

1. Introduction

There has been an astronomical increase in the number of all types of lawsuits since the 1960's – 70's. Why the increase?

Although many believe it is due to an oversupply of lawyers who are looking for more things to litigate, this may not actually be the case (though perhaps there are exceptions). How this crisis developed, and the relationship between ethical and legal issues requires further exploration.

In a recent survey of physicians, 58% reported that they have been sued at least once. The specialty with the highest percentage of lawsuits was Obstetrics-Gynecology (OB-GYN) at 83%, while Pediatrics was the lowest at 42%. When you realize that you have about a 50:50 chance of being named in a malpractice suit, you can begin to address the issue realistically instead of hoping that it won't happen. The contents of this book offers you the chance to minimize your liability by learning about the most common areas of legal focus – and the particular blind spots in your practice.

As presented in Chapter 2, medical malpractice suits prior to 1960 were based on fairly obvious and egregious cases – as were most non-medical suits, such as employment issues or product liability. The principles of tort law (boring as they may be) are also explained in Chapter 2. An introduction to risk management is presented in Chapter 3. Chapter 4 outlines major issues that clinicians face daily in their interactions with patients. More esoteric (but not less important) issues regarding liability are discussed in Chapter 5.

Following this, there are chapters on managed care, regulatory issues, organizational issues, and specialty-specific information. The text then finishes with some specific tools which describe how to deal with certain high-risk patient scenarios.

Although the chapter on regulatory issues is presented in Chapter 7, this is an area that has given physicians the most concern over the past several years. It has taken on a huge specter of importance – almost overshadowing the medical malpractice concerns.

The Relationship Between Ethics and Law

Ethics are the *principles* of proper or morally correct conduct within a society (a branch of philosophy). **Law** defines the *rules* of conduct as established by a society.

The relationship between ethics and law generally applies in the following way: basic ethical principles frequently lead to the development of law through case precedent and statute. The relationship between the two is dynamic – and based on many forces in society, the nation, and the world.

First, a focus develops on an issue within a society. If enough people feel strongly about the moral “rightness” of the subject, a significant power base develops and legislation may follow. In this way, legislation now formalizes the rules governing certain behaviors.

Even laws are not sufficient to bind individuals to abide by ethical principles. Some regulatory bodies set their standards at an ethical, as opposed to legal, level. Those to whom the regulations apply must then follow the stated standards. An example of this principle involves state boards of medicine. These boards, after full and fair hearings, may suspend or revoke the licenses of physicians, even if a law hasn't been broken. In other instances, court decisions set precedents based on the ethical issues involved in the dispute. Some of the more common non-medical issues involve: abortion rights, capital punishment, and civil commitment.

There is no doubt that the majority of physicians are unequivocally committed to the ethical practice of medicine. Medical ethics focuses on doing what is considered morally right in the evaluation and treatment of patients.

History of Medical Ethics

Medical ethics has a long history, beginning with the Oath of Hippocrates, which is really just a concise statement of principles. The Oath was created during the period of Greek prosperity around the 5th Century BC. Although adapted in the 10th or 11th Century AD to eliminate references to paganism, it has remained as the essential statement of ideal conduct for physicians, and the ideal in protecting patients' rights. The two primary principles of medical ethics are:

Autonomy – the right of every competent person to be able to decide what will be medically done to him or her.

Beneficence – known simply as “do good for the patient” (also known as **nonmaleficance** – *Do No Harm*).

Thomas Percival, an English physician, made a significant contribution to Western medical ethics with the publication of his Code of Medical Ethics in 1803. In 1847, the first official meeting of the **American Medical Association (AMA)** was held. At that meeting, the founding members adopted the first American Code of Ethics, which was based on Percival's code. Although there have been revisions, the essence of this code has been maintained. In 1977, a revision was made that sought to achieve a proper and reasonable balance between professional standards and contemporary legal standards.

