Medical Malpractice: A Dilemma in the Search for Justice

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MEDICAL MALPRACTICE: A DILEMMA IN THE SEARCH FOR JUSTICE

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Having been invited to write an essay on medical malpractice for the Law Review, I vowed to avoid the opprobrious conduct currently in vogue with lawyers and physicians. The search for justice on behalf of injured patients deserves more than recriminations. It demands our best introspective thoughts, examining the causes and searching for solutions that will bring justice for patients, physicians, hospitals, attorneys, and society in general.

I. A BRIEF HISTORY

A. From Babylon to London

Throughout history, every civilized society has had medical healers, under some name or other. In earliest recorded time, these medical healers were perceived to have a special relationship with the gods; later, they professed to have some special knowledge which exceeded that of the lay person. For that reason the society would grant them special privileges in performing medical or surgical treatment upon others. Recognition of the potential for the harm or abuse resulting from unbridled privilege led to regulation of medicine in every society. The Code of Hammurabi from ancient Babylon was the first codified principle of law. Criminal law was guided by the principle of lex talionis — the eye for an eye, tooth for a tooth, concept. Medical practice was included under this principle, and carelessness and neglect were severely punished as a clumsy surgeon might lose both hands for a maiming opera-

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tion. The ancient Egyptians had specialists for various parts of the body, and if they wandered outside their special area of expertise or varied from the specifically prescribed modes of treatment, untoward results were punishable by death.

The historians of classical Greek culture have arrived at the conclusion that there were no legal mechanisms whereby those injured by a physician, or relatives of a deceased, could seek legal redress. One historian explained that the ultimate penalty for a physician was ill repute. This remedy was of little solace to patients and their relatives and confuses today's legal scholars, because in that society even homicide was the subject of private suits. There was, however, a theoretical consideration of malpractice as arising from willfulness, negligence, or ignorance. Plato's thinking on the subject of ignorance as a cause of injury by physicians is apropos even today. He said ignorance falls into two categories: (1) simple ignorance causing minor errors; and (2) the double ignorance occurring when the physician is gripped not only by ignorance but also by a conceit of wisdom for things the physician knows nothing about.

The Greeks furnished the great ideas, but the Romans translated them into practical use. The Romans distinguished between dolus (evil intent), culpa (including both negligence and incompetence), and casus (accident). Dolus fell under the intentional action of willful, intentional harm. Culpa and casus came under unintentional action. The complex ambiguities of these concepts were a source of much legal ink for the Romans, as it is today. The Romans did recognize that there might be potential for harm without evil intent and established specific, albeit limited, provisions for seeking redress against the negligent or incompetent physician.

During the period 400 A.D. to 1300 A.D., the admixture of religion and medicine created the sense that disease was

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3. See Amundsen, supra note 2, at 175. It is interesting that both Plato and Aristotle believed that physicians' actions could be best judged by other physicians.
4. See id.
punishment for evil. Since there was virtually no rational medical treatment in this period, death and injury were considered the will of God and not to be questioned. This was a poor time for physicians and lawyers, as well as patients.

In fourteenth century England malpractice was closely interwoven with the theory of contract.\(^5\) Physicians were commonly retained for set fees to provide care to wealthy personages or monastic groups, and suits arose when a physician would not travel to advise and examine them\(^6\) or when a patient would stop paying the retainer fee.\(^7\)

In England, the first classical malpractice case was recorded in 1375.\(^8\) Although the surgeon was acquitted on a technicality, the judge stated that the surgeon indeed would have been liable for negligent treatment of a wound. By 1435 a second medical opinion was compulsory in London for "critical" cases.\(^9\) Master surgeons and physicians were appointed by the mayor to conduct peer review of their profession and to be available for consultation prior to the treatment of these cases. They were also called to testify in recorded malpractice suits. Some surgeons began taking out malpractice "floater" policies on individual patients prior to treatment that might lead to death, serious injury, or accusations of malpractice.\(^10\)

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5. For a discussion of the relationship between the medieval medical practitioner and early vestiges of the common law, see generally Post, Doctor Versus Patient: Two Fourteenth-Century Lawsuits, MED. HIST., July 1972, at 296-300.
6. Having been paid, the physicians would not make house calls.
7. These cases presage current health maintenance organizations (HMO) contracts by 600 years.
10. See id. at 161.
B. In the United States

The oldest recorded American medical malpractice litigation occurred in 1794 in Connecticut.\textsuperscript{11} There were twenty-seven malpractice suits in the United States between 1794 and 1861 that were adjudicated as appeals in various state supreme courts and thus available for review.\textsuperscript{12} Two-thirds of these suits involved injuries relating to orthopedic problems: fractures, amputations, and dislocations. Five involved obstetrics. This review is interesting because the malpractice suits then as now are a reflection of the predominant surgical practice of the time.

