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Rx for Malpractice

Albert Averbach

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The volume of malpractice cases against doctors and hospitals has reached staggering proportions. They are being filed at the rate of 10,000 a year. It has been estimated that the cost for malpractice claims—including court judgments and out-of-court settlements—now totals at least 50 million dollars a year. The *Journal of the American Medical Association* has stated:

The risk of being sued by a patient is one of the facts of life for a physician in active practice. It cannot be ignored or wished away. It must be anticipated and faced.¹

In a survey conducted by the American Medical Association, it was reported that one out of every six physicians practicing medicine today has had at least one malpractice claim made against him.² In California the ratio is one out of every four doctors. In a ten-year period, it was reported that there was an increase of claims to an extent of 1000%. Jury awards have reached unprecedented high levels. Within a recent twelve-months' period, there was a jury verdict of $1,500,000.00 for a paralyzed anesthesia mishap victim in Florida. Within a short time thereafter a California jury reported a $1,400,000.00 verdict in an anesthesia "misadventure" for a paralyzed man and a $1,250,000.00 verdict shortly thereafter was reported in Albuquerque, New Mexico, for a boy who suffered scalp radiation burns during treatment for ringworm. These cases are the highest single injury jury awards in the United States, and all three of them are malpractice victories. I predict that within a span of five years hence we will read of three million dollar jury awards in medical-hospital malpractice cases.

The American Medical Association's Law Department prepared a survey of the limits of insurance coverage for malpractice in 50 states and the District of Columbia for the year 1963.³ 57.7 per cent of the doctors reporting carried $50,000/$100,000 malpractice policies and only 0.6 per cent carried a million dollars or over. 0.1 per cent carried $500,000/million. The cost of increasing a policy from $50,000/$100,000 to a million dollars is trifling and the hazards of high jury verdicts is currently so great that a doctor needs to reflect seriously upon whether or not he is adequately protected.

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[Editor's Note: This article is part of the proceedings of the American College of Legal Medicine's annual convocation. Please see Editor's Note at the beginning of this symposium.]

* Of the New York Bar; of Seneca Falls, Syracuse, and New York, New York.


A number of suits have been filed against a pharmaceutical manufacturer in connection with the drug MER/29, in which the total demanded in the complaints was stated to be four and one half million dollars. Many of the suits so brought involved named doctors as defendants with charges of negligent acts in prescribing the drug. This is the pattern that is causing great consternation among doctors for many suits are now pending against physicians who have prescribed drugs which have resulted in (untoward) effects.

Chemotherapy, anesthesia, surgical and/or medical advances in procedures seem to coincide with the filing of malpractice suits. Every tragedy that becomes the subject of extensive coverage by the news media shortly turns into a focal point of malpractice litigation. This, of course, is inevitable and will ever be thus. Doctors for many years have been "spoon fed" stories and warnings about malpractice suits and hazards. Nothing, however, has been constructively advocated as to how this tide can be stemmed or what can be done in the face of it. Some years ago, Mark Twain wrote, "Everybody talks about the weather, but nobody does anything about it." It is our objective in this article to not only alert the medical profession and the hospital administrators about the hazards of malpractice litigation, but in some measure to offer suggestions as to means and methods of avoiding such suits and their dire consequences.

The statistics herein reported are frightening and staggering. They have been referred to at the very beginning of this article not as "scare headlines" but merely to acquaint the medical profession and hospital administrators with the current problems.

As a trial lawyer, I have probably sued more doctors and hospitals in the past 40 years than has any other attorney in the country. I have been privileged to speak before more medical, nursing and hospital administration groups than any other plaintiff's trial lawyer on the subject "Rx for Malpractice." My views have been published in Hospital Physician, Medical Economics and other medical journals. It is, therefore, fitting and proper that I state some positive suggestions to avert a foreseeable national tragedy.

An orthopedic surgeon has recently written me that malpractice suits in the Commonwealth of Pennsylvania have reached "epidemic proportions over the past three years." One hospital in particular has about one hundred such pending suits. The malpractice insurance rates in Philadelphia for orthopedic surgeons have had a sixfold increase from an average of $600 to $3,300. Most insurance companies have dropped out of the field and are refusing to write any malpractice policies for any new physician moving into the area. He wrote that there is presently only one company writing coverage for surgeons. This doctor writes, "Obviously
no physician would dare practice without malpractice insurance coverage."

