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The Malpractice Problem—Its Cause and Cure: The Physician's Perspective

JAMES J. STEWART*

The medical malpractice problem in Indiana is one of recent origin. One need look back only a few years to discover a situation in which the filing of a malpractice action was rare, and settlement or recovery was even less frequent.¹ The reasons are evident:

(1) There was a close rapport between physician and patient, who occasionally paid his doctor bill with produce in place of cash.

(2) The "locality rule"² and "conspiracy of silence"³ made recovery against the physician difficult even where the plaintiff presented a meritorious claim.

(3) Claim consciousness,⁴ prevalent among the populace today, was virtually non-existent. In recent years there has been an escalation of all types of insurance claims, with a concomitant broadening of the nature and scope of personal injury and damage claims.⁵ For many years the majority of personal injury claims were directed against railroads or other industrial entities, pitting the employee against his employer. With the advent of the automobile, the automobile accident

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¹ The average award in malpractice cases during the period 1970-1975 was \$282,403. The average award during the period 1930-1970 was only \$23,127. Bloomington Daily Herald-Telephone, Jan. 14, 1975, at 1, col. 1.

² See *Worster v. Caylor*, 231 Ind. 625, 110 N.E.2d 337 (1953); *Adolay v. Miller*, 60 Ind. App. 656, 111 N.E. 313 (1916). The standard by which a physician's actions are judged in determining whether they constituted negligence is that of the skill and knowledge of physicians with a similar practice in similar localities. Thus a physician in a rural area would not be required by law to exercise the skill and knowledge of a physician in a large metropolitan teaching hospital. With increased communication throughout the country, the rationale for this rule has been lost.

³ See, e.g., *Gould v. Winokur*, 98 N.J. Super. 554, 237 A.2d 916 (1968). Physicians, because of professional loyalty and insurance company pressure, will often refuse to give the expert testimony needed to establish the standards of knowledge and skill against which a defendant's conduct will be measured. Without this expert testimony, a plaintiff often cannot meet the initial burden of establishing a *prima facie* case of negligence.

⁴ See D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 5.09 (1973).

⁵ Medical claims are increasing at about 8-10 percent per year. See generally DEP'T OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (1973) [hereinafter cited as COMMISSION REPORT].

became a principal source of personal injury claims and, after the passage of workmen's compensation laws,⁶ the automobile accident became the major source of personal injury litigation.

Perhaps the modern malpractice dilemma can be traced to Robert Keeton and Jeffrey O'Connell's forceful advocacy of "no-fault" automobile insurance.⁷ These theorists were first considered radicals by the legal profession, and their theories were scorned by most observers. However, "no-fault" proponents were not easily discouraged, and within a few years the first "no-fault" legislation was enacted.⁸ At this writing several states have "no-fault" automobile insurance laws,⁹ and federal legislation is threatened.¹⁰ There is no denying that the proliferation of "no-fault" automobile legislation has restricted the practice and diminished the earnings of personal injury lawyers for both plaintiffs and defendants. Indeed, some students of the malpractice problem have advanced the theory that the first signs of general acceptance of "no-fault" legislation and theories marked the advent of the malpractice boom.¹¹ Responsible studies have demonstrated the early development, and rapid increase, of malpractice claims in the states where the "no-fault" laws were first enacted. Unquestionably, "no-fault" accelerated the development of the products liability action, a

⁶ See, e.g., IND. CODE § 22-3-3-1 *et seq.* (Burns 1971), the Indiana Workmen's Compensation Statute which was enacted in 1929.

⁷ R. KEETON & J. O'CONNELL, BASIC PROTECTION FOR THE TRAFFIC VICTIM: A BLUEPRINT FOR REFORMING AUTOMOBILE INSURANCE (1965). The authors criticized the application of negligence theory to automobile accidents, and proposed an alternative which would make reparation for certain physical injuries not dependent on the presence or absence of primary or contributory negligence. Liability was to be placed on the insurance company of the driver who was injured or whose passengers were injured. This type of compensation plan is commonly referred to as "no-fault" compensation.