The concept of medical negligence began to evolve from the unintentional tort of negligence in this period. Courts upgraded physician responsibility for the care of their patients and expected doctors to practice up-to-date medicine. Physicians were alarmed at the increase in malpractice claims, and it is believed that some practitioners stopped their surgical practice because of the threat of malpractice.\textsuperscript{13}

With the introduction of anesthesia in 1846, the practice of surgery expanded to operations within the abdominal cavity and was no longer primarily orthopedic and superficial-infection therapy. Over the next forty to eighty years, operations became standardized with predictable mortality and morbidity. By the 1920s hospitals began to provide more sophisticated laboratory equipment to analyze blood and urine, as science crept unobtrusively into patient care. In the latter half of the nineteenth century, malpractice claims continued, but

\begin{enumerate}
\item \textit{See} Reed, \textit{supra} note 1, at 53 (discussing Cross v. Guthrie, 2 Root 90 (Conn. 1794)). In \textit{Cross}, a husband sued a physician for the death of his wife who was undergoing a mastectomy. He alleged unskillful, ignorant, and cruel treatment.
\item \textit{See} Burns, \textit{Malpractice Suits in American Medicine Before the Civil War, Bull. Hist. Med.}, Jan.-Feb. 1969, at 42. One of the suits originated in a Racine, Wisconsin circuit court in 1853. \textit{See id.} at 43-44 (citing Reynolds v. Graves, 3 Wis. 371 (1854)). During this period, Abraham Lincoln had been a defendant's attorney in a malpractice suit. \textit{See} Letter from Clark Heath to editor, \textit{New Eng. J. Med.}, Sept. 23, 1976, at 735-36. The letter refers to a quote attributed to Lincoln in defense of the accused surgeons: "Mr. Fleming, instead of bringing suit against these surgeons for not giving your bone proper attention, you should go on your knees and thank God and them that you have your leg." \textit{Id.} at 736.
\item \textit{See generally} J. Elwell, \textit{A Medico-Legal Treatise on Malpractice and Medical Evidence, Comprising the Elements of Medical Jurisprudence} (1860). Elwell published the first systematic review of American malpractice claims and recognized that they had become a part of American medicine.
\end{enumerate}
the numbers are difficult to ascertain. What was evolving legally was the elevation of standards set by the courts.¹⁴ Physicians were originally held to the standards of their type of medicine, that is, homeopathy, allopathy, and the like. But as medicine became more scientific, all practitioners were held to certain minimal local standards. *Pike v. Honsinger,*¹⁵ an 1898 case in the New York Court of Appeals, stated the principles that with some modification provided standards and precedent for cases since then. Over the years, there was a change from local standards of care to national standards of care.

Between 1935 and 1955, there were 605 malpractice cases in the United States, an average of thirty-one cases per year.¹⁶ In this period, California was the leader with almost seventeen percent of all the cases, followed by New York, Washington, Ohio, and North Carolina.¹⁷ Fifty percent of cases were from eight states.¹⁸ Between 1945 and 1949, the fewest number of cases occurred, and the largest judgment was $115,000.¹⁹ This was the calm before the storm.

The advent of antibiotics in the 1940s and the scientific technological revolution left no area of the body unexplored, surgically or medically. Truly for the first time in the history of medicine, physicians had a greater chance of helping patients, rather than hurting them, with treatment. The science of medicine exploded, as laboratory tests and x-rays increased diagnostic ability and added greater accuracy and quantification of disease states. Physicians became more accountable for what they did, and their interpretation was more easily questioned by attorneys who could also review the same objective data and assess the physician’s interpretation of results. The number of claims continued to rise, and by the 1970s physicians perceived the increase in the number and the size of claims as a threat that instigated job actions, strikes, and sit downs. It was called a crisis. However, a crisis can be a truly

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¹⁵. 155 N.Y. 201, 49 N.E. 760 (1898).
¹⁷. See id. at 368.
¹⁸. See id. at 369.
¹⁹. See id. at 381.
marvelous mechanism for the withdrawal or suspension of established rights and the acquisition and legitimization of new privileges. Indeed, there was a problem, as hospital malpractice premiums by 1976 were $1.2 billion per year, up from $61 million in 1960.\textsuperscript{20} Physicians' premiums were skyrocketing, the number of claims was continually increasing, and this environment led to a "siege mentality." By 1975, the primary concern was the unavailability of liability insurance.

