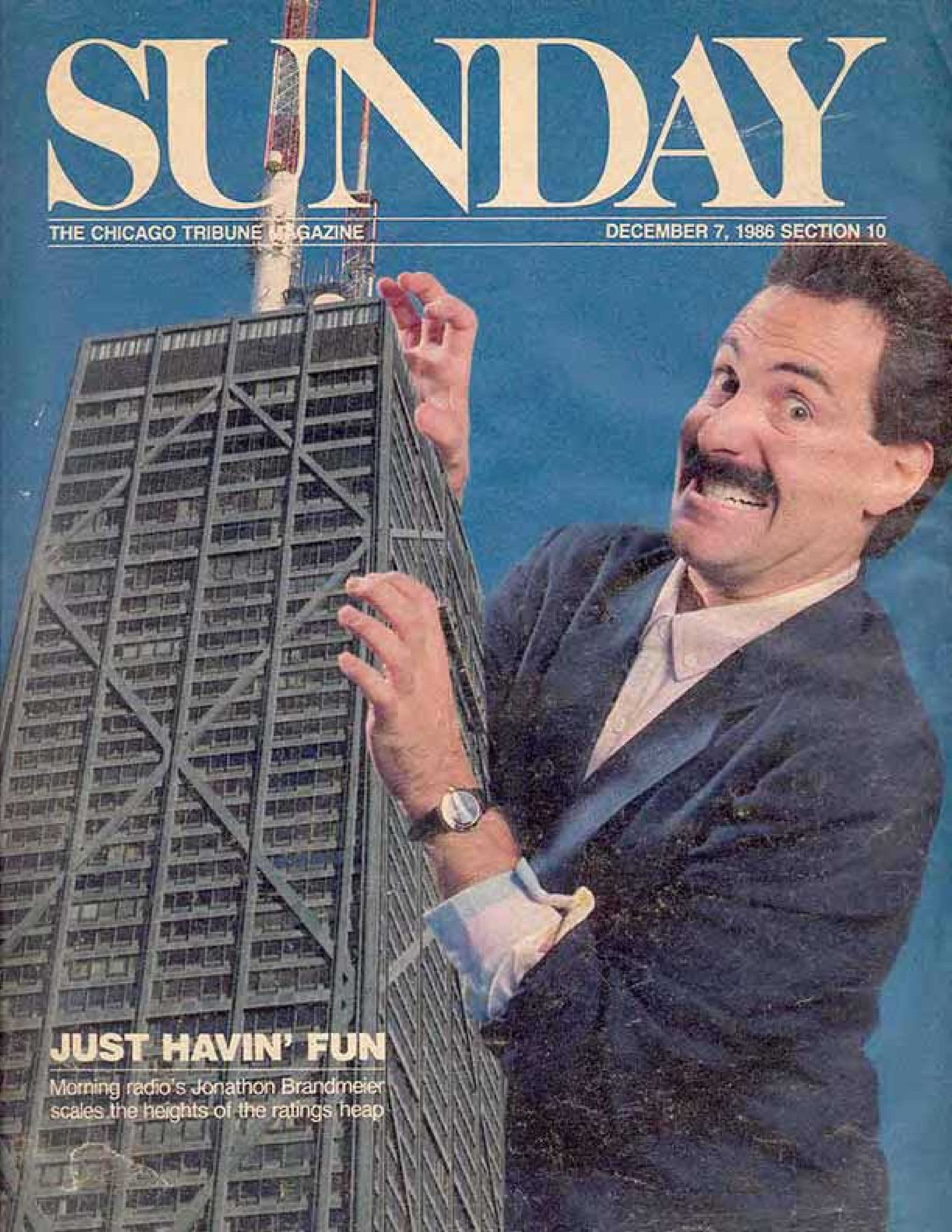
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Sunday
The Chicago Tribune Magazine December 7, 1986

Strong medicine

It could prove to be a cure for the nation's malpractice malaise—but some may find it hard to swallow

Article by Richard Cavalier
Illustrations by Cathie Bleck

Medical malpractice has always existed. Nobody ever bothered to count the cases early in this century because under the Victorian doctrine of charitable immunity, physicians and institutions of good intent were almost untouchable in the courts.

That doctrine was demolished in the consumer revolution of the 1960s, and medical malpractice lawsuits became common. Yet there is evidence to indicate that the blame for today's malpractice crisis may lie not with a lawsuit-happy public but with the policies of the health-care, legal and insurance establishments, those groups that most decry the current situation.

As Mark Twain might have put it, "Everybody talks about medical malpractice, but nobody does anything about it."

To be sure, there is much activity in various state legislatures and among national professional legal and health-care organizations. But nearly all this activity has been directed at the symptoms, not the disease itself.

Every involved party—the doctors, the lawyers, the insurance companies, the patients themselves—can with some degree of truth claim it has not caused the malpractice crisis. As a result, the public hears only conflicting opinions: A medical malpractice crisis exists—or it doesn't. The crisis, if it exists, can be resolved by strict laws—or the laws aren't working, and the crisis can't be resolved at all. And it's always caused by "the other guy."

The confusion generated by those conflicting claims has its own fallout. It undermines the trust between patient and physician, aggravates the legal adversary relationship between an injured person and the health-care provider and further delays intelligent solutions to the problem.

Such solutions were outlined near the beginning of the malpractice crisis in a 1973 Report from the U.S. Department of Health, Education and Welfare [HEW], now the U.S. Department of Health and Human Services. Titled "The Report of the Secretary's Commission on Medical Malpractice," the 150-page document offered nearly 100 recommendations for changes at local, state and national levels of government and in America's health-care system to stave off what was already at that time a growing problem.

The commission was composed of 21 respected physicians and allied professionals, lawyers, educators in the medical-legal field and insurance executives.

Among the commission's recommendations was one "to explore new types of compensation systems to help persons who sustain injuries arising out of medical treatment with or without regard to negligence."

Although the commission's findings and

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recommendations have been largely ignored, one medical organization has taken the HEW recommendations to heart with surprisingly good results. And throughout the country other programs are being tried that could eventually bring the malpractice crisis under control.

Today Los Angeles County operates what is probably the nation's largest health-care complex. The complex includes one convalescent and eight acute-care hospitals, four major comprehensive health-care centers, 49 clinics, paramedic services, plus probationary health services for the jail system, including a 100-bed infirmary.

At the height of the first malpractice crisis, in the mid-1970s, this health-care system found itself unable to buy insurance coverage on traditional terms. Insurance companies were demanding higher rates to insure hospitals against malpractice suits—and narrowing the coverage of their policies.

But what is a "malpractice crisis?" The 1973 HEW Report—which urged statistical quantification of incidents of malpractice—quotes the injury rates from two small studies. One, a study of several hundred patients at two small hospitals, found a rate of treatment-caused injury of nearly 8 percent of patients admitted.