The preamble from the **1999 AMA Code of Medical Ethics** states that: *“The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self.”* The following seven principles adopted by the AMA are not laws, but standards of conduct, which define honorable behavior for physicians.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
3. A physician shall respect the law, and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

In many medical negligence cases or in complaints before state medical boards, lawyers often quote the above principles where there is no statute or case law that is clearly applicable. The full text of the Code of Medical Ethics is published by the Council of Ethical and Judicial Affairs of the AMA. All physicians should have access to this volume, as it addresses clinical issues that occur

frequently, as well as others that are less common (e.g. the use of minors as organ donors). It offers references for both peer-reviewed research articles and case law on a wide variety of clinically relevant topics.

The relationship between law and ethics can be further clarified. Ethical values and legal principles are often closely related, *but ethical obligations typically exceed legal duties*. Being cleared of any legal wrongdoing does not necessarily clear one of charges of unethical conduct within a professional society or board of medicine.

Physicians who belong to one or more national medical groups are sent statements of ethics developed by such specialty or subspecialty societies. Membership to these organizations indicates a commitment to the ethical principles so espoused. If a member is charged with violating an ethical principle, the appropriate committee within the organization conducts an investigation. If the charge is found to be valid, the member may be sanctioned or expelled. When this occurs, it may be publicized, and the action sent to that member's state of licensure. It therefore behooves you to be aware of the stated ethical principles of the societies to which you belong.

The Parallel Between Medical Malpractice Litigation and Social Issues

Thirty years ago, you would not have been able to find much written about many of the legal issues which presently affect medical care. Changes have occurred primarily because many of the issues currently considered to be in the legal realm were previously viewed as ethical concerns. While many physicians have the perception that the medical malpractice litigation frenzy of the 1970's, 80's and 90's developed *de novo* (as lawyers discovered new and fertile ground), the roots are much deeper, and not limited to the medical arena.

The changes occurring in the realm of medical malpractice litigation parallel other social issues and their sequelae. From the 1950's – 70's, this country saw many far-reaching changes occurring concurrently: the Civil Rights Movement, Vietnam protests, the Women's Movement, consumers' rights groups, etc. These organizations became very vocal, and very powerful. As support increased for these causes (and the underlying rights they espoused), supportive and protective legislation was passed, and legal precedents were set.

With the passing of enhanced legislation to protect a variety of individual rights, an increase in litigation followed. Lawsuits were brought forth both by individuals and organizations. Many physicians will actively defend their freedom to practice independently. It is the same principle – exercising decision-making autonomy – that has given rise to many of the legal changes in medicine.

Caveat

The autonomy of the physician is *never* lessened by ensuring the autonomy of the patient.

The Scope of Medical Malpractice Litigation

The scope and extent of medical malpractice litigation is quite broad. . . but it could be much worse. Some basic information and factoids to consider are:

A. Between 1977–1992 there were 12,829 physicians involved in 8,231 closed claims:

- Physician care was defensible in 62% of cases and indefensible in 25% (the remainder were indeterminate)
- The plaintiff received payment in 43% of the overall number of claims; patients still received money in 21% of cases where medical care could be defended, but did not always receive money (91%) in cases where medical care could not be defended
- The severity of the injury was not associated with the payment rate in cases resolved by a jury.

Other studies have revealed that the severity of the disability predicts an award for the plaintiff (not simply that an adverse event occurred, or that there was negligence involved)

B. In an annual report to Congress in 1991, the Physician Payment Review Commission noted that awards were higher (using identical juries) when it seemed that the defendant could pay more. Jury awards for leg amputation cases (in various scenarios) were:

- \$199,999 – auto accident case
- \$330,000 – private property owner case
- \$687,000 – product liability case
- \$754,000 – medical malpractice against a physician
- \$761,000 – workman's compensation

C. There has been a definite, and continued increase in the amount of money awarded in medical malpractice cases. For example, from 1995 to 1998 in North Florida:

- The size of the *average* plaintiff verdict has increased from \$1.2 million (1995) to \$2.6 million (1998)
- The size of the *median* award rose from \$270,000 to \$665,000
- This compares (favorably?!) with the 1998 *average* award in New York City of \$6.1 million, and a *median* of \$1.1 million!

