Professional liability in the 1980s: Problems and solutions

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At the first Convocation of the American College of Surgeons in 1913, President John M.T. Finney said in his Presidential Address: "The history of surgery in the United States and Canada is opened to a new page. When at some future time the historian comes to write on that page the record of events that have led up to this meeting, he will there record the taking of another step in the progress of medicine in general and of surgery in particular in Canada and the United States. What is consummated here tonight is destined to produce a deep and lasting impression upon medical progress not alone in those countries but indirectly the world over."[1]

In his Presidential Address in 1954, my chief, Alfred Blalock, to whom I owe so much, emphasized the common feature that binds us. He said: "All physicians—whether active practitioners, teachers, investigators or administrators—have a single common objective which unites us all. This is the welfare of the sick."[2]

The American College of Surgeons has traditionally been committed to excellence in patient care and to continuing education. In the opinion of observers worldwide, the quality of the annual Clinical Congress has risen to the rank of first place. The expanding edge of scientific knowledge is revealed in the research papers presented by our bright young surgeons at the sessions of the Forum on Fundamental Surgical Problems. Updates on all important aspects of surgery and the surgical specialties are presented in the various postgraduate courses each year. Topics deserving special emphasis are presented at the general sessions by panels representing different points of view, and the audiovisual presentations illustrate the newer surgical techniques. All members of the College have an obligation to honor and maintain this tradition in the future.

In addition to its strong emphasis on education and patient care, the College has also been interested in a number of socioeconomic issues in the broad field of health care. At its recent retreat, the Board of Regents considered seven such topics and prepared position papers concerning each. In its final conclusion, the report stated: "Of all the socioeconomic issues facing the surgical profession, that of professional liability most urgently calls for resolute action by the College. The College is unequivocably committed to seeking legislative reform of the professional liability system on the national and local level in cooperation with all of its constituencies and all other medical and non-medical groups striving for a solution for this complex problem."

The Board of Governors has also voted this issue the most important of our current problems, further emphasizing its significance today. It is this paramount issue that I wish to discuss.

Malpractice in history

To comprehend this complex subject, a knowledge of the history of professional liability is essential. While the Code of Hammurabi is generally regarded as the first of the codified principles of law to mention the issue of malpractice, classic Greek culture, as cited by Plato, held that actions of physicians should be judged *only* by other physicians. Aristotle emphasized that the only penalty applicable to any *real,* or *perceived,* wrongdoing by a physician was limited solely to injury of his reputation and to nothing else.

In English law, the first recorded decision concerning civil liability of a surgeon was an action brought before the King's Bench in 1374 against a surgeon named J. Mort involving the treatment of a patient who had a wounded hand. In that decision, the defendant was held not liable because of a legal technicality, but the court ultimately ruled that if negligence could be proven by such a patient, the law would provide a remedy. However, of much significance, the court further held that: "If the surgeon does so well as he can and employs all his diligence to the cure, it is not right that he should be held culpable."[3] It is interesting that even in medieval times attempts were made to control medical and surgical professional liability by purchasing a renewable "floater" policy by which consultation was mandatory on each high-risk case.[4]

In England, plea records were kept and have been maintained to the present. These serve as a body of evidence for subsequent decisions and generally mean that a decision of a higher court has the force of law and is in essence binding on future cases of a similar type. This is the legal doctrine of *stare decisis,* and to this day one of the most striking

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features of English Common Law is its adherence to precedent.

In 1423, the Joint College of Physicians and Surgeons of London produced the "Ordinance Against Malpractice."[4] Interestingly enough it is written in English rather than Latin or French, which were the classic legal languages of the day. This ordinance required a surgeon to report all patients who were desperately ill within three days.

Fortunately for those in the British Isles and Canada far fewer medicolegal suits are filed than in this country. The difference is largely due to the fact that contingent fees are not legal in Britain, and that the judges are primarily responsible for court decisions rather than trial by jury. Moreover, the British society is not nearly as litigious as ours. For centuries the British have maintained a strong sense of justice coupled with emphasis on fairness.