Although that study is subject to challenge, the extent of malpractice is knowable, and has been for many years, within acceptable limits of statistical variation.

An earlier study, based on 1,000 patients, put the rate at 5 percent; this study was published in 1955 by the Journal of the American Medical Association.

In 1976 Don Harper Mills, M.D., J.D., then president of the American College of Legal Medicine, released a study based on a random selection of patient records from throughout the state of California for the year 1974. Based on review of more than 20,000 cases, the Mills team concluded that the rate of treatment-caused injury is 4.65 percent of all hospital admissions.

But only about 0.79 percent of the 20,000 cases suffered injury that was due to negligence. The latter would be considered potentially compensable events in most legal and hospital systems.

The seriousness of the problem is apparent when all the statistics are converted to numbers involving real people. At the Mills report rate, about every 21st or 22d patient experiences some harm from treatment, which is not necessarily anyone's fault. That totals about 465 in every 10,000 hospital admissions.

At the Mills rate, 79 of those 465 patients might deserve compensation.

A community hospital with 100 beds can admit about 10,000 patients per year, based on an average stay of slightly over three days. The average stay seems to be declining somewhat, and not all hospital beds are always full; so the precise numbers can be challenged, but the principle is correct.

Given approximately 36 million hospital admissions in the nation in 1984, negative outcomes from treatment were experienced by about 1,700,000 patients. Among that number at the Mills rate would be 284,000 people injured through someone's fault. Some injuries are not serious or permanent, some are; many are not revealed.

In September, 1985, the Public Citizen Health Research Group, under the direction of Dr. Sidney Wolfe, a Ralph Nader associate, released a report on disciplinary actions against doctors for malpractice. The report estimated that although from 136,000 to 310,000 cases of medical malpractice occurred in the nation in 1983, states took disciplinary action against only 563 of the physicians involved, or just 1 in 250 cases.

While acknowledging that the disciplining of doctors by the states can be improved, an AMA executive challenged statistics in the report.

Dr. James Todd, senior deputy executive vice president of the AMA, said states had disciplined 500 more doctors than the report said. That would about halve the ratio, to 1 disciplinary action in 125 cases.

Asked to estimate the number of incidents of medical malpractice in the nation today, Dr. Todd responded, "It's unknowable. Projections from any study are purely speculative" because "studies are limited" and sometimes "incomplete." "It is inappropriate to quote speculative figures as if for real," Todd concluded.

Dick Layton, former general manager of the AMA's physican-owned American Medical Assurance Co., says: "A doctor is not necessarily aware he has damaged a patient, but if he is aware, I'd advise: 'Don't be defensive; be open. Discuss untoward events with patients. People who lie have to worry about it.' " Considering how many patients get medical care of all sorts, the profession has, Layton insists, "a very good safety record. But in the public's view, someone's always at fault, so they can always find a lawyer to file a case."

A statistical analysis of patient records of the Los Angeles County health-care system for 1974 confirmed the Mills report rate of 4.65 percent injury from treatment but found the culpable incidents to be "about 1 percent of all patient admissions," quite a bit higher than Mills'. Since then the Los Angeles County system has found a way to reduce that 1 percent culpable injury rate by two-thirds, although its achievement goes almost unheralded.

In 1974 the county was able to arrange coverage [beyond a $5-million-a-year deductible] from Lloyd's of London on condition that Lloyd's be permitted to operate the county's risk-management program. In 1975 Lloyd's American counsel, the San Francisco-area law firm of Golman & von Bolschwing, took charge.

It formed a new firm, Professional Risk Management Inc. [PRM], that established communications between hospital staff and PRM as privileged under law, permitting medical personnel to report to PRM any injuries to patients resulting from treatment. In exchange, PRM agreed to shield medical personnel from unfavorable publicity unless and until they were found guilty of negligence in a court of law.

Injured patients, in turn, were informed of their injury and offered voluntary settlements which, if accepted, saved both sides time and cut litigation fees.

"Los Angeles County directs PRM from the standpoint of policy. PRM has the discretionary authority to make settlements up to a set sum, and the county attorney and I approve any settlements over that figure," says Henry Bachrach, chief of risk managment for the County of Los Angeles. "The key element is an efficient incident-reporting system. That requires the willing cooperation of the medical staff, who realize that it is in their best interests, and is not punitive."

"We felt a 1-percent rate [of injuries due to negligence] was far too high," says Gus von Bolschwing, PRM's president and chief counsel. A trial lawyer specializing in malpractice cases, von Bolschwing has represented plaintiffs as well as defendants. "We knew as insurance people that we had to do something about that," since litigation costs are such a large part of the overall cost. Litigation doesn't begin unless someone is damaged or believes he has been.

But there were human considerations, too. "We also felt that to win the cooperation of the injured patient, we would have to be eminently fair," he continues. "That meant both full and prompt disclosure of injury, whether or not culpable, and also free future care for that injury plus just compensation."

The combination of close monitoring of potentially compensable events as they occurred and professional staff education has reduced the 1974 rate of 1 percent culpable injury to just one-third that figure today, according to von Bolschwing.

"We're now at the point," he adds, "where culpable events are the result of accidents that could not have been foreseen. The staff are aware of their responsibility and

cooperate fully. In fact, they over-report incidents—and we like it that way: There are almost no surprises later."

But early in the experience, despite the full endorsement of county and local hospital administrators, there was some resistance. "Many of the staff felt that as trained professionals they shouldn't have us looking over their shoulders," says Frank D. Heckman, senior vice president of PRM. "It's curious. Even people pledged to saving lives must understand the purposes and values of crisis intervention and monitoring before they become enthusiastic."

After a decade of seeing the results of this approach, Heckman says, "they're committed. A doctor who made a mistake in surgery broke scrub to phone us [immediately alerting others to the patient's special needs], then re-scrubbed and finished the operation."

PRM earns that trust by its policy of shielding accused professionals from the glare of publicity that often surrounds announcement of a major claim. Not until a jury finds a doctor guilty is that doctor's name made known to the public. Otherwise, all cases are handled in the county's name.

Because of its extensive computer databank, PRM knows with a high degree of certainty which cases of patient injury could include an element of fault. Administrators of the individual facilities move quickly to deal with all injuries.

Los Angeles County has not achieved its success by "dumping" indigents elsewhere or by discharging Medicare or welfare patients prematurely, the "quicker and sicker" syndrome associated with recent federal reimbursement policies.

"Los Angeles County facilities are treatment areas of last resort," says Heckman. "We must accept and hold patients for the full duration of their needs, by law. We must accept rich and poor alike—we cannot select. The mix of the county's population is the mix of the county's hospital system."

So convincing is the record at Los Angeles County that in 1983 the Regents of the University of California assigned the risk-management of the university's health-care system to a PRM sister firm. The university owns five major hospitals and operates a sixth [a major affiliate], along with clinics on each campus.