(Author's Note: Sincere apologies to those researchers who have provided data from good and valid research. When addressing medical malpractice, there is a huge body of contradictory data, which is why I prefer to call them "factoids" in this presentation.)

Now to the "glass is half full" way of looking at other factoids. There have been several excellent studies looking at hospital admissions and outcomes over time from the 1970's through the '90's. One very consistent fact is that:

- 1% of all hospital records reveal that an injury was caused due to negligence, yet less than 10% of these injuries ever lead to a formal claim.

More factoids:

- Less than 10% of all lawsuits go to juries, and of these, two-thirds find for the defendant physicians (even when physician peer-reviewers found the cases indefensible half of the time!)
- Approximately 4% of all hospitalizations result in adverse events, and more than one-quarter of these are due to substandard care
- There is a 12-fold variation in the rates of adverse events between facilities and physicians; the percentage due to negligence ranges from 0 to 70%
- It is estimated that there are approximately 180,000 deaths annually which can be attributed to iatrogenic causes; half of these are due to negligence

The obvious conclusion to draw is that rather than bemoaning the severity of the medical malpractice crisis – rejoice! It could be much worse. What we as physicians should be most concerned about is minimizing the variation in practice, the incidence of avoidable adverse events, and in particular, the numbers of injuries and deaths due to negligence.

Tort Reform

This may be putting the cart before the horse (the discussion of torts is in the next chapter), but it is important to see the big picture of litigation, and be aware of the competing forces involved in determining the amount of money at stake in litigation.

As the settlements awarded by juries increased, so did malpractice insurance costs. Multiple steps were taken to curb the skyrocketing costs, and tort reform was one of these measures. Many states have enacted legislation that limits the amount of money a jury can award to a plaintiff in medical malpractice cases (and other civil cases). Sixteen states have laws that limit the amount of recovery for non-economic damages (including pain and suffering, inconvenience, disfigurement, loss of quality of life, etc.). Five other states have a limit on economic damages (discussed in Chapter 2). Some states do not allow awards for non-economic damages (such as pain and suffering). There are also a variety of requirements for arbitration, settlement conferences, and other options designed to avert a jury trial (and decrease the astronomical costs of litigation).

An example of early tort reform (established in 1975) is in the state of California, that has a \$250,000 cap on the amount a person can receive to compensate for pain and suffering.

Other mechanisms focus on attorneys' fees, and may limit the percentage an attorney can collect on **contingency** (which means the lawyer does not get paid unless he or she wins). The attention to fees is an attempt to limit the incentive for an attorney to pursue cases – i.e. he may not take a case if he'll win only \$250,000, but is far more likely to if he thinks he can win several million dollars.

In spite of all the negative information you hear, remember that only 10% of cases ever get to a jury trial, and of that 10%, about two-thirds of juries find for the defendant physician(s).

Why Do Patients Sue?

Before launching into an overview of negligence law (followed by the many situations that place you at risk for experiencing a suit), consider this simple equation:

Medical Malpractice Suit = Bad Outcome + Bad Feelings

A bad outcome is just that – there *must* be some tangible physical or psychological injury. Although a patient may not like a physician's looks or attitude, or not improve from the treatment provided, these are not adequate grounds for a lawsuit. There must be an actual *injury* (more to follow).

We all have known, seen, or heard of physicians who were not the best in the skill department (e.g. "I wouldn't let Dr. Nincompoop take care of my dog. . .") and he would at times have a bad outcome. Yet, the patients never seemed to sue him. Why? Because they liked him. He probably has a great bedside manner and demonstrates genuine concern. This may have been accomplished through active listening and facial expressions/demeanor indicating empathy. As far as the patient was concerned, the doctor could do no wrong (which emphasizes the importance of peer review in some cases!).

