .I am a little more careful today because of the potential for suits. And all of my colleagues—physicians in both community hospitals and university hospitals—indicate that they are responding to the larger number of suits . . . by taking a greater degree of care. . . .I would like to raise the heretical possibility that the increase in claims may not be inappropriate. . . .Before we tinker too much with the system, we had better understand its implications for quality of care" (Schwartz, 1977).

shortening the "tail" and reducing the uncertainties of size of "reserves," whose recent extraordinary expansions have accounted for much of the premium increases. Some of the statutes which tie the time period to the date of occurrence without regard to time of reasonable "discovery" do injustice to patients whose injury does not become apparent for a considerable time after the medical encounter. These should be adjusted.

Requirements for regular reporting of claims and recoveries are important. In the past, legislatures and insurance commissioners have lacked reliable data. Commissioners are now being pressed to exercise powers they have long held nominally, to regulate rates and review the procedures of insurance companies in arriving at rates. They will now have better tools for effective regulation as well as more public support. The behavior of insurance companies who elect to stay in this business is likely to be significantly affected.

The "collateral source" rule will have a moderating effect on awards. However, while it is proper that double collections on the part of plaintiffs be avoided, it may be unfair and socially undesirable that the prudence of the plaintiff in paying premiums for health insurance, for example, should redound to the benefit of the guilty defendant. This can be avoided by keeping the defendant liable for the full cost of damages, but having the duplicating portion go into a special fund, either to reduce premiums across the board or for use by the state in promoting various health safety or "risk control" programs. Many authorities question the desirability of any collateral source rule.

The widespread experimentation with "screening panels" and with arbitration are positive and hopeful trends. The panels should reduce the number of cases that are filed and might otherwise reach trial stage, thus reducing the duration of time consumed and expenses on all sides. However, screening could also cause protraction because of the two-stage requirement. Screening must be accepted as bona fide, not as a hurdle before trial, to be effective. The effectiveness of the panels will in part depent upon their credibility as fair and impartial tribunals. Thus the one-sided structure of the type of panels prescribed in Indiana and Nebraska—with only physicians as voting members—offers less promise than those which represent a diversity of interests and skills. The experience of screening panels will require careful evaluation.

Arbitration, in lieu of court cases, is growing and appears to be

gaining acceptance rapidly. The American Arbitration Association has become actively engaged in keeping track of all types of arbitration and is conducting experimental projects to help design the best instruments for resolving health conflicts. It provides expert guidance around the country. The preliminary signs are that arbitration reduces the "tail" as well as costs and avoids the glare of sensational publicity that often accompanies a court case. The informality of the process, compared to court trials, appears to offer more equity. Even the existence of the arbitration option appears to raise sensitivity and reduce claims.

On the insurance side, potentially the most significant development is the emergence, with legislative sanction, of doctor-owned and hospital-owned malpractice insurance carriers. In a very brief time several of these mutual companies have demonstrated that they can provide coverage at lower premium rates than commercial carriers were asking, and there are good reasons why they should. Such companies are spreading rapidly. They could quite possibly become the dominant medical liability insurors.[33] In addition to cost-saving, there are other heartening prospects in this development. Such companies will give health care providers a more immediate and palpable stake in prevention and they will be in a better position to exercise controls. All malpractice claims will automatically come to their attention and be known to fellow professionals. The financial burdens will be more readily traceable to their source. These companies will be less inhibited about intervening in the medical practice arena, where insurance companies feared to tread. They are likely to find it profitable to cooperate with and help underpin the disciplinary powers of state licensing authorities and medical societies.

Placing limitation or controls on lawyers' fees was a reasonable act (although physicians who fought for this may have some second thoughts since the logic might also be applied to limiting physicians' fees). But all legislatures wisely rejected pressures to do away with the contingency fee system. That would have been discriminatory. Legal actions are very expensive and cannot ordinarily be undertaken by anybody without substantial means. Despite "legal aid" and other devices, the contingency fee is for most people the only practical and effective means of entry into the legal system for damages where lengthy legal services are required.