In 1973, the Department of Health, Education, and Welfare's Malpractice Commission strongly recommended pretrial screening panels as the primary method for speeding resolution of medical liability claims and eliminating nonmeritorious suits.\textsuperscript{21} Many states reacted with legislation in about 1975. In Wisconsin, the legislature, in an attempt to get justice for physicians, patients, providers, and attorneys, set up the Patient's Compensation Panel and the Patient's Compensation Fund. The intent was to require that allegations of medical malpractice against a Wisconsin health care provider be heard by a panel prior to the filing of a circuit court action.\textsuperscript{22} The Patient's Compensation Fund was created for the purpose of paying the portion of the settlement or award against the health care provider in excess of the insurance coverage required to be procured privately by all health care providers — $200,000 per claim and $600,000 in aggregate claims per year.\textsuperscript{23} Has the panel system been helpful to all or has it been solely for the protection of providers — physicians and hospitals?

\section*{II. The Problem}

From July 1, 1975 to June 30, 1984 a total of 2,012 malpractice claims were filed with the compensation panel in Wis-

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\textsuperscript{23} This fund is paid for by the providers' contributions.
consin, more than fifty percent in the last three years.\textsuperscript{24} Obviously, the incidence of claims has risen precipitously. Malpractice premiums for providers dropped initially, then rose dramatically as the frequency of claims and the size of awards and settlements grew.

Not only has this affected physicians, but these costs were passed on to patients leading to higher health care costs for every citizen of Wisconsin.\textsuperscript{25} Today, professional liability insurance adds about $3 to the cost of a visit to a physician, $5 per day to the average hospital bill, and up to $300 to the cost of some births.\textsuperscript{26} In Wisconsin, medical liability premiums totaled $27.9 million, and it is estimated that the accompanying defensive medicine — ordering all possible laboratory and x-ray tests in fear of reprisal — adds approximately $240 million to the Wisconsin health care bill.\textsuperscript{27}

In this climate, malpractice attorneys are crying for the abolition of the compensation panel citing four main reasons.\textsuperscript{28} They claim that the panel system: (1) causes unnecessary delay in final disposition of a claim; (2) is biased because there are two physicians, one attorney, and two lay persons on a formal panel; (3) produces findings which have a "chilling effect" on any circuit court trial; and (4) protects repeat offender physicians about whom nothing is done. Let us now examine these arguments carefully.

\begin{table}[h]
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\begin{tabular}{|c|c|c|c|}
\hline
Year & Claims Filed & Claims Paid & Average Paid/Claim \\
\hline
1978 & 145 & 4 & $138,064 \\
1980 & 262 & 10 & $203,353 \\
1982 & 413 & 18 & $238,022 \\
1983 & 376 & 25 & $426,672 \\
1984 & 451 (projected) & & \\
\hline
\end{tabular}
\caption{Wisconsin Compensation Panel Experience}
\end{table}

\textsuperscript{24} See Wisconsin Legislative Council Staff, Data Relating to Medical Malpractice, Informational Memorandum 84-25, Aug. 7, 1984, at 3 [hereinafter cited as Legislative Council].

\textsuperscript{25} Wisconsin Compensation Panel Experience

\textsuperscript{26} See State Medical Society of Wisconsin, Report to the Legislative Council Special Committee on Medical Malpractice, Sept. 4, 1984, at 3 [hereinafter cited as SMS Report]. SMS information was obtained from the Patient's Compensation Fund.

\textsuperscript{27} See id. at 2.

\textsuperscript{28} See, e.g., The Medical Malpractice War, Nat'l L.J., Aug. 27, 1984, at 1.
Does the panel system cause unnecessary delays? The facts say no. Panel cases disposed of before a hearing have a median age of 362 days, while similar cases in circuit court require 532 days. The median age of panel cases resolved through the hearing process is 391 days, while circuit court trials last 655 days. Once opened, a case is usually resolved within one year. For informal panels reviewing smaller claims, eighty-five percent are settled in less than one year. For formal panels reviewing larger claims, sixty-four percent are disposed of in less than one year and an additional twenty-two percent are disposed of in less than one and one-half years. Before the panel system was instituted in 1975, it took an average of two years for a Wisconsin claim to be resolved; now it has been cut to less than one year.

Indeed, any delays are due to lawyers and Wisconsin's three year statute of limitations. Indiana and Wisconsin have the same incidence of malpractice claims, yet Indiana attorneys get matters on file one year sooner because they have a two year statute of limitations. And when a one year statute of limitations existed in Ohio, the claims also were filed on time.

Thus, the lawyer's argument does not withstand scrutiny, as indeed the panel system has effectively decreased the time to resolution for patients. The system has not been perfect, but with 1,152 claims filed in the last three years, the panel system was physically unable to meet its original goals. It is to the panel system's credit that it still resolves claims sooner than before its existence.