In the United States the first liability case was filed in 1794, as Cross vs. Guthrey; it also involved a surgical procedure. The husband of a deceased woman sued because of alleged negligence in the performance of a mastectomy.[3] The operation was characterized as being conducted "in the most unskilful, ignorant, and cruel manner, contrary to all the well-known rules and principles of practice in such cases, that the patient survived by but three hours, and the defendant had wholly broken and violated his undertaking and promise to the plaintiff to perform said operation skilfully and with safety to his wife." In the end the jury found the physician liable and awarded damages.

An early medicolegal treatise on malpractice was published in 1866 by Dr. John J. Elwell, a professor of criminal law at Western Reserve University.[5] The evidence comprising the elements of medical jurisprudence of that day were carefully reviewed in this monograph. In the preface, Dr. Elwell said: "It is my earnest desire that its mission may be beneficial, by relieving, to some extent, the labors of the attorney, while it sets forth and maintains the rights of the medical and surgical practitioner, not shielding the culpable and guilty, and at the same time bringing the two professions into closer union, producing greater harmony, sympathy and usefulness." It is an extraordinary text even today and is fascinating reading.

Gathering storm

In a collective review of the era between 1794 and the Civil War in 1861, historian C. R. Burns could find only 27 malpractice suits that were adjudicated as appeals in the various state supreme courts.[6] During the 20-year period from 1935 to 1955, there were only 605 cases, or an average of 30 each year, predominantly in California and New York. After 1955, it became clear that professional liability suits began to rise dramatically and especially during the last decade.

The gathering storm and the impact of these events on the delivery of health care, health-care costs, and health manpower prompted the appointment of the Presidential Commission on Medical Malpractice. This commission carefully reviewed medical liability claims throughout the nation and found that in 1970 there were some 15,000 claims filed. The rapid escalation of this problem is emphasized by the fact that in the 40 years between 1935 and 1975, 80 percent of all medical professional liability suits were filed in the last five years of that period.

The escalation in the total number of professional liability claims beginning about a decade ago has been astonishing. For the years 1975 and 1976, the National Association of Insurance Commissioners identified 14,074 such claims. The next 30-month period included 57,926 claims, or an average of 23,169 per year. In 1983, 77 percent of the carriers surveyed showed 32,324 cases and, if projected, the expected total exceeded 42,000.[7]

Data collected in California show that the impact of verdict awards for the period 1972 to 1983 was remarkable. In 1972, the average award was $200,296. Over the next decade, the total amount of the verdicts rose sharply with the average award to the plaintiff increasing to $649,000 in 1983!

The number of suits in the nation settled in excess of $1-million has shown a striking rise. Data indicate that by 1981 the number of cases settled of this magnitude had risen to more than 50 annually.

Another factor of considerable concern is the inequity in the rates of professional liability policies in relation to geographic location, even within a single state. In New York the rates for general sur-

geons vary from $21,000 in upstate New York to $47,000 on Long Island, with a differential for neurosurgeons of $44,000 in upstate compared to $98,000 on Long Island. The premiums for other specialties follow a similar pattern with wide variations depending upon the location within the state.

The rapid escalation in the cost of policies was emphasized in 1974 when a single company insured approximately 95 percent of the practicing physicians in the State of Maryland and the premium was raised 46 percent, immediately followed by another 48 percent increase the following year. When the second increase was rejected, the company ceased writing policies in Maryland.

Such problems led to the establishment of physician-owned nonprofit companies to provide insurance. The total number of these companies has now risen to 37 serving 39 states throughout the nation. As is true for private insurance companies, the physician-owned companies have been compelled to increase their premiums in order to remain solvent. One state that established a mutual company in 1979 found it necessary to increase the premiums 109 percent in the first five years, with an additional 47 percent increase last year. In another state, the average premium has increased 22 percent each year since inception of the program in 1980.

Impact on patient and physician

Despite the staggering increases in premiums, the present system remains totally inadequate for the patient and physician alike. One of the most distressing aspects of current professional liability insurance is the small percentage of the insurance premium dollar that is actually awarded to the patient, generally cited as being about 28 cents on the dollar, a very poor commentary on the system.

The total payment of premiums for insurance policies versus the amount paid in claims shifted dramatically in 1978. Prior to 1978, most insurance companies were able to operate without financial losses, but since that time, the situation has changed dramatically. The companies' losses have escalated and while premiums paid increased from $1.2- to $1.57-billion dollars or 31 percent between 1977 and 1983, the losses soared to $817-million in 1979 and to nearly $2-billion in 1983. Last year, Best's Insurance Management Report said: "Medical malpractice is reaching the point of no return in terms of producing investment income and the lost revenues that exceed the underwriting costs."

