

Tulsa Law Review

Volume 8 | Issue 2

Fall 1972

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Recommended Citation

Stephen L. Andrew, *Malpractice Suits: The Increased Cost of Health Care*, 8 Tulsa L. J. 223 (2013).

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MALPRACTICE SUITS: THE INCREASED COST OF HEALTH CARE

Action by husband and wife charging the defendant surgeon with negligence in connection with the treatment of a cancerous condition in the wife;¹ action by female plaintiff charging the defendant surgeon with malpractice in carrying out an operation to change the appearance of her anatomy;² action by a twenty-four year old male to recover damages which resulted when the defendant surgeon permitted an electric light bulb to pass through the plaintiff's throat and lodge in his lung;³ action by father and son to recover damages sustained when the defendant physician failed to adequately care for the minor who was admitted to defendant's hospital suffering from third degree burns covering eighteen percent of his body;⁴ action by parents and infant for damages sustained when the defendant physician used an unsterile instrument to circumcise the two day old child;⁵ action for damages which resulted when the defendant surgeons broke off and left an instrument in the plaintiff's body during surgery;⁶ action by husband and wife to recover damages for injuries to the wife which resulted when the defendant physician left

¹ *Gist v. French*, 136 Cal. App. 2d 247, 288 P.2d 1003 (Dist. Ct. App. 1955) (judgment for plaintiffs in the amount of \$79,000).

² *Gluckstein v. Lipsett*, 93 Cal. App. 2d 391, 209 P.2d 98 (Dist. Ct. App. 1949) (judgment for plaintiff in the amount of \$115,000).

³ *Rhodes v. Lamar*, 145 Okla. 223, 292 P. 335 (1930) (judgment for plaintiff in the amount of \$8,000).

⁴ *Carrasco v. Bankoff*, 220 Cal. App. 2d 230, 33 Cal. Rptr. 673 (Dist. Ct. App. 1963) (judgment for plaintiffs in the amount of \$41,500).

⁵ *Valentine v. Kaiser Foundation Hosps.*, 194 Cal. App. 2d 282, 15 Cal. Rptr. 26 (Dist. Ct. App. 1961) (judgment for plaintiffs).

⁶ *Taylor v. Milton*, 353 Mich. 421, 92 N.W.2d 57 (1958) (judgment for plaintiff in the amount of \$2,500).

a laparotomy sponge in the female's abdomen following a caesarean operation;⁷ action against a physician for convulsive fractures sustained by a patient while undergoing insulin therapy for the treatment of emotional illness;⁸ action by the mother of a boy who died within twenty-four hours of an accident, charging the defendant physician with malpractice for failure to diagnose and treat an epidural hemorrhage;⁹ action for damages due to plaintiff's loss of an eye following surgery performed by the defendant physician;¹⁰ action for damages sustained when the plaintiff's appendix was not removed to its base.¹¹

The preceding cases are representative of the causes of action brought against physicians prior to 1970.¹² A review of these actions reveals three common characteristics. First, in each action brought to trial a *prima facie* case of negligence existed against the physician. Second, in each of the cases the plaintiffs violated the long standing belief that the "physician knows best" and alleged that the proper degree of care had not been exercised. Third, these allegations were generally made in the community where the physician had established his practice of medicine.

⁷ *Key v. Caldwell*, 39 Cal. App. 2d 698, 104 P.2d 87 (Dist. Ct. App. 1940) (judgment for plaintiffs).

⁸ *Mitchell v. Robinson*, 360 S.W.2d 673 (Mo. 1962) (judgment for the defendant).

⁹ *Huffman v. Lindquist*, 37 Cal. 2d 465, 234 P.2d 34 (1951) (judgment for defendant because of insufficient evidence).

¹⁰ *Scarano v. Schnoor*, 158 Cal. App. 2d 612, 323 P.2d 178 (Dist. Ct. App. 1958) (judgment for defendant).

¹¹ *Haggerty v. McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962) (judgment for defendant).

¹² See also *Riley v. Layton*, 329 F.2d 53 (10th Cir. 1964); *Christopher v. United States*, 237 F. Supp. 787 (E.D. Pa. 1965); *Kolesar v. United States*, 198 F. Supp. 517 (S.D. Fla. 1961); *Tyler v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969); *Corey v. Wilson*, 93 Idaho 54, 454 P.2d 951 (1969); *Denison v. Goforth*, 75 Wash. 2d 853, 454 P.2d 218 (1969); *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1949).

With the introduction of new techniques for the care and cure of diseases, the '70's will see new types of actions being litigated against the physician. Suit may be brought due to a malfunction of a cardiac pacemaker, the failure of a renal dialysis machine, the malfunction of a heart valve replacement, the adverse effects of new drugs, the failure of an artificial body organ, or even a faulty computer diagnosis. In essence, while the allegations as to the cause of injury may change, physicians will continue to be subject to malpractice actions in the future.

