Professional liability—
the crisis and approaches to the solution

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Mr. Past President, Mr. Chairman, Officers, Regents, Governors, Distinguished Guests, Fellows, Ladies, and Gentlemen: the greatest honor an American surgeon can receive is to become President of the American College of Surgeons. I appreciate your trust and esteem in granting me this high office. With great humility I pledge my best efforts to live up to your confidence during the critical period we face together.

The strength of this great College lies in its Fellows. Each of the Fellows initiated during this Convocation represents the result of a strong scientific and humanitarian educational process, culminating in acquisition of professional knowledge and skill gained during prolonged periods of graduate education and clinical service as residents and, for most of you, shorter periods in surgical practice. You have been carefully evaluated and, as a result of the excellence of your performance, have been found qualified to become Fellows. Your added strength will serve to sustain the vigor of our great organization. It is a pleasure to welcome you as Fellows of the American College of Surgeons.

Your entry into this Fellowship of surgeons comes at a time of turbulence and uncertainty in the professional lives of physicians and surgeons in the United States and to a lesser degree in those of our Canadian confreres. The largest and most ominous problem that all of us face is the professional liability crisis.

As Dr. C. Rollins Hanlon stated in a concise report on this topic in the April 1975 issue of the ACS BULLETIN, ". . . It is no exaggeration to label the situation a crisis . . . Most urgent is the issue of insurance availability. It is one thing to pay high premiums . . . even when these are projected to absurd levels . . . But when absolute unavailability of professional liability insurance threatens one or several states, with the imminent risk of shutting down the provision of service to patients, no one can characterize the term crisis as overdrawn".[1]

In the short time since Dr. Hanlon's report the malpractice crisis has evoked actual and

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In brief . . .

In this presidential address, delivered October 16, 1975 in San Francisco during Convocation ceremonies of the 61st annual Clinical Congress, Dr. Scott reviews the major aspects of the professional liability dilemma, focusing on the factors, as they apply to patients, physicians, hospitals, and lawyers, that seem most important in causing the increasing number of suits.

He then discusses both short range and long range approaches to the solution, emphasizing that, unlike a scientific study in which hard data can be accumulated and analyzed, the dearth of factual information regarding the problem is a major stumbling block, and if the frequency of claims and suits is to be reduced, it is vital to obtain facts concerning the medical events that cause them.

threatened strikes by physicians and shutdowns in hospital services in several states, and has been recognized as a national emergency threatening the continuity of health care throughout America. There are opinions by the thousands concerning the causes and possible solutions for the malpractice crisis, but hard data on these subjects are very scarce. Let us look at some of the limited factual information on the background of this crisis in professional liability.

Ten years ago only one malpractice jury verdict in the United States had reached one million dollars. And, according to medico-legal expert David Rubsamen, the number of verdicts in excess of three hundred thousand dollars could be counted on the fingers of both hands. Today over 30 malpractice awards and settlements over $1 million can be identified. And in California alone there were at least 34 awards of $300,000 or more in 1974".[2]

The enormity of the present situation is absurdly illustrated by the malpractice suit filed in California recently that reportedly asked for several billion dollars in damages for the plaintiff, not to mention his legal advisors.

The depth of the problem is incisively depicted by a New York City malpractice case that was concluded earlier this year. A young woman, now 22 years of age, brought suit against physicians who had treated her as a premature infant in 1953. Oxygen had been used in her incubator and her survival was accompanied by blindness. In the early 1950's oxygen therapy was commonly used in support of premature infants and only later was it discovered that retrolental fibroplasia and blindness could result from such treatment. As the trial progressed the plaintiff settled the lawsuit out of court for $165,000; the jury was reported to be ready to award her almost a million dollars.

Several frightening elements in this case are pertinent to the present medical liability crisis: (*1*) the physicians were held to be liable for therapy considered proper at the time of its use, (*2*) the award came 22 years after the event, and (*3*) the jury was prepared to award over five times as much in damages as the plaintiff was willing to settle for.

Looked at from the viewpoint of an insurance company any one of these three factors can cause an actuarial nightmare. If physicians are responsible for the side effects of therapy even when these are not known at the time of treatment, the potential liability is enormous. Physicians are theoretically liable to litigation for decades, in fact as long as their patients are alive. Juries will likely continue to be generous in their awards to aggrieved plaintiffs. The insurance company can readily conclude that medical malpractice is an area of insurance coverage that defies actuarial analysis and decide to get out of the business.

