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Marcus L. Plant
*University of Michigan Law School*

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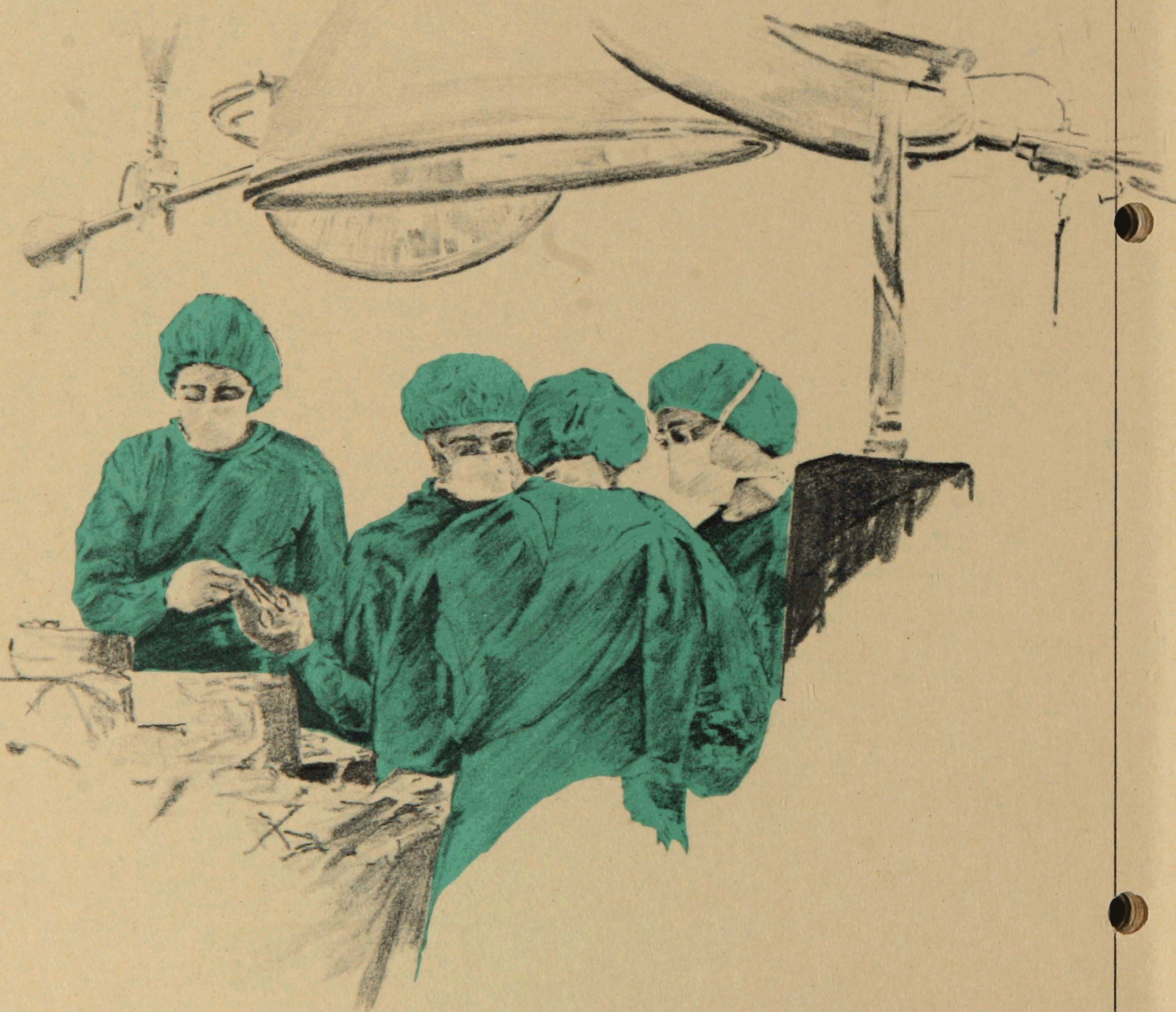
# The Medical Malpractice "Crisis"

by Marcus L. Plant
Professor of law
The University of Michigan



[Based on a speech before the Committee of Visitors of the University of Michigan Law School, October 24, 1975, Ann Arbor, Michigan.]

### Introduction

The problem in preparing this discussion was to determine what to omit. When I have finished some may think that I did not omit enough! But at the risk of superficiality or banality, I am going to limit myself to survey treatment rather than in-depth analysis.