Given its detailed computer databank, PRM has been able to spot patterns in incidents and take remedial action. For example, an upsurge in damage to the collarbone of newborns was traced to an improper technique demonstrated by an instructor. A remedial course was given to his entire class, which was then monitored for six months. In another instance a rash of complaints identical in nature was traced by computer to one individual, who was also given remedial instruction and monitored.

The combination of injury-reduction measures, plus full and prompt disclosure of injury, worked a minor miracle in the late 1970s. Overall costs of malpractice claims fell a full 40 percent against a rising national trend, despite increased settlement amounts paid to injured patients, often in structured, or staggered, settlement programs that provided, in extreme cases, for the education of minor children and other family needs.

"We run the program with a realization of—and concern for—the problems of the injured party," Bachrach stresses. "So we frequently make interim expenditures on their behalf for needed care [and occasionally provide financial assistance, if the need is great] even before culpability is determined and the case settled. It's the human factor: We don't lose sight of the injured patient's needs."

That flies in the face of the conventional wisdom of the industry, which tolerates hiding injuries and/or denying fault. After 10 years, Bachrach says, Los Angeles County is "markedly lower in total claim costs but with a significantly greater percentage of the settlement going to the injured party. This is due in no small part to the shortening of the period in which plaintiff attorney fees mount. So far, it's proving out very well. Based on statistics, I believe we have one of the best programs in the country."

So fair are the PRM offers of settlement that the Los Angeles courts, which review all settlements involving minors or mental incompetents, routinely approve them. For their own protection, some patients hire attorneys, on a standard-fee basis for time and service, to oversee the settlements.

"The reduction of litigation costs made this possible," according to PRM's von Bolschwing. But in the early 1980s, given the lure of multimillion-dollar awards, the percentage of patients who refused offered settlements, in favor of trial by jury, increased. So has the number of non-meritorious cases "brought by inexperienced attorneys. The experienced attorney will not take a case that doesn't belong in court," he says. "We will not settle nuisance suits—that invites more."

Court battles are not uncommon, but PRM fights all claims that it believes have no merit.

So despite PRM's record of risk reduction, the firm is still confronted with the general problems caused by an increase in malpractice lawsuits nationwide. As a result, PRM's overall cost of malpractice claims has risen. Instead of being 40 percent lower, as in the 1970s, Bachrach estimates that its cost of settlement is now 24 percent lower than the average.

There exists no simple definition of what constitutes an injury worthy of compensation.

Iatrogenic injury—that is, injury caused by treatment—can be real and serious without being a result of anyone's negligence. For instance, many people are allergic to penicillin [or other drugs], yet no one knows before the first injection. No one is at fault on the first occasion of a drug reaction, even if it is severe. A physician will administer an antidote [if one exists], and the problem should be resolved. The physician should enter the allergic reaction in the patient's medical records, and the patient should carry a warning on his or her person in case of accident.

There also are culpable injuries, in which negligence or fault are factors, and for which compensation might be justified. If the physician, for example, has no antidote on hand, and if complications occur, he could be liable. If the antidote is administered but doesn't work, the physician is probably not at fault, but the manufacturer could be. Or if the product used was not fresh, several people might be at fault. Finally, if the original physician ever gave the same patient another shot of this drug, he would be liable, as would be any other physician who had access to the complete medical record, unless it was the only appropriate drug and the patient agreed to risk the consequences.

The security many of us feel about hospital care is due in part to the relatively few cases of patient injury that make the evening news. Only when a spectacular dollar award or a public figure is involved do we get details. Most of those details will not be clarified or confirmed if the case is settled out of court, and settlement terms sometimes prohibit publicity.

Three notable local malpractice injuries that have made headlines involve two children and one adult. Both of the children's cases were settled out of court, so there is no legal determination of cause or culpability on record.

- "Baby Ryan's" parents claimed compensation in his name for alleged delivery-room events that resulted in a lifelong handicap. A settlement in excess of $14 million will have an eventual value of more than $100 million if the child lives into old age.
- "Infant Ian" has been in a coma since 1982, when he underwent surgery for a hernia at the age of 9 weeks. His surgeon performed successfully, but a subsequent lawsuit charged that someone in the operating room accidentally shut off the oxygen on the anesthesia equipment, causing permanent brain damage to the baby. A settlement of more than $6 million hinged on a charge of negligence against both an anesthesiologist and the hospital for failing to monitor the infant's breathing.

● Survivors of a Skokie man who died of medical complications resulting in part from a misdiagnosis were awarded $1 million by a Cook County Circuit Court jury. Two doctors, an anesthesiologist and the hospital were named as defendants.

If the injury and fault are clear, then an admission of liability could be made and a settlement offered [under the PRM system]. But under our current legal system, compensation is never automatic or certain, regardless of fault or severity of injury, because the burden of proof is always on the patient.

If a patient is not sure whether damage has occurred [the facility or physician is not obligated to admit either injury or blame for it], the patient needs access both to his medical records and to a professional who can interpret those records. [In Illinois the patient is entitled to a copy of his records, but he often must pay for it.]

Yet not all states permit a patient to see copies of his records, not all states prohibit alteration or destruction of unfavorable entries in those records, and any physician who offers an unfavorable opinion of the physician or facility under review can be sued for slander or libel unless the opinion is given in court testimony.

If damage is suspected or even evident, most injured patients will need to consult an attorney. Under the current system it's difficult for an injured patient to avoid filing a legal claim unless he accepts a voluntary offer of settlement. Many patients feel even then that they would like an attorney's advice.

Currently courts are clogged with cases that could be addressed by other, less costly means, including binding arbitration. Because many patients cannot pay the cost of a lawyer's fee up front, many attorneys take such cases on a contingency-fee basis. That is, the attorney is paid a portion of the dollar award [commonly one-third] if he wins. Health-care providers and their insurance companies say the attorney can be paid too much by that method. The HEW report recommended that a payment scale be adopted, providing lesser percentages of higher awards. That would permit contingency fees to continue because HEW found such payments to be helpful to the patient unable to pay an attorney outright.

But the HEW report also noted that the contingency-fee arrangement might not attract an attorney if the amount of the award is likely to be low, and it asked for a guarantee of legal services to patients with meritorious claims regardless of the amount in question. That need has not been addressed.

A meritorious claim is one in which there is a reasonable possibility that a specific injury was caused by negligence. It is the duty of the jury, if the claim goes to trial, to determine whether an injury has occurred, whether the pain, suffering and/or loss of income are great enough to justify compensation, whether negligence caused or contributed to the injury and if so, how great the compensation should be.