Many of the suits threatened or actually instituted could and should have been avoided. Bernard D. Hirsh, then Head of the Law Department of the American Medical Association, wrote an article with reference to blood transfusions in which he said:4

Approximately three thousand persons die every year as a result of an estimated 3,500,000 blood transfusions which are given annually in the United States. As a cause of death, the blood transfusion ranks with appendicitis or anesthesia. * * * The techniques for typing blood and checking the findings are about perfect but most of the deaths result from human error. It is this factor of human error which has been responsible for blood transfusion accidents that have caused serious disability and death, and has resulted in malpractice settlements and judgments as high as $150,000 where the wrong blood was administered.

When the immense panorama of medicine, surgery and all the related sciences is considered, it becomes readily apparent that if blood transfusions alone are productive of such a volume of litigation, then the entire picture on a country-wide basis must truly be earth shaking!

If we assume that the usual prayer for damages in each malpractice suit averages $500,000.00 and we have estimates of 10,000 suits of malpractice being filed annually against doctors, that would total 5 billion dollars. Add to this the amount demanded against hospital defendants, nurses and others, and we have an incredible picture confronting the treating professions. This volume of 10,000 cases per annum is equivalent to the annual number of cases disposed of at trial level in all of the Supreme Court sessions in the entire State of New York!

The Reasons For Such Unprecedented Litigation

First and foremost, the reason that so many malpractice suits are presently commenced is unquestionably the doctor’s "loose talk." A doctor speaking at a seminar of the American Association of Medical Clinics said, "Careless statements by physicians about their colleagues and their professional skill has been the cause of between 25 per cent and 30 per cent of malpractice actions."

Paul R. Hawley, while Director of the American College of Surgeons, was quoted in the following fashion: "One-half of the surgical operations in the United States are performed by doctors who are untrained or inadequately trained to undertake surgery." * * * "One of the world’s most distinguished surgeons has told me that ‘at least one-half of his entire practice consists of attempts to correct the bad results of

4 Responsibilities in Blood Transfusions, 1 Medicolegal Digest (2) reprinted in 2 Tort and Medical Yearbook 876 (1962).
surgery undertaken in community hospitals by doctors inadequately trained in this field." 5

Dr. James C. Doyle of the University of California, after studying 6,248 hysterectomies, reported that two out of five were unnecessary and unwarranted. 6 Dr. Walter C. Alvarez is reported as stating that in 385 appendectomies studied, 225 were mistaken diagnoses or not acute attacks. 7

Dr. Arthur James Mannix of the Department of Surgery of the New Rochelle Hospital in New York, stated: "Errors in judgment or technique concerning either the anesthesia or the surgery, or a combination of the two, contribute close to 50 per cent of the mortality in the operating room. It is here that death occurs, not only because of the gravity of the disease or the magnitude of the procedure, but also because someone in a responsible position ignored some fundamental principle of good therapy." 8

Dr. Miley B. Wesson has written that "My observation has been that every malpractice suit, without any exception, is instigated either directly or indirectly by a doctor." 9 In the Journal of the American Medical Association, 14 per cent of the cases reported resulted from criticism by other doctors.

It is amazing how often clients of this office report that a doctor, viewing a surgical scar, has violated the specific instructions of the A.M.A. Legal Department, reading as follows: "Many actions are the result of an unwise statement made to a patient or a friend of the patient by the attending physician, his partner, assistant, or office nurse. Care should be taken to avoid making any remark which may be construed as an 'admission' of fault. It is understandable that such remarks are usually made under emotional stress or when exercising 'hindsight' in the face of an unsatisfactory result, even though proper practice has been followed throughout. The effect of such a remark on a jury is incalculable and almost impossible to counteract."

The A.M.A. published 21 prevention "commandments," the third of which reads as follows: "The physician must avoid destructive and unethical criticism of the work of other physicians." Notwithstanding this adjuration, many clients have reported a doctor saying, "What butcher made that horrible looking scar?"

6 T. F. James, The American Weekly; and Averbach, 3 Handling Accident Cases 9 (1958).
7 Averbach, 3 Handling Accident Cases 9, (1958).
The late Dr. Louis J. Regan, an authority on malpractice and author of two editions of Doctor and Patient and the Law, said, "The precipitating cause of a majority of all malpractice actions is found in the unwise comments or criticism of physicians with regard to treatment given to patients by other physicians. Commonly it is criticism by a succeeding physician of the work of his predecessor on the case. Various authorities have estimated that 50 to 80 per cent of all the suits for malpractice would be eliminated if such destructive criticism could be stopped."

