Letter from . . . New York

Some aspects of US medical malpractice insurance

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The foremost topic of conversation among doctors in the USA, golf excluded, is probably not the impending introduction of some form of national health insurance and not the increasing governmental interference in medical practice, but is probably malpractice insurance. Almost every issue of many of the "throwaway" journals contains an article on the subject. *Resident and Staff Physician*, a widely read monthly journal of some standing, has a monthly feature on malpractice insurance.

Cost of malpractice insurance

Premiums vary widely in different parts of the USA and even in different parts of a particular State. The cost also varies according to the practitioner's specialty, being greatest for neurosurgeons and orthopaedic surgeons and least for psychiatrists, and the amount of "coverage" provided by the policy.

Coverage is a term probably unfamiliar to most British doctors. A US doctor can elect the amount of his malpractice coverage in the same way that an individual can decide upon the amount of his life insurance. A common amount of coverage is \$100 000/\$300 000 although \$1 000 000/\$3 000 000 is probably more usual among high-risk specialists. In California the limit of coverage is \$5 000 000/\$5 000 000. The former figure in each instance represents the coverage for damage sustained by one person and the latter the total liability of the policy for all damages in one year.

Malpractice premiums have increased greatly in recent years. In 1963 in New York City as a general surgeon I paid \$367 annually for a \$100 000/\$300 000 policy. In 1971 the cost was \$4 893; now it is \$8 965. Few surgeons are content with such low coverage; the rate in New York City for \$1 000 000/\$3 000 000 is \$13 089. For the same coverage a psychiatrist pays \$1066. Insurance costs more in New York City and the adjacent counties than in other parts of the State. Generally, the farther away from the city the lower the premium. In Troy the cost is \$5900 for \$1 000 000 coverage for a general surgeon and \$470 for a psychiatrist.

The State with the highest premiums is California, particularly the southern part. The \$1/3 000 000 policy for the highest-risk specialists costs \$36 239 and the \$5/5 000 000 coverage costs \$47 846. The lowest rate for \$1/3 000 000 is \$4306. The State with the lowest premiums is (or perhaps by now was) South Carolina. When I moved there for one year (1973) my premium for \$100 000 coverage was only \$469. By comparison, a typical annual premium rate in Canada is \$200 and in Australia \$50.

In addition to the three factors already mentioned—amount of coverage, specialty, and State—one additional factor may affect any doctor's insurance premium. If he has had one or more malpractice suits settled against him there is likely to be an increase in his premium. One cardiac surgeon is reportedly paying a six-figure premium for his insurance.

Not only have doctors suffered from increased insurance costs but so have hospitals. A New York City hospital, Beekman-Downtown, was reported in that city's *Daily News* as paying a \$1 300 000 premium for coverage of \$1 000 000. (No, the figures are not reversed.) Hospital insurance premiums have increased dramatically in New York State, adding as much as an additional \$50 to the average patient's hospital stay. One Buffalo, New York, hospital had its 1975 insurance premium increased by 758%, and a New York City hospital's increase was 1297%, the latter representing an insurance cost of \$1425 a bed.¹

Many hospitals require that doctors submit proof annually of their malpractice insurance coverage as a requirement of continued staff membership. This is because it has become routine for the hospital as well as the doctor to be sued in every alleged malpractice case where the patient was admitted to hospital. If the doctor had no insurance the hospital alone would probably be sued. Whether or not it is legal for a hospital to force a doctor to carry malpractice insurance has not yet been settled by the courts.²

Why so many lawsuits?

There are several reasons why so many doctors are sued for malpractice, imagined or real. First, and foremost, is that the lawsuit for damages, for any reason whatsoever, is as much a part of US life as baseball. The USA is the most litigious land on earth; there are, so far as can be determined, more lawsuits of all kinds than in the rest of the entire world. "Sue the SOB" seems to be part of the national philosophy.

Secondly, it is possible to institute a lawsuit on grounds that would be considered unethical (by lawyers) or unfriendly or immoral (by plaintiffs or lawyers) in some other countries. For example, if a guest gets drunk at a party at my house, falls, and breaks his ankle there is every likelihood that he will sue me. He reasons, quite correctly, that my household insurance policy includes a rider to cover such accidents and that I, personally, will suffer no financial loss (except, possibly, an increase in my premium). The fact that we may have been close friends for years will probably not enter into the matter. The same philosophy extends to all aspects of US life, including particularly medical practice. Personally, I think that I should be able to sue the drunken guest and indeed I could, even if he didn't sue me.