This tort system has led to rising numbers of lawsuits and rising dollar amounts of jury awards. Despite skyrocketing premiums for medical malpractice insurance, it has become hard to find coverage at all in certain high-risk medical specialties—such as obstetrics—and insurance companies have threatened to refuse coverage in geographic areas with high claim rates. In protest, some Massachusetts obstetricians went "on strike" briefly in February, refusing to see newly pregnant women.

Some physicians and facilities opt to pay the higher premiums and pass the costs along to patients directly. Some physicians have even elected to practice without insurance. To help reduce their personal risk, they refuse to take patients previously treated by another physician.

Many—and perhaps most—health-care providers are practicing defensive medicine, that is, ordering extra tests and second opinions not considered necessary in the past. Their hope is to build a case record that precludes a charge of negligence.

The added cost is passed on to the general public in the form of higher costs for physician care, hospital beds, lab tests and health-insurance premiums, as the health-insurance companies try to cover themselves.

The health-care industry has asked state courts to put a cap on awards, ending multimillion-dollar awards.

On Feb. 7 Gov. James Thompson proposed capping awards, along with attorney fees. To date, such legislation has not passed in Illinois.

[Last year the Illinois legislature passed amendments to the state's medical malpractice code, which establish a review panel, consisting of a judge, an attorney and an appropriate medical specialist, to review all legal claims regarding patient injury alleged to result from negligence.

[If the panel votes 3 to 0 against the merit of the claim, and if the patient and his attorney subsequently take that case to jury trial and lose, then the patient/plaintiff can be assigned all litigation costs of the defendant, who may be an individual or a hospital.

[The law does not provide for automatic review by the state of the records of the attorney who took to the jury and then lost a case without the panel's Affidavit of Merit.]

The record to date on caps is mixed. Capping reduces any given payout but does not eliminate the original injury and therefore cannot contribute to reducing the number of lawsuits. As a result, some attorney groups charge that the health-care industry is seeking caps to put itself above the law of responsibility for negligence.

Fewer than half of all lawsuits claiming patient injury that reach a jury result in guilty verdicts and awards.

The health-care industry points to this fact as an indication of the frivolous nature of most suits, but that is an oversimplification. Cases of clear negligence are often settled out of court, leaving both the very tough and the very frivolous cases to be contested before a jury.

Because of the cost of fighting any jury trial, some insurers agree to settle out of court cases involving small amounts, even when the physician or facility can be shown to be innocent, a practice that encourages more frivolous or nonmeritorious suits.

Yet, on the whole, it would seem that the health-care industry has spent more energy trying to stop or reduce a patient's ability to sue, or to collect huge awards, than it has trying to reduce the incidence of injury through negligence.

The net effect has been to put financial considerations ahead of human considerations, to raise costs to the public simultaneously with raising risks to the patients, and to delay the reforms needed to coincide with the viewpoint of the 1973 HEW report: "... society's prime concern must always be the injured patient. His first need is prompt and effective remedial care. He often needs replacement of lost income for his support and that of his dependents, and he may need long-term rehabilitation. ..."

The report also urged all parties to cooperate to collect and report information relating to medical injuries and medical malpractice. In the nearly 14 years since the HEW report appeared, the health-care industry has failed to gather nationwide data on the actual frequency of injuries to patients. The industry focuses on claims made, a lesser number.

One failing of statistics—even correct statistics—is that they're abstract. Damage is happening to people, but nearly all private statistical databanks [such as those of professional associations or insurance companies] tend to deal with claims filed or with incidents per hundred hospital beds or claims per hundred insured physicians, as the insurance trade counts.

That abstract view permits industry leaders to deal in a rather detached way with the pain, suffering, financial re-

versals and even wrongful deaths of patients.

PRM discovered early in its program at Los Angeles County that the more prompt and full the disclosure of injury and the more generous the settlement offered, the more cooperative the patients were and the less costly the incident became.

The 1973 HEW report urged medical, dental and nursing schools to develop and require participation in programs that integrate training in the psychological and social aspects of patient care with the physical and biological sciences.

Although virtually every health-care provider now has a program called "patient safety" or "quality assurance" that deals with prevention of injury or injured patients, such programs are not standardized.

In the late 1970s PRM also began human-relations training for supervisors to teach them how to deal with patients. So successful was the program in improving attitudes and measurably reducing negative incidents that PRM offered the two-day seminar to the entire health-care field. It found few takers, and the idea was abandoned.

That's unfortunate because the PRM seminar included legal presentations by some of California's most respected plaintiffs' attorneys—supposedly the "enemy"—who volunteered their services in discussing legal liability.

But is the PRM/Los Angeles County program worthy of national notice?

Carol Golin, publisher of the Medical Liability Monitor, which profiled the PRM program in 1978, terms it a "commendable" risk-management/loss-prevention program. "Loss prevention programs are now proliferating everywhere. [They] range from superb to very good to minimal," Golin says.

C. Duane Dauner, president of the California Hospital Association, says, "PRM is one of the longer-term programs. If it's getting the results claimed, it should be studied" and adopted into educational programs conducted by "us, schools, insurers and others."

He is less optimistic about full disclosure of patient injury, unless there are further changes in the legal system, because full disclosure at this point, in his view, might only invite further lawsuits.

The Los Angeles County Medical Association [LACMA] sponsors two risk-management programs. One is SCPIE, the Southern California Physician's Insurance Exchange, with about 9,000 policyholder members among physicians in private practice; the other is a commercial carrier with about 500 more policyholders.

"We encourage people as much as possible to participate [in risk management] with one of these two carriers," says Frank Clark, executive vice president of LACMA.

His associate, David Zeitlin, LACMA's director of communications, had direct experience with the Los Angeles County/PRM program through his prior affiliation with the LAC Harbor/UCLA Medical Center during the formative period of the PRM program.

"PRM's incident-reporting system is most unusual. It's a marvelous program. It clears the air by admitting an honest mistake—or even a boo-boo; these things happen. But the patient is properly treated [for that injury] and remunerated—he gets more" at less cost to the county. "So even on a fiscal basis, it makes sense."

If the program is so good, why is it so little known?

"Good question," says Zeitlin.

The Harbor complex is a strong link between the Los Angeles County health-care system and the state university. Zeitlin estimates that about 600 physicians on the UCLA faculty, most with private practices, volunteer 30,000 hours of their time each year to teach interns and resident doctors at Harbor. To teach is a faculty requirement; the amount of time is voluntary.

"Contact [between new interns and residents] with practicing physicians is when learning really happens. That's

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experience talking—not just books," says Dr. Stephen A. [Tony] Greenberg, director of quality assurance and risk management at the Harbor complex. He was formerly an associate professor of pediatrics at the UCLA School of Medicine.

But education in human relations and other aspects of risk management is "sorely needed," Greenberg says. "Most schools offer no classes on malpractice or law, so most professionals are not too knowledgeable."