However, it would appear that the '70's should also see a reduction in the litigation of claims with the first of the three common characteristics. This reduction will occur, not because sponges and instruments will no longer be closed within surgical openings, but because the insurers of physicians will settle more of these claims out of court. While the insurers will continue to litigate the "unjustified" actions, they will agree, with increasing frequency, to settlement of the *prima facie* claims.

The second and third common characteristics will also continue to exist into the '70's. No longer is the belief that the "physician knows best" viable. Perhaps this can be attributed to the fact that the concept of the family physician is no longer prevalent in our society. The heart specialist is a heart specialist, not a family physician. Today we do not choose a physician, we are referred to one depending on our affliction. During the '70's the relationship between the physician and patient will continue to become less personal and more business oriented. As a result, patients who are given improper treatment will be even less hesitant about bringing suit against their physician.

The fact that malpractice suits have been brought and will continue to be brought has had three adverse effects on the practicing physician. First, the premiums the physician

must pay for malpractice insurance have increased substantially:

In New York the rates have increased 439 percent in the last 5 years. This is during the period of July 1, 1966 to July 1, 1971

The average rates for all doctors in New York effective July 1, 1971, is \$1,811 for limits of \$500,000/\$1,500,000.

The highest rate for a doctor in New York who has not been surcharged for poor experience is \$6,797 for limits of \$500,000/\$1,500,000.

The highest rate charged a doctor whose rates have been surcharged for bad experience is \$23,000.¹³

The second, and most important, adverse effect is that the fear of a malpractice suit may affect the method of practice adopted by the physician:

After a physician has had a suit brought against him the threat of possible future suits hangs over him like a cloud. It affects his daily life and never again does he enjoy his work as much as beforehand and probably does not do as good a job. He may tend to avoid treatment problems simply because they carry considerable risk and potential legal action.¹⁴

As stated by a prominent physician:

Physicians state that they must practice defensive medicine because of the number of claims and that they have discontinued performing certain procedures because of their inherent risk. Physicians are practicing defensive medicine and not good medicine. Until some physicians feel that there will be some relief from malpractice litigation they will continue to act defensively. This attitude will not change.¹⁵

¹³ Linster, *Insurance View of Malpractice*, 38 *INS. COUNSEL J.* 528, 529 (1971).

¹⁴ Daughtry, *The View of the Medical Profession*, 38 *INS. COUNSEL J.* 534, 536 (1971).

¹⁵ Goldsmith, *Medical Malpractice Trends*, in *LEGAL MEDICINE ANNUAL*: 1971 at 451 (C. Wecht ed. 1971).

The third adverse effect is that a malpractice suit may affect the physician's professional reputation in the community where he practices. This is directly related to the second effect and may cause him to lose patients either directly or through referrals from other physicians.

The effect of malpractice suits has also been felt by the consumer or patient in two major areas. First, the cost of health care has substantially increased. Through January, 1972, using the health care components of the Consumer Price Index, the Daily Hospital Service Charge has increased 67.1% since 1967 and the Physician's Fee has increased 32.3%.¹⁶ Second, the consumer will not receive either the best, or the most economical, treatment available if his physician is practicing defensive medicine.

Malpractice suits have and will continue to have effects on both the physician and the consumer. Higher malpractice insurance premiums have a direct inflationary effect on the cost of health care. This cost is increased even more by the practice of defensive medicine. The use of extra diagnostic tests, the opinion of one or more consultants, and other defensive practices may safeguard the interest of the physician, but they must also be paid for by the patient. While some of these extra tests and consultations may result in better treatment, most will not be reasonable or necessary for the actual needs of the patient. Since physicians, like all businessmen, pass their costs on to the public, the consumers will, in the long run, absorb the entire cost of the malpractice phenomenon.

The question that must be considered is whether or not the consumer should bear the increase in the cost of health care which is attributable to the practice of defensive medicine.

¹⁶ Information furnished by the Research Department, Group Hospital Service, Tulsa, Oklahoma.