The immediate malpractice "crisis" does not lend itself readily to scholarly dissertation. It is a political maelstrom, characterized by highly opinionative assertions. Facts often seem irrelevant and the more strident voice prevails.

There are four interests involved: the insurance carriers, the medical profession, the legal profession, and the consumer or patient.

Since World War II there has been an on-going debate as to how society should manage catastrophic personal injuries incurred in the course of medical or surgical treatment. The immediate so-called "crisis" developed in late 1974 and early 1975 because a number of important carriers of malpractice liability insurance announced enormous increases in premium rates—increases which the governor of New York described as "obscene." Other carriers announced termination of coverage of certain specialties or of the writing of medical malpractice insurance altogether.

The explanation offered for such drastic actions is that carriers either cannot make enough money at going rates or are actually losing money. The numerous reasons given in explanation range from the ridiculous through the plausible to the convincing. A sample of the ridiculous is the claim that a flood of malpractice litigation was started when no-fault automobile insurance was inaugurated because lawyers previously active in that area transferred their efforts to medical malpractice. No data is ever offered to support that claim; it is usually stated slyly on radio and television talk shows with the assertion that it is "an interesting coincidence" that the increase of malpractice cases coincided with the adoption of no-fault—another assertion which is not supported by data. The theory has some kinship to astrology.

Somewhat more persuasive is the idea that the carriers find it difficult or impossible to make actuarially sound predictions of liability from year to year because of the so-called "long tail" problem in medical malpractice. By this is meant that because of the language or judicial interpretation of statutes of limitation, lawsuits may be started during the current year based upon occurrences that took place 5, 10, or in some states possibly 20 years ago. This has long been recognized as a serious problem.

Other reasons offered are the higher level of patient expectation of success (the Marcus Welby syndrome); lowering legal requirements for success in malpractice suits; the greater volume of medical care to increasing proportions of our population; the contingent fee system; and many others.

The announcements of increased rates of cancellations brought consternation in many quarters. Some physicians even stopped practice or limited themselves to emergency practice. There ensued 10 to 12 months or frenetic activity on the part of medical societies, bar associations, trial lawyers' associations, state houses, executive mansions, carriers, and insurance commissioners. Some of the antics were vaguely reminiscent (at least to an oldster) of the Keystone Cop comedies that were so entertaining in the earlier days of the movies. For example, in Michigan a group calling itself the Physicians Crisis Committee prepared a strange document entitled "Petition," asking the Supreme Court of Michigan to promulgate contingent fee limitations in malpractice cases and supporting its request in large part with clippings from the Detroit newspapers attached as footnotes. This was filed with the court administrator with the demand that it be referred "to the appropriate staff

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committee" without any provision for notice, answer, hearing, or the taking of evidence. With assistance from the Bar Association the subject was properly presented to the supreme court, which later issued a schedule of maximum contingent fees.

A more serious and distressing development was that something like warfare developed between the two supposedly learned professions of medicine and law. Newspapers and pulp magazines had a field day and propaganda pronouncements and pa

a shouting contest is not that it will injure the throats of the participants but that it will leave wounds that heal very slowly and scars that may be permanent. There is some evidence that that may have happened.

The product of the cauldron has begun to emerge in the past few months, and it is a mixed bag. Some is good and helpful. Some is neutral, i.e., neither helpful nor harmful; these are mostly measures embodying pet theories of an individual or group. Some is bad—even vicious—or at least potentially harmful.

I will not try to describe it all but will refer only to segments from the enactments of Michigan, New York, Indiana, and Pennsylvania.

The direction a state goes in seeking the solution depends on its concept of the problem. If it is thought that the major component of the problem is legal, i.e., that the "crisis" is a function of deficiencies in the legal system, the legislative solution will have one kind of mix; but if it is thought that the major component is economic, i.e., that the "crisis" is the result of putting too heavy a burden of catastrophic loss on too small a base of insured population, the legislative mix will be entirely different. And between these extremes there may be gradations of remedial efforts.

### Availability of Insurance Coverage

In all four states one or more acts seek to make it certain that professional liability insurance will be available to any eligible health care provider desiring it.

