TESTIMONY ON MEDICAL LIABILITY

Presented to
Senate Subcommittee on Health

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April 18, 1975
Mr. Chairman and members of the Committee, I am Dr. Glenn Molyneaux, a practicing internist in San Francisco. Currently, I serve as the President of the American Society of Internal Medicine. With me is Dr. William R. Felts, a member of ASIM's Board of Trustees. ASIM is a federation of 51 component societies of internal medicine. It has more than 13,500 members who, by training and practice standards, are recognized as specialists in internal medicine. Most are private practice internists delivering primary care, subspecialty care or both. We will not comment on any specific pieces of legislation before the Congress. We shall address issues. We believe that, when an act of negligence by a physician leads to injury, disability or death of a patient, compensation is in order. This is malpractice. However, medicine is less than an exact science. Frequently, undesirable outcomes follow appropriate medical care. Such outcomes are not the result of malpractice. Unrealistic patient expectations at times convert such outcomes into professional liability claims. They should not be compensated through a medical liability system if society does choose to compensate such outcome, the financial support should come from some other source. We believe the current legal system's failure to make this distinction is one of several major factors that has contributed to the current crisis in medical liability. This statement will discuss this and other factors that should be addressed in any legislative solution to the crisis. Since it was founded in 1956, ASIM has been concerned with the quality, availability and cost of medical services for the public. The rapidly increasing rates charged to physicians for medical liability coverage have recently become a significant force to drive the cost of medical care upward. It must also be recognized that a tremendous additional financial burden has been created by what has come to be known as defensive medical practice. Admittedly, there is no possible way to estimate the dollar value of those procedures that physicians have carried out to document their clinical decisions in order to reduce the possibility of medical liability actions. The availability, and hence quality, of care are also threatened as insurers announce they will abandon the medical liability insurance field. We believe that legislative relief is essential to reach an equitable solution to the non-medical problems that have contributed to this crisis. Legislation should cover reform of the entire legal process as it relates to medical liability. We suggest that some form of arbitration would be the most equitable for all parties concerned.
We hope that the appropriate solutions will be reached by state legislatures. We believe the federal government should become involved only where the states are unable to address specific problems (for example, in the creation of a reinsurance pool).

Any legislative solution should take into consideration the nature of medical practice. Medical practice is based on a series of decisions that depend on the development of as adequate a data base as can be obtained. Judgments and decisions are made after the careful weighing of many variables, some of which are related to the natural course of an illness, some to unexpected complications of the illness, some to the concomitant presence of multiple abnormalities, and some to risk factors inherent in any diagnosis or treatment. Decisions to intervene are based on an agreement between physician and patient with these variables in mind. Behavioral variation by individual patients contribute significantly to the outcome and often are not made known to the physician.

The occurrence of an undesirable outcome following appropriate medical care is therefore not within the control of the physician. Such outcome occurs as an integral risk of medical care and should not be the basis of legal action.

Medicine has an ever increasing number of diagnostic and therapeutic tools with which to intervene in the patient's behalf. These tools increase the inherent risks of medical intervention. These various factors have heightened the internist's concern over the growing medical liability crisis.

ASIM has been deeply involved in the development of methods to assure the quality of medical care and hence minimize the risks of malpractice. As early as 1969, we promoted the formation of state and local peer review committees and encouraged members to serve on these committees. ASIM has supported the intent of PSRO legislation in many ways including the publication of a guide to its implementation and participation in the current Private Initiative PSRO project.

The Society recognizes and accepts medicine's responsibility to assure the competency of physicians through the mechanism of the State Board of Medical Examiners. States should be encouraged to increase the powers of Boards of Medical Examiners if needed and to increase the funding and personnel of such Boards so that substandard practitioners can be re-educated or removed from the practice scene.

It is important to recognize that following a period of formal training, each physician develops specific competence in medicine based on his personal interests, past experiences and practice situation. Hence, it has become essential to develop new methods of assessing performance to define the levels of a physician's competence. ASIM is in the process of developing and evaluating a method of assessing the competence of a physician by evaluating his performance in his own practice setting. This project has been supported by voluntary contributions from both ASIM members and non-member internists.
We believe that such efforts to assure the quality of care should continue to be the responsibility of the medical profession. We therefore believe that federal licensure or relicensure will not be necessary.

We feel that the PSRO system in its present stage of development, is incapable of carrying out the wide-ranging functions necessary to assess the quality of medical care provided by individual physicians.

We believe that any legislative approach should address the problem of medical liability and should not be used to introduce restrictions that are unrelated to that problem, such as mandatory acceptance of Medicare assignments or required consultation with other specialists before surgery.

We are practicing internists, not experts in drafting legislation. But we believe we recognize some of the problems responsible for the current crisis and can suggest solutions. We realize that many of our suggestions are within the responsibility of state government.

1. The absence of data on costs incurred by insurance carriers in providing liability coverage makes it impossible to determine a fair rate of payment for such coverage. The insurance industry should provide such figures and thereby demonstrate its accountability to physicians, the public and the government.

2. The traditional system of payment for legal services should be reformed so that fees to attorneys more closely reflect the value of the services they have rendered. Present statistics indicate that only 17 percent of the professional liability insurance premium is returned to an injured patient. We feel that this is deplorable. Fee-for-service or sliding scale contingency fees should be utilized.

3. The statute of limitation on malpractice actions should be realistically reevaluated and appropriately revised. Two years would seem to be a realistic time period.

4. A malpractice suit against a physician should be brought to trial within 180 days of filing.

5. The medical record of the plaintiff should be made available, upon request, to the plaintiff's attorney prior to the filing of any legal action.

6. The concept of res ipsa loquitur should be reexamined in light of the fact that the "conspiracy of silence" no longer exists.

7. Binding arbitration and judicial specialization options appear to merit additional experimentation as substitutes for the jury system.