On July 30, 1965, Congress enacted Public Law 89-97, "Health Insurance for the Aged Act."¹⁷ The purpose of this legislation was to:

[P]rovide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing three new health care programs: (1) a compulsory hospital-based program for the aged; (2) a voluntary supplementary plan to provide physicians' and other supplementary health services for the aged; and (3) an expanded medical assistance program for the needy and medically needy aged, blind, disabled, and families with dependent children.¹⁸

Congress defined the hospital¹⁹ and physician²⁰ services which were to be covered and excluded those items which were not to be covered with explicit statutory language.²¹ Germane to this discussion is the following exclusionary language used by Congress:

(a) Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services —

(1) which are not *reasonable and necessary* for the diagnosis treatment of illness or injury or to improve the functioning of a malformed body member.²²

The purpose of this language was stated by Congress in terms of examples:

[P]ayment could be made for the rental of a special hospital bed to be used by a patient in his home only if it was reasonable and necessary part of a sick persons treatment. Similarly, such potential personal comfort items and services as massages and heat lamp treatments would only be covered where they contri-

¹⁷ 42 U.S.C. §§ 1395 to 1395kk (1970).

¹⁸ 1965-1 U.S. CODE CONG. & AD. NEWS 1943.

¹⁹ 42 U.S.C. §§ 1395d, 1395x(b) (1970).

²⁰ 42 U.S.C. § 1395k (1970).

²¹ 42 U.S.C. § 1395y (1970).

²² 42 U.S.C. § 1395y(a) (1) (1970) (emphasis added).

bute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Expenses for custodial care would also be excluded.²³

If "reasonable" is defined as "fit and appropriate to the end in view"²⁴ and "necessary" as "something which in the accomplishment of a given object cannot be dispensed with",²⁵ then the following conclusion may be reached: Congress, in funding Public Law 89-97, did not intend to provide benefits for services which were not appropriate for the alleviation of an adverse condition afflicting a patient. In other words, the inference that must be drawn from this exclusionary language is that Congress did not intend to absorb the additional cost of health care which is attributable to increased malpractice insurance premiums and the practice of defensive medicine.

Congress provided for the use of public agencies or private organizations to facilitate payments to the providers of health services under both "Part A—Hospital Insurance Benefits for the Aged"²⁶ and "Part B—Supplementary Medical Insurance Benefits for the Aged."²⁷ One of the functions of these agencies or intermediaries is to provide the appropriate benefits on each claim in light of the congressional intent manifested in the statute. Consequently, an intermediary may refuse to make payment on a claim on the grounds that the services provided were not reasonable and necessary.

If the intermediary denies benefits to the insured, the insured has a statutory right to a hearing to determine the validity of this decision.²⁸ To date, there has been no judicial review of these hearings due to the fact that the hearing examiners have consistently decided in favor of the insured.

²³ 1965-1 U.S. CODE CONG. & AD. NEWS 1989.

²⁴ BLACK'S LAW DICTIONARY 1431 (rev. 4th ed. 1968).

²⁵ *Id.* at 1181.

²⁶ 42 U.S.C. § 1395h (1970).

²⁷ 42 U.S.C. § 1395u (1970).

²⁸ 42 U.S.C. § 1395ff (1970).

The following excerpt from a hearing examiner's opinion is an example of the logic currently used in these decisions:

[C]laimant [77 years of age] was admitted to the hospital on May 25, 1970, and remained there as a patient through June 28, 1970 [T]he hospital insurance program paid for services from May 25 through May 31, 1970, and denied payment thereafter.

The medical evidence of record herein establishes that the physician's orders, with reference to the care of the claimant after May 31, 1970, consisted of a regular diet, laboratory and diagnostic studies and oral medications of aspirin, cafergot, milk of magnesia, feorinal, dramimine, oxaine, and elixin terpin hydrate [O]ther orders were for intramuscular injections of sodium luminal, whenever necessary, and enemas when needed.

. . . .

[I]t is . . . difficult for this hearing examiner to reconcile himself to the fact that, when one places themselves under the care of a physician in a hospital, how are they to know when it is no longer necessary for them to remain in the hospital, other than by reliance upon their attending physician to discharge them from the hospital.

The medical evidence of record establishes that the claimant herein was 77 years of age at the time she was admitted to the hospital . . . that she had no way of knowing what was necessary hospital treatment and what was unnecessary hospital treatment

Accordingly, it is the decision of the hearing examiner that the claimant is entitled to hospital insurance benefits for the period from May 25 through June 28, 1970, under the provisions of the Social Security Act, as amended.²⁹

²⁹ Hearing conducted by the Social Security Administration, Bureau of Hearings and Appeals, February 11, 1972, Muskogee, Oklahoma.

The stated purpose of Public Law 89-97 is to provide benefits for reasonable and necessary medical care for the aged. However, the hearing examiner, in the foregoing example, allowed a recovery of hospital insurance benefits even though, by his own language, he indicated that the services provided were neither reasonable nor necessary for the proper treatment of the claimant. The logical basis for this decision is that the patient or consumer is not the proper party to be responsible for knowing what is and what is not reasonable and necessary health care.