Another factor that has contributed to rising premiums and withdrawals from the medical liability field has been the economy. As cited by Don Harper Mills, the capacity of casualty carriers is limited by their earned surplus; this surplus dropped precipitously with the fall in the stock market during 1973 and 1974. The result has been a sharp reduction in the number of doctors the carriers can afford to underwrite.[3]

Ten years ago at least 30 insurance companies in the United States offered medical professional liability insurance. Today this number has dropped to eight or nine, with announcements by several of the remaining companies of their intent to withdraw from professional liability coverage or, as an alternative, to remain in the business only with enormous increases in premium rates.

Although the gut issue of medical professional liability is far more than an insurance problem, the total unavailability of professional liability insurance in some areas of the country plus the exorbitant premium rates proposed by the few remaining insurance carriers have clearly been the precipitating factors in the present compound crisis.

Much less clearly can we identify the fundamental factors that constitute the etiology and shape the pathogenesis of the disease we are discussing. At a national conference on medical professional liability held in Arlington, Virginia last spring, an effort was made by various panelists to fix the "blame for the malpractice problem", on various scapegoats. According to reports of the conference, over-expectations by patients are large contributing factors. Physicians and insurers said that contingent fees and lack of selectivity by lawyers in choosing cases were responsible. Attorneys and insurers stated that the problem could begin only in a hospital or physician's office. Lawyers and physicians blamed a general greed among insurers for escalating premiums.

Let us review the factors that seem most important in the cause of the increasing number of malpractice suits and the current professional liability crisis as applied to patients, physicians, hospitals, and lawyers.

Patients

In a recent article, "Changing Climate for Medicine", Philip Abelson emphasized that the essence of practice of medicine is in the interaction between patient and physician and indicated that in good medical practice there is no substitute for the conscience of the physician. He further pointed out that, "Intervention by the Congress and by the administration has come because of demands of the public that are based at least in part on unrealistic expectations of what can be delivered in the way of patient care. The average person's concept of what is possible medically is conditioned by a memory of miracle drugs and polio vaccine and by accounts of organ transplants and great new medical discoveries. The public expects the best possible medical care but wants it delivered in the style of a generation ago—the doctor appearing at home with a black bag and a stethoscope . . . The public also has come to demand that physicians never make mistakes in technique or judgment as indicated by the current rash of malpractice suits".

Dr. Abelson summarizes accurately the viewpoints of the public that constitutes our patients and our sources of potential claims and suits. In the past decade we have seen the development of "consumerism" and an increasingly litigious attitude on the part of the American public in all aspects of human activity—certainly this litigious attitude seems to focus with increasing frequency on medical accidents and injuries, real and alleged, in physicians' offices and in hospitals.[4]

In commenting on a report of the Legal and Ethics Committee of the Study on Surgical Services for the United States (SOSSUS), committee chairman Dr. Henry Schwartz stated, "There is a growing force of well informed consumers who prefer a role in determining health policies. From the public point of view, the quality of health care is assessed through the outcome of the services rendered rather than through the provider and practitioner credentialling process. This implies corrective action if care does not meet acceptable criteria . . .".[5]

The trial lawyers and the insurance companies apparently agree that a fundamental cause for litigation lies in the feeling of the patient and his family that the physician has not provided first rate diagnosis, treatment, and results. In addition, as pointed out by arbitration expert Robert Coulson, there is the factor of institutionalization: "The personal warmth between doctor and patient has cooled. Medical care is no longer a transaction between an individual patient and an individual physician . . . Although the doctor is still professionally responsible for patient care, he is more likely to be acting as part of a medical team. Other professionals, as well as assistants, technical employees, and suppliers of equipment and drugs also are involved in the treatment". Coulson thinks that medical care and professional liability are becoming institutional problems.[6]

However, plaintiff's attorney R. M. Markus has emphasized that the large institution and specialization are not necessarily synonymous with depersonalized medicine. Looking at the record of claims filed state by state, he finds little correlation between incidence of claims, the medical sophistication of the state, and the amount of so-called mass medicine practiced here. Rather, Markus believes that a fundamental cause of such claims is poor rapport between patients and doctors: "A client will come in to me and say he wants me to sue his doctor, but as we talk, I realize what he's describing is not bad medicine so much as bad personal treatment. Until I sort out the one from the other, I can't even tell whether the case has legal merit . . . what drives the patient to me in the first place is not always the medical result . . . Underlying the patient's complaint there is most always a tale of his physician's rudeness, arrogance, or assembly line indifference".[7]