The greatest disservice to the medical profession in recent years, however, in my personal opinion, comes from the rash of hospital, nursing and medical T.V. shows which deal with the subject of malpractice trials. In one particular year, it seems that every medical and legal program series was trying to outdo each other in jumping on this "band wagon." Millions of people watched the "Ben Casey," "Dr. Kildare," "General Hospital," "The Nurses," "Breaking Point," "The Eleventh Hour," "Judd for the Defense" and other series programs of like ilk which have made the viewing public malpractice conscious and have alerted the public to such potentials.

A striking example was the "Dr. Kildare" program dealing with the "Good Samaritan," in which a $55,000.00 jury award was visualized as having been found for the death of a child in a roadside birth. Within a few weeks there followed a program entitled "Conspiracy of Silence" dealing with a malpractice problem on "The Defenders" program. Further, in one week, within a span of four days, three popular T.V. shows, "Ben Casey," "Dr. Kildare," and "The Defenders," had their programs built around malpractice suits. Many of these programs painted lurid pictures wholly unwarranted by the law dealing with malpractice and were the foci of malpractice infections.

One of the greatest, single reasons for the current frequency of malpractice actions is the thoughtless leaving in waiting rooms of medical journals containing malpractice articles. Medical Economics in a memo from the editors of this widely-circulated journal said: "Medicolegal twist—How can a doctor start a malpractice suit against himself? By placing Medical Economics or the A.M.A. Journal in his reception room. * * * Medical Economics doesn't belong in any doctor's waiting room. It's written to help him with practice-connected business problems, and these don't make appropriate reading for sick people waiting to see him. * * * Malpractice articles are even more of a problem. According to our readership surveys, malpractice is the topic that doctors most want to read about. The reason is obvious: In our present claims-conscious era, facts about malpractice are the doctor's best defense. But the best defense can be undermined if he passes these articles along to his patients."

The most important factor today behind the current wave of disaffection among the patients toward the treating physician and surgeon,
is the doctor's own public image, which is slipping. And the reason it is slipping, is unfortunately, the public utterances that the doctors have permitted, sanctioned or approved. Some of the public utterances were on television, radio and motion picture portrayals, and some in books read by the public. There have been many books published for mass reader consumption that have been highly critical of the medical profession, such as:

- Kramer, *The Negligent Doctor*
- Gross, *The Brain Watchers*
- Doctor X, *Intern*
- Rogers, *Oath of Dishonor*
- Gross, *The Doctors*
- Greenberg, *The Troubled Calling*
- Kerr, *The Clinic*
- Anonymous, *The Healers*
- McLeave, *The Risk Takers*
- Cook, *The Plot Against the Patient*
- Martin, *All the Gods and Goddesses*
- LaSagna, *The Doctors' Dilemmas*
- Wilson, *Hall of Mirrors*
- Barkins, *Are These Our Doctors?*
- Blaustein, *Doctors' Choice*
- Winchester, *The Practice*

Many of the magazines with extensive reader circulation, such as, *The Saturday Evening Post, Reader's Digest, True, Good Housekeeping, Red Book*, and many others, as well as newspapers have carried numerous stories of and concerning malpractice actions, all of which have contributed in large measure to the current crop of malpractice suits.

One of the most recent articles appeared on the front page of the *Wall Street Journal*, February 28, 1969, entitled “Suing the Doctor” with subtitles as follows: “Chances for Success in Malpractice Suits Are Rising, Experts Say,” “Court Lawyers Make It Easier to Circumvent Lack of Physicians' Testimony,” “A Threat to Medical Care?”

Medicine must do something about the “loose talk” that is responsible for “anti-doctor” expressions on radio, television, public platforms, medical society meetings, and in journals containing malpractice articles, mass media books, pamphlets and articles which are lighting the fires of the suit-minded public these days.

In an issue of *Good Housekeeping Magazine*, we find the following in a feature article: “... some authorities have argued within medical circles that a significantly high number of operations are not justified. * * * ... a survey released last year by the Columbia University School of Public Health and Administrative Medicine on care received by Teamsters Union members and their families claimed: Twenty of sixty hysterectomies in the cases studied were considered unjustified. ... * * * In seven out of 13 Caesarean sections questions were raised about the oper-
Additionally, records of the Joint Commission on Accreditation of Hospitals, the medical world's own watch dog for safe hospital practices, have shown that there are doctors who operate needlessly. In one instance, 80 per cent of the appendixes removed by one Michigan surgeon were normal. It was learned he was deliberately diagnosing menstrual pain in young girls as appendicitis. A surgeon in Indiana was cited for unnecessary operations. In a 10-year period, he had performed 16,104 major operations, an average of 5.2 a day, six days a week. Such disclosures have shocked the public and the medical profession.

