Just as patients do not come to a medical office with the intention of suing the physici
an, physicians have no intention of harming their patients. The extensive training
physicians undertake and the nature of the services they provide make them
dedicated to doing their best for the well being of their patients. Medical training
itself inculcates physicians with the philosophy of not making mistakes. The crite
rion for establishing medical malpractice is negligence on the part of the physician
that is the proximate cause of an injury suffered by the patient. The definition of
negligence refers to “an unintentional act or failure to act.” If a physician acts in a
negligent manner regardless of whether he or she causes harm to a patient, it is an
unintentional error. Allegations of negligence are thus not simply a legal challenge
for physicians but are also a professional and psychological affront. It is very unset-
tling for the physician who acts with the best of intentions to face the allegation that
his or her care was negligent.

For physicians, who are trained to search for the truth, the process of litigation is
antithetical to their manner of reasoning. The adversarial system of the law is not
necessarily a search for the truth but rather the selective presentation of only that evi
dence that is favorable to the plaintiff or to the defendant. Physicians are usually
uncomfortable and unfamiliar with this process in much the same way as are patients
in a medical office or in the operating room. The natural desire of the physician is to
devote his or her time and effort to the practice of good medicine and to spend as little
time as possible considering the possibility of litigation. As a result, most physicians
know relatively little about medical malpractice litigation, and unfortunately many
view this lack of knowledge as a badge of honor. For these physicians, contemplation
of litigation is an unnecessary burden on the practice of medicine, and many regard
with disdain those physicians who participate in malpractice litigation as defense or
plaintiff experts. The average physician discounts the importance of modeling
the practice of medicine in order to minimize the risk of litigation and also to maxi
mize the opportunities for successfully defending lawsuits. Failure to implement
these modalities can increase the tendency for a patient to sue and/or compromise the
defense of a lawsuit.1 Paradoxically, many of these suggested practice patterns are
identical to the advice of practice management consultants whose job it is to grow
practices and to whom physicians listen attentively.
The frequency and severity of claims against physicians have multiplied many times during the past few decades. This has been referred to as a “malpractice crisis,” a misnomer implying that malpractice is the problem. There is, however, no demonstrable actual increase in malpractice. There has been a significant change in the physician–patient relationship. Advances in medicine have proved to be a double-edged sword. Although they have greatly improved the quality of medicine, the advances have also increased patient expectations. Unfortunately, many patients not only want to be cured but they also expect to be cured, and anything less than a complete cure will be unsatisfactory. During the course of physician–patient encounters there is something the physician does or fails to do that leads the patient to consider a lawsuit. Thus, in many instances, the problem is not necessarily the litigious patient but rather the lawsuit-causing physician.

As an in-house reviewer for medical malpractice insurance companies and as an expert witness, I have reviewed over 900 medical malpractice claims for the purposes of collecting data for publications. This experience has revealed specific recurrent patterns of physician behavior and patient management that encourage litigation and others that discourage it. Fear of the unknown can be unpleasant for both the patients contemplating their prognosis and the physicians involved in medical malpractice litigation. It is the purpose of this book to provide sufficient enlightenment about medical malpractice litigation to allay the anxieties of physicians regarding lawsuits, thus maximizing their performance and enjoyment of the practice of medicine.

This book presents, in a clinical, nondidactic manner, the basic elements of the law regarding medical malpractice litigation as they apply to the practice of medicine in order that the physician can understand that which is required for more effective risk prevention. The presentation is unique in that material is presented almost exclusively by physicians and from the physician’s point of view rather than by attorneys as a treatise on the law in order that it can be more easily incorporated into the routine practice of medicine. The concept of informed consent is presented from the physician’s point of view in order to stress that it can be a powerful risk prevention measure instead of merely a legal encumbrance. Discussion of the sequence of events in a medical malpractice lawsuit is presented by a physician rather than by an attorney in order to be more physician friendly. It is designed to help the physician navigate the journey more easily by means of simplification of the facts and with suggestions that have stood the test of time.

The chapters by the defense’s and plaintiff’s attorneys and the judge are designed to avoid legal terminology wherever possible and will familiarize the physician with “secrets of the trade” and how best to manage the litigation process, discovery, trial testimony, and