Is the panel system biased? Of the 1,512 closed claims, case disposition has been evenly divided between claimants and physicians. Fifty-six percent of all claimants received some compensation through the panel system, as either pre-hearing settlements or panel awards. In fact, claimants in Wisconsin are more likely to be compensated than claimants

29. See SMS REPORT, supra note 24, at 21 (figures exclude Milwaukee County).
30. See id. (figures exclude Milwaukee County).
31. See MEDICAL PROTECTIVE COMPANY, PROFESSIONAL LIABILITY IN WISCONSIN, Sept. 4, 1984, at 4 (presented to the Wisconsin Legislative Council).
32. See id. at 4-5.
in other states.\textsuperscript{34} Nationally, in the years 1975 to 1978, claimants prevailed in jury trials fourteen percent of the time, while in Wisconsin panel hearings, claimants won thirty-one percent of the cases.\textsuperscript{35} These data hardly support the bias claim. Claimants in Wisconsin utilizing the panel system are twice as successful as plaintiffs in jury trials.

Does the panel system produce a "chilling effect"? In the establishment of the panel system, the legislature allowed the findings of formal panels to be admitted in a subsequent circuit court trial. Lawyers feel this admission has a "chilling effect" on later trials.

In Wisconsin between 1975 and 1981, a review of ninety-five panel findings that were in favor of the physician revealed that twenty-three were ultimately settled with payment to the claimant.\textsuperscript{36} Thus twenty-five percent of physician panel victories were ultimately settled with payment to the claimant when the insurance companies ignored the panel findings. When one remembers that Wisconsin panel verdicts are in favor of claimants more than twice as often as national court verdicts, providers have a greater right to concern than plaintiffs and their lawyers. And since less than ten percent of the panel cases were carried to a jury trial, it is difficult to find much merit in the "chilling effect" claim.\textsuperscript{37}

Finally, are there many "repeat offenders" who are not disciplined? The answer is of great concern for physicians, who would be subsidizing these repeat offenders through premium payments to insurance companies and the panel system. There is no financial or professional incentive to protect repeat offenders. Medical malpractice falls under the broad category of unprofessional conduct. This is a problem because while conduct may be unprofessional it does not necessarily constitute medical malpractice. The way the system works is that complaints to the Medical Examining Board are investigated by an attorney; the board then prioritizes the complaints and decides the course of action. The board may receive allega-

\textsuperscript{34} See SMS Report, \textit{supra} note 24, at 22 (citing study by the National Association of Insurance Commissioners).

\textsuperscript{35} See id. at 23.

\textsuperscript{36} See id.

\textsuperscript{37} See id. at 22.
tions from: (1) the Department of Justice (Medicare fraud); (2) the Federal Drug Enforcement Administration (prescriptions); (3) Department of Health and Social Services (nursing homes); or (4) other physicians, pharmacies, and nurses. Only hospitals and the Patient's Compensation Panel are required to report to the Medical Examining Board. The compensation panel must report negligent providers to the board. A hospital must report the name of any staff member who loses hospital privileges for more than 30 days or resigns from the staff for 30 days or more. However, Wisconsin does not require the reporting of malpractice claims settled without panel awards. For example, from 1975 to 1980, 700 cases filed with panels were settled prior to a panel hearing; thus no reports were issued to the Medical Examining Board. Further complicating the issue is the fact that insurance companies may settle a claim without the provider's approval since the settlement may be less than the anticipated expenses of preparing for a panel hearing. If providers and insurance companies fought all claims, there would be legal delays, a backlog of cases, and increased insurance premiums. These settlements indeed may allow a repeat offender to obfuscate the problem.

A fair solution to this has been proposed by the Medical Society: make all claims settled over $25,000 result in a report to the examining board. This solution would not cause great paperwork for insurance companies. With computer technology, records could be easily kept, and paid claims could be categorized when reported to the board. They could distinguish between cases in which negligence appears to have occurred and those in which the issue of negligence was doubtful, but it was financially expedient to settle.

The Medical Examining Board's division of enforcement has less than five full-time investigators and only two attorneys assigned to work with them. This staff must be increased if one expects two attorneys to review the over 400 claims filed each year. In this way, repeat offenders could be better identified, investigated, and disciplined. The board currently has difficulty even identifying the problem, much less dealing with it; in this area, the Medical Society and trial lawyers are in

38. See LEGISLATIVE COUNCIL, supra note 24, at 3.
39. See SMS REPORT, supra note 24, at 9.
agreement. This does not, however, detract from the panel system’s merits.

The Wisconsin Medical Society does have two recommendations that bear on this subject. First, it advocates that the Medical Examining Board contract with the Wisconsin Medical Society to investigate and review data on offenders. The Medical Society already does this with Medicaid offenders, and there is a great financial incentive for all providers to identify offenders who repeatedly increase every physician’s premiums. There would be no incentive for physicians to cover up, ignore, or subsidize substandard care of patients. And second, the Wisconsin Medical Society has also supported an increase in license fees if that increased revenue would be specifically allocated to pay trained board investigators. This proposal has been offered in two budget bills without being acted upon. The Medical Society has recognized the problem and has proposed some solutions but to little avail.

