Chronological: Hospital Association of Hawaii Monthly Meeting, Honolulu

SPEECH BY SENATOR DANIEL K. INOUYE
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MALPRACTICE

A patient is admitted to a hospital for a minor operation. The surgical procedure is carried out without complication. In the recovery room, while the attending nurse is temporarily distracted, the patient--still groggy from the anesthesia--tumbles out of his bed. The result is a suit for $500,000, brought against the hospital, the nurse, the attending physician, and the anesthesiologist. After six months of negotiations, the claim is settled out of court for $80,000; the patient is compensated, his attorney is recompensed...and the hospital, a few weeks later, is notified that its malpractice insurance premium has been doubled.

This scenario has become the abiding nightmare of the hospital administrator. Over the last few years, a steady and startling increase in the number and size of malpractice claims has turned the potential nightmare into an actual crisis for our health care systems.

Today, in contrast to the 6,000 claims of fifteen years ago, there are approximately 20,000 claims being filed each year, fully three-fourths of them arising from treatment within hospitals. The average settlement has quadrupled since 1970 and the average jury settlement has rocketed from $60,000 in 1965 to $350,000 today.

Not only are malpractice suits becoming more numerous and financially devastating, but they are also coming increasingly to be directed against hospitals. Not long ago, a patient would only name the hospital as a defendant in his suit if the injury had been physically associated with the facility--for example, if the patient had fallen off of a gurney or received an infection from unsterilized instruments. Today, however, hospitals are being held responsible for the actions of their individual staff personnel. The doctrine of superior respondent--the superior must answer--makes the hospital liable for the mistakes of its employees. Indeed, hospitals have even been sued for the very fact of their retaining incompetent practitioners on their staffs. In short, there are few malpractice cases arising from in-hospital treatment which do not involve the health care institution as well as the individual provider. As the legal concept of medical liability expands to include acts of omission as well as acts of commission, it carries the hospital along on the litigative tide.

The end-product of this expansive trend in personal injury litigation has been an expensive trend in medical liability insurance, surfacing throughout the country. In Chicago, the Michael Reese Hospital learned that its insurance premium would reach a quarter million dollars this year, up from $80,000 last year. Long Beach Memorial Hospital in California has watched its rates zoom from $340,000 last year to $820,000 for 1975. Two hospitals in Alaska have chosen to operate without insurance rather than pay premiums that would add $85 to the average patient's bill.

As for Hawaii, we have not been immune to the phenomenon. At Queen's Hospital, premiums have been hiked this year above the two-hundred thousand dollar level, and at St. Francis Hospital, the previous price-tag of $79,000 has been increased three times over.

The same phenomenon is occurring throughout the country, adding up to an impressive aggregate. Whereas in 1960, doctors and hospitals paid a total of about $60 million per year for insurance, in January of this year hospitals alone were paying an annualized sum of $750 million. And in the half-year since then, this has climbed to an annualized cost of $1.25 billion.

Greater than the fear of inflated premiums, however, is the continuing worry that malpractice insurers will withdraw all coverage eventually. The possibility looms large here in our State where the primary insurer, Argonaut, is already indicating that it may soon abandon the malpractice business. Argonaut has already withdrawn from sixteen of the 28 states in which it formerly did business. In the remaining twelve, it has for all intents and purposes made coverage unavailable by requesting rate increases ranging from 300 to 545 percent.

Of course, many physicians in this country are caught in the same bind. High-risk physicians, in particular, are being forced to curtail their practices by premiums which reach well into the five-digit range or by notices of cancellations of their policies. This, too, redounds against the medical institution since it forces the closing of surgical facilities and emergency rooms. Wayne State Medical School in Michigan, for example, discontinued all patient care earlier this year when their 77 faculty physicians lost their coverage.

The closed doors of this institution could be the harbinger of a more widespread disaster to come if the present difficulties persist unchecked and develop into a full-fledged health care availability crisis.

The person who ultimately will suffer the effects of that crisis will be the very person who should have our first and most enduring concern--the patient. Of course, that will not be the only point at which the patient will pay for the malpractice squeeze. Whenever a hospital's insurance premium has taken a jump, the cost has been largely passed along to the patient in the form of an extra four or five dollars per bed per day tacked onto his bill. When hospital personnel begin to practice defensive medicine as standard operating procedure--ordering X-rays, drugs,and diagnostic tests to an extent required only for'courtroom' competence--the health care consumers in this country wind up paying an estimated two to seven billion dollars for services they might just as well never have received.

This is the price-tag attached to the malpractice crisis, needless costs which contribute to what is already an annual national health care bill of over $100 billion. Unfortunately, the causes of the malpractice problem are less easy to identify than are the costs. Whenever we look for the causes, each of the different parties involved in the Great Malpractice Debate comes up with a different explanation.