A third, and no doubt the greatest, cause of the high incidence of suits is the legal profession itself. Its standards are very different from those of its British counterpart. The joke about "ambulance chasers and accident watchers" is in fact no joke:

such lawyers do exist and in no small numbers.³ I personally know of several instances in which an attorney, the preferred term here, on hearing of an accident has telephoned the injured person, unsolicited, to offer his services on a contingency basis (see below). On several occasions when in practice in New York City I was called by attorneys in accident cases with the request to "examine him thoroughly, take a lot of x-ray photographs if you think they are necessary, and send a generous bill." Once an attorney telephoned to say "I am sending over a man from my office who has a lot of bruises and lacerations from an automobile accident." Note the order of the patient's priorities—attorney first, surgeon second.

Any surgeon, and in particular any orthopaedic or plastic surgeon, has a host of such stories to tell. My object in noting these incidents is not to indicate that the entire US legal profession behaves in such a manner, but there are so many who do that it is sometimes difficult to believe that all do not. In fairness one must admit that an attorney, writing a similar paper, could easily make a similar observation about certain practices of the medical profession.

The number of lawyers practising no doubt has some bearing on the number of lawsuits. Just as there are too many general surgeons in US cities, there are also too many lawyers. On the other hand, the shortage of doctors in rural areas is not always paralleled by a shortage of attorneys. I spent one year in practice in a town in South Carolina, with a population of 1200, which was the county seat for 11 000 people. There were four doctors (three GPs and myself), and eight attorneys in the town.

The "contingency fee" system accounts for most of the lawsuits. The lawyer takes the case on the understanding that if he is unsuccessful in securing an award for damages there will be no charge for his services. If he is successful his services cost from 35% to 50% (more usually the latter) or even more of the damages awarded the plaintiff. This figure may or may not include the attorney's "expenses." Ultimately, the average plaintiff is lucky if he finally receives 20% of the damages awarded. Mills, a doctor attorney, states that "doing away with the contingency fee system tomorrow would probably eliminate 90% of new suits against doctors and hospitals." He adds that "there is no question but that some of the legal fees achieved via the contingency fee are unconscionable."⁴

Res ipsa loquitur

This doctrine, "the thing speaks for itself" or "look what the doctor did to me," is a potential thorn in the side of all doctors. The courts tend to take no cognisance of the fact that all the doctor's actions may have been in full accordance with accepted medical practice. The patient is limping; therefore the orthopaedic surgeon must have made some mistake.

The fact that the surgeon may have informed the patient in writing of the possible complications of the operation does not prevent him from being sued if a recognised complication, beyond the surgeon's ability to prevent, occurs; *res ipsa loquitur*, damages against defendant.

Seemingly contrary to the "innocent until proved guilty" practice of English-speaking courts, a plea of *res ipsa loquitur* shifts the burden of proof to the doctor that he acted in accordance with the prevailing and accepted standards of care.

Rates of increase of malpractice premiums

In 1976, the Travelers Insurance Company, which provided malpractice insurance coverage for most doctors in Southern California, sought a 486% increase over 1975 premiums. This figure was said to have been based upon past and potential malpractice claim losses.⁵ The State Insurance Department of California, which controls applications for rate increases in

all types of insurance within that State, granted a raise of \$327%. This resulted in a strike or slow-down by most doctors in high-risk specialties. All elective surgery was reduced in amount or postponed entirely, hospital occupancy rates declined drastically (to half or less), and many employees were dismissed.⁶ This state of affairs persisted before the anaesthesiologists, the prime movers in the strike, returned to work—at the increased premium rates.

In New York State a proposed 197% increase in premiums in 1975 led to the formation, through the State Medical Society, of the Medical Liability Mutual Insurance Company. All doctors wishing to be insured through MLMIC were required to pay a non-refundable subscription of \$1750, plus annual premiums depending on geographical location. The \$1750 will be increased to \$2100 in July 1977.⁷ So far, MLMIC has managed to hold down premium increases to considerably below those forecast by private insurance companies.

Because of similar, even greater, rates of increase for hospital insurance, groups of hospitals have also formed self-insurance organisations—for example, a group, at present consisting of 48 hospitals in New York State, has just formed (1 June 1977) the Hospital Underwriters Mutual Insurance Company, which, of course, is duly approved by the State Insurance Commissioner. The HUMIC can offer malpractice insurance coverage to its member hospitals at reasonable rates.