⁸ MASS. ANN. LAWS ch. 90 § 34A *et seq.* (1975).

⁹ See ARK. STAT. ANN. § 66-4014 *et seq.* (Cum. Supp. 1973); COLO. REV. STAT. ANN. § 10-4-701 *et seq.* (1973); CONN. GEN. STAT. ANN. § 38-319 (Supp. 1975); DEL. CODE ANN. tit. 21 § 2118 (1974 Supp.); FLA. STAT. ANN. § 627.730 *et seq.* (1972); HAWAII REV. STAT. § 294-1 *et seq.* (1974 Supp.); ILL. REV. STAT. ch. 73 § 165.150, repealed by P.A. 78-1297 § 22 (Cum. Supp. 1975); KAN. STAT. ANN. § 40-3101 *et seq.* (1973); MD. ANN. CODE art. 48A § 538 *et seq.* (Cum. Supp. 1974); MASS. ANN. LAWS ch. 90 § 34A *et seq.* (1975); MINN. STAT. ANN. § 72A.149 (1968); NEV. REV. STAT. § 698.010 *et seq.* (1973); N.J. STAT. ANN. § 39:6A-1 (1973); NEW YORK INS. LAW § 670 (Supp. 1974); ORE. REV. STAT. § 743.786 *et seq.* (1974); PA. STAT. ANN. tit. 40 § 1009.101 *et seq.* (Cum. Supp. 1975); P.R. LAWS ANN. tit. 9 § 2051 *et seq.* (Cum. Supp. 1974); UTAH CODE ANN. § 31-41-1 *et seq.* (1953); VA. CODE ANN. § 38.1-380.1 (Cum. Supp. 1975). Some of this legislation has come under constitutional attack. See, e.g., *Grace v. Howlett*, 51 Ill. 2d 478, 283 N.E.2d 474 (1972); *Pinnick v. Cleary*, 360 Mass. 1, 271 N.E.2d 592 (1971). See generally Note, *A Constitutional Perspective on the Indiana Medical Malpractice Act*, 51 IND. L.J. 143 (1975), *infra*.

¹⁰ See S. 354, 93d Cong., 1st Sess. (1973), introduced by Sen. Philip Hart, and H.R. 10, 93d Cong., 1st Sess. (1973), introduced by Rep. Moss.

¹¹ Cf. Brant, *Medical Malpractice Insurance: The Disease and How to Cure It*, 6 VALPO. U.L. REV. 152 (1972), where the author views the interest in medical malpractice as prompted by the same symptoms that brought about discussion of auto insurance and the various no fault proposals.

natural forerunner of the professional liability claim. Escalation of the number of malpractice claims in Indiana has occurred at an amazing rate, as evidenced by the studies of the two major professional liability carriers in this state.

By late 1974 doctors were convinced that "trial" lawyers had methodically and deeply furrowed their domain. Moreover, the attorneys were systematic in their approach, publishing and circulating data on the ways and means of successfully establishing the malpractice action. Thus, when Dr. Gilbert Wilhelmus, of Evansville, Indiana, was elected president of the Indiana State Medical Association in October 1974, he resolutely declared that he was directing his entire regime to an attack on the malpractice problem,¹² and the association's attorneys were enlisted in this effort. A "team" of attorneys, which included Geoffrey Segar of the Indianapolis firm of Ice, Miller, Donadio & Ryan, Mark Gray of Kightlinger, Young, Gray & De Trude, and this writer, undertook to draft remedial legislation for the consideration of the legislature. Implicit in the decision to undertake this project was the conviction that remedial legislation was essential to the preservation of the health care system.