According to many lawyers with whom I have spoken, the problem lies with the medical profession. The malpractice crisis, I have often been told, has been caused by malpractitioners, pure and simple. The problem can therefore best be alleviated through the continuing, redoubled efforts of the legal profession to root out the incompetent physician and defend his hapless victims.

For the insurer, the problem is a legal system which is over-lax with the aggrieved patient. Patients are able to bring claims twenty years after receiving the treatment which gave rise to their injuries. Lawyers can sue for any amount they please, even going so far as to ask for one billion dollars as did one attorney in California recently. According to insurers, the legal system will have to be tightened up--with ceilings on malpractice awards and shorter statutes of limitation--if there is to be any underwriting of the malpractice business at all.

As for the health care provider, the problem is the misinformed patient with unrealistic expectations, the ambulance-chasing attorney who heightens those expectations, and the inexpert juries who unfairly reward those expectations.

Each of the groups involved in the malpractice dilemma thus points to the others in assigning blame. Each claims

to recognize what originally caused the problem, but none recognizes what now perpetuates it--namely, the unwillingness of the professional groups to recognize their own contributions to the crisis.

The fact is that all involved parties must share the blame. The lawyer, for example, has not been a selfless crusader for medical competence. While his activities may occasionally serve this function, they could be much more accurately targeted. As it is, defendant-doctors win approximately 80 percent of the cases which come to a trial verdict. The fact that so many non-meritorious cases reach the courts would tend to discount the professional restraint and objectivity which lawyers claim to exercise in screening their cases.

Nor do lawyers have only the interests of the injured patient in mind. Were that the case, I doubt that they would continue to insist on the reasonableness of the contingency-fee system. Is it reasonable for a crippled patient who receives a $500,000 judgment in a malpractice trial--an award meant to meet his expenses for the remainder of his life--to then surrender a flat one-third or one-half of it to his attorney? Is it reasonable when another patient whose likely indemnity falls below $10,000 is unable to find an attorney willing to work for so small a sum? Until these failings of the contingency fee system are acknowledged, the good intentions of the legal profession must remain in some question.

We should also question the self-portrayal of insurance companies as well-intentioned enterprises seeking a solution to the malpractice problem. If anything, malpractice carriers have only succeeded in keeping a complex issue clouded in uncertainties by refusing to disclose pertinent data on their underwriting principles and practices. They ask us to accept unquestioningly their claim that the malpractice business is an uninsurable venture.

But rather than accept this assertion on blind-faith, we should demand candid responses to certain critical questions. How is it, for example, that only 16 cents of every premium dollar actually goes toward compensating the malpractice victim--compared to 44 cents for auto liability insurance, 93 cents for Blue Cross, and 83 cents for other health insurance? Where does the other 84 cents go? How is it that Kapiolani Hospital which has never had a malpractice claim settled against it, is facing a 300 percent increase in its premium this year? How do insurers make

the projections of future losses upon which occurrence policy premiums are based? What are the actual loss ratios--that is, ratios of claim settlement costs to premiums--of the insurance industry today? Given the fact that loss ratios were as low as 54 percent in 1970, and given the fact that carriers can earn profits off of ratios of over 95 percent because of their returns on invested reserves, what explains their sudden inability to make money? To what extent did their investment portfolio losses during the Nation's economic slump contribute to the malpractice problem?

These questions have yet to be satisfactorily answered by the insurance industry. Until they are, it will be difficult, it not impossible, to design an appropriate solution to the malpractice problem. Accordingly, I recently requested the Committee on Commerce in the United States Senate to launch an investigation into the malpractice insurance business. I believe it is time that we recognized the uncooperativeness of the insurance industry and acted as necessary to circumvent it.

So too must the medical profession recognize its contributions to the malpractice crisis, put aside its professional sensitivities, and reestablish its good faith intention to reach a reasonable solution to the problem.

And that means, among other things, turning to the task of cleaning house. The medical house is not rife with incompetence; when a profession has over 3 billion patient contacts each year and incurs only 20,000 claims, of which only one-half may be meritorious, I would hardly call this a shameful record. But malpractice does exist. One hospital adminstrator remarked to me that when he reviews medical records, he is constantly amazed at the number of malpractice incidents which are simply never recognized as such by the patient. An effective quality review system will be crucial to reducing this incidence of malpractice.

This does not mean, however, that the incidence of malpractice suits will also diminish. It would be a mistake to equate malpractice with malpractice suits, as so many lawyers are willing to do. The fact is that most suits are brought not against the underskilled, substandard practitioner but against the most highly-trained specialists, practicing in the most complex and challenging areas of medicine. The elimination of medical incompetence

would still not make the malpractice lawsuit a legal anachronism.