The Michigan and New York programs are impressive. Michigan has created a state-operated medical malpractice insurance fund. Close to 1,000 binders have already been issued to physicians at what had come to be considered reasonable rates; e.g., Class V neurosurgeons (a high risk category) $900 per month for $200,000-$600,000 coverage ($10,800 per year). An executive of an insurance company

should be nervous about that development; while the statutory life of the fund is limited to 18 months, these things have a way of not dying—particularly if good results emerge, as they sometimes do from government agencies. I understand that the state medical society is providing for the creation of a so-called "captive" insurance agency—another development that an insurance company should find ominous.

New York's technique was to create a Joint Underwriting Association (a JUA) of all personal injury liability insurers in the state. It will exist for six years. It will not function unless there is no private insurance available as determined by the superintendent of insurance in consultation with the commissioner of health. A reserve fund of $50 million of state money was established and assessments must be paid if the fund drops below $25 million. The New York State Medical Society is also permitted to set up a so-called captive company.

Indiana and Pennsylvania have also made provision for availability of insurance but I want to refer to their systems later.

**Provisions Relating to Insurers' Finances**

Related enactments that I view with great favor (and here my bias shows) are those such as Michigan's act that require the insurance commissioner to investigate annually the reserve practices and investment income of medical malpractice insurers doing business in this state. The stated purpose is to determine if the industry is making excess profits. A collateral result should be better information as to the *source of the losses* that carriers are alleged to be suffering. There is some opinion (and I share it) that at least in the case of some companies those losses are to be attributed in large part to decline in investment income and values, rather than excessive payouts on liability claims. Many organizations (such as colleges) which depend on investment stability or growth and which account for the value of investments at the lower of cost or market show substantial losses in recent years, some to the point of disaster. I have not seen any careful analysis of this aspect of liability insurers' financial affairs, and would hope and urge that such information will be developed.

In that connection let me quote some recent remarks by Richard F. Gibbs, M.D., J.D., who is chairman of the Massachusetts Medical Society's Professional Liability Committee and its Medical Malpractice Commission. Writing in the *Journal of Legal Medicine* for February, 1975, he says:

> The State Insurance Commission serves as the watchdog regulator who requires the insurance carriers to justify all proposed rates with supporting data which include loss development and trending statistics. In this author's experience, no state—with the possible exception of Pennsylvania—has come close to exercising its police powers in impounding for careful expert scrutiny *the purported losses* and requests for rate increases of any professional liability insurance company doing or seeking to do business in the particular state. This is, of course, a serious indictment of the regulatory department of government for its ostensible failure to protect the public from unjustifiable increases in the cost of health care delivery based upon *fallacious representation* that professional liability insurance, if available at all, is very, very expensive. *(Emphasis supplied.)*

New York has also enacted a revision of the statute to require insurance company reports to the insurance commissioner every six months.

Now if you believe the basic problem to be economic, you would not go much further in legislating. You might embellish the New York and Michigan systems for insuring availability of insurance and keeping the insurers honest.

But if you consider basic deficiencies in the legal system to be the source of the "crisis," you take quite a different tack, as did Indiana and Pennsylvania. Their solutions are drastic ones, providing insurance coverage incidentally but making substantial changes in the legal system relating to medical malpractice.

"[S]omething like warfare developed between the two supposedly learned professions of medicine and law . . . Even bumper stickers appeared."

The Indiana statute requires that prior to commencement of any action for malpractice against a health provider there be a panel review of the complaint. The panel in each case will consist of one attorney and three physicians; the attorney acts in an advisory capacity, is chairman of the panel, but has no vote. The physician members are chosen from all who hold an Indiana license to practice medicine. Each party selects one physician and the two select a third. The parties may agree on the attorney member of the panel; if no agreement is reached the attorney is selected by lot from the list of Indiana attorneys on the rolls of the supreme court; five names are drawn and each pary strikes two.

The evidence that may be considered by the panel is unlimited. The attorney-chairman advises the panel on legal questions and prepares its opinion. The panel's function is to express and expert opinion on one or more of the following aspects of the case:

A. The evidence supports the conclusion that the defendant failed to comply with the appropriate standards of care;

B. The evidence does not support that conclusion;

C. There is a material issue of fact bearing on liability and not requiring expert opinion, to be decided by the court or jury;

D. Defendant's conduct was or was not a factor in the resultant damages. If it was, did plaintiff suffer any disability, its extent and duration, and the permanent impairment or percentage of impairment.

The report of the panel is admissible in evidence at any subsequent action by the claimant but is not conclusive; either party may call any member of the medical review panel as a witness and he or she must testify. A panelist has absolute immunity from all civil liability for any communication or functions as a panelist.