The basis and validity of this conviction was recently illustrated by an article published in Best's "Insurance News Digest." The author noted that the office of the California Legislative Auditor General contends that seven California insurance companies ultimately will pay out \$183,000,000 more on malpractice insurance claims than they have collected in premiums during the last fifteen years. Furthermore, "[o]f the total paid claims costs . . . claimants receive approximately 56 percent, attorneys about 40 percent, and direct costs other than legal accounted for the remaining 4 percent."¹³

Thus, it is no wonder that the medical profession has cast a jaundiced eye upon the legal profession. In fact, we found that many doctors, particularly those least informed of the details of the problem, tended to blame first the lawyers, and secondly the insurance companies, for their dilemma. That malpractice insurance costs had become excessive and were going to increase was not disputed, even by the plaintiffs' bar. Two frequently cited examples are illustrative.

Last spring, while we were in the throes of attempting to write the new Indiana statute, I received a long distance telephone call from a San Francisco pediatrician. He had a small clinical practice in con-

¹² See 67 J. IND. ST. MED. ASS'N, President's Page (1974).

¹³ *Insurance Educator: California Medical Malpractice Study*, 213(14) THE WEEKLY UNDERWRITER 20 (Oct. 11, 1975).

junction with other pediatricians. Their business had reached the point where they felt justified in employing an anesthesiologist. For this reason they secured the services of a young man who had just completed his residency and who had not yet entered private practice. The pediatricians agreed to pay him a salary of \$42,000 a year, providing him, of course, with a fully equipped office. They did stipulate, however, in view of the insurance problems prevalent among California physicians, that it would be necessary for him to make arrangements to obtain his own liability insurance. When the anesthesiologist attempted to procure liability coverage, he discovered that most companies were not interested in insuring him at all. He finally found one company which was willing to write a policy for a \$32,000 a year premium, a sum which constituted 75 percent of his income before taxes.

The other example occurred here in Indianapolis. On December 23, 1974, Community Hospital announced that it was discontinuing all elective surgery because its anesthesiologists were unable to renew their insurance policies.¹⁴ A real crisis was narrowly averted when the Insurance Commissioner of the State of Indiana, through a little arm twisting, induced one of the few carriers who was still writing liability insurance in Indiana to take the risk, at substantially increased rates, for a trial period pending developments in the Indiana legislature.¹⁵ The rates for the anesthesiologists increased some 500 to 600 percent.¹⁶

In the beginning doctors also blamed the insurance companies, claiming that such escalation in premiums was a "rip off" and unconscionable. The doctors had great difficulty in understanding that, in reality, the writing of malpractice insurance had become so hazardous that most of the insurance industry really would have preferred to abandon the business altogether. The premiums at which these companies could profitably write liability coverage were so astronomical that the companies were embarrassed to even quote figures. This situation was dramatically illustrated when I requested, and was granted, permission to meet with the Board of Directors of the Indiana Insurers Institute, an association of all the companies writing casualty insurance in the State of Indiana. None of these companies was writing malpractice insurance, with the exception of one company that wrote some excess coverage. I was soliciting support for the Indiana bill which we were preparing and the Institute had an experienced and influential

¹⁴ Indianapolis Star, Dec. 20, 1974, at 1, col. 1.

¹⁵ Indianapolis Star, Dec. 21, 1974, at 1, col. 3, and Dec. 24, 1974, at 1, col. 1.

¹⁶ Fort Wayne News-Sentinel, Nov. 14, 1974, at 2B p. 11, col. 1.

lobby. I outlined the proposed bill and our plan of presentation, emphasizing that I sought only assurances that they would not oppose our efforts. These assurances I obtained with one condition which was stated quite clearly: *the bill would contain no provision which could require the insurers, under any circumstances, to become involved in insuring the liability of doctors or other health care providers.* The insurance writers made it crystal clear that such business was no longer attractive to them and that they wanted no part of it. Only with such assurances could I elicit from them a promise of "no opposition" to our bill. In subsequent consultations it was with considerable difficulty that I was able to convince the Indiana State Medical Association's Board of Directors that this really represented the attitude of the insurance industry in Indiana.