Although the panel system should not be abolished for the reasons cited by malpractice attorneys, it may still be improved. One improvement would be to utilize, on a rotating basis, retired or reserve judges and a retired physician. They would sit on panels involving the larger claims or those of repeat offenders, and their prestige would lend more authority to their findings. And to obviate any claim of conflict of interest, they should be paid by the state.

III. Patient Care Standards

It would be impossible to deal with all the implications of the present malpractice problem, but there are two scenarios that adversely affect patients, physicians, hospitals, and attorneys. Most reviews allude to a diminution of patient care standards, but do not demonstrate how this will occur. The following two scenarios provide some insight into the evolution of the bigger problem.

A. The Ob-Gyn Scenario

The practice of obstetrician-gynecologists (Ob-Gyn’s) is going to be the first area of patient care adversely affected.

40. *See id.* at 8-9.
Throughout the country, sixty-six percent of Ob-Gyn's have been sued.\textsuperscript{41} The frequency of claims has tripled since 1976, with the rate growing ten percent per year.\textsuperscript{42} In Wisconsin, the current premiums for Ob-Gyn's are $18,600. There is in 1985 an anticipated rise of seventy-five percent on the current basic premium of $8,600 and a two hundred and fifty percent rise on the Patient's Compensation Fund premium of $10,000. If this occurs, the 1985 premium will rise to $15,000 for primary coverage and $25,000 for the fund premium for an estimated total of $40,000.

This malpractice insurance premium will have certain immediate effects on physician fees. Established Ob-Gyn's will pass these costs on to all young parents and those requiring gynecologic surgery. The fear of suits will again raise the cost of defensive medicine. Although this fear is felt to be exaggerated by many, one example may suffice. Neural-tube defects can be detected intra-utero by an expensive, somewhat risky, test that will have to be performed on all women despite the fact that these defects occur in only one in 1,000 newborns. Since Ob-Gyn's are being held liable if they do not suggest this test to an expectant mother, despite the low incidence of this defect, and allow her the choice of abortion, they will be forced to perform a multitude of tests not routinely done. The Ob-Gyn's cannot guarantee a perfect baby for all. This situation is unfair, impractical, and impossible, but it creates a specter in the Ob-Gyn's psyche that is not unreasonable.

In the long-term, Ob-Gyn's will drop out of obstetric practice, leaving lesser-trained physicians and midwives to perform almost all deliveries. Eighteen percent of Ob-Gyn's in Wisconsin have stopped accepting high-risk patients, such as diabetics, hypertensives, and women over thirty-five.\textsuperscript{43} It is all well and good to say that they will be referred to high-risk units in university centers, but babies are not predictable; having to travel long distances will lead to more unattended deliveries. This risk carries an increased maternal mortality rate, and the inaccessibility of this service is going to lead to a


\textsuperscript{42} Id.

\textsuperscript{43} See \textit{SMS REPORT}, supra note 24, at 6.
greater maldistribution of medical resources. Fewer new physicians will be able to afford the insurance to start practice, and within ten years there will be fewer Ob-Gyn's available throughout the state. This will adversely affect the children and grandchildren of every person in Wisconsin.

B. Federal Scenario

Standards, rules, and regulations have usually been the domain of the individual states. However, as total health care costs have escalated, the federal government has been seeking ways to contain costs. The greatest concern is that looking at medical care through a financial tunnel may lead to health care as a commodity provided by the government at the lowest cost and not as a commitment to excellent care for all.

The establishment of DRG's is the first step, already in effect. A DRG is a form of reimbursement to hospitals by disease related groups. Diseases are categorized, and a prescribed number of hospital days are reimbursed for each category. It is hoped that this may work to eliminate inefficient practice patterns and thus save money. Economist Patricia Danzon feels that for DRG's to work "they must not be held to the customary norms of traditional fee-for-service medicine." This willingness to subvert medical standards for economic purposes is frightening.

Danzon and Duke Law Professor Clark Havighurst raise the DRG question in relation to the standards required of health maintenance organizations (HMO's). An HMO contracts with a group of people to provide for all health care needs for a set cost per year. It theoretically provides incentives to physicians to keep patients out of hospitals and thus lowers health care costs. They further suggest that an HMO might contract to be bound not by a community standard of care, but by the standard of other HMO's in the country. Federal programs such as Medicare might also set up their own standards of care that would be based on economic considerations. Private insurers may offer a third more expensive plan and higher standards would be expected. It is conceivable that there could be two, three, or more standards of medi-

cal care based on the third party payor. Would economic restraint be translated into a different legal and medical standard of care? Havighurst casually said, "Only trial lawyers would have reason for complaint."45 This is not true. The patients would have every reason to complain as would concerned physicians. The obvious answer to a multi-level standard of medical care has already been articulated: everyone would be subject to the federal standard which would be predicated on economics and politics, leading to the lowest common denominator being the standard. The federal government would have control of medical care and standards. However, there is little history that suggests it would function better than the post office or any other federal agency.