In the opinion of Eli Bernzweig, formerly the executive director of the HEW Commission on Medical Malpractice and formerly a vice-president of the Argonaut Insurance Company, the primary cause of professional liability claims is iatrogenic medical injury. He is quoted as stating, at a conference sponsored by HEW last spring, "The time has come for all parties seeking solutions to malpractice problems to recognize that the root cause of the current malpractice problem is the substantial number of injuries and other adverse results sustained by patients during the course of hospital and medical treatment".

Bernzweig apparently believes that the severity of the injury is more likely to determine whether a claim will arise, than is the probability that the injury was caused by substandard care or negligence. Further, in his opinion, secondary or contributing causes include such factors as interpersonal problems with breakdown of rapport between patient

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and physician or health care provider, frustration with the manner in which specific complaints about modes of treatment and complications are handled, unrealistic expectations by patients concerning outcome of treatment, a growing national trend toward health care consumerism, and other sociological stimuli to litigation.[8, 9]

Physicians

According to Don Gussow, the first recorded malpractice suit was tried in England in the 13th century. The first such suit in the United States occurred in 1790. Throughout the 19th and the early half of the 20th centuries, such litigation was quite uncommon. The change in incidence began in the 1950's and suits have flourished in the 60's and 70's.[10]

Insurance Service Office, an independent rating organization, estimated that in 1966 only 1.7 physicians per 100 were sued by patients. By 1972 this figure was 3 per 100. For the last several years the number of claims filed against physicians has increased by eight to nine percent per year. Awards in these claims have increased on an average of 13 to 14 percent per year. Insurance companies responded in the decade ending in 1970 by increasing professional liability premium rates by 540 percent for physicians other than surgeons and by 950 percent for surgeons. In this crisis year of 1975 all physicians and surgeons engaged in private practice faced additional increases of several hundred percent in premiums or total nonavailability of professional liability insurance coverage. It is estimated that nearly $2 billion will be collected in this coming year in medical professional liability insurance premiums. Surgeons will pay well over 60 percent of this enormous total.

In a report for the former HEW Commission on Medical Malpractice, Rudov, Myers, and Mirabella analyzed medical professional liability claims closed in 1970. They found that 59 percent of physicians named in claim action were in solo practice. Physicians in partnerships accounted for another 25 percent, practitioners in groups eight percent, doctors working in institutions four percent, and the remainder was comprised of miscellany.[11] From this study it appears that ten times as many claims are filed against physicians in solo and partnership practice as against those who practice in groups.

What factors account for this highly significant difference? Hard data not currently available are needed to answer this question. One speculative answer might be that the peer review inherent in the "gold fish bowl" of group practice may serve to reduce the number of medical injuries and resulting claims. But more than speculation is needed for a valid answer.

Do these increases in claims and insurance premium rates reflect comparable increases in negligent conduct by physicians and hospital personnel?

Eli Bernzweig answers this as follows: "First, let us begin by recognizing the vast difference between actual or de facto malpractice (injury resulting from negligent conduct) and malpractice claims (mere allegations that an injury was caused by negligent conduct). Secondly, . . . there is absolutely no basis for concluding that all or even a majority of malpractice claims are attributable to negligent conduct—although some undoubtedly are, and the number may be growing".[8]

As early as 1955 David Barr found that five percent of 1,000 patients who were admitted to the medical wards of a large metropolitan hospital sustained "unfortunate sequelae and accidents attributable to sanctioned and well-intentioned diagnosis and therapy".[12] Bernzweig estimates that the percentage of iatrogenic injuries sustained to total units of hospital care provided on a nationwide basis is in the range of five to ten percent. It is his opinion that the vast majority of these injuries are not due to negligence, but many of them are preventable.[8]

In a recent loss-control program conducted on some 8,000 liability policyholders who were members of county medical societies in southern California, Johnson and Higgins of Los Angeles looked into 2,300 claims occurring over a four year period. The firm found that ten percent of the claims had been brought against only 46 doctors and each of these doctors accounted for four or more claims. Only three of these physicians had anything derogatory in their records. An analysis based on underwriting criteria concluded that these 46 doctors all had sound professional credentials and backgrounds of experience. Only twelve of the 228 cases against the 46 began in their offices. Only two of the 46 physicians with multiple claims were general practitioners and only one was an anesthesiologist. Twenty-eight of the 46 were board certified specialists and eleven others were reported to be board eligible. Six were foreign medical graduates, all of whom had received their residency training in American hospitals.