[33]There is also a movement towards self-insurance. The largest example is probably the Kaiser-Permanente Medical Care Program.

The universal rejection by the legislatures of pressures for some sort of "no-fault" compensation to replace tort liability was disappointing not only to the AMA but also to others who were spawning such proposals in a variety of shapes and sizes.[34] The allegation by some that such a system would reduce costs proved unpersuasive; the contrary may be more likely. In the course of such proposals, allegations were made about workmen's compensation—which was invoked as a model—that were erroneous. It was said that such a system would greatly reduce administrative costs, particularly because it would eliminate or sharply reduce the amount of litigation. That has not been the experience of workmen's compensation where litigation flourishes with only the character of the issues changed.[35] It is also overlooked that the severely limited awards to seriously injured workers tend to diminish in proportion to wages. There is merit to a social policy that would compensate people for serious economic loss due to accidents, but it is difficult to see why that should be confined to people whose accidents happened to be medical; that seems to be the task of a more broadly financed social insurance system. In 1974 New Zealand started a comprehensive accident-compensation system under which benefits are paid without regard to fault or where the injury occurred. In 1975, Sweden initiated a no-fault patient-injury compensation system under which the patient retains the right to sue for negligence if he chooses. It is probably too early for an accurate evaluation of either system. Clearly, this issue demands very careful study; as noted earlier, this is now being undertaken by responsible sources.

One final prospect for reduced insurance costs should be noted, although its source is independent of the malpractice controversy. A large element in the size of financial recoveries for malpractice is the cost of medical care. If some form of national health insurance is truly in prospect, as most people believe, that would remove a substantial burden from malpractice insurance. The existence of a National Health Service in Great Britain is one of the reasons for

[34]See, for example, Havighurst and Tancredi (1975). A variation of this approach—called "Designated Compensable Events"—is now being studied by an American Bar Association Committee.

[35]See Somers and Somers (1954). "Administrators and scholars, once in full agreement on the evil of litigation, are now divided. . . .Most now appear to have considerable doubt whether the original idea of making courts and lawyers unneccessary in compenstion activities can ever be achieved, or even whether it would be desirable" (p. 188). See also A.H. Bernstein, "Hospitals, Workers' Compensation, and No-

the awards there being comparatively low, because the costs of medical care are publicly financed and do not fall on malpractice insurance—although in Great Britain also the number of malpractice claims is increasing.

These and other new developments do furnish cause for optimism that the malpractice insurance crisis will pass. Whether that will be enduring depends more upon whether all involved continue to take alert and active advantage of the new climate for containing the causes of malpractice suits within the health care system itself, now that malpractice is "out in the open."

With the improved flow of information that is now developing, the greater sensitivity to the shortcomings of past insurance practices, the greater involvement of health care providers in the insurance business, and the heightened degree of official supervision, I believe we can look forward to further reforms in malpractice insurance practices and legislation aimed at improving delivery of health care. Here we can only enumerate briefly a few such possibilities.

Mainly, reformed insurance practices can establish better and more direct incentives, through rewards and penalties. They can better distinguish between offenders and non-offenders, thereby reducing the load carried by the large majority of practitioners for the misdeeds or omissions of a minority. They can reward specific practices that undertake to prevent malpractice and malpractice claims. To a limited extent this is already done through experience rating of hospitals and penalty premiums imposed upon multiple claims physicians. But thus far these have been employed in very limited and relatively crude fashion, and they have been ineffectively confined to negative incentives. Differential premiums can be used not only in relation to malpractice cost experience but also in relation to positive preventive risk control measures.[36]

The hospital is obviously the place that warrants primary attention—not only because the large majority of malpractice events originate within its walls (and also the most expensive ones),

Fault," *Hospitals*, May 1, 1977, pp. 126–135.

[36]Whether malpractice liability influences the behavior of providers is an arguable issue because no firm data are available. This author agrees with Dr. Schwartz (see note #32) and finds the evidence unmistakable that it does. I find it odd that many of the same people who deny the behavioral effectiveness of malpractice liability also assert the pervasiveness of "defensive medicine"—an apparent contradiction.

but also because systematic preventive and policing programs are more readily feasible in an institutional setting. Since the vast majority of physicians are hospital-affiliated, the institutions's principles and practices can have substantial effect upon physician behavior in their own offices as well.