A Washington Post article, which received wide circulation through the media of reprints in area newspapers, contained the following language: "Over 1,200 Patients Will Die Accidentally Says Harvard Doctor: About 1,200 hospital patients are accidentally electrocuted annually while receiving 'routine diagnostic tests' or treatment because of faulty equipment." The source of the information was Dr. Carl W. Walter, Clinical Professor of Surgery at Harvard Medical School and a surgeon at Peter Bent Brigham Hospital, Boston. The disclosures were made by Ralph Nader in testimony before the National Commission on Product Safety. Dr. Walter said in a telephone interview that "many of the electrocutions occur during diagnostic procedures in which the patient is hooked up to electronic systems. Almost invariably, he said, the deaths are listed as cardiac arrests—and who's to prove electricity did not cause the heart stoppages." He further said that "most hospital electrocutions occur when untrained hospital employees link together incompatible electronic units. But other such deaths, he said, are caused by surges of high voltage leaking from equipment, poor circuit design and connecting patients to electronic equipment for long periods of time—as in intensive care units." 10

Medicine is organized on a national, state and local level, and many of the medical societies have decried the public utterances herein referred to. Yet, nothing concrete seems to have resulted from such endeavors. I believe that such utterances are doing immeasurable harm to the medical profession as a whole and are the causative factors for the current rash of malpractice litigation. As a lawyer examining many files charging acts of malpractice against hospitals, doctors and nurses, I can safely assert that many of these claims would never have come to light except for the T.V. programs, radio programs, books, newspapers and magazine articles about the subject of malpractice. The amazing thing about these T.V. enactments of malpractice courtroom scenes is the fact that credits are given to the A.M.A. for their cooperation. It is my understanding, however, that the scripts are not submitted in advance for crit-

ical analysis to the A.M.A. If my understanding is correct, it seems to me that great harm is being done the doctor’s public image and a definite constructive program is needed on the part of the doctors to make certain that objectionable scripts dealing with doctors are carefully screened in advance, not after the harm is done. Letters of protest are fruitless and are not accomplishing any constructive results.

One of the “Dr. Kildare” programs showed trial lawyers involved in a malpractice case in an unfair light. As a result, a plaintiff’s bar association of fourteen thousand members filed protests with the Federal Communications Commission, the National Broadcasting Company and the producers of the T.V. show. It resulted in action because assurances were secured that all future scripts would be subjected to and edited by a board of attorneys. This agreement came from the Motion Picture Code Agency. Action of this sort is badly needed on behalf of the medical profession to prevent untold harm now being done by some of the T.V. programs.

A Senate Subcommittee, inquiring into the drug industry, released a story in connection therewith to indicate that “more than 1.3 million therapeutic misadventures occurred last year with respect to widespread adverse drug reactions.” Unquestionably, this news release will generate further malpractice suits. David Sarnoff is quoted in the Committee report as stating, “The thrust of invention and development has placed us all in an informational pressure cooker, and nowhere is this fact more clinically apparent than in the field of medicine. I am told by a doctor friend that 7 out of 10 prescriptions written today are for items unknown to medicine before World War II. The communications problems that result are more serious here than in any other area, since human health and life itself are involved. * * *”

Don E. Francke, a hospital pharmacist, is quoted as saying: “Despite the efforts of the A.M.A.’s Council on Drugs, physicians today do not have the help they so desperately need in selecting drugs. How do they select the ‘best’ drug from some approximately 45 different tranquilizers, 20 psychic energizers, 20 sedatives, 25 antihistamines, 30 antispasmodics, or 30 diuretics available when each is said to be the ‘best’? Until evaluative information is available, a larger number of physicians will pride themselves in prescribing the latest drug and the newest combination, thus perpetuating the vicious cycle. No basic progress will be made in correcting this problem until physicians themselves recognize that a problem exists and that they themselves have helped to create it.”