By far the bulk of the claims—185 or about 81 percent—arose from elective surgery performed on hospital in-patients by attending physicians with appropriate privileges.

This study fails to validate a 1970 senatorial subcommittee report that ascribed rising professional liability insurance rates to "bad apple doctors who are chronically negligent to the point of incompetence". According to the California report, virtually none of the 228 cases involved actual negligence, but most were described as "bad accidents" that couldn't have been forecast on the basis of the physician's past history or his use of controversial procedures.[13]

Hospitals

The Johnson and Higgins study indicates that the majority of claims derive from injuries sustained in hospitals. Hospitals are commonly named as codefendants in such suits. The liability crisis has affected them severely and is of enormous concern to all voluntary institutions providing health care.

As is the case with physicians, in the last decade voluntary hospitals in the United States have had to cope with a steadily increasing number of claims for damages from patients, and a skyrocketing rise in premiums for liability insurance to cover their complex and varied professional and nonprofessional employees. Premium rates for many hospitals for fiscal year 1975–76 have been escalated from 300 to 1,000 percent. In my own institution, the 500-bed Vanderbilt University Hospital, in the relatively non-litigious community of Nashville, Tennessee (where insurance companies paid out only $15,750 in jury verdicts for malpractice claims in the four-year period between January, 1971 and February, 1975), the hospital's liability premium for its nonphysician employees has been increased from $59,000 for fiscal year 1974–75 to $395,000 for fiscal year 1975–76. This does not include the 1975–76 premium for liability insurance for the house staff, an additional $150,000. In high-risk states such as California, New York, New Jersey, and Florida, these large increases in premiums will probably seem quite modest.

Throughout the country, the cost of increased premium rates for liability insurance imposed on voluntary hospitals will be necessarily passed on to the patient in the form of equivalent increases in the cost of hospitalization. As a tangible example, the elevated premium rates will necessitate that Vanderbilt University Hospital increase its already high daily room rate by at least $7.00 per day.

In the course of a patient's hospital experience, where is an injury or mishap in diagnosis or management that gives rise to a liability claim most likely to occur? Is the emergency department the most fertile breeding ground for malpractice claims, or is it the area of the operating rooms and the postoperative recovery-surgical intensive care complex? Accurate answers to these questions are difficult to find. The HEW Commission reported that emergency and surgical care are the sources of most malpractice claims. The Johnson and Higgins survey found that only nine of 228 claims, slightly less than four percent, originated from emergency department activity. While this figure is well below that of 14 percent reported for emergency services in a similar study for a ten-year period in Maryland, the limited information available implicates the hospital's operating rooms, with their complex functions, related postoperative care facilities, and multiplicity of personnel, as the source of most such claims.

In an April *JAMA* article on "Malpractice Litigation", Don Harper Mills emphasized that most claims and suits are predicated on the existence of definable injuries to patients, such as surgical complications, adverse drug reactions, failure to interrupt the natural course of a disease, or injury through lack of diagnosis or cure. Mills points out that "available information about the number and quality of injuries induced, both negligently and non-negligently, at the hands of health providers is wholly inadequate".[3]

We simply do not know how many iatrogenic medical injuries occur annually in our hospitals, how many are related to operating room activities, or how many are related to the other multiple functions and areas within the hospital. We have no statistical data on the kind of injuries that occur or why they occur. We do not know how many of them are preventable. And, as emphasized by Mills, "not only do we not know what we are dealing with but no one has yet made a concerted effort to find out".

Lawyers

Many physicians, understandably, are annoyed or angry at the role of lawyers in this problem. Few doctors understand the role of the lawyer in our society, especially when he brings suit against us, but we welcome his help

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when we need his legal skill in our defense! Most of us, I believe, agree with Sam Johnson, as quoted by Boswell in a *Tour to the Hebrides* in 1773, "A lawyer has no business with the justice or injustice of the cause which he undertakes . . . the justice or injustice is decided by the judge".