Indiana's malpractice law

In 1974 Indiana, with a practising doctor as its governor, passed a law relating to medical malpractice. Under this a doctor's liability in any one case was limited to \$100 000. The total damages that could possibly be awarded to a patient were limited to \$500 000. Any difference between the \$100 000 and any higher award would be paid by a State-administered fund financed by a 10% surcharge on doctors' and hospitals' annual insurance premiums. Furthermore, a case could not go to trial until screened by a panel of three doctors and a lawyer.⁸

The law had the effect of making it easier for physicians to obtain malpractice insurance coverage, with some reduction in premiums from those previously paid. Initially at least, the number of malpractice claims fell, no doubt as the result of pretrial screening. Indiana attorneys, not surprisingly, considered the law to be unconstitutional.

Some States—for example, Illinois and Idaho—have ruled against laws limiting malpractice damages. A Tennessee court has declared that pretrial hearings give doctors a discriminatory class advantage.⁹ Further, some States' constitutions forbid a limit on recovery of damages in any lawsuit. Indiana's constitution, on the other hand, has no such prohibition.

The initial results of Indiana's law, though encouraging, must be viewed with guarded optimism until the constitutionality of the law is tested. So far this has not been done.

"Going bare"

Because of the great increases in insurance premiums, or because of actual unavailability of any insurance company willing to provide the coverage, many doctors in different States have ceased to carry such coverage. Colloquially, this is known as "going bare." In Nevada, for example, it is estimated that 30% of all doctors have gone bare. One California orthopaedic surgeon, whose premium rate was raised to almost \$48 000, simply wrote to his patients and displayed a notice in his office that he could no longer afford malpractice insurance.

Some doctors feel that going bare will decrease the potential number of lawsuits on the grounds that stones do not bleed. Others, with purely referral practices, have felt that it may adversely affect the number of referrals. It is too early yet to say which, if either, of these views is correct.

Amounts of damages awarded or sought

Unlike British courts, US law courts permit suits specifying the exact amount of damages sought. There does not have to be any justification in the suit for the amount of damages demanded. The philosophy of the plaintiff's attorney seems to be "let's sue for a million and if we get ten thousand we're still ahead." The jury's philosophy seems to be "a million is too much, but ten thousand is all right and so both lawyer and doctor should be happy." In addition to suing for damages caused by injury allegedly resulting from the doctor's negligence, the plaintiff can (and usually does) sue for punitive damages. One husband sued for loss of his wife's conjugal and housewifely services when she had a necessary hysterectomy performed, on the grounds that the surgeon had not secured his permission for the operation.

To date, the largest settlement made has been for \$26 million in a case in which the plaintiff became paralysed. In this particular case damages are being paid on a periodic basis and will cease if the patient dies; the figure was based on the estimated life expectancy. The greatest amount of damages sought has been \$100 million in California (one might almost add "of course").

As a result of the recent "swine flu" vaccination programme in the USA, many lawsuits have been filed against manufacturers of the vaccine, despite a Federal law, passed beforehand, which protected the companies from such suits. The first 104 claims, for a total of \$10.7 million, included one for \$1 million by a man who claimed he was made impotent by the vaccine. The other claims included damages for five deaths, loss of salary because of illness and damage to a patient's blouse when a clinic worker spilt acetone on it.⁹

Out-of-court settlements

One of the biggest problems faced by doctors who wish to fight malpractice claims is the tendency of insurance companies either to settle cases before trial despite the doctors' opposition or to exert pressure upon the doctors to permit such settlements. (Of every 100 claims, four or five go to trial and about 50 are settled out of court.¹⁰) In these cases the insurance companies, who seem to have at heart their own interests rather than those of their clients, simply take the line of least resistance: it is cheaper to pay than to fight. The doctor, who in fact in many cases is absolutely guiltless of malpractice, is thus not given the opportunity to clear his name.

The doctor's only recourse in such cases—if he cannot force the insurance company to support him—is to dismiss the company attorney and to hire another at his own expense. Because of the expense in both time and money of such a course of action few doctors care to pursue this course. Most can thus be persuaded to permit an out-of-court settlement. Since it may be several years before a malpractice case actually comes to trial, the out-of-court settlement saves the doctor from needless worry and many possible hearings during those years.

Countersuits

In 1976 a Chicago radiologist was sued for having failed to diagnose a minor finger injury. The finger had been splinted, which would, in any event, have been the appropriate treatment. The jury ruled that the suit had no merit. The radiologist then brought a countersuit against the patient and her attorney and was awarded \$8000 in damages.¹¹ Within the first year after the countersuit the incidence of malpractice suits in the Chicago area was said to have fallen by about 75%. Since then, many doctors have been encouraged to mount countersuits.