Not only did a substantial segment of the medical population feel that lawyers were a part of their problem, but they were also highly critical of a vital adjunct of the legal system, the contingency fee, which they felt was an abomination which should be abolished. Of course, many reputable lawyers feel that there should be no controls whatsoever placed upon the contingency fee arrangements.¹⁷ Nevertheless, some observers feel that in some instances there has been sufficient abuse of the contingency fee to warrant controls. Certainly, a flat 50 percent contingency fee, plus expenses, is not justifiable, and has been judicially condemned.¹⁸ On the other hand, it is difficult to argue against the old adage that the contingency fee is "the poor man's ticket to the court house." Those of us who were involved in drafting the Indiana legislation had to work long and hard to try to convince doctors that the contingency fee concept should be retained, and that it is an important element of our judicial system. The authors agreed, however, with the doctors that there should be some control of contingency fees, and we advocated adoption of the New Jersey law which provides a sliding scale for determining contingency fees.¹⁹ Unfortun-

¹⁷ F. MACKINNIN, *CONTINGENT FEES FOR LEGAL SERVICES* (1964) presents a detailed analysis of the contingent fee system in the United States and offers criticisms and proposals for regulation.

¹⁸ See, e.g., *Vaughan v. Atkinson*, 206 F. Supp. 575 (E.D. Va. 1962); *In re Cohn*, 46 N.J. 202, 216 A.2d 1 (1966).

¹⁹ N.J. SUP. CR. R. 1:21-7(c), adopted by the New Jersey Supreme Court in 1971, effective Jan. 31, 1972, reads as follows:

(c) In any matter where a client's claim for damages is based upon the alleged tortious conduct of another, including products liability claims, and the client is not a subrogee, an attorney shall not contract for, charge, or collect a contingent fee in excess of the following limits:

- (1) 50% on the first \$1000 recovered;
- (2) 40% on the next \$2000 recovered;
- (3) 33½% on the next \$47,000 recovered;

ately, we were not completely successful in having our recommendations in this connection adopted by the Indiana legislature, where the bar is, of course, quite influential.

As a matter of fact, opponents to fee control have a strong argument. They point out that doctors, for the most part, are at liberty to contract with their patients for their fee. Price control has never been a very popular concept among business and professional men. Why shouldn't the plaintiff's lawyer be at liberty to contract with his client? Eventually the argument was settled by compromise, and the Act now provides for no control over the attorney's fees relative to the first \$100,000 of recovery, with a 15 percent maximum contingency fee on any recovery over and above this amount.²⁰ Frankly, the doctors are still not happy about the contingency fee and sincerely feel that the sliding scale formula is the most equitable arrangement. It is their position, also not without merit, that the insurance premium dollar would go further if less of it went into the lawyer's pocket.

There is another institution which has been sanctified by the legal profession but about which the physician is at best skeptical. This is the jury system. Many doctors are convinced that the excessive verdicts which are driving insurance premiums upward are the consequence of a clever lawyer's ability to make an emotional appeal to a jury, irrespective of the merits of the controversy. To some extent, certainly, this contention cannot be denied. This writer, though it may sound like heresy coming from a trial lawyer, must confess to some skepticism concerning the value of the jury system in the malpractice action, and to doubt about whether its benefits are outweighed by its costs.

In the malpractice action, there is a limited insurance base, but tremendous exposure. For example, in Indiana there are fewer than 5,000 practicing physicians, or insureds; yet everyone goes to a doctor so that the physician's exposure to a claim is quite substantial. By comparison, there are approximately one million persons in Indiana driving automobiles. Again, almost all citizens are potentially exposed to an auto injury but, while there are only 5,000 "insureds" in the malpractice field, there are approximately one million "insureds" in

(4) 20% on the next \$50,000 recovered;

(5) 10% on any amount recovered over \$100,000; and

(6) where the amount recovered is for the benefit of an infant or incompetent and the matter is settled without trial the foregoing limits shall apply, except that the fee on any amount recovered up to \$50,000 shall not exceed 25%.