"That's why we work closely with PRM. Its staff gives specific examples from law and cases in separate meetings for medical specialty areas. They answer all the questions."

One of the most effective programs last year, according to Greenberg, was a mock trial on a negligence suit. "That registered—we plan to repeat that format this year. Our doctors and nurses are more aware and, hopefully, more careful" as a result.

Why, Greenberg is asked, is such a program not more widely known?

"Possibly [because of] different interests between hospitals and physicians, or insurance companies and policyholders. But many risk managers belong to the California Association of Hospital Risk Managers. We meet monthly and present guest speakers. Several officers in recent years have been PRM people. They have such a spirit for educating their peers that their ideas are going around, even though not necessarily through the professional societies."

Why should the industry approach to risk management be so fragmented more than a decade after the medical malpractice crisis began?

"There's no concerted and conscious effort [on the part of the health-care industry] to seek out successes and analyze factors that led to those successes, and then to apply and adapt them to the particular institution's needs," says Bachrach. "When I've talked with other risk managers, they seem to focus on the insurance industry's argument of 'Why look for claims?' rather than on the results we've had from looking."

Layton agrees: "Some places won't discuss that someone is culpable and that something can be done. They don't want seminars that advertise the problem. Some people don't believe in risk-management programs. Some risk managers and private physicians won't work together. Doctors are not employees. They say, 'We'll review it and let you know.' "

Meanwhile, the problem grows, propelled by lawsuits, not human considerations.

Because the extra costs of defensive lab tests, misdiagnosis and hidden injury are picked up by the health-insurance policies held by the public, it would seem that insurance companies should be interested in the PRM approach.

Yet when the program was described to a Chicago-based health-insurance company, a vice president said, "We don't write malpractice coverage."

Similarly, a vice president of one of Chicago's largest underwriters of all types of insurance responded, "We already use structured settlements."

"Insurance companies have for years used legal suits as a means of measuring serious claims," says PRM's Heckman. "They track the suits with the intention of settling on the courthouse steps. It was true in 1975, and not much has changed over the years."

Delaying payment permits funds earmarked for settlements to earn interest for the insurance company while the claimant's case can grow weaker because of the

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loss of witnesses over the years. Heckman sees the insurer's willingness to settle nuisance suits as irrational.

Given the general climate of erosion of the sense of personal responsibility—the "Where's mine?" syndrome—PRM's von Bolschwing reluctantly supported the request of the California health-care industry to put a cap on the amount any jury can award in compensation for pain and suffering. That cap, recently upheld by the California Supreme Court, is $250,000. The inequity is that a brief period of pain and a lifetime of pain now have identical cash values in California.

"But we must start somewhere," von Bolschwing says. "Otherwise the entire medical system could collapse."

"The system is not perfect," says Robert Elsner, executive vice president of the California Medical Association [CMA], "but awards for pain and suffering should aid the injured. They were not intended to go to the heirs." He sees more incremental, structured settlements going to the injured party "during the lifetime" and then ceasing.

"I'm convinced that claims-prevention activity will significantly reduce the number and cost of suits," argues Dr. Allan K. Briney, a private physician who is chairman of the board of governors of LACMA's risk-management program.

"We've reviewed all our claims for the last 10 years, Briney says. "Patient accidents do not follow a pattern except in OB [obstetrics], where there's an automatic suit if the baby is not perfect.

"The problem is societal," Briney believes. "The public expectation [goes] beyond what medicine can provide. There's avarice among legal professionals, with large numbers of lawyers seeking money and a justice system based in many instances on sympathy [for the injured party], not medical fact."

Briney feels that his program does "a great deal of claims prevention and of educating" policyholder/members regarding incidents of malpractice.

But do they practice voluntary disclosure of injuries?

"It depends. If the physician is obviously at fault, we go to the patient. If there's a question of fault, we do not contact the patient. I don't agree that we can tell everyone who [is injured or] hurts himself that he's entitled to compensation. It's not necessarily malpractice," Briney says.

Asked to explain the conflict between his views and PRM's experience with prompt and full disclosure of all known injuries, Briney says he's not familiar with the PRM program but that there are sure to be differences between any hospital system and a private-practice system of risk management. "It depends in part on definitions, including, 'What is a potentially compensable injury?' "

"I can't see the connection—we don't operate hospitals," says Howard Williams, VP for communications at Physician Insurance Management Corp. in Orange, Calif. PIM has the same relationship to Briney's organization as PRM has to the Los Angeles County health-care system.

Agreeing that the discrepancies could lie in definitions, Williams explains, "Briney and we would be surprised if no-fault saves money . . . but I'd need to know more about the [PRM] data.

"About 75 percent of claims are dropped or tossed out [by the courts]," he says. "About 8 to 9 percent go to court because of a dispute on liability or because they ask too much; and we win 80 to 90 percent of the cases tried. The balance—about 15 to 16 percent—are valid and settled."

PIM's statistical base might not be reconcilable with PRM's, Williams feels, because of further complications between two main types of policies. An occurrence policy covers anything that might happen to a given physician in a year, whether or not revealed and claimed in that year. A claims-made policy covers actions filed in a year whether or not the injury occurred in that year.

Is a policy based on claims-received substantially cheaper?

"Not in the long run," says Williams, although it's cheaper initially because "only 15 percent of all claims [ultimately received] are received in the first year, 45 percent in the second year, and 15 percent in the third year. Finalizing could take up to 10 years—the 'long tail.' "

How can that be reconciled with PRM's actual experience that the "long tail" disappears with full and prompt disclosure?

"I'm not sure," Williams says, "but I'll look into it."

Does the insurance industry itself want to know the facts on a comprehensive, nationwide scale?

The National Association of Insurance Commissioners, based in Kansas City, recently completed a 3½-year study of 71,000 medical malpractice cases. The published version of the $50,000 study did not sell enough copies at $200 each to offset its cost. The copies are now discounted to $100, and the study is not likely to be repeated.

One complaint of the insurance companies is that the long judicial process can prevent the closing of any particular year's records for a decade or more. That results in part from some judges' willingness to accept late claims on discovery of injury, regardless of the time elapsed.

Insurance companies would like a definite cutoff date, or statute of limitations, on malpractice suits, but that could encourage the concealment of patient injuries and could saddle the injured patient with a lifetime of bills rather than fair compensation.

On Feb. 6, 1986, the Illinois Supreme Court approved a four-year limit to filing claims on incidents that occurred before the passage of the law.

Yet in the experience of PRM, that long wait between injury and claim evaporates under a policy of full and prompt disclosure because virtually all legitimate cases are identified and acted on early; the rest are opposed in court. Few legitimate claims escape detection, "and our willingness to fight discourages nonmeritorious claims long after the fact," says von Bolschwing. "There are many benefits to honesty and human consideration."