After the panel has functioned, plaintiff may sue. If he does, other changes in the legal process now operate.

A. No dollar figure may be included in the *ad damnum* clause of the complaint; the prayer is to be for such damages "as are reasonable in the premises".

B. The maximum amount recoverable for *any injury or death of a patient* may not exceed $500,000.

C. The total amount recoverable from any one health care provider qualified under the statute is $100,000.

D. Any amount recovered in excess of $100,000 from any health care provider is to be paid from a special fund called the "Patients' Compensation Fund." The Patients' Compensation Fund is collected by the insurance commissioner from all health providers in Indiana on the basis of 10 percent of the cost to each health care provider for the maintenance of financial responsibility. Each health care provider is required to file with the commissioner proof that he is insured by a policy of malpractice liability insurance in the amount

of at least $100,000 per occurrence. When the fund exceeds the sum of $15 million the commissioner may reduce the surcharge so as to maintain the fund at approximately that level.

E. Plaintiff's attorneys' fees from any award made from the Patients' Compensation Fund may not exceed 15 percent of any recovery from the Fund. There is no comparable provision with respect to recovery from the first $100,000 from any health care provider. Thus it will be to the advantage of plaintiff's attorneys to join as many health care providers as possible; e.g. if five health care providers are joined and all five are held liable, an award of $500,000 would be subject to an unlimited contingent fee.

F. There are elaborate provisions for handling settlements that may involve the Patients' Compensation Fund.

Whether the restrictions created by the Indiana law will withstand constitutional attacks remains to be seen. My friends in the Indiana bar assure me such attacks are already in preparation.

Pennsylvania takes a comparable approach. A panel review is required, pre-trial. The panel consists of seven persons: two lawyers, two doctors, and three non-professionals, i.e., consumers. Its proceedings are bound strictly by conventional evidence rules. Its decisions are comparable to those of Indiana. Its decision is admissible in evidence. It is the authors' idea that this system eliminates the constitutional objection to admission of a panel decision based on inadmissible evidence. In effect Pennsylvania's plan provides for *two* trials—a deliberately contrived procedure. But there is no limit on damages.

### Measures Relating to the "Long Tail" Problem

Many states have done something about the statute of limitations. As indicated previously the "long tail" problem is what is involved. In Michigan a new statute provides that a cause of action based on a claim of malpractice of a person who is a member of a state-licensed profession accrues at the time a person discontinues treating the plaintiff, regardless of the time plaintiff discovers or otherwise has knowledge of the claim.

Indiana has imposed a two-year statute of limitations which runs from the "date of the alleged act, omission, or neglect" except that a minor under the full age of six years shall have until the eighth birthday to file a claim.

In New York the statute was reduced to 30 months with 10 years in case of disability due to infancy or insanity and with one year from the time of discovery of a foreign body.

While it is important to solve the long tail problem, it is possible that these statutes, particularly the Indiana statute, may be too restrictive; conceivably, in the case of a patient who did not discover the foreign body for a period of more than two years (and there have been such cases) it could be held unconstitutional.

The most extreme device for solving the long tail problem is the "claims made" policy. Such a policy pays for only that liability manifested by a lawsuit during the year in which the policy is in force; any lawsuit brought after the policy year expires will not be covered.

This arrangement is in contrast to the "occurrence policy" which covers liability for any incident that occurs as a result of treatment during the policy year.

The "claims made" policy has been highly touted in certain quarters of the insurance industry as a solution to the long tail problem. It is probably a delusion and a trap, however. It is a delusion because it is represented as a way to cut the cost of premiums. But that cost is sure to rise from year to year as the tail begins to build from previous years' insurance. It is a trap because once a physician purchases such a policy it will be impossible for him to convert to an "occurrence policy" without spending additional funds to cover the tail left over from the "claims made" policy. Furthermore, at his retirement, disability, or death, he or his estate will have to purchase insurance coverage for the tail. In the case of some physicians (e.g. those who give prenatal care) this could run for eight years and nine months in Indiana.

The Indiana statute provides:

> Only while malpractice liability insurance remains in force are the health care provider and his insurer liable to a patient, or his representative, for malpractice to the extent and in the manner specified in this article.

This may mean that there can be only "claims made" coverage in Indiana; it may mean there can only be "claims made" liability. The language is strange and Indiana lawyers with whom I have talked do not fully understand what it means.