The rule was upheld in *American Trial Lawyers Ass'n v. New Jersey Supreme Ct.*, 66 N.J. 258, 330 A.2d 350 (1974).

²⁰ IND. CODE § 16-9.5-5-1(a) (Burns Sudd. 1975).

the automobile field. Consequently, there are many more premium dollars to pay automobile claims than there are to pay malpractice claims. Since the exposure is almost as great in one instance as in the other, the malpractice premium is much more costly than the auto premium. It has been difficult for both doctors and legislators to realize that this is part of the problem.

Most of the exorbitant malpractice verdicts, ranging from one to seven million dollars for a single injury, have been rendered by juries.²¹ These awards are obviously a consequence, at least in part, of jury sympathy or prejudice. It was for this reason that the attorneys for the Indiana State Medical Association, employed to draft a malpractice bill, recommended removal of the malpractice action from the jury system, and replacement of the jury with a review board composed of two physicians appointed by the Indiana State Medical Association, two lawyers appointed by the Indiana State Bar Association, and two laymen appointed by the governor.²² It was believed by the doctors that such a tribunal would be more responsible in recognizing a meritorious claim and more realistic in its award. This writer felt that a question of weighing values was involved. On one hand, the drafters had to acknowledge that our proposal constituted some erosion of the traditional judicial system with its emphasis on jury determinations. On the other hand, we felt that such an approach might be worth the cost when measured against the potential destruction of the medical profession as we have known it.

It is still my belief that the board concept will prove to be, at worst, a noble experiment. It may even prove an indispensable element of the solution to the problem, despite its apparently revolutionary nature. The fact is that there are a number of academicians who have questioned the value of the jury system in the civil action in any case.²³ The acute medical malpractice problem can only fan that smoldering fire.

In summary, I believe it can be authoritatively stated that it is the general opinion of the Indiana State Medical Association that the original bill,²⁴ as it passed the House of Representatives, was a better law than that which finally evolved. It was better because:

²¹ Law Professor J.B. Dunlop, who teaches courses in civil liability for personal injuries, including medical malpractice, at the University of Toronto, pointed out that only half of all personal injury actions in Canada are tried by juries and that awards are much smaller than awards in the United States, particularly in medical malpractice cases. Welch, *Medical Malpractice in Canada*, COMMISSION REPORT, Appendix 849, at 852.

²² H.R. 2063 § 8, 99th Ind. Gen. Assembly (1975).

²³ See Steuer, *The Case Against the Jury*, 47 N.Y.S.B.J. 101 (1975); but see Knittel & Aeiler, *The Merits of Trial by Jury*, 30 CAMB. L.J. 316 (1972).

²⁴ H.R. 2063, 99th Ind. Gen. Assembly (1975).

(1) The Patients' Compensation Board provided a more experienced and stable tribunal for litigation of the technical issues generally involved in a malpractice action.

(2) It provided for expeditious handling of the malpractice claim, impossible under the current judicial system, yet retained the substantive tort law and conventional avenues for judicial appeal.

(3) All reasonable costs, including claimant's expert witness fees, could be assessed against the responsible health care provider.

(4) It provided for punitive damages in appropriate cases.

(5) It provided for a reasonable schedule of benefits and guidelines for damage awards.

(6) It provided for payment of unlimited expenses for maintenance of life or health in the case of catastrophic injury.

(7) It provided a reasonable sliding scale contingency fee schedule, insuring that more of the malpractice award went into the patient's pocket.

(8) It eliminated attack by collateral sources (the subrogated claim of Blue Cross-Blue Shield, for example).

All of this would have been accomplished without further burden upon the taxpayer or the health care provider's liability insurer.

Clearly, it is the physician's belief that the law enacted by the 1975 Indiana Legislature constituted a giant step forward in the cure of an acute problem. If the patient suffers a relapse, it is the physician's firm belief that more radical surgery, in the form of legislation incorporating the above-mentioned features of the original bill, will be necessary to remove all of the malignancy.