But the insurance industry is not alone in lacking an appreciation for a people-oriented approach to medical malpractice. In 1978 a group of leading physicians and hospital administrators, conferring on patient safety, recommended expanded human-relations programs, incident-review panels and discipline for defaulting practitioners, among other quality-assurance measures.

The report, "Sharing Responsibility for Patient Safety," was signed by the American College of Surgeons, the American Hospital Association and the American Medical Association—but only after key recommendations on human relations and accountability were removed from it by the AMA.

It is evident that individual professionals were prepared to act on the 1973 HEW report, although their professional societies were not.

The professional societies—both health-care and legal—correctly deny having the power to establish national policy, but they overlook their power to influence that policy with pilot programs, such as the one in Los Angeles.

Aside from these questions, there are currently three kinds of professionals who deal with the human side of malpractice, patients' rights. They are patient representatives, patient advocates and crisis interventionists. The patient rep tries to assist injured patients, the patient advocate fights for restitution after injury, and the crisis interventionist is authorized to interrupt an event or process to prevent injury from happening in the first place.

The National Society of Patient Representatives [NSPR] of the American Hospital Association sees the patient rep as "a generalist, listener and communicator who serves as a liaison between patients and the hospital staff." A business organization might call it customer rela-

tions or customer service. When a problem occurs, the patient rep tries to work things out for the ultimate benefit of the company [the hospital], which wants the customer to be satisfied and not sue. Reps can and do propose policy changes to eliminate problems.

A patient advocate speaks first and foremost on behalf of the patient/customer, even if it means opposing the hospital. This form of service is related to the governmental concept of the ombudsman, who cuts through red tape to win restitution if necessary. It is a difficult position for any hospital employee to be in, since the system he opposes also pays his salary. However, some patient reps occasionally perform this type of function.

The AHA and its NSPR, now 15 years old, still do not have a set of performance or educational standards for patient representatives. Each hospital develops its own sets of policies, duties and authority for its patient rep.

At present NSPR has about 1,000 members, and perhaps 55 percent of the nation's 6,000 hospitals can say they have a functioning patient-rep program.

An innovator, NSPR's first president, Ruth Ravich, linked her hospital social-services wing at New York's Mt. Sinai Hospital in 1967 with the professional medical staff to create the first formal patient-rep program in the nation. It operates independently of, but in concert with, the hospital's quality-assurance departments in charge of loss prevention.

In a 1969 journal article, Ravich wrote: "A patient-rep program requires the freedom to negotiate with heads of medical and administrative departments and the ability to act as catalyst for necessary changes in the system."

That's still true, she says. "Dealing with the patients is the easy part. Dealing with administration and defensive heads of departments is the difficult part and takes special skills. On paper, a patient rep has little power at all, so we must gain the cooperation of staff" and work through the designated authorities. She operates a 24-hour hotline so the staff can report incidents that need attention.

Ravich believes skill levels are rising together with education levels. She says most current NSPR members have at least a bachelor's degree in social work, and perhaps 25 percent have earned a master's degree.

Opening lines of communication with the patient is still the first order of business. "If the hospital shows concern after an incident or accident, then [patients] can understand," Ravich says. Yet some hospitals will bill the patient for treatment to correct the injury caused by treatment, even if it was the hospital's fault. "Patients can't go home with an extra bill—that triggers [lawsuits]," she says. Some hospitals choose to have patient reps deal even with those patients who intend to sue; the Mt. Sinai reps do not.

Programs are not standardized. Each is developed to meet the perceived needs of the given facility.

"Our function is to enhance communications, address problems raised and settle them amicably," says Henry Taylor, director of Northwestern Memorial Hospital's patient representative program. "We stay in constant touch with the physicians, but we don't police." Any professional discrepancies would be "left to peer review."

At Evanston Hospital there is no patient-rep staff, although one is being developed, according to Catharine H. Weiland, head of the hospital's complaint program.

She views herself as a "patient advocate and facilitator." Patient and staff "can communicate initially in person, if they like, but ultimately in writing."

"We respond in writing after researching and solving the complaint. I'm an intermediary. I listen to both sides and make a decision." A good portion of her time goes to "questions of courtesy, efficiency or billing. People want to be listened to. If a problem has legal implications, it is not necessarily brought to the hospital's attention through this mechanism but tends to go through our risk-management department."

Might a medical procedure be stopped by crisis intervention?

"Theoretically anyone could stop a procedure," Weiland says. "Also, any employee could fill out an incident report for peer review. We operate on checks and balances."

Yet the filing of incident reports and peer reviews generally happens *after* the incident or injury. In the opinion of one of the nation's first crisis interventionists, working professionals should be so sensitized to human needs as to avoid common errors.

"Some professionals are compassionate by nature," says the Rev. Robert Holderby, "but others perform by rote in what they perceive to be the stereotypical role: distance, and emotionally unreachable efficiency." Holderby pioneered crisis intervention in hospitals in Chicago and later worked on programs in Los Angeles.

"To the professional in the healing arts, compassion and empathy for the 'whole' patient aids the healing process and is therefore efficient and effective professional practice. Once this is made clear, most of the [reluctant members of the] staff change their viewpoint and their attitudes," he says.

That philosophy was echoed in more practical terms by PRM's Heckman. "Risk managers know," he says, "that emotionally sterile individuals can cause unnecessary or avoidable injuries. Some professionals feel, 'If I goof—well, that's what the insurance is for.' They don't feel a responsibility for the person who might be injured."

Crisis intervention was virtually unknown back in the mid-1960s when Holderby found himself constantly in hospital emergency rooms or at the scene of tragedies and crimes as the Protestant chaplain of the Chicago Police Department.

Tolerated in most inner-city hospital emergency rooms because of his position and familiar with standard procedures because of his Navy experience as an operating-room aide, Holderby repeatedly challenged medical professionals who he felt were psychologically abusing their patients. He admonished staff who shouted at or taunted patients about their fears. At times he stopped incidents of physical abuse of patients already in pain.

He tells of intervening when an emergency-room doctor used an adult-sized speculum [vaginal dilator] to punish an 11-year-old rape victim who was resisting the doctor because of her fear of more pain.

An elderly woman became so distraught with an emergency-room resident's gruff commands to relax that an unusually heavy set of weights failed to pop her dislocated shoulder back into place. The next step would have been general anesthesia, more weights and more residual pain.

When Holderby began to talk with her, the resident physician asked, "What are you going to do—pray it in?" Holderby kept talking; the patient became engrossed in the conversation and relaxed; within a few minutes, the shoulder returned to normal.

Staff attitude governs these situations, Holderby believes. Although he's willing to practice human concern while others practice medicine, Holderby insists, "Ideally, staff would do both—I wouldn't be needed."

In Holderby's view, physical and emotional pain are equally serious. "It's unfair and unwise," he says, "to let an injury progress if the damage can be rectified or contained on the spot."