What factors have influenced lawyers to increase so drastically the number of claims and suits alleging medical malpractice in the last decade? According to David Rubsamen, "First, there is the increased availability of medical witnesses to the plaintiff-patient. Second, there is the greater willingness of juries to examine critically the conduct of physician and hospital defendants. And, third, as jury verdicts grow in size and frequency, highly skilled trial attorneys are attracted to the gold fields of malpractice litigation".[2]

In a medical malpractice suit the tort of negligence is established by the plaintiff's proving to the jury's satisfaction that the injury he allegedly sustained resulted from the defendant's failure to use due care. The plaintiff's medical expert witness is said to be the most critical element in the picture. "In the past", Rubsamen says, "the reluctance of physicians to testify against a colleague kept a firm lid on malpractice litigation . . . As expert witnesses for the plaintiff become more available, experience proves that plaintiff's verdicts progress from a rare event to an occasional one. Then, they become frequent".[2]

As a matter of current record, it is now possible for a plaintiff's attorney to obtain a review of the merits of a case he has under consideration for a malpractice suit from a firm of medico-legal persons. The attorney may also obtain, from the files of the firm, the name of a presumably competent and pertinent medical witness who allegedly will testify for the plaintiff for a fee.

Is medical malpractice litigation truly a "gold field" for lawyers as David Rubsamen and others have said? Let us look at available facts. According to a 1969 congressional study, the lion's share of the total cost to the insurance companies of malpractice suits and claims goes to the legal community. The study indicated that only sixteen cents of the malpractice premium dollar is paid to patients with untoward results or injuries. It is estimated that the insurance premium pool pays out over 80 cents of each dollar in administrative costs and in legal fees to the counsel for plaintiff and for defendant. The dollar awards are split between the successful plaintiff and his attorney according to a schedule of contingent fees agreed on in advance.[20]

Estimates on the size of contingent fees received by plaintiffs' lawyers for winning malpractice suits vary from 33 to 50 percent, or more, of the award or settlement. As a concrete example, the experience of a single insurance company in my state was quoted in an editorial last spring in a Nashville paper, ". . . of the $543,053 the company paid out in malpractice suits in Tennessee in 1974, the lawyers received 60 per cent, or $327,146". On a country-wide basis, including the high-risk states, projections for fees paid to attorneys for malpractice suits become enormous.

Many physicians believe that the problem of medical liability suits, which is uniquely severe in America, would be reduced promptly by measures to eliminate or limit the American custom of the contingent fee for legal services. According to F.B. MacKinnon, the practice of contingent fees—taking a percentage share of the money recovered for damage or injury—began originally among American lawyers as a method of providing legal services for those unable to afford counsel.

Although considered an unethical practice in Canada, England, and most other countries, the contingent fee contract is now the most dominant method for financing litigation for both rich and poor in the United States. MacKinnon states that, ". . . fundamental changes in attitude toward litigation in general have accompanied the development of contingent fees in the United States. One such change is the departure from the English view that litigation is a social ill, which like other disputes and quarrels should be minimized; to this end, one who stimulates or assists lawsuits to which he is not a party is dealt with as a troublemaker in England (the basis for the crime of barratry) . . . in England the economic risks of litigating have been magnified by the general rule that the loser pays his opponent's attorney's fee, while in this country a party runs no such risk and, under a contingent fee contract, a losing plaintiff will not have to pay even his own attorney".[14]

In his April *JAMA* article Mills stated, "Doing away with the contingency fee system tomorrow would probably eliminate 90 percent of new suits against doctors and hospitals merely because most patients could not otherwise finance the prosecution of their claims". The counter argument to this viewpoint, held

by plaintiffs' attorneys, is that the use of contingent fees (although rarely used in smaller claims) makes the services of lawyers equally available to people of all economic classes. Thus the controversy continues. Until some other method is devised to compensate attorneys, Mills believes the solution to the ills of the contingent fee system is control rather than abrogation.[3]