Concomitant with an increase in suits against physicians, the same has occurred to hospitals throughout the nation. Hospitals are now experiencing a rapid increase, and the St. Paul Fire and Marine Insurance Company experience shows a rise in hospital suits of 76 percent between 1979 and 1983.

The present system of infringements upon the medical profession as a direct result of the flagrant abuse of matters dealing with professional liability is emphasized by the understandable reluctance of physicians to accept high-risk cases in which lawsuits are likely. For example, a questionnaire survey done by this College in 1984 showed that more than 40 percent of the members restricted their practice with the intent of avoiding high-risk problems.

Moreover, the American College of Obstetricians and Gynecologists recently testified that 60 percent of the nation's obstetricians have been sued at least once and 20 percent have been sued three times or more. For this reason, nine percent of its membership has already ceased practicing obstetrics and a significant percentage has been forced to increase fees as much as 30 percent to cover the charges of increased liability insurance. In careful studies, *Jury Verdict Research* has shown that the most expensive lawsuits settled in favor of the plaintiff are ones that involve birth injuries, with the mean award now at $1½-million. Moreover, a recent case was settled at $8-million. With this in mind, as well as the uncertainty of the statute of limitations in these cases, more than 25 percent of the physicians in Florida have ceased managing obstetrical patients.

In a recent study, the American College of Obstetricians and Gynecologists surveyed 560 members of its Michigan section. More than half said they either stopped delivering babies as of May 31 or planned to do so because of skyrocketing malpractice costs. The physicians ranked the lack of limit on potential malpractice awards as the top liability-related problem today.

The impact of this problem is further emphasized by recent experiences on the island of Molokai in Hawaii. The physicians ceased practicing obstetrics after learning of a massive increase in their malpractice insurance premiums. Dr. Ralph Hale, chairman of the department of obstetrics and gynecology

at the University of Hawaii in Honolulu, says that pregnant women must now travel to Honolulu a week before their scheduled date of delivery and emphasizes that this has caused them and their families considerable psychological and financial disadvantage.

Such problems are paradoxical since the patient with a complex illness who needs the best medical care possible has increasing difficulty in obtaining it. Moreover, the cost of *defensive* medicine, that is, the ordering of many, often expensive examinations solely for malpractice protection, is variously estimated to cost the nation between a minimum of $15-billion and in a more recent survey up to $40-billion annually.

The recent practice of awarding large sums to those who experience completely unpredictable complications from the standard vaccinations given our children to prevent communicable diseases is another example of poor judicial settlements. This has, quite understandably, resulted in many physicians not wishing to administer these important vaccines. Moreover, of the 13 original pharmaceutical firms producing vaccines in this country, due to the flood of malpractice suits, only two remain in the nation today. This may well constitute a public health hazard in the future for this country as well as for other nations around the world who depend on our vaccines.

Working toward solutions

At this point it is appropriate to emphasize the necessity for the medical profession to assume a greater positive societal role in establishing a fair and realistic solution for compensation of patient injuries. It is now reliably estimated that about five percent of all hospital admissions have some unexpected adverse event, primarily problems unassociated with professional management. As a matter of fact only a small number of these cases actually represent malpractice. Moreover, unless malpractice can be clearly established, the settlement should not require a lawsuit or a trial by jury.

Therefore, it should be our goal to foster programs to assure that all patients have a form of health insurance to compensate them adequately but in no way to overcompensate for economic losses in such instances.

Lawyers themselves have great concerns about their own malpractice "crisis." The *Journal of the American Bar Association* recently noted that the legal community is concerned about the 300 percent rate increase that lawyers' liability insurance carriers are passing on to those whom they insure this year. The medical profession should be aware of the fact that less than 10 percent of the legal profession is involved in professional liability litigation, and many are staunch and effective defendants of physicians.

In our efforts to achieve a solution to this vexing problem, many in our profession do not fully comprehend the legal aspects in relation to the law of the land. As a result of the evolution of common law in this country, professional liability law is determined largely by the state legislatures and the courts in the individual states. A significant problem is the fact that there is considerable variation from state to state. Should Congress pass definitive legislation interpreted as being restrictive, it might violate the Constitution on the basis that such legislation may override state law by a federal mandate.