Another devastating factor is the recent publication in area newspapers of the amounts paid to doctors under the Medicaid programs. A recent front page article in the Syracuse, New York, Herald American (Sunday, March 9, 1969) stated “the two-year figure comes to an eye-opening $4,738,099.16. The free service for eligibles during 1967-1968
comes to a grand total of $19,111,251.16." Then follows, a full-page listing of the various doctors in Onondaga County showing the totals paid for the year 1968. The high man on the "totem pole" was listed as having received payments of over $59,000.00 and over $13,000.00 in addition. Similar articles have appeared in various newspapers across the country.

What Can Be Done to Stem the Tide of Malpractice Litigation

Experience dictates the obvious fact that many of the malpractice suits which result in adverse newspaper notoriety, when a jury has reported its verdict, could have been avoided by a prompt settlement of the meritorious case. Presently, with but few exceptions, there is no concerted effort on the part of medical society groups at local levels to create so-called "malpractice screening committees" to review charges of malpractice before they get into the courts. Such committees would do much to remedy the current situation.

Meritorious claims against doctors should and could be settled out of court without damage to the profession. Meritorious claims of malpractice should not be allowed to go free of penalty. There is a contagion about malpractice suits which is nurtured by publicity. The winning of a suit that has gained newspaper, TV and radio coverage encourages the filing of similar suits.

Most state medical societies have grievance committees which should be utilized more frequently to give prompt and fair consideration of the complaints made by patients against doctors. In various areas of the country there are county screening committees which investigate and screen the unjust from the just complaints. These committees when convinced that the doctor has committed an act of malpractice that has harmed the patient are in a position to offer medical testimony in the courts if the case is not promptly settled out of court. One of these county plans is the so-called Pima County (Arizona) Plan. It has been adopted and in effect in about 23 states among which are Alameda County, California; Santa Clara County, California; Los Angeles, San Francisco and San Diego, California; Washoe County, Nevada; Virginia; Idaho; New Mexico; Bergen, New Jersey; Delaware; Nassau County, New York; Buck County, Pennsylvania and so forth. The Pima Plan consists of a panel of an equal number of doctors and lawyers selected from the county medical society and the Bar Association. The function of this panel is to screen malpractice claims made against doctors of the particular county.

Under the Pima County plan, the attorney for the claimant of malpractice writes a letter to the chairman of the panel setting forth the claim. Authorization is given to inspect the medical records, but the proceedings of the panel are confidential. The claimant's letter is transmit-
ted to the doctor against whom the claim is asserted. A hearing date is fixed.

At the hearing, the claimant's attorney may present his case in any way he sees fit, following which the attorney for the doctor puts on his case in any manner he chooses. The parties and the witnesses may be questioned by either side. When the hearing is terminated, the panel proceeds to answer the question, "Is there substantial evidence of malpractice?" If the answer is in the affirmative, the next question is, "Was there substantial injury resulting from the malpractice?" A negative answer to either question ends the matter and the attorney for the claimant refrains from filing suit unless "strong and overriding reasons compel such action to be taken." If both questions are answered in the affirmative, the medical society cooperates with the claimant in the preparation and trial of his case.

The Pima County plan does not prevent the commencement of malpractice cases, but it succeeds in most instances in the stopping of unjustifiable lawsuits and it provides, where justified, medical evidence in court which is the trial lawyer's great bugaboo. Settlement of just cases is enhanced, and, to a large measure, the image of the doctor is enhanced.

I heartily recommend the adoption of such a joint plan by the county Medical Society and the county Bar Association in every county in the nation. I firmly believe that such panels will do much to prevent the filing of unnecessary malpractice lawsuits, to eliminate the necessity of trial courts stretching the rules of "res ipso loquitur" and also the enactment of state laws similar to that of Nevada, Massachusetts and Alabama which have lessened the restrictions on the requirement for the need of expert testimony. The wider use of such advisory panels would also put a stop to the oft-quoted phrase "conspiracy of silence" as applied to the medical profession. I am informed that the experience of those counties which are operating under a malpractice screening plan is favorable and that such plans, in large measure, eliminated the friction existing in many areas between the medical profession and the law profession.

In a report of the Committee on Medico-legal Problems of the American Medical Association, published in its Journal, it is stated that for the sake of both himself and his colleagues, the doctor should make a determined opposition to an unjustified claim. Conversely, he has a moral obligation to settle and grant damages to a patient he has injured through negligence or breach of duty.11

The AMA study indicated that out of each 100 claims asserted each year, 15 remain pending, 22 are dropped, 42 are settled, 4 result in

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verdicts for patients, and 17 result in verdicts for physicians. Out of the total of 100 claims, 43 resulted in lawsuits and 57 did not. . . .