IV. MEDICAL SOCIETY PROPOSALS

The most critical area of change must be the expense of malpractice insurance, since premiums have increased the cost of health care and limited the availability of certain medical services.46 The Wisconsin Medical Society has made several proposals designed to control this expense. First, raise the threshold to the Patient's Compensation Fund. Increasing the threshold (to $500,000 per claim, for example) would reduce the fund's liability, reduce duplication of efforts by primary carriers and the fund, and provide a stronger incentive for primary carriers to perform adequate loss prevention, claims management, and legal services. The original concept was that the fund would function as a catastrophic loss pool. However, from 1979 to 1983 the average dollar amount of claims paid by the fund has substantially exceeded this figure. In 1983, for example, 25 claims were paid at an average of $426,672 per claim.47 It is obvious that awards greater than $200,000 have become the rule rather than the exception. The fund is threatened with insolvency, and this proposal would be a step toward the financial security of the fund.

Second, limit fund liability. Purchasing reinsurance could limit the amount the fund would pay on any given claim in a

45. See id.
46. See supra notes 24-27 and accompanying text.
47. See SMS REPORT, supra note 24, at 3.
given year, and a statutory limit of $1,000,000 per claim as a fund responsibility would also limit liability. This is in no way a limit on recovery or a cap on awards but simply a limit on the fund's liability. Physicians with need of more coverage than their primary insurance plus $1,000,000 in fund coverage could obtain it from the private market.

Third, structure payment of all fund awards. Currently awards in excess of $1,000,000 are paid in installments of $50,000 per year. This concept could, for example, be broadened so that all fund awards could be paid at $200,000 per year. Also, periodic payment of future damages — such as future medical expenses, modifications to residences, and purchase of specialized equipment — as incurred rather than as lump-sum payments would improve the management of fund assets.

Fourth, prohibit duplication of benefits and reduce awards by the amount available from collateral sources such as health and disability insurance, worker's compensation, and social security. The Rand Corporation's Institute for Civil Justice reported that a mandatory collateral offset is extremely effective in reducing the size of excessive jury verdicts and settlements.

Fifth, limit awards for non-economic damages such as pain and suffering. Limits of $100,000, $200,000, and $500,000 have been suggested in other states. Data compiled from reports in the Wisconsin Law Reporter showed that non-economic awards exceeded economic awards. Pain and suffering, being subjective emotions, can lend themselves to manipulation not only because of the jury's subjective assessment (sympathy) but also because of the attorney's skill and the claimant's appearance and demeanor. These factors have led to wide fluctuations in awards for the same type of injury.

Sixth, bifurcate the trial. Separate hearings on the liability and damage issues should be held. If liability is determined in

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48. St. Paul Fire & Marine Company stated that seventy-five percent of its insured physicians have policies with a limit of one million dollars. See id. at 12.
49. AMERICAN MEDICAL ASSOCIATION SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, PROFESSIONAL LIABILITY IN THE 80's, Nov. 1984, at 15.
50. See SMS REPORT, supra note 24, at 11. Information compiled from the Wisconsin Law Reporter between January 1, 1982 and June 23, 1984 indicated non-economic awards of $6,357,490 and economic awards of $5,143,110.
the first hearing stage, the parties proceed with a hearing on damages. Plaintiffs' attorney Timothy Aiken stated that this proposal "makes sense . . . and would cut panel time at least in half."\textsuperscript{51}

Seventh, restrict appeals of panel decisions. Measures must be taken to dissuade claimants who lose at the panel level from appealing cases to the circuit courts. Requiring the posting of bonds that are sufficient to cover the other party's legal costs has been suggested in other states. These are but a small percent of cases that are heard and should not be a great burden on over ninety percent of cases. The predominant reason for panel case dismissal is absence of merit or lack of prosecution.\textsuperscript{52} From 1978 through 1981, eleven percent of all cases were dismissed.\textsuperscript{53} This increased to thirty-one percent dismissals in all cases for 1983.\textsuperscript{54} While not resulting in payment, congestion of the panel system delays resolution of meritorious claims and is expensive for the panel administrators and insurance carriers.

Eighth, implement loss prevention measures. State-wide data on claims must be gathered so that abuses of claims can be analyzed and prevention measures focused appropriately. This data should be reviewed by a physician committee for loss prevention and peer review purposes.

Ninth, sanction "repeat" offenders. If peer review indicated multiple cases of negligence by a particular physician, sanctions such as surcharges, restricted coverage, or referral to the Medical Examining Board would be imposed.