At the other end of the spectrum, we have some colleagues of whom you might joke, "I would never see Dr. I.M. Godsgift unless I was *really* sick." These are the folks who may be brilliant in their respective fields, but have almost reptilian personalities. They usually don't see this as a problem, or may be so arrogant they don't care – but the patients (or their families) do. As you'll see, the recurrent theme of effective communication will become evident. Talking to a person using polysyllabic jargon in a condescending manner does not constitute effective communication. The resentment that most people feel when they are spoken down to may not become evident if all goes well. However, when there is a problem, all of this resentment comes bubbling to the surface and finds somewhere to vent (like a bad remake of *The Poltergeist*).

Many authors report a quasi-rule of thirds:

- One-third of patients will never sue
- One-third will sue if they ever get a chance
- The rest fall somewhere between

Beware of the latter group, and don't give them a reason to want to seek out an attorney with your name on their minds, lips, or subpoenas.

One survey found that 98% of patients wanted or expected their doctor to acknowledge an error whether this caused any harm or not (more on this in the last chapter). The patients who suffered from moderate to severe errors were more likely to report the doctor to authorities or consider suing if the doctor failed to disclose the error. Most people do not expect their doctors to be perfect, but they do expect them to be honest.

A study of families who sued their child's doctor after a perinatal injury showed that 24% of those who filed a lawsuit did so when they realized the physician:

- Was not completely honest
- Allowed them to believe things that were not true
- Intentionally mislead them

Another 20% sued because they said it was the only way they could find out what really happened!

One unsettling editorial by a physician spoke of his recommendation to a friend that he sue his surgeon after an operation was performed removing all but the upper 5% of his stomach (because of a misdiagnosis of gastric cancer). It turned out to be peptic ulcer disease. What angered the patient (and his physician friend) was the flippant response of the surgeon who offered neither an explanation nor an apology.

References

American Medical Association: **Code of Medical Ethics – Current Opinions with Annotations**. American Medical Association, Chicago, 1999

Borbjerg RR: **Medical Malpractice and Folklore, Facts, and the Future**. *Annals of Int Med* 117:788-791, 1992

Bozeman FC: **Sky-High South Florida Verdicts Spread to North Florida**. *Escambia County Medical Society Bulletin*, Oct 1999

Brennan T: **The Harvard Medical Practice Study. The Mental Health Practitioner and the Law**. Harvard University Press, Cambridge, 1998

Brennan TA, Sox CM, Burstin HR: **Relation Between Negligent Adverse Events in the Outcomes of Medical Malpractice Litigation**. *N Engl J Med* 335:1963-1967, 1996

Crane M: **Malpractice Wars**. *Medical Economics* 26, July 1999

Hickson GB, Clayton EW, Githens PB, et al: **Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries**. *JAMA* 267:1359-1363, 1992

Lally JJ: **Why I Urged My Friend to Sue His Doctors.**
Medical Economics 151-152, July 26, 1999

Sloan FA: **Medical Malpractice Experience of Physicians: Predictable Or Haphazard?**
JAMA 262:3291, 1989

Taragin MI, Willett LR, Wilcek AP et al: **The Influence of Standard Of Care and Severity of Injury on the Resolution of Medical Malpractice Claims.** *Annals of Int Med* 117:780-784, 1992

Tort Reform Battles: Sometimes the Force Is With You.
Medical Economics, 133-142, July 26, 1999

Vidmar N: ***Medical Malpractice and the American Jury.***
University of Michigan Press, Ann Arbor, 1997

Witman AB, Park DM, Hardin SB: **How Do Patients Want Physicians to Handle Mistakes?**
Arch Intern Med 156:2565-2569, 1996