Approaches to the solution

When a catastrophic event occurs, unless previous, careful planning for orderly management has been initiated, a helter-skelter rush of proffered solutions is apt to ensue. Until recently the federal government has stayed away from intervention in the malpractice crisis, and former HEW Secretary Weinberger consistently voiced his opposition to federal involvement in the problem. However, multiple bills have been already introduced in the Congress, offering a variety of federal solutions, often equipped with the buried hook of rigorous federal controls over the practice of medicine. Dr. Roger O. Egeberg, assistant to the secretary of HEW, recently indicated that the administration may have to get involved in the malpractice crisis: (*1*) if an impasse occurs in a state so that malpractice insurance is not available to certain specialties and therefore the practice of medicine is stopped in these fields; or (*2*) if insurance unavailability and high premiums limit the capacity of young physicians to enter practice in certain states and increase the trend to early retirement of older physicians; or (*3*) if the costs of premiums for physicians and hospitals continue to rise astronomically from an estimated one billion dollars this year toward an estimated two billion dollars next year with concomitant increases in the cost of defensive medicine; then the federal administration is likely to move in.

However, Dr. Egeberg emphasizes that the professional liability problem currently is the business of the states. He urges that physicians take the lead in the solution. His conclusion in a recent address to the American College of Legal Medicine was, "There is an obvious degree of defeatism among physicians. And if there is much defeatism you can be sure that the federal government will be willing to come in and exploit it".[15]

The short-range approach to the solution

The primary need in the insurance crisis is an immediate solution that will make medical professional liability insurance available in every state at affordable premium rates. Collaboration between the major carriers, insurance commissioners, state medical societies, health care providers, professional societies, and state and federal governments has been effective and impressive throughout this country in recent months in approaches to this critical short-term goal.

Legislation designed to deal more equitably with issues and problems in state laws that have previously made medical liability insurance an "actuarial nightmare" for insurance companies has been enacted by an increasing number of states. These legislative reforms include such aspects as a patient's compensation board, a statewide joint underwriting association, medical review panels, modifications of the statute of limitations, modification of the collateral source rule, restriction of the contingent fee, a ceiling on awards, classification of the issue of informed consent, more stringent authority granted to licensure boards for disciplinary actions against aberrant practitioners, modification of the doctrine of res ipsa loquitur, elimination of ad damnum, and establishing alternatives to the tort system such as arbitration, no-fault insurance, or workmen's compensation.

Indiana's new malpractice law has been hailed as an example of model legislation by Dr. Egeberg and by the AMA, but Dr. G.M. Wilhelmus,[16] new president of the Indiana State Medical Association, has recently stated, "Though the new law should help solve some of the most immediate problems, we know it's no panacea . . . We're happy with the 75 percent we got (through the legislature), but the other 25 percent is very important and we intend to keep trying for that, too".[16] However, a spokesman for the trial lawyers has indicated that even the watered down version of the bill originally put forward by Indiana doctors is distasteful to them and predictions are that the provisions of the Indiana Act and those recently enacted by many other states will soon be challenged in the courts as to their constitutionality.

Another approach to the short-range solution is that of the "captive" insurance company. Several state and regional medical associations have selected this approach. Others have helped to develop legislation to establish a joint underwriting association in the state to provide malpractice insurance on a temporary basis until

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insurance companies of the private sector reestablish a stable market for medical liability insurance.

The American College of Surgeons earlier this year carefully investigated all aspects of this approach. After a favorable response from over 7,000 Fellows indicated willingness to provide capital funds in support of an insurance program sponsored by the College, a professional liability insurance plan was outlined and, with the approval of the Board of Regents, was presented to the entire Fellowship for consideration. A substantial number of Fellows responded favorably by submitting contributions as requested. However, a number of technical and complicated issues related to the insurance entity moved the Board of Regents not to activate the program.

The long-range approach to the solution

Regarding the professional liability problem, I believe it is apparent that, unlike a scientific study in which hard data can be accumulated and analyzed, there is a dearth of factual information. Under the present system of tort litigation alleging medical malpractice, the first element is medical injury—injury to a patient as a result of his receipt of medical, surgical, or hospital care. The second element is fault. Injury and fault are the factors that form the basis for such litigation. If the frequency of claims and suits is to be reduced, it is vital to obtain facts concerning the medical injuries that initiate them. Data are needed concerning the types of injuries, their incidence, severity, places and circumstances of occurrence, how and why they occur, and their preventability. The insurance carriers have great stores of such data in their claim files. A mechanism is needed to extract and analyze these data if it can be done legally and ethically.