Professional liability litigation is regarded by many as a contagious disease of the social body, because the winning of a suit inevitably encourages the filing of others as patients become increasingly "suit conscious." Each successful defense of an unjust suit, on the other hand, serves as a discouragement to the filing of others. . . .

**Doctors Are Now "Target" Defendants**

As a direct result of sensational publicity in connection with malpractice suits, recent medical "exposes," judicial misunderstandings and the writings and utterances of the physicians themselves, an upsurge in medical malpractice suits filed and awards granted have been noted as recent developments. A few years ago the public was so enamored of the doctors' image that it was quite difficult to convince a jury that he should be stigmatized by a plaintiff's verdict in any malpractice suit.

But now the tide has turned; in large measure due to the newspaper accounts of large sums paid to doctors under Medicaid or Medicare programs. Today a patient contemplating a malpractice suit against a doctor is impressed by the fact that usually the doctor is living in the most elaborate home in the town and is driving the most expensive foreign car, such as a Ferrari or a Bentley, and apparently from all outward appearances is well able to pay a substantial judgment, so the patient does not hesitate to sue for a large sum.

**Education of Doctors As to Malpractice Pitfalls**

Many medical societies are currently utilizing the expertise of lawyers handling malpractice cases to talk to medical society groups about common errors and pitfalls which lead to malpractice litigations. The author has had the privilege on many occasions of talking to national, state and county medical groups on malpractice subjects. It is surprising how much misunderstanding exists currently among physicians and surgeons about the subject of malpractice. Conferences of this nature should be encouraged so that the doctors can fully resolve some of their misapprehensions.

**Legislative Reforms**

Two states have enacted laws that permit introduction of standard medical texts to establish malpractice (Massachusetts and Nevada). Other states will probably follow suit if the medical profession does not take the lead in providing medical testimony where patent departures from accepted medical practice is illustrated. Alabama, by judicial rule,

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12 Ibid.
permits a plaintiff to "outflank" the conspiracy of silence by using medical books as substitutes for medical testimony in malpractice cases. Wisconsin, by statute, permits out of state doctors to testify in Wisconsin in malpractice cases.  

Unless some realistic soul-searching is done by the medical profession, the reluctance of doctors to testify in a meritorious case will reach the proportions of a national scandal and result in a definite swing of the courts and public opinion in favor of injured claimants.

Prophylaxis For Malpractice

Every major court decision in the field of medical-hospital malpractice has resulted in severe setbacks in medical or surgical procedures. Many of the laboratory tests and X-ray procedures that materially add to the cost of hospital patient care are truly chargeable to some malpractice award. Doctors are busy insulating themselves from the threat of a malpractice suit by more consultations, more lab tests, more X-rays, more work-ups at more expense to the patient.  

The Courts have become increasingly aware of the reluctance of physicians to testify against their errant brothers. More and more courts have uttered the words "Medical Conspiracy of Silence." As a result, the expanded theories of physician or hospital liability have found sanctions. The use of the doctrine of res ipsa loquitur ("The thing speaks for itself") has been stretched beyond understanding, particularly in the State of California. To stem the tide, New Jersey enacted a Court rule requiring submission of medical malpractice cases to a screening committee made up of two doctors, two lawyers and a former Justice of the Supreme Court or former Judge of the Superior or County Court who acts as chairman of the subpanel and votes only in case of a tie. But the statistics show that such procedure has not cured the malpractice problems in New Jersey.

Recently, a Judge of the United States Court of Appeals for the District of Columbia Circuit wrote:  

The court finds that the patient's claim founders on the wall of protection with which the law surrounds the doctor. I would hold that the jury should have been permitted to decide whether an inference of negligence should be drawn from the fact that, in removing her tooth, the doctor fractured her jaw.

The law of malpractice is clearly defined in most jurisdictions as it is here. Before the plaintiff-patient can recover, he must show that

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13 See, Wisc. S.A. § 147.14(b).
14 N.J. Court Rule 4:25B—Professional Liability Claims Against Members of the Medical Profession; Procedure.
his injury resulted from his doctor's failure to exercise that degree of care and skill exercised by a doctor practicing the same specialty in his locality. In mounting such proof, the plaintiff must prove by testimony from the defendant's own professional colleagues what the degree of care and skill in the area is and that the defendant failed to exercise such care and skill. The human instinct for self-preservation being what it is, there is often disclosed in the trial of these cases what has been referred to as the conspiracy of silence—the refusal on the part of members of the profession to testify against one of their own for fear that one day they, too, may be defendants in a malpractice case.