It is for this reason that several members of Congress have introduced bills, each of which sets forth a proposed *model* statute to be voluntarily adopted by each state legislature in exchange for a grant of federal funds to establish a proper administrative structure for professional liability settlements. Each state would have a limited amount of time, generally three or four years, to establish such a system in order to receive the federal funds.

The positive and highly effective impact of federal incentives passed by Congress to encourage the states to act responsibly and promptly is dramatically shown by the linkage of federally financed highway funds to the states passing appropriate legislation designed to prevent automobile accidents occurring while drivers are under the influence of alcohol. Such legislation from Congress has been successful in making positive and needed changes on important issues, especially when linked to the receipt of federal funds for related projects considered essential by the respective states. Surely, the professional liability problem is deserving of such attention and of rapid solution.

The prime features of these congressional bills, which are designed to attack the basic inadequacies in the present professional liability system, include: limitations on contingency fees and other types of attorneys' fees, the formation of screening panels

with uniform standards (including the principle of exclusive jurisdiction), the establishment of standardized risk-management programs, and the setting of specific time limits on the final decision (that is, six months to a year). Of particular importance is the need for free exchange of information about all sources of compensation for the plaintiff, with no restrictions, so that fair judgments can be rendered rather than the huge and frequently unjustifiable settlements often awarded by the courts today. In other words, *collateral sources* of funding should be open for both parties to review. Provisions should be made for dismissal of frivolous claims, and the plaintiff should be made to pay administrative costs. Finally, periodic payment of claims should be the rule, with payments made over time rather than in a single large settlement that is often not in the patient's best interest. While the decisions of the panels can be appealed, tight restrictions would make it difficult to overturn a panel's decision.

Bills in Congress

The United States Congress has recently given recognition to the groundswell of dissatisfaction and the inequities involved in the current malpractice situation. Bills introduced into both the House of Representatives and the Senate are designed to stimulate the states to pass specific and prescribed laws designed to ameliorate the problem.

On July 25, 1985, Congressman W. Henson Moore from Louisiana rose in the House of Representatives to say: "Our Nation is faced with a serious crisis. There are few states that are not enduring some problem with the high cost of medical malpractice insurance premiums. Fortunately, my State of Louisiana enacted comprehensive reform about five years ago and consequently we are not faced with nearly as serious of a crisis as are states like New York, Florida, Massachusetts, and California.

"Nonetheless, this insurance affordability crisis will not go away. Newspaper headlines, television news reports, and magazine cover stories continually remind us that the high cost of medical malpractice insurance is forcing some health-care providers out of the practice of medicine. Patients are no longer assured of access to quality health care in the United States."

This bill was introduced in an effort to bring reform to compensation in professional liability cases. Patients are assured compensation for medical bills, loss of wages, cost of rehabilitation, and living expenses. Its potential disadvantage is the fact that it is in a sense a no-fault plan and could therefore become "open-ended," thus requiring excessive funding; it could well become unaffordable.

In the House of Representatives, Congressman Mrazek introduced a bill on June 4, 1985, with the intent: "To establish a program in the Department of Justice to fund State medical malpractice programs which comply with Federal standards, and for other purposes." This bill has many features which would quite likely go far in the solution of many aspects of this problem.

In the Senate, Senator Inouye introduced a bill on January 3 designed: "To limit the costs resulting from acts of negligence in health care and to improve the level of health care services in the United States, and for other purposes." The American Medical Association has prepared a draft bill on tort reform, and Senator Hatch has introduced this bill in the Senate.

While the effects of all bills designed to achieve tort reform will yield improvement, it should be recognized that patient insurance is also essential for the ultimate solution. This College should support those features in each of the bills that will yield the best long-term solution, and this is apt to require modification and combination of one or more of the current bills now in Congress.

The members of this College are greatly indebted to the Regental Committee on Professional Liability and to its Chairman, Dr. Frank C. Spencer, and to our extraordinary Director, Dr. C. Rollins Hanlon, whose wisdom and leadership remain unequalled. This committee is preparing a position paper that will be of much significance to all Fellows of this College.