Tenth, tighten the statute of limitations. Current statutes allow three years from the incident or one year from discovery of the injury, but never later than five years from the incident for adults; minors are bound by the adult statute or age ten, whichever is later. The American Medical Association has developed a model bill which allows two years from the incident or two years from discovery, but never more than four

\textsuperscript{51} See Wisconsin Legislative Council, Special Committee on Medical Malpractice: Summary of Proceedings, Sept. 4, 1984, at 11.
\textsuperscript{52} See SMS Report, supra note 24, at 21.
\textsuperscript{53} See id.
\textsuperscript{54} See id.
years from the incident for adults and the adult statute or age ten, whichever is later, for minors.

Finally, limit attorney contingency fees. Several states have proposed sliding scales — for example, limit attorney fees to thirty-three percent of awards of up to $100,000, twenty-five percent of awards between $100,000 and $200,000, twenty percent of awards between $200,000 and $300,000, and fifteen percent of awards in excess of $300,000. This concept, which has been adopted by several states, ideally should be carried out by attorneys and not by state law. A group of reasonable attorneys who are most involved could set better guidelines. However, some prompt considerations of this subject by attorneys would be advisable. The federal government, as insurer of one-third of the population through federal programs, and the state see this limitation solely as a cost containment measure and not necessarily from an attorney’s point of view. However, there is recognition of the fact that limiting the contingency fee may spur attorneys to seek higher damages than they would under the current system, and the move could well be counter-productive.

V. PHYSICIANS AND PATIENTS & LAWYERS AND CLIENTS

The barely comprehensible complexities of the malpractice problem have perversely led to oversimplification, suggesting it is just lawyers versus physicians. Unmentioned, but faintly recognized, are the facts that the patient is the victim and that society in general is affected through the malpractice problem’s effect on the quality and availability of the modern advances of medicine. Thoughtful legislators recognize there is a problem, but the media’s role in publicizing hostility and recriminations between physicians and lawyers has made it appear that legislators must choose sides. We all have to help solve the problem for the patient’s sake. Physicians and lawyers have to see the relationship of their work to the whole fabric of culture and society. In doing this, we may elucidate rather than castigate, but it does require more introspection on all sides.

Dr. James Todd, while President of the Physician’s Insurance Association of America, said “efforts directed toward tort reform and legislative relief must be reasonable and not self-serving. Malpractice is a medical problem not a legal one,
and those injured as a result of negligence are entitled to fair and prompt compensation.” Agreement with that point of view is shared by the vast preponderance of physicians. However, honest and competent physicians have the right to be free from spurious and frivolous claims that adversely affect their ability to care for patients. In the remainder of this essay, I would like to share personal introspections, from a physician’s point of view, on the relationship of the physician to the patient, society, and attorneys as brought to light by the medical malpractice problem.

The patient, often neglected in this controversy, deserves some clearer definition. Pellegrino has pointed out that the word “patient” is derived from the Latin *patior* which means “to suffer” or “bear something.” It does not mean long-suffering. People become patients when they recognize that they lack the knowledge or skill to deal with illness. Their ability to function as “whole” persons is compromised, and they seek help from one who professes special skills and knowledge to deal with that loss of wholeness which is a disease state. It is an *unequal* relationship. Patients, by presenting themselves, acknowledge that they need help from someone who has more powerful tools and knowledge. This inequality is indeed recognized by patients as a diminution of their person, their ego, and their self-esteem, as well as a purely physical diminution. Patients are confronted with their own mortality, perhaps for the first time, and are no longer in control.

Patients present a problem because they have sought out the physician who professes to know how to help. Faith and confidence in that physician are an important prerequisite for healing to occur. Patients do not want to hear negatives or limitations. They want to be made whole and, because it works so often generally, expect that it will be just as easy individually. Medicine has been presented as “a miracle an hour with a few minutes out for commercials” — the Marcus Welby syndrome. This unequal relationship imposes great responsibility upon the physician who has professed to be skilled and knowledgeable with a commitment of those skills and knowledge to the benefit of others.

The word profession comes from the Latin verb *profitero* which means to make a public avowal or proclamation. While its earliest use was associated with vows to join a religious order, it later became a declaration of possession of skills and knowledge to be placed in the service of others. It is equally applicable to law and ministry. It has been bastardized today to mean a prestigious occupation; however, to return it to the older more meaningful level we must have "commitment," which means one places one's service to others above one's own self. This is a difficult goal to strive for. If not always attained, it should be assiduously sought after as often as possible because the inequality between physician and patient is a potential source of patient resentment when profession of skills and knowledge are not manifest, or are performed carelessly.

In all efforts to explain the marked increase in malpractice claims nationally and locally, there are the usual stock answers depending on whether one talks with physicians, lawyers, patients, or legislators. I will not reiterate all of the reasons, but will try to reason from the definitions above to understand the motivation for the litigious avalanche.