In an effort to lighten this enormous burden, plaintiff-patients have sought to use the doctrine of res ipsa loquitur, on the theory that, at least in those cases where the conditions which cause the injury are completely under the control of the doctor, the patient has no way of knowing, and therefore showing, what the doctor did that lacked the degree of care and skill required by the law. Most courts have now recognized the application of this doctrine in malpractice cases, but in a very limited area. Where the cause of the injury is such as to be obvious to the lay mind, like leaving a sponge or surgical instrument in the body during an operation, no expert medical testimony is required to show that, but for negligence on the part of a surgeon, the injury would not have resulted. This court has recognized the application of res ipsa in such situations. . . .

This protective wall which the law has erected around doctors is founded on the philosophy that if an extraordinary and injurious result were held to be evidence, however, slight, of negligence on the part of the physician or surgeon causing the bad result, few would be courageous enough to practice the healing art, for they would have to assume financial liability for nearly all the "ills that the flesh is heir to." This philosophy may have been sound in the nineteenth century before the days of liability insurance. But today, with insurance, financial responsibility is not one of the dangers to the doctor in a malpractice suit.

A California Court said: 16

But gradually, the court awoke to the so-called "conspiracy of silence," no matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him in litigation based on his alleged negligence. Not only would the guilty persons thereby escape from civil liability for the wrong he had done, but his professional colleagues would take no steps to insure that the same results would not again occur at his hands.

The courts have utilized the doctrines of "res ipsa loquitur," "informed consent" and "captain of the ship" to impose liability to overcome the so-called "conspiracy of silence."

Dos and Don'ts to Avoid Being Sued

The best way to avoid being sued for malpractice is to establish and continue a good patient-physician relationship. The two incendiary elements that bring about malpractice cases are generally a poor medical or surgical result and a breakdown of the patient-physician relationship. Many malpractice suits can be prevented or avoided by the doctor if he is careful in his attention to the patient and the establishment of a good rapport between his patient and himself, especially so in the case of a bad medical or surgical result.

If a patient has been fully forewarned of the possibility of a bad result in the case before the commencement of treatment or surgery, there is less likelihood of the commencement of a law suit. It is, therefore, vitally important that the doctor give serious consideration of forewarning the patient of possible dangers or risks of complications so that the patient will understand what is apt to happen and is far more likely under those circumstances to accept the suggested surgical or medical treatment with knowledge of the possible consequences. A frank discussion with the patient in advance of treatment or operative procedure frequently is a perfect insulation against later discontent and malpractice suits.

It is important also that doctors fully understand the various situations which would make one physician or surgeon liable for the acts of malpractice of another. This means a realization of the law of "vicarious liability" for the acts of an agent, an assistant, an employee, or an attending physician called or recommended by the doctor, of a substitute of a physician employed or acting jointly, of an operating surgeon for the acts of malpractice for the anesthesiologist or the nurse anesthetist or for the acts of the nurse, for the acts of a staff physician or one with hospital privileges, for the acts of a physician employed by the hospital, for post-operative care, and for the neglect or failure of post-operative care.

Many articles have been written about the doctrine of "respondeat superior," of the doctrine of "vicarious liability," and of the "captain of the ship" doctrine. All of these various doctrines have immense overtones on the questions of liability in a malpractice case. In most of the states Courts have imposed liability on the surgeon for the negligent acts of those assisting him in the course of an operation. This would include the negligence of nurses, interns, physicians, and surgeons under the so-called "borrowed servant rule."

The principles of responsibility for the acts of the agent have been labeled by the courts in many styles, some understandably and some hard to understand. These terms include "captain of the ship," "vicarious liability," "borrowed servant rule," and the "respondeat superior rule." The application of these various rules are not easily explainable nor are...
they well understood by the medical profession but frequently the ques-
tion of who is legally responsible is of paramount importance and an
understanding of the principles that make the master liable for the acts
or neglect of his servant are vital.

The nurse or nurse anesthetist is an employee of the hospital. How-
ever, while scrubbing or administering any anesthesia for a surgeon, she
is under his exclusive control the law says, even though she is hired and
paid by the hospital and can be fired by the hospital. So in the operating
theater, she becomes the servant of the surgeon, but once she enters the
operating room to administer anesthesia, she is under the sole direction
of the surgeon and not of the hospital and under the “borrowed servant”
doctrine, she becomes the servant of the surgeon under his exclusive
control which makes him responsible for her acts of negligence. How-
ever, this situation does not apply in case of a medical anesthesiologist
and some cases have been decided that he is also a “captain of the ship”
and his acts of negligence do not generally make the surgeon liable.
However, there are modifications of the rule and exceptions thereto.