### Miscellaneous Measures—Some Good, Some Not So Good

**In many states** provisions were enacted designed to reduce the amount of malpractice by incompetent practitioners. These include provisions for continuing medical education; investigation of complaint; reporting disciplinary actions to appropriate registration and licensing boards; providing confidentiality to information received by licensing boards; assuring civil and criminal immunity for persons providing information to licensing boards; fingerprinting applicants for medical licenses; creating penalties for failure to comply with subpoenas; and so on. In some laws the disciplinary power of the licensing boards is expanded. Measures of this kind are responsive to the conviction held in some quarters that the reason medical malpractice litigation has increased so sharply is that there has been a sharp increase in medical incompetence attributable in part to laxity of the medical profession in policing itself.

The theory is debatable. Malpractice claims are not limited to (or even largely concentrated on) quacks; it is often the most competent who are successfully sued.

**Among developments** that I would consider favorable are statutory provisions enacted in New York to reestablish traditional safeguards around the malpractice cause of action that has come to exist under the name "informed consent." In general this type of lawsuit is based on the theory that the physician has failed in his duty to inform the patient of collateral risks attendant upon a planned medical procedure. Properly safeguarded it is a legitimate cause of action. In the late 1960s and early 1970s half a dozen courts of last resort in the country have deleted the requirement of expert testimony for establishment of breach of the physician's duty and placed decision of that issue in the hands of the jury. The only guideline for the jury under these decisions is whether the patient, as a reasonable person, would have wanted to know of the collateral hazard, and whether the patient as a reasonable person would have gone ahead with the surgery had he known of the collateral risk. This has opened the potential for malpractice litigation considerably and it is a rare malpractice complaint these days that does not have a count on informed consent with almost uncontrolled discretion in the jury. New York's new statute creates several limitations. First, such cases may be brought only after non-emergency therapy or diagnostic procedures that involve invasion or disruption of the integrity of the body. Second, expert medical testimony is required and the burden is on the plaintiff to prove lack of informed consent. Third, it sets up four defenses (common knowledge of risk; patient's willingness to take the risk or unwillingness to be informed of it; consent not reasonably possible; reasonable expectation of adverse effect of disclosure) not always recognized by courts. It is my view that the New York statute is an improvement in the situation. However, I admit to a bias, having been very suspicious of this entire cause of action from the time it developed in the late 1950s and disturbed by the way it has been unjustifiably exploited in certain instances.

**An example of the legislation** not helpful but not harmful is Michigan's amendment of the so-called "Good Samaritan" act. That statute, in general, provides that if a physician or registered professional nurse renders medical aid at the scene of an emergency he or she is not liable for ordinary negligence but only for gross negligence or wilful and wanton misconduct. Thirty to forty states have legislation of this kind. Its need has never been established and it is the result of a sort of "legal spook" which has haunted the medical profession since the early days in the post-World War II era. Under the recent legislation in Michigan the benefits of that statute are extended to persons who give emergency aid in life-threatening situations at a hospital when their duties do not require them to act. Included in the benefits of the statute are dentists, podiatrists, interns, residents, licensed practical nurses, registered physical therapists, clinical laboratory technologists, inhalation therapists, certified registered nurse anesthetists, X-ray technicians, and paramedicals.

"[A 'claims made' policy, which] pays for only that liability manifested by a lawsuit during the year in which the policy is in force . . . is probably a delusion and a trap . . ."

I have yet to see a case in which any of the people described was sued because of negligence in an emergency situation in a hospital; nor have I ever seen any data that suggests that such persons were deliberately withholding emergency aid in life-threatening situations because of the fear of medical malpractice suits. Nonetheless it does no harm to have such legislation on the books and possibly it may do some good. It surely is not a landmark of progress.

**Another such measure** is a Michigan enactment which prohibits the provision, offer to sell, or sale of information relating to the treatment of a person under the care of a physician without the consent of the physician or patient. Again, I question whether there was much of a problem or whether many malpractice suits were generated through the sale of information of this kind. If it were indeed something that needed attention, it would seem that there was adequate authority in the supreme court and in the bar association to discipline the attorneys who were engaging in this type of practice, much as it is within the province of the court to correct ambulance-chasing in automobile accident cases.