Apparently the insurance regulators are moving in this direction. At its meeting earlier this year, the National Association of Insurance Commissioners developed a closed claim form on medical professional liability that calls for information regarding the nature of the injury, the location and circumstances, the claimant, the defendant, the settlement, and other pertinent data. This information is to be reported by carriers on all closed claims after July 1, 1975. Data will be coded and stored at NAIC headquarters. The statistical information derived from this approach should be of great value in the future to the insurance industry and to the medical profession.

However, the medical profession and the hospitals need to collect similar data concerning medical injuries in our patient population, including those that never result in a liability claim or suit. If we are to develop effective programs to prevent the occurrence of injuries, we certainly need statistical description of the injury universe.

Elimination of the fault system of compensating injured patients is urged by some advocates of legal reform who prefer a no-fault system similar to workmen's compensation. Jeffrey O'Connell of the University of Illinois is a leading advocate of no-fault liability insurance applicable to all sorts of accidents, including auto accidents, those stemming from manufactured products, medical and surgical treatments, and injuries sustained in a hospital setting. The no-fault concept has been quite successful for auto insurance in those states that have adopted it.

In Professor O'Connell's plan of no-fault compensation for medical injuries, the patient would receive prompt and certain payment of medical expenses above his basic health insurance coverage and loss of income during his period of unemployment. The patient would agree to forego compensation for pain and suffering, which constitutes a large proportion of financial loss for insurance companies and physicians under the existing tort liability system. Legal fees are also excluded in the no-fault system, so that this form of coverage is sometimes called "No-lawyer insurance".[17, 18]

David Rubsamen opposes a literal no-fault system as requiring an absurd standard of perfection in every therapeutic and diagnostic effort. Every disease process that ends in death or serious injury would be potentially compensable. He suggests that a no-fault system might work satisfactorily if restricted to elective surgery.[19] Professor O'Connell also advocates limited medical liability in his elective no-fault system.

One of the questions that must be asked of any system under consideration is whether the health care providers can continue to be the financial source for compensation to injured patients. Mills has asked, "Even if a no-fault compensation system can reduce the cost of individual claims, is the injury universe from which these claims arise so large that the total cost will smother the profession? It may be necessary . . . to change the method of financing as well as the system of compensation".[3]

Those recommendations of the Study on Surgical Services for the United States pertaining to professional liability have accurately outlined many of the objectives for amelioration of the professional liability crisis. I urge each Fellow of the College to read this section in the summary report of SOSSUS,[5] so as to be better acquainted with all elements of the problem and its possible solutions.

The American College of Surgeons, ably represented by Dr. C. Rollins Hanlon and staff, has been working with the American Hospital Association, the AMA, the Medical Liability Commission, HEW, consultants and representatives of the insurance industry, and medico-legal experts, "To delineate the problem", as Dr. Hanlon stated in April, "settle on suitable local approaches, and avoid direct involvement of the federal government in attempted solutions".[1]

The College must mount a broad investigational and educational program for Fellows and for the public that will develop new solutions concerning professional liability. However, I agree with Mills that, "Continuing education and even recertification of practicing physicians will affect the malpractice litigation phenomenon only after adequate information about injuries and their causes has been accumulated, evaluated, and incorporated into proper prevention programs".[3]

The importance of avoiding injury to patients while undertaking their treatment is not new to physicians. Four thousand years ago the Babylonian King Hammurabi codified the laws of human behavior for his subjects, including eleven paragraphs that refer to physicians and veterinarians. Excerpts from these codes, in the translation of Charles Edwards, are as follows:

If a doctor has treated a Freeman with a metal knife for a severe wound and has cured the Freeman, or has opened a Freeman's tumor with a metal knife and cured a Freeman's eye, then he shall receive ten shekels of silver . . .

If a doctor has treated a man with a metal knife for a severe wound and has caused the man to die, or has opened a man's tumor with a metal knife and destroyed the man's eye, his hands shall be cut off.

While the penalties of the Code of Hammurabi seem unduly severe to us today, they are forceful reminders to all who deal with the health of their fellow human beings of the ancient admonition, "Primum non nocere"—a primary consideration in the care of patients is to do them no harm.

I shall close by reminding each of you that the American College of Surgeons, since its founding, has had as its salient objective the improvement of care of the surgical patient. The Clinical Congress, with its wealth of surgical instruction, is an important contribution toward meeting that objective. The College has long had a major educational role in the management and prevention of injury. Iatrogenic medical injury presents a uniquely important challenge to the College for investigation and control. Thank you.

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