But this does not dull the argument for greater professional discipline. When the combined activities of all the existing review mechanisms--the tissue committees, medical society committees, PSRO's and state examining boards--produce only 12 revocations of licenses on grounds of professional incompetence in the entire country, as was the case last year, the need for improvement is clear. Having heard this same concern voiced by members of your Association and other medical groups, I am hopeful that the health professions will not shrink from this task. For too long the malpractice debate has been one of self-serving arguments in which doctors, lawyers, and insurers have assumed defensive, self-righteous, and uncompromising postures. I would like to see your profession rise above this sorry debate by reaffirming its traditional and cardinal concern for the patients it serves.

It is true that the patient must also accept some blame for the present crisis; too many patients enter hospitals expecting the outcome of treatment to be Marcus-Welby perfect. When the result is short of this unrealistic standard, the patient files suit. But if this is the case, you should bend yourselves to the task of educating the patient to a more realistic standard. You have all experimented with the means for doing this--patient grievance mechanisms, improved patient-physician communication, and so on--and I hope you will continue to do so. Do not let the malpractice debate degenerate into the sort of patient-physician warfare that marks the malpractice trial. Adversary attitudes will only divert us from the real needs of the patient.

At present, it is clear that the patients' interests are not being served fairly or fully by the existing system for handling malpractice claims. In fact, I find it difficult to say whose interests--aside from the attorneys' for both sides--are well served by a malpractice action.

A person bringing suit for a medical injury faces a process which is both emotionally and financially taxing. The average time for a malpractice action to reach a trial settlement is five years. During that time, the patient must fend for himself when it comes to paying medical expenses, often while under the additional handicap of serious wage-loss. He must gamble on accepting an out-of-court settlement,

or holding out for a jury decision. And in the end, he sees his award partially depleted by the fees of attorneys and expert witnesses.

The pain and suffering of the defendants in court are equally bad. The physician, nurse, administrator, technician--all are forced to spend long hours in the courtroom away from their patients and responsibilities. Regardless of the outcome of the trial, the sensational publicity regularly given malpractice suits may permanently mar the reputation of the health care provider and his institution.

Moreover, a dramatic presentation--an empty pants-leg, an unsightly facial scar--may sway the jury to compensate the plaintiff even though his injuries may have been the unavoidable outcome of responsible, flawless treatment. The final injustice comes when the defendant later receives a notice of cancellation from his insurer.

Perhaps in a way, the eventual unavailability of all malpractice insurance would be the best thing that could happen for health care providers. I say this because of a theory which lawyers call the "deep pockets" theory. Patients are more willing to sue their doctors, and juries are more willing to compensate the plaintiff when they know that the defendant has the "deep pockets" of an unsurance company behind him. Take away these resources and you might take away a goodly portion of the present lawsuit volume.

But I hope this will not be the only "solution" left at this point. We would be cutting off our nose to spite our face if we were to cut off the only source of compensation available to the validly aggrieved patient. More appropriate responses to the malpractice crisis should be and are being considered by the many states thus far affected by the problem.

Since January of this year, over 200 bills have been introduced in state legislatures to solve the malpractice problem. I am pleased that Hawaii was among the first to actually enact legislation, passing Act 161 to provide for a joint underwriting association in the event that all malpractice insurers withdraw from the State. The American Hospital Association has also been quick to act, developing a promising plan for a captive-reinsurance company. Both of these proposals should help to alleviate the immediate insurance availability problem, and both are coming at an opportune time, thanks to

the foresight of their proponents.

But we should also recognize that these approaches--like many others being considered around the country--are only short-term solutions. They are stop-gap remedies, designed to treat the more vexatious symptoms of the malpractice crisis. They will not get at the more fundamental ailments afflicting our existing system for handling malpractice claims. They will not make the claims process more equitable, nor expedite the settlement of medical injury disputes, nor prevent the further upward spiral of claims, nor avoid another crisis further down the road. To accomplish these goals, we will need a more comprehensive approach.

It was this concern which originally prompted me, in January of this year, to introduce two bills in joint sponsorship with Senator Edward Kennedy. I believe these bills, S. 215 and S. 482, are important not only for their content but for their intent. They were not put forward as perfect cure-alls for our malpractice ills, but rather as purposeful prods to direct public attention toward this issue and to suggest preliminary proposals from which a final solution might evolve.

S. 215 would establish a federally-administered no-fault system for compensating medical injuries. Similar to Workmen's Compensation, it would allow persons sustaining injuries as the result of medical treatment to recover benefits for their injury-related losses regardless of whether negligence had been involved.

I believe that two powerful arguments commend this approach to our consideration. First, a no-fault approach recognizes that medicine is an imperfect science in which the most competent physician performing in accordance with the highest existing standard of practice can still injure his patient. The present legal system fails to recognize this fact. If a jury wants to compensate an injured person, it must find the practitioner guilty of negligence. And so the system is occasionally moved to pin blame on a blameless physician. No-fault would put an end to this unfair, senseless stigma.