**Indiana has provided** that liability cannot be imposed on a health care provider on the basis of an alleged breach of contract, expressed or implied, unless the contract is expressly set forth in writing and signed by the health care provider or authorized agent. The door to charlatan abuse is opened wide.

**Advance payments made** by a defendant health care provider are not to be construed as an admission of liability for injuries or damages suffered by plaintiff or anyone else. Such advance payments may reduce the ultimate amount payable under any judgment that is rendered in an action.

### Long Range Solutions—The Arbitration Alternative

The last mentioned enactments are patchwork—attempting to plug a leak here and there—"straightening the deck chairs on the Titanic." The medical malpractice problem has been developing for at least two and perhaps three decades. Other basic changes have long been advocated.

A compensation system similar to workmen's compensation is one proposal. No state has ever come close to adopting it. There was one drafted for introduction in the Indiana legislature last December—I have a copy of the 10th draft put together by lawyers for the Indiana State Medical Society. It was rejected by the legislature.

A number of so-called no-fault systems have been proposed. One attracting attention recently is that of Professor Jeffrey O'Connell of the University of Illinois Law School which is based on mutual agreement; he has a statute fully drafted to implement it. Again I do not get the impression that it is being given very serious consideration anywhere, through Professor O'Connell's effectiveness is not to be discounted.

The system that I think holds considerable promise is the one adopted by the Michigan legislature in July 1975 (and rejected in Pennsylvania) which provides for voluntary arbitration of any dispute arising out of health care. The statute authorizes the health care provider to offer the patient an agreement to arbitrate. It may not be made a prerequisite to treatment, so there is no compulsion; furthermore it may be revoked by the patient (but not by the health care provider) within 60 days after execution by a notice in writing.

Within the Bureau of Insurance there is created an arbitration advisory committee which is to review operations of the system, suggest changes, generate a pool of arbitrator candidates, and so on. If this committee is not stung to death by gnats and does a good job the system has great promise.

One reason I am sanguine about this kind of system is that a very similar system has been working successfully in Southern California. Under a joint contract between the California State Medical Association, the California Hospital Association, and the American Arbitration Association, a number of hospitals in Southern California have been offering patients entering the hospitals an agreement to arbitrate, although not requiring that they execute it. They have a place on the form in which the patient may indicate that he does not wish to arbitrate. The patient may revoke the agreement within 30 days after leaving the hospital. So far, out of over 400,000 patients entering the participating hospitals in the Los Angeles area, less than 200 to 300 patients have either refused to sign or later rescinded within the 30 day period (mostly lawyers, their wives, or secretaries). Over 400,000 patients have agreed to arbitrate and have not revoked. The arbitration procedure has been employed only twice since 1969; there are at present four or five other cases contemplated. This means that there has been better than 99 percent acceptance, which is simply a magnificent achievement, especially in Los Angeles or anywhere else in California!

It should be added that coupled with the arbitration system there is a sort of low gear mediation service that is afforded when disputes arise. The mediation service screens and resolves the bulk of the complaints.

The Southern California plan is the brainchild of a San Francisco lawyer named Howard Hassard and his associates. He has been the source of a number of creative ideas in this field. While it may be too early to draw any final conclusions, the results so far have been extremely promising. It is for this reason that I was happy to see the Michigan legislature open up this kind of system. Businessmen long ago found that it was to their advantage to arbitrate rather than to litigate. The arbitration procedure works well with respect to disputes arising under labor contracts. I see no reason why it should not work well in the medical malpractice field, particularly if it is aided by some kind of a mediation system.

Of course the problem may be solved by changes in the health care delivery system. Some of the large health systems (e.g. the Kaiser-Permanente plan in California) require as a condition of membership in the plan an agreement to arbitrate and this has been upheld by the California Supreme Court. Health maintenance organizations are on

the rise; we have a rather elaborate Michigan statute to foster the growth of such organizations and lawyer friends of mine in the field are busy breaking new ground in setting up such arrangements. No reason seems to exist why a person who wants to join a health maintenance organization with a provision for prepaid medical service could not be required to agree to arbitrate disputes arising out of the service rendered.

If we ever get a national health system it is almost certain to include provision for compulsory arbitration of disputes. Senators Kennedy and Inouye have already introduced a bill that would promote mandatory arbitration of medical malpractice claims to be enacted by the states under federal guidelines.

Above all what we need is regular, detached study of the problem with decision for change made after deliberation and quiet reflection. We have had enough of oratory and crisis.