Despite continued resistance from medical staff, who cherish and protect their independence, hospitals are being forced by court decisions to assume larger responsibility for care rendered in the institution whether by its own employees or by private attending physicians. Ever since the historic Darling case was decided by the Illinois Supreme Court in 1965, courts have increasingly enlarged the accountability of the hospital itself. Another milestone in this direction was passed in the notorious case of Dr. John G. Nork in 1973.[37]

The Superior Court of California ruled that if a hospital knows, or should have known, that one of its patients is liable to be a victim of malpractice by a physician on its staff, whether that physician is an employee or an independent practitioner, "it is liable on the basis of corporate liability." It is not immune from liability merely because it conformed to the standards of the industry and because it is required to function under a self-governing medical staff. The fact that the medical staff is theoretically independent and that its audit and disciplining procedures are inadequate offers no excuse for the hospital.

Such legal trends give underpinning to the potential of tying differential premium rates to the development of preventive and prompt remedy programs. A hospital which, in addition to meeting standards of accreditation and certification for participation in government programs and the requirements of the Professional Standards Review Organization, has effected an approved comprehensive preventive program, could be given a substantial dis-

[37]Although admittedly an extreme instance, the Nork case offers no comfort to those who argue that all apparent malpractice derives from unfortunate accidents rather than misconduct. Dr. Nork, who admitted guilt, was involved in at least fifty unnecessary and damaging operations in what the court called "a systematic scheme of fraud by the physician" who "for nine years made a practice of performing unnecessary surgery and performing it badly simply to line his pocket." During all these years of malfeasances his medical staff colleagues did and said nothing. At the time the decision was handed down, Dr. Nork was still in the practice of medicine. His license was finally withdrawn three months later. For an excellent summary of the legal aspects of the case, see Jahns (1974).

count on its basic insurance premium rates. The program should combine standards of care with patient education, formal patient rights, and preventive methods for overcoming misunderstanding and disagreement, and accessible prompt means for settling unresolved claims and differences, involving the participation of those served as well as those who serve.

Even now, the more progressive hospitals have begun to develop such procedures for what the growing hospital literature calls "risk control" programs, with consistent reports of success not only in financial aspects but also in terms of patient relations. An organization called Hospital Association of Risk Managers has recently been established. One of the hospitals that has been using a patient grievance mechanism, which includes several of the elements listed above, the 500-bed Halifax Medical Center in Daytona Beach, Florida, saved, according to outside analysts, an estimated $750,000 to $1 million in the three-year period 1972–75 (Mullin, 1975).

Another positive action process that insurance can foster is to set aside a small fraction of premiums, say 2 percent, for a fund to be employed for development, dissemination, and technical assistance in preventive and risk control measures.[38] The better workmen's compensation carriers have been doing this for years in their "safety" programs and found it profitable. It is the type of activity especially appropriate for the doctor and hospital-owned insurance companies.

It is more difficult to devise a positive program for self-employed physicians in their offices. However, consideration should be given to offering discounted premium rates to physicians who actively and formally participate in an approved hospital or similar Health Maintenance Organization program of the type described. This might not only encourage participation but also strengthen the hospital's influence over its staff's practices. It may be anticipated that there would be a salutary carry-over into the doctor's office practice. Special discounts might be offered to physicians covered by a PSRO which elects the option to extend its jurisdiction to office as well as hospital practice.

[38]St. Paul Fire and Marine Insurance Co. is now providing such a service. This company reduced its insurance rates in seventeen states during 1976 and early 1977 and credited an 11 percent drop in claims in 1976 "to greater doctor involvement in malpractice-prevention programs" (*Medical Economics*, May 16, 1977, p. 11).

However, a more effective negative sanction may also be needed for physicians. At present, in most states, the doctor will only experience penalty if there are multiple successful claims against him. Even then the penalty comes later in the form of higher premiums in subsequent years. That may not be sufficient.