This decision, and the logic which underlies it, has three major and unfortunate consequences. First, by allowing the claimant to recover, congressional intent has been thwarted. Second, by providing full benefits to the claimant, the hearing examiner has sanctioned the practice of defensive medicine. Third, by allowing a full recovery, the hearing examiner has forced the Social Security Administration, and in turn the American public, to absorb the costs which flow from the malpractice phenomenon. In reality, this decision, while beneficial to the claimant, is detrimental to the remainder of the consuming public.

There can be no argument with the hearing examiner's decision that the patient should not be responsible for knowing what is and what is not reasonable and necessary services. However, to escape the consequences outlined above and to effectuate the intent of Congress, the burden of responsibility must be placed somewhere. The question, thus, becomes whether the attending physician or the hospital administration should be responsible for making this determination. In enacting Public Law 89-97 Congress answered this question with the following provision:

(k) A utilization review plan of a hospital or extended care facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this subchapter and if it provides —

(1) for the review, on a sample or other basis, of

admissions to the institutions, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) *with respect to the medical necessity of the services*, and (B) *for the purposes of promoting the most efficient use of available health facilities and services*³⁰

This provision indicates that Congress intended to place the burden of responsibility on the hospital administration. Thus, the medical necessity and reasonableness of care rendered by a physician in a hospital should be determined by hospital based utilization review committees.

Since Congress has placed the burden of responsibility on the hospital, the controversy over the reasonableness and necessity of health care services provided to a patient should be between the intermediary and the hospital, and not between the insurer and the claimant. And, if at an administrative hearing it is determined that the care provided was not reasonable and necessary, then the hospital should absorb the expenses incurred by the patient which were not covered by health insurance.

The majority of the population of this country is not entitled to the health insurance benefits provided by Public Law 89-97. Consequently, an individual who desires health insurance protection must obtain it either on a group basis at his place of employment or on an individual basis. While the scope of benefits differ, most of the private health insurance programs available today are drawn in language similar to Public Law 89-97.³¹ These private, as opposed to governmental, insurers have also expressed the intent that they will

³⁰ 42 U.S.C. § 1395x(k) (1970) (emphasis added).

³¹ The "Group Membership Agreement", Group Hospital Service, Tulsa, Oklahoma, provides as follows:

ARTICLE V. EXCLUSIONS

. . . .
 (3) Hospital Care and Services principally for diagnosis, diagnostic study, or medical observation

not provide benefits for unreasonable and unnecessary services provided to the insured.

As a hypothetical example, assume that an individual covered through private health insurance is put in an Oklahoma hospital by his physician on May 25 and is discharged on June 28. Assume also that his insurer has denied benefits for the services provided after May 31 on the grounds that they were not reasonable and necessary. Based on an average charge per day for Oklahoma hospitals during 1971 of \$89.93,³² an additional \$2,607.97 would have to be paid to the hospital. If a subsequent determination is made that the services rendered were not reasonable and necessary, then consideration must, again, be given to the question of whether the patient, the attending physician or the hospital should absorb the additional amount.

(even though therapy directed toward the relief of symptoms may be rendered) when the necessary Care and Services could properly be provided on an Out-Patient basis and the condition of the Subscriber or the nature of the procedure does not necessitate that the Subscriber be hospitalized as an In-Patient; or for convalescent or rest cures, or custodial care

The "Group Major Medical Membership Agreement", Group Hospital Service, Tulsa, Oklahoma, provides as follows:

ARTICLE 1 — DEFINITIONS

. . . .

(1) **COVERED MEDICAL EXPENSES:** The term "Covered Medical Expenses" shall mean customary, reasonable, and necessary charges in the community where the service is incurred

³² Information supplied by the Research Department, Group Hospital Service, Tulsa, Oklahoma.

Since Oklahoma has a statute³³ which implies that every licensed hospital in the state may make use of a utilization review procedure, the argument made with respect to Public Law 89-97 may be restated. The primary controversy should lie between the hospital and the private insurer, with the hospital absorbing those expenses incurred by the patient which are determined to be not properly covered by the health insurance.

There can be no doubt that malpractice suits have had an adverse effect on both the cost of health care and the quality of health service available to the consuming public. There appears to be no immediate solution to this problem. However, as the patient or consumer is least able to judge the reasonableness and necessity of the treatment he receives, he should not have to bear the increase in the cost of health care which is attributable to the malpractice phenomenon.

Today our legislatures are inquiring into the problems inherent in automobile liability insurance, perhaps this is the appropriate time to consider the similar problems that exist in the health care field.

Stephen L. Andrew

³³ OKLA. STAT. tit. 63, § 1-1709 (1971), which states in part:
Physicians and others appointed to hospital utilization review committees for the purpose of determining the optimum use of hospital services shall be immune from liability with respect to decisions made as to such utilization and actions thereunder so long as such physicians or others act in good faith