I state categorically that the increase in claims does not represent a decrease in the quality of medicine locally or nationally. In both Wisconsin and the nation, medical practice is the highest quality in the world. Why, then, the paradox of increasing claims, and yet better medicine?

Let us reexamine malpractice under the three groupings identified by the Romans because they are still apropos. There is *dolus*, the use of medicine with evil intent and treachery. This conduct is a rare complaint and, when present, is dealt with by criminal law. Then there is *culpa*, which includes negligence and incompetence, and *casus*, which is accidental conduct. These two come under unintentional action, or now, action that results in a tort.

Definition is easy, but discerning the difference is much more ambiguous. The ambiguities result from the fact that medicine, despite fantastic progress, is not an exact science. Untoward or adverse results of medical treatment may occur without negligence or accident. Every proposed treatment or operation has certain negative side effects, an established incidence of complications and failures that occur regardless of
how skillfully the treatment or operation is performed. It is the physicians' perception that lawyers do not understand this point and feel that negligence is behind every complication, side effect, or failure of therapy. It is all too easy for physicians to ascribe a lawyer's eagerness to sue for self-serving motives largely because of the contingency fee. While we realize that the contingency fee is the "key to the courthouse," we resent that as a result of the contingency fee the lawyer becomes a proprietor and partner in the suit. Lawyers have not diminished this perception by their media advertisements and portrayals of a "million dollar club." Physicians perceive this not as a pursuit of justice for the injured patient but as a technique that stimulates every patient to seek fortune through the malpractice suit.

The rise in the number of malpractice claims is not solely a creation of the lawyers' ingenious advertising. Medicine itself has contributed to the problem: as the scientific aspects of medicine exploded, the physician became identified as a medical scientist. Mastery of scientific knowledge and technology lead to many physicians apotheosizing themselves and their profession. This unfortunately is a double-edged sword. Lost was the humility of imprecise knowledge, and acquired was the hubris of technology. Physicians had been seduced into thinking that mastery of science and technology made them masters of the patient. Neo-Cartesian reductionism led medicine to believe that human beings are an electron transfer system gone awry, that can be righted by science if only well enough understood. Specialization and the acquisition of highly specialized knowledge was the logical aftermath of the scientific, technological breakthroughs depicted as daily events to the public by improved media communication systems. In the course of these technological successes, personal and hospital aggrandizement were not trivial events.

Lost in the hubris of the moment was the fact that physicians are unable to confer immortality. The patients, who by definition are not whole, were having expectations heightened, and specialization led to patients being treated skillfully for their individual parts. Specialist physicians became "part" doctors, and lost was the physician who could see patients as more complicated than the sum of the parts. Impersonality, inherent in specialization of medical care, while successful for
many isolated problems, does not react well anymore to the majority of illnesses since illness does not usually occur in a vacuum. The whole of a person provides the setting in which illness occurs. The complete physician has to understand as much as possible about a whole patient to help the entire patient be made whole. There is a dichotomy between the true benefits of reductionist specialization and the needs of a whole patient.

This dichotomy can only be addressed when knowledge and skills provide physicians with an understanding of their limitations. The patients also must be made aware of medicine's limitations and not just its successes. Even the benefits of a simple aspirin must be weighed against its potential, but significant, harmful side effects. Surgeons must realize that the feasibility of an operation is not necessarily an indication for its performance. Physicians must differentiate between what a treatment does to a patient and what it does for a patient.

The physician's knowledge of beneficial and adverse effects of a treatment must be presented to the patient and be consonant with the patient's expectations from that treatment. The definition of consent is "to feel together" and "to feel with." Put in the context of physician hubris and unrealistic patient expectations, untoward, unexpected results lead to patient anger from unfulfilled expectations. This leads a disappointed patient to seek an attorney, turning the patient into a client.

Patients have been converted to clients by both professions. Physicians have been deficient in dealing with the whole patient and not recognizing and explaining the risks and limitations of therapy. By not understanding that medicine is not an exact science, lawyers seek to redress every untoward event by a lawsuit, even when no negligence is involved. I am not discussing motivation for claims when there has been negligent action, but those instances in which untoward results have occurred that could have been anticipated in a certain percentage of patients. Physicians cannot be held to be guarantors of cure, nor should they present themselves as such.

The big problem lies not in the cost of liability insurance but in the consequences of the adversarial quality that relationships between physicians and lawyers have assumed. So-
ciety will protect itself from this destructive attitude. If confronted with no other choice, the federal government will intrude with cost containment measures that will lead to a lower quality of care for everyone. Before this occurs, both professions have to rid themselves of their entrepreneurial members who denigrate their respective professions. The time for self-serving rhetoric is past. For all parties concerned, come let us reason together for justice.