Most doctors are strong advocate of co-insurance in ordinary patient health insurance—that is, the patient is directly responsible for paying a given percentage of the bill, rather than full coverage by insurance—on the principle that there needs to be a financial discipline against overuse. This principle of co-insurance should be at least as applicable to malpractice insurance wherein the physician's liability is usually transferred to the insurance carrier. A sliding percentage scale of co-insurance, up to some set maximum, say, $10,000, would have some obvious advantages. It would bring some reduction in regular base premiums. Since the majority of doctors do not experience malpractice suits, most doctors would gain. Burdens would fall more directly and equitably on suit-prone physicians. Equally important, there would always be a visible correlation between particular cases and costs in the consciousness of the doctor and he would have a more direct concern about the level at which settlement is made.

One of the most frequent arguments against greater or more direct penalties on doctors is that they cause indulgence in extravagant "defensive medicine"—unnecessary X-rays, lab tests, hospital days, etc. It is a rather convoluted argument, saying that if you hold a doctor financially accountable for malpractice acts, he will retaliate or defend himself by indulging in other improper practices which are not legally considered malpractice. In fact, nobody really knows how much defensive medicine is really being practiced and monetary guesses range very widely, depending upon what the guesser is trying to prove. In the muddy definitional waters of medical practice, it is not even clear what defensive medicine is (Mechanic, 1975). It is often subdivided into "negative defensive medicine" and "positive defensive medicine"—the latter being procedures that *should* have been undertaken in any case—and these concepts are not entirely clear either. It is not known how much of the unnecessary procedures are attributable to malpractice fears and how much to the fact that the victimized patient's bills are covered by health insurance, or how much to the "technological imperative" that characterizes modern medical care, or to other

causes.[39] Before the malpractice crisis we heard just as many complaints about excessive medical procedures, but then they were being wholly blamed on health insurance.[40]

In any case, most of these expensive procedures take place in the hospital. It is another reason for strengthening the standard setting, reviewing, and disciplinary responsibilities of the hospital. Aside from his own professional principles, the doctor is likely to be as concerned over the opprobrium of his peers and possible loss of hospital privileges as he may be of malpractice suits. Insofar as so-called "defensive medicine" causes deliberate wasteful practices it should, of course, be deplored. But insofar as it means stimulus for appropriate caution and care, it is a plus (Quayle, 1975).

The foregoing comments and suggestions are of far less consequence than the spirit behind them, a primary concern for the health aspects of the malpractice problem. As indicated, the malpractice situation is complex and multidimensional. I have been able to discuss only a few of its many aspects. But I have tried to emphasize that among its many significations is the often neglected fact that it signals something amiss in health care itself and in the relationships between the providers and receivers of care. While there is much to be remedied in many elements of this complicated problem, the most urgent needs and the most promising paths lie in seizing the malpractice crisis as an opportunity for dealing more effectively

[39]West Germany, for example, has been experiencing at least as large an increase in defensive medicine—defined as additional diagnostic procedures per medical encounter—without the impetus of any malpractice crisis (Reinhardt, 1976).

[40]There is indeed a new tendency to make malpractice and "defensive medicine" convenient explanations for all increases in medical prices and costs. Total costs have been rising at a compounded annual rate of over 12 percent per year and health service prices at about 8 percent for a decade. But hospitals and physicians, in statements to the press (and in paid advertisements), were attributing their 1975–76 increases to malpractice premiums. See, for example, Altman (1975). Similarly, hospitals have been increasing required tests of patients for many years. But in 1975, such inflation of care was being attributed to "defensive medicine." As one hospital in a community adds two routine tests upon admission—and such tests represent the more profitable features of a hospital's business—others follow, and then that becomes the accepted "community standard of care." See, for example, *Medical Economics*, July 21, 1975, pp. 11–12. There is apparently no burden that cannot be translated into an asset.

with the quality of care and introducing counter influences against the technological depersonalization of the health care process. If such actions are taken, whatever effects they may have on malpractice costs—and I believe they will be highly salutary—we will have gained much as a society.