A jury in Florida has recently awarded an orthopaedic surgeon \$175 000 in damages against a lawyer and a former patient for suing him without valid grounds.¹² If the verdict is upheld on

the expected appeal its impact could be far-reaching, affecting not only groundless medical malpractice suits but also the vast number of groundless and "padded" personal injury claims filed after automobile accidents. (New York, and some other States, have enacted "no fault" automobile laws. An injured person cannot claim damages for personal injury unless his medical bills exceed \$500. There is a great tendency to "pad" these bills so that damages may be sought.)

An interesting sidelight of malpractice generally is that attorneys' malpractice premiums are also increasing rapidly. An individual lawyer in New York now pays \$612 a year for a \$100 000 policy, compared with \$302 two years ago. California lawyers pay \$1200 to \$1800 for the same coverage, an increase of 500% in the past two years.¹³

Possible solutions

Among possible solutions that have been considered are the enactment of laws concerning malpractice suits, along the lines of the Indiana law, in those States in which such laws would not be prohibited. There are two big barriers to such a course of action that are, it would seem, almost impossible to overcome—firstly, the differences in State laws and, secondly, the fact that perhaps 70% or more of all US legislators (senators, representatives, and assemblymen) are attorneys. Since it is unlikely that malpractice legislation acceptable to both doctors and attorneys in all States will ever be passed, the next possible solution is to try to reduce the number of suits within the present legal framework.

The following ways were suggested by a panel of six defence attorneys.¹⁴

Informed Consent—Surgeons in the USA have had increasing pressure put on them to tell patients of the risks of, and the alternatives to, proposed surgical procedures.¹⁵ Indeed, surgeons or others performing any procedure whatever are supposed to inform patients accordingly. The fact that the patient was informed, and what he was told, are to be included in the case notes. Studies using tape recorders have shown that patients rarely remember what they have been told and some even vehemently deny ever having been told, even when confronted with the taped record.

Colleagues should be wary of making defamatory or suggestive remarks when seeing the results of other doctors' treatment—One attorney said that this represented the largest single cause of malpractice litigation. On the other hand, it may be argued that we doctors have a moral duty to attempt to right obvious wrongs caused by our colleagues. I know from personal experience that it is very hard not to make some suit-causing comment when asked to treat a 21-year-old woman suffering the effects of removal of her normal uterus and ovaries.

Especial attention should be paid to dissatisfied patients to find the causes of their complaints and to attempt to remedy them by frank discussion.

Accurate records must be kept, particularly timed and dated records of visits to patients. A doctor has often lost a lawsuit simply because he did not keep accurate records.

Doctors are urged to maintain good rapport with their patients—One attorney observed that "the old family doctor who simply sat and held the child's hand didn't get sued, even though he did little more than that." Although it would seem likely that patients are less prone to sue a loved and respected doctor, I agree with Mills⁴ who states that he is "not convinced that such rapport will be an effective deterrent."

The doctor must never admit to the patient that he has made a mistake—One surgeon who, for good cause—presumed appendicitis—operated on the son of a nurse employed at his hospital, found and removed a normal appendix. "I guess I made a mistake on that one," he told the mother. Although the boy suffered no ill effects, the surgeon was sued for damages for "pain and suffering." The case was settled out of court for \$2000.

Statute of limitations

In each State, a "statute of limitations" exists with regard to most crimes. This is the number of years beyond which a suit cannot be brought against the alleged or actual criminal. For medical malpractice this time is around three years in many States; it was recently reduced to two-and-a-half years in New York.

The limitation time in some States starts at the time of the act of alleged malpractice, such as surgery; in other States, it begins at the time of discovery of the act. In the former case there is thus a set time after the act beyond which no malpractice action may be brought. In the latter—for example, suppose a small instrument were left in the abdominal cavity for years without causing symptoms—the limiting time could begin many years after the surgical procedure.

In some States a person operated on as a minor may institute a lawsuit within the limiting time after reaching his majority, which is age 18 years in the US. For example, if the child were operated on at age 1 year in a State in which the malpractice statute of limitations was six years, the surgeon could be sued for alleged malpractice 23 years after the operation.

Recently, an adult who, as a newborn baby, had been given oxygen at birth and who subsequently developed retrolental fibroplasia, was awarded considerable damages even though the treatment was considered proper at the time.