Second, no-fault would place greater emphasis on seeing to the quick and adequate compensation of the injured person. Rather than placing a premium on the determination of fault or the pursuit of retribution, it would focus on the specific restorative needs of the patient--medical expenses, lost income, and so on.

Of course, I also have some reservations about no-fault.

There are several unknowns on which the feasibility of the proposal may hang. For example, it may not be possible to unambiguously define a compensable injury if the only requirement is that it be treatment-induced. In addition, since no-fault would compensate more people, it might prove too expensive in spite of the savings it would produce by reducing court costs, defensive medicine, windfall settlements, insurance marketing expenses, and so on. It might have to be financed through a social security type of tax instead of through premiums paid by health care providers.

These potential drawbacks of no-fault should not be underplayed: but neither should they prematurely discourage us from fully considering what is a promising, comprehensive alternative to our problem-ridden tort system.

My second bill, S. 482, would provide minimum standards for malpractice arbitration systems in the individual states. Malpractice claims would be submitted to panels of qualified medical and legal experts for their decision. If accepted by both parties to the dispute, the decision would be binding. Otherwise, the claim would proceed to a court trial into which the arbitrators' findings would be admissable.

Arbitration has already been demonstrated to be effective in California. Like no-fault, it shows great promise of serving the concerns of patient and physician alike in an expeditious and equitable manner.

Both S. 215 and S. 482 take an eclectic approach to the malpractice crisis and are directed toward a variety of the factors contributing to the situation. Both bills impose controls on attorneys' fees in malpractice actions. And both, as you are probably aware, contain provisions for upgrading the quality of health care and eliminating wasteful medical treatment. These provisions would require physicians who participate in the no-fault or arbitration systems to comply with minimum national standards of licensure, accept PSRO review of their performance, and obtain confirming opinions prior to performing surgical procedures.

These provisions have naturally stirred some controversy. They have been criticized as undesirable and unwarranted extensions of the long Federal arm into the affairs of the medical profession. I personally would agree that it is undesirable to involve the Federal government in these matters. But I cannot agree that it is unwarranted. As I have pointed out already

the medical profession and the individual states have a deplorable record of inactivity and foot-dragging in the area of quality review. I earnestly hope that they will move now to improve this record and improve it dramatically. But if their inactivity persists, to the continuing detriment of the public, then I do not believe the Congress should or will sit back in ignorant complacence.

This same rationale applies to the malpractice issue as a whole. I do not want to see Congress intervening in this matter. As I have said on several other occasions, Hawaii will be better off developing its own solution to the malpractice problem rather than obeying the dictates of an HEW official 5,000 miles away. But if the crisis continues to grow and worsen, it will be an invitation to Congress to take control. After all, the crisis is a widespread one, affecting over three-fourths of the States. It threatens to deprive millions of Americans of their access to health care, a possibility which legitimately compels concern and action at the national level. If the States will not act on this concern--and act appropriately--the Federal government will.

If the States will not go beyond short-term solutions, then long-term solutions will have to be fashioned in Washington, D.C.

And if the States solve the problem by sacrificing the rights of the patient--if they set arbitrary and unreasonable ceilings on malpractice awards, if they establish unfairly obstructive statutes of limitation, or if they otherwise bar patients financially or legally from prosecuting their claims--the Congress will have little choice but to pass corrective, pre-emptive legislation.

I do have confidence that reasonable voices will prevail in our own State and than an effective and equitable solution will emerge within the next few months. As hospital administrators, you are in a pivotal, albeit difficult, position to press for the necessary changes. Your position is difficult in that you are responsible for and accountable to more than one group. Your responsibility extends to both your patients and your housestaff personnel. Moreover, the law has made you accountable for the actions of your employees, yet it has failed to clearly define the relationship between the administrator and the hospital trustee, thereby weakening your ability to control the employees or policies for which you are responsible. The end result, of course, is that it becomes difficult within your own institutions to effect the changes--in staffing, peer review, consent procedures, and so on--that might alleviate the malpractice

problem.

But you may nonetheless be in a pivotal position to effect changes in policy and law at the state level. Your accumulated expertise on the subject of malpractice, your knowledge of health systems, and your multiple roles as administrators would all be valuable to the persons who will develop Hawaii's malpractice solution. I cannot sufficiently urge you to contribute to the efforts of the State Legislature and the Governor's recently-appointed commission on malpractice in their continuing efforts to deal with this issue.

I must congratulate you on the initiatives that you have already undertaken in this regard. But may I exhort you to pursue them now with vigor. Political inertia, professional myopia, and months of work still separate us from a responsible and complete approach to the malpractice problem. But I am hopeful that your efforts, coupled with your dedication to both the recipient and the provider of health care, will advance us toward that essential end.