No amount of rationalization or even discussion in this article would
serve the purpose of pointing out the many pitfalls to liability presented
to a doctor under the current state of malpractice law. Obviously, a doc-
tor busy with the details of his own practice isn’t going to have time to
go through the reported cases of the many jurisdictions to determine the
applicability of the various situations pointed out as hazardous in this
article. It is, therefore, recommended that on any question involving
a decision as to whether or not a doctor should engage in a partnership
practice or with associates on sharing space that counsel skilled in mal-
practice law be consulted in an advisory capacity. There are many cur-
rent pitfalls which a doctor must know about and protect himself
against.\textsuperscript{17}

The True Solution of the Problem

It is my considered opinion that the consent forms for hospital and
surgical use must be redrawn and throughout the country a new pro-
vision inserted requiring the patient to agree \textit{before} surgical, medical or
hospital service \textit{is commenced} to an arbitration agreement.

The arbitration clause should require the naming of a doctor, a law-
year and an experienced scientific man (such as a Fellow of the American
College of Legal Medicine) or the American Arbitration Association to
arbitrate any and all alleged malpractice disputes between client and
doctor or hospital.

California has recently modified the Conditions of Admissions forms
of several hospitals to include an arbitration clause reading as follows:

Arbitration Provision: Any controversy or claim for which there would be an action under the substantive law of the Land arising out of or relating to this agreement, whether involving a claim in tort, contract or otherwise including the issue of arbitrability itself, shall be settled by arbitration in accordance with the procedural rules of the American Arbitration Association and upon the substantive law of the Land. Judgment upon the award rendered by the Arbitrator(s) may be entered in any court having jurisdiction thereof.

Insurance companies are accustomed to the arbitration of claims among themselves. Millions of such claims involving property damage losses are so handled. Arbitration clauses are common in industry labor contracts, insurance contracts for fire losses, disputes between manufacturer and retailer and many other situations. A New Jersey court has held that the court should encourage arbitration of disputes between attorney and the client.\(^\text{18}\)

New York State's present Civil Practice Law and Rules provides for arbitration by statute law (Article 75). New York Arbitration Law basically has been held to be sound and has been the model for the laws of other states. It was first enacted into law in 1921. Section 7501 provides as follows:

A written agreement to submit any controversy thereafter arising or any existing controversy to arbitration is enforceable without regard to the justiciable character of the controversy and confers jurisdiction on the courts of the state to enforce it and to enter judgment on an award. In determining any matter arising under this article, the court shall not consider whether the claim with respect to which arbitration is sought is tenable, or otherwise pass upon the merits of the dispute.

An example of the usage of arbitration by medicine can be found in the Court of Appeals decision: "In the Matter of the Arbitration between the Astoria Medical Group et al, respondents and Health Insurance Plan of Greater New York, appellants."\(^\text{19}\)

Encouragement is absolutely necessary for the appropriate use of arbitration procedures in this classification of litigation. It is unreservedly recommended to alleviate the present unsettled situation existing in the courts of the country with reference to the interpretation of the physicians' responsibility as well as the hospital's responsibility and liability to the patient. It is possible by the use of arbitration clauses to remove medical-hospital malpractice cases from the courts. They no longer belong there. They should be promptly removed for the good of all—this includes the deserving plaintiff whose claim might be rejected because of jury antipathy to bringing in a deserved jury award against

a doctor or hospital, as well as a doctor or hospital sued by a tragically injured patient who could succeed merely by the imposition of the doctrines of "res ipsa loquitur," "captain of the ship" or lack of "informed consent."

My views on this subject have been widely circulated in articles entitled "A Plaintiff's Attorney Says Medical Malpractice Cases Don't Belong in the Courts!," which appeared in the January 1969, issue of Hospital Physician and in the March 17, 1969 issue of Medical Economics.

Emotions are too easily aroused to gamble with a fair determination in such cases at the hands of laymen serving as jurors or from judges, with no educational background in medicine or surgery. The proper place for such cases is in arbitration where scientific minds can be recruited to resolve differences of such nature. The time is now ripe for such a change!