It can thus be seen that in some States a paediatric surgeon may have the spectre of malpractice at his elbow all his working days—and even after he retires.

What of the future?

There is nothing in the present mood of the USA, as nearly as one can judge after 22 years of observing the local medical scene, to suggest that malpractice suits will do anything but continue to increase in both numbers and amounts of damages claimed, along with increases in premiums. Furthermore, at the present rate and with increasing amounts of damage settlements, malpractice insurance may possibly become unobtainable through private insurance companies. Medical societies and hospitals accordingly will have to form their own insurance organisations.

Among the reasons that suits are likely to increase is the collective opinion of many of us trained elsewhere, even allowing for any unfavourable bias, that far too much accent has always been placed on the dollar in US medicine. It has been common practice here for many years, particularly in cities, as distinct from usual procedure—for example, in my native Australia in the days of private practice—to sue patients who did not pay their bills. On the other hand, also different from my homeland, it has been common practice for patients who could well afford to do so not to pay. In fact, under some medical insurance policies, the doctor's fee is sent to the patient, who may put the money to his own use instead of paying the doctor. It is very hard to say, in regard to the dollar aspect of practice, who is more to blame, doctors or patients.

In current idiom, the "image" of the US medical profession is by no means as good as it was 10 or even five years ago. Many doctors have been publicly accused of fraud in regard to Medicare (Federal) and Medicaid (State) funded medical assistance. In fact, a list of doctors who had supposedly received more than \$100 000 from Medicare in 1975 was widely circulated in the daily press. The list, as subsequently admitted by the Secretary for Health, Education, and Welfare, was grossly in error and even included doctors no longer practising and one who had died in 1974. Unfortunately, the damage had already been done: the impression of the profession gained by the general public will scarcely cause a decrease in lawsuits.

If ultimately, though at present this seems unlikely for some years if ever, US doctors become in effect Government employees as in Britain, lawsuits will gradually decline as it will

not be so easy to sue Uncle Sam. Rather, perhaps, it may not be so easy to collect from him.

There are certainly faults on both sides—doctors who do in fact commit malpractice, a large percentage of surgery still being performed by unqualified "surgeons," and lawyers who do in fact solicit cases unasked or who sue on the flimsiest of grounds in the hope that the insurance company will make a nuisance-value settlement. The US medical profession is continually attempting to improve its standards of practice and I believe the same is true of the legal profession. Unfortunately, it is very difficult to have an incompetent doctor or an unethical lawyer disbarred from practice.

Although I believe that, ultimately, sensible malpractice statutes will be enacted nationwide, I am equally in no doubt that before this occurs there will be considerable battles between two professions that should instead be working together for the common good.

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ONE HUNDRED YEARS AGO An inquest was held at the Town Hall, Dawlish, before H Michelmores, Esq, coroner, touching the death of Sarah Crudge, a young woman, aged 23, belonging to Devizes, who died suddenly, soon after undergoing an operation. Mr F M Cann, surgeon, said the deceased came to him on account of having a squint. After seeing the deceased two or three times, he agreed to perform an operation on the eyes. It was rather a peculiar case; he did not like to give chloroform. It was not from any dislike to administering chloroform that he said this; but from the fact that, in operations of this kind, it might be necessary, after administering it once, to let the patient come round and administer it again. Deceased rather disliked the idea of the operation being performed without the use of chloroform, and he therefore told her she must wait. He subsequently performed the operation as described; but previously to his doing so, he examined her and considered her a fit subject for chloroform. Deceased inhaled about four drachms of chloroform during the operation. After the operation, deceased spoke to him and appeared perfectly right. He saw deceased again between nine and ten o'clock. She was then sound asleep and appeared to be going on all right, her pulse being quiet and regular, and nothing unusual about her. When called at half-past eleven o'clock to see deceased, he found her dead. Mr H S Gaye of Newton had made a post mortem examination of the body of the deceased. On examination of the brain, he found it softer than natural, and coagulated blood in several places. The other parts of her body were healthy. He believed death to have resulted from effusion of blood on the brain. He thought death was accelerated by the vomiting caused by the administration of chloroform. The chloroform would not have caused death, and it was evident that there was previous disease of the brain. The quantity administered was small for an adult, and it might be assumed that at least half was not inhaled. Even if it had been, there was nothing unusual in the dose. He had not a shadow of doubt that long sustained disease of the brain was the cause of death. The jury found that deceased died from disease of the brain, hastened by the effects of chloroform, properly administered, and exonerated Mr Cann from all blame. (*British Medical Journal*, 1877.)