References

Altman, L.K. 1975. Malpractice Rates Drive Up Doctor Fees. *New York Times*, July 27.

American Insurance Association. 1976. Medical Malpractice Insurance Reports. Revised. Mimeographed (Dec. 1).

American Surgical Association Statement on Professional Liability, September, 1976. *New England Journal of Medicine* 295: 1294 (December 2).

Bernstein, A.H. 1974. The Litigious Physician v. the Medical Establishment. *Hospitals* (Dec. 1): 83ff.

Blum, R.H. 1958. Malpractice Suits—Why and How They Happen. A Summary of a Report to the Medical Review and Advisory Board of the California Medical Association.

Curran, W.J. 1975. Law-Medicine Notes. *New England Journal of Medicine* (December 4): 1183.

———. 1976. How Lawyers Handle Medical Malpractice Cases. U.S. Dept. of Health, Education, and Welfare, Publication No. (HRA) 76-3152, p. 32. Cited: Preliminary Report of the Select Committee on Medical Malpractice of the California State Assembly.

Curtis, L.R. 1975. On the Other Hand. *Medical World News* (July 14):40.

Havighurst, C.C. and Tancredi, L.R. 1975. Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice. *Health and Society/ Milbank Memorial Fund Quarterly* 51: 125–168.

Health Lawyers News Report. 1975. 3:4 (November).

Hersch, H. 1976 Hospital Malpractice Claims. ACHA Research Quality Cassette No. 76-3.

Insurance Services Office. 1976. All-Industry Committee Special Malpractice Review: 1974 Closed Claim Survey: Condensed Analysis. November. p. 25.

Jahns, M.L. 1974. Court Decision Would Extend Liability. *Hospitals* (January 16): 31–34.

Lavin, J.H. 1975. Malpractice Insurance: Local Solutions Won't Work. *Medical Economics*, (November 10): 29-49.

Mechanic, D. 1975. Some Social Aspects of the Medical Malpractice Dilemma. *Duke Law Journal* 1975: 1189–1192 (January).

Medical World News. 1973. Will Relicensure Come to Depend on Continuing Education. (June 22): 18.

Mullin, J.L. 1975. (Insurance Consultant to Halifax Medical Center, Daytona Beach) Interview, June 23, 1975.

National Association of Insurance Commissioners. 1976. Medical Professional Liability Survey. Milwaukee, Wisconsin. Vol. 1, No. 2 (September).

Owens, A. 1976. How Much Have Malpractice Premiums Gone Up? *Medical Economics*, (December 27): 101–108.

Quayle, Christopher. 1975. Those Lawyers are Forcing Us To Be Better Doctors. *Medical Economics* (September 1): 61–63.

Reinhardt, U.E. 1976. Health Manpower Policy in the U.S. Paper presented to Bicentennial Conference on Health Policy, University of Pennsylvania. November 11–12. Mimeographed (pp. 39–40).

Schwartz, W.B. 1977. In *The Medical Malpractice Dilemma*, pp. 4–5. Washington, D.C.: American Enterprise Institute for Public Policy Research.

Smith, Donald F., & Associates. 1975. Hospital Insurance Company Study for the New Jersey Hospital Association. January 8 (p. 3).

Somers, H.M., and Somers, A.R. 1954. *Workmen's Compensation*. New York: Wiley & Sons. See particularly: The Pervasive Litigious Atmosphere, pp. 178–191.

———. 1961. *Doctors, Patients, and Health Insurance*. Washington, D.C.: The Brookings Institution (pp. 472–475).

U.S., Congress, House, Committee on Interstate and Foreign Commerce. 1975. An Overview of Medical Malpractice. Committee Print No. 4, March 17 (p. 13).

U.S. Dept. of Health, Education, and Welfare. 1972. Report of the Secretary's Commission on Medical Malpractice. Publication No. (OS) 73–88 (January); also the Appendix, Publication No. (OS) 73–89.

Waxman, H.A. 1975. Spiraling Costs: A Health Care Slide. *Trial* (May/June): 24.

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