Lincoln and malpractice

In closing these remarks, I wish to call attention to the fact that in 1856, four years before he was elected President, Abraham Lincoln was involved in a malpractice suit[8] and the proceedings were published in the *Daily Pantograph* in Bloomington, Illinois. This suit was the first filed for malpractice in the McLean County circuit court; Dr. Crothers and Dr. Rodgers were the defendants. The plaintiff, Samuel Fleming, had sustained a fractured leg and

engaged them to set the bone. The break was a bad one, and the healing process was slow and when completed, as not to be unexpected in an elderly patient, a slight shortening of the limb occurred. The plaintiff felt that the two surgeons had not given the fracture proper attention and sued them for malpractice.

Lincoln defended the two surgeons, both known to be distinguished in their profession, and he actually used a chicken bone to explain the different conditions in bones of young people compared to those of advanced age. He stressed the fact that the bone of a young person has a springy, wiry condition that makes it less apt to break and it has a tendency to knit quickly. In the case of older individuals, however, Lincoln said, the bone is more brittle because lime and other qualities impair the healing process.

In his final statement, Lincoln concluded a brilliant summary by saying: "Mr. Fleming, instead of bringing suit against these surgeons for not giving your bone proper attention, you should go on your knees and thank God, and them, that you have your leg. Most other practitioners with such a break would have insisted upon amputation. In your case, they exercised their skill and ability to preserve it and did so. The slight defect that finally resulted, through nature's method of aiding the work of the surgeons, is nothing compared to the loss of the limb altogether."

It is apparent that this language, ever so concisely structured, and yet with great depth and scope of meaning and conviction, is akin to the style which he was to later use in his Gettysburg Address. It is obvious that Lincoln committed his thoughts and soul to the defense of these surgeons and the jury promptly returned a verdict in favor of the defendants and indeed placed the cost, which reached a large figure, on the plaintiff in this historic case. Lincoln's great wisdom, analytical thought, accumulation of scientific evidence, and final judicial summation challenge us today to be active participants in the framing of national legislation to be considered, and indeed passed, by the United States Congress as soon as possible. All of us know that a case such as Lincoln so brilliantly concluded, and indeed won, is not rare but common in these *alleged* malpractice suits. Such unnecessary suits, which take much of the physician's time and cause both anguish and pain to patients, family, and physicians alike, should and can be dealt with in a more effective and intelligent way. Through the activities of this College, and most important through your personal support, these solutions now seem within reach.

The mounting tide has now swept this issue to the feet of our lawmakers in Washington with the writing of specific bills. Although we each recognize that the final solution will not be easy and that multiple factors are involved, nevertheless, the tidal wave must be continued until the appropriate solutions, both for physicians and patients alike, are found and established. This can be achieved especially through the thoughtful modification of the far-reaching bills that are currently being considered in the Congress. Of equal importance will be the enabling acts, which must be passed by the legislatures of the states.

Every member of the American College of Surgeons can and should become a part of this vital effort through state legislators and the Congressmen and Senators in Washington. This is a time for *action*, not, as some have said, for further study. This College is clearly on the move and we enlist support from each Fellow, which will be essential for success.

References

1. Transactions of Societies. American College of Surgeons. Surg Gynecol Obstet, 18:124, 1914.
2. Blalock, Alfred: Our Obligations and Opportunities. Bull Amer Coll Surg 40:1, March-April, 1955.
3. Sandor, AA: The History of Professional Liability Suits in the United States. JAMA, 163:459, 1957.
4. Cosman, MP: The Medieval Medical Third Party: Compulsory Consultation and Malpractice Insurance. Ann of Plas Surg, 8:152, February, 1982.
5. Elwell, JJ: A Medico-Legal Treatise on Malpractice and Medical Evidence. Baker, Voorhis and Company, Publishers, New York, 1866.
6. Burns, CR: Malpractice Suits in American Medicine Before the Civil War. Bulletin of the History of Medicine, p. 42, January-February, 1969.
7. AMA Special Task Force on Professional Liability and Insurance: Professional Liability in the '80s. Chicago, Illinois, AMA, 1984.
8. Health, C: Letter to the Editor, "How Abraham Lincoln Dealt with a Malpractice Suit." N Engl J Med, 295: 735, 1976.