Despite staff objections to his presence, Holderby was first tolerated and then welcomed by hospitals because the patients were responding favorably to his help. His clerical training in psychology and the related social sciences enabled him to reassure the frightened ["It's normal to be a little scared. . ."] and comfort the aggrieved.

He did simple things, too, explaining routine delays to the weary and reading medication instruction to those patients he felt were too proud to admit they couldn't read.

Holderby's service as a crisis interventionist was an unpaid, self-appointed ministry.

In 1968 the late Dr. T. Howard Clark, then chief of professional staff at Illinois Masonic Medical Center, gave

Holderby a paid consulting/teaching contract.

Soon he was officially accepted at Cook County, Jackson Park, Henrotin and Mercy Hospitals. And Michael Reese Hospital and Medical Center, on Chicago's Near South Side, became the volunteer Crisis Ministry's home base long before Holderby was formally hired there.

In 1969, before the July 4th weekend—always a busy time in hospitals—Reese initiated an ombudsman program in its emergency room and ambulatory clinic. Reese appointed two highly regarded community residents as the first staff ombudsmen, and Holderby trained them. They were Christine Leak, R.N., a veteran of field-combat nursing, and Mahon "Gam" Washington, a retired businessman. Both now deceased, theirs proved to be the nation's first such posts with authority to intervene in questionable situations. Both did, on occasion; and both told of being called turncoats and spies by a few indignant staff.

Leak said she wondered whether she indeed helped reduce the number of injuries, since, she felt, "some staff members figured that now it was somebody else's job, so they didn't have to worry about patient safety." The program was abandoned in the early 1980s in an economic cutback. Reese continues to operate a traditional patient-rep program, begun in the early 1970s.

"We know the patient rep program is not doing what Holderby was doing," says Ivan Dee, Reese's director of community relations. But if attention from a patient rep prevents a lawsuit following a confirmed injury, that's a firm statistic; whereas an incident prevented never enters the records. Therefore, according to Dee, "the statistics on crisis intervention were not easily proved in a time of dollar shortage. Both are needed; and the time might come when we would want to take that approach again."

Reese saved more than one-third in litigation costs during the early years of the crisis-intervention program, according to Max Brown, then a Reese staff attorney. The Los Angeles risk-management program saved 40 percent in litigation fees. Crediting the cost saving to good human relations, PRM also hired Holderby for its staff-education program.

Because of this remarkable parallel in experiences, Holderby is convinced that what's good for the patient is good for the hospital. "Reese began with an altruistic motive," Holderby says, "and found that they were saving money. PRM intended to save money fairly and found that the more humanistic they became, the more they saved."

Still, he doesn't believe that a competent crisis-intervention program would be easy for every hospital. A crisis interventionist needs two capabilities, he believes. First, the formal training to deal with traumatic situations, both physical and emotional. Second, the authority to intervene directly in an untoward event in progress. Few—perhaps none—of the AHA patient reps now have such authority. Any employee can report any incident through channels, of course.

Intervention was and remains the critical distinction between the two approaches. Holderby participated in early patient-rep programs at AHA's invitation, and he believes that AHA will move toward prevention of injury as its goal.

PRM's von Boschwing agrees. "If there were more Holderbys available, there would be fewer problems."

It seems likely that federal law will take the nation's health care in a more responsible direction whether or not the health-care and legal organizations participate. Legislation is pending to encourage or require the health-care industry to gather and act on the best evidence about medical malpractice available [much of which exists today in California] and also to provide a cooling-off period to restrain impetuous legal action by patients.

In Congress a Medical Offer and Recovery Act is being sponsored by Reps. Henson Moore [R., La.] and Richard Gephardt [D., Mo.] that would prohibit patients from filing medical malpractice suits for six months if settlements are offered voluntarily. That incentive to the health-care industry should help to encourage early and full disclosure of injuries, although a patient would still have the right to go to court to try to increase the settlement offer.

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Another bill, introduced in the Senate by Sen. Ron Wyden [D., Ore.], would require that all malpractice verdicts be tracked by physician's name and kept on file in Washington. Hospitals would be required to investigate a physician's credentials before hiring. Computer tracking of malpractice cases became law in New York in the closing months of last year.

In 1985 the U.S. General Accounting Office began a statistical survey of privately held data related to medical malpractice, endeavoring to reconcile all the different ways incidents are counted and classified.

A key weakness of the GAO survey is that of the health-care industry itself: The sample comes from 25 insurance companies selling malpractice insurance in 1983. It includes 1,700 cases from among all their claims *closed* in 1984, which still cannot measure *all* the incidents of injury or even negligence.

PRM's database is among those being surveyed, but the GAO's project is not intended to count or estimate total numbers of patient injuries as a proportion of admissions.

There is value in it nevertheless. The first GAO report, published in February, 1986, identifies alternative compensation systems that would reduce the number of lawsuits filed. Among the alternatives are screening panels, binding arbitration and other devices used to determine fault and monetary compensation and no-fault-based procedures including no-fault medical malpractice insurance for doctors, medical adversity insurance for patients and social insurance approaches like those used in Sweden and New Zealand to compensate injured patients, whatever the cause of injury.

The second of five reports, released in late summer, focused on medical malpractice insurance costs and related issues.

Once industry statistics are reconciled, it will be easier for the public to compare those claims-related results to the Mills/PRM patient-related statistics. Then it might be possible for the industry to understand the patient's point of view and provide for just compensation under voluntary disclosure.

But attitudes cannot be legislated. Health-care professionals will need more education—and in some instances, re-education—in human relations, and the public will need to learn it has responsibilities and risks, too.

Although health-care professionals constantly tell the public not to expect TV's miracle-of-the-week, that message isn't sinking in, Holderby believes. "It would be far more productive for the public to understand that medicine is not risk-free and that patients must share risks inherent in the practice of medicine."

A full explanation of the problems, dangers and treatment alternatives facing the patient is known as informed consent, but critics feel that many patients who sign on the dotted line are not fully informed and therefore resent unexpected complications, even if the physician and institution are blameless.

Holderby's latest project is a nondenominational seminar program in crisis intervention and counseling for the clergy. Member of the clergy generally lack the degree of training in trauma counseling given to hospital chaplains, even though they often encounter similar crises.

The ultimate education must be social, Holderby believes: "Only public awareness and the demand for reforms will solve the human problem."

If every 21st patient is hurt under the current system, are we ready to change the system?

We are attempting to pay all costs of medical care through user fees. We do not fund our police and fire departments through user fees—we consider that all of us benefit equally by the security provided. So we tax. Also, our orchestras, opera companies and museums are applauded for running a deficit in order to keep ticket prices low enough to let virtually anyone in. Community fundraising pays the debt.

Hospitals are not immune to budget problems. Somewhere between the utilitarian fire department and the arts complex lies a workable approach to national health. ■

United States
General Accounting Office
Washington, D.C. 20548

Comptroller General
of the United States

B-221239

May 20, 1987

The Honorable John Heinz
Ranking Minority Member, Special
Committee on Aging
United States Senate

The Honorable John Edward Porter
House of Representatives

Over the past 2 years, at your request, we have issued a series of reports presenting information relating to increases in the cost of medical malpractice insurance. Those reports have provided us a basis for presenting in this, the final report on the subject, our conclusions, recommendations, and suggestions.

More than anything else, our work has convinced us that actions need to be taken by all groups affected—physicians, lawyers, hospitals, insurers, and patients—if we are to see progress in addressing the problems. Debate on the medical malpractice problem has often become very emotional. Who cannot have compassion for a person who has suffered a serious permanent injury as a result of a particular medical procedure? But given the advances in medical technology, the difficulty of procedures that would not even have been attempted 10 or 15 years ago, what degree of perfection should we expect from our medical community? These types of issues are not resolved merely by increasing our knowledge of what the data show about a particular problem. They strike at the heart of the ethics and values that are a part of our society. Our conclusions, recommendations, and suggestions are designed to further the debate on how states and the federal government may want to look at the issue. We believe carefully contemplated actions can have a positive effect.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to the Secretary of Health and Human Services, the Attorney General, appropriate committees and members of Congress, and leaders of state legislatures, as well as other interested groups and individuals.

Charles A. Bowsher

Charles A. Bowsher
Comptroller General
of the United States

Executive Summary

Purpose

Increases in the costs of medical malpractice insurance over several years resulted in Senator John Heinz and Representative John Edward Porter's requesting that GAO assess the nature of the problems, how various states have tried to deal with them, and what federal and state actions may be warranted.

The purpose of this report, the final one in a series of five, is to suggest actions that appear to GAO to be appropriate beginnings to address medical malpractice problems.

Background

Malpractice insurance costs for physicians and hospitals rose from $2.5 to $4.7 billion from 1983 to 1985. As a percentage of average gross business expenses, insurance costs for physicians rose from 8 to 10 percent during this period. For physicians in certain specialties, costs increased more. About 43 percent of the medical malpractice claims closed by insurance companies in 1984 were closed with an indemnity payment. Eighty percent of the injuries occurred in hospitals, and about 71 percent of the providers involved were physicians. The average payment for injury was about $81,000. The median payment was $18,000.

Medical malpractice affects us all in one way or another—either through injury or increased costs to health care providers, insurers, or consumers. Even though the injured party is compensated for such injuries, the real hurt or damage cannot be fully measured. The damage to an accused health care provider can also not be fully measured even when the provider is found not to be at fault.

A key policy question to be addressed is who or what is responsible for medical malpractice problems. Is it physicians who are negligent? Is it insurance companies trying to get higher profits? Is it lawyers bringing suits to increase their income? Is it patients who have unreasonable expectations of medical procedures and health care providers? Is it the system for resolving claims?

Results in Brief

Overall, GAO's work showed that there is no clear answer as to the causes of the increases in the cost of medical malpractice insurance. And there is no specific action that GAO could identify that would guarantee that insurance rates will not continue to increase. But there are actions all affected parties could take that may have some promise of reducing the cost of insurance.

These actions include reducing the incidence of medical malpractice by assuring that physicians are held accountable by their peers and others for the manner in which they practice medicine; improving efficiency, predictability, and equity in the way medical malpractice claims are resolved (by determining appropriate changes in state tort laws or developing viable alternatives to the tort system); determining the extent to which regulatory agencies have and use information to make decisions about rates and solvency; and better educating patients as to what their expectations should be from the health care system.

Those taking such actions, particularly concerning the tort system, must consider the consequences of these actions on the injured. Policymakers must give serious consideration to the inherent trade-offs any solution will have since most potential solutions to the problems are at the expense of one or more of the affected parties.

GAO Analysis

Reducing Medical Malpractice Incidence

Eliminating, to the extent possible, the conditions that lead to malpractice is the ideal way to deal with the problem of increasing insurance costs. Doing this requires aggressive action at the state level and by the providers of health care, primarily physicians and hospitals.

For example, state legislatures, where they have not yet done so, could require health care providers to participate, as a condition of licensure, in risk management programs, which are designed to educate providers about better ways of delivering an acceptable quality of health care to help minimize the possibility of malpractice suits. (See pp. 16-18.) Physicians and other health care practitioners could also be more aggressive in assuring that the members of their profession are adequately trained, supervised, and, where appropriate, disciplined. Past reports have shown that relatively few physicians and other practitioners are disciplined by appropriate professional or state agencies. (See pp. 13-15.)

In 1984 GAO reported that a health care practitioner licensed in more than one state could have one of those licenses revoked or suspended by a state licensing board, but could relocate to another state and continue to treat patients. H.R. 1444 and S.661, currently being considered by the Congress, would nationally exclude these practitioners from participation in Medicare and Medicaid. (See pp. 15-16.)

AMA/Specialty Society Medical Liability Project

a coordinated effort by America's physicians to address professional liability

Steering Committee

American Academy of Family Physicians
American Academy of Orthopaedic Surgeons
American College of Cardiology
American College of Obstetricians & Gynecologists
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Society of Nuclear Medicine
Society for Vascular Surgery

<u>For Release January 13, 1988 at 11:00am</u>

MEDICAL GROUPS OFFER PROPOSAL TO RESOLVE MALPRACTICE CRISIS

For further information, see attached list of Medical Association Representatives

Washington, D.C. -- A radical proposal to resolve medical malpractice claims fairer and more efficiently was unveiled today by the American Medical Association and 32 national medical specialty organizations (The AMA/Specialty Society Medical Liability Project).

The proposal calls for a fault-based administrative system, under the jurisdiction of strengthened state medical boards or a new state agency, which would totally replace the existing court/jury system. It is proposed at this time only as one promising alternative to the tort system -- an alternative that needs to be tested in one or more states before it can be proposed broadly as a solution to the continuing problem of medical professional liability.

"Organized medicine is not abandoning the court system or traditional tort reform, but we have an obligation to patients and physicians to experiment with different approaches to medical professional liability", says James S. Todd, M.D., Senior Deputy Executive Vice-President, speaking on behalf of the AMA/Specialty Society Medical Liability Project, an umbrella group which has been studying possible long-range solutions to the continuing medical malpractice problems.

Dec 7, 86?

"We have worked for over a year with a unique coalition of lawyers, physicians and public policy experts -- inside and outside of organized medicine -- to design what is above all a fair system -- fair to the patient, the physician and the public. We believe that more patients injured by medical negligence will be compensated under this plan, but that fewer dollars will be spent on meritless claims and unnecessary transaction costs," Dr. Todd explains.

Top sheet of seven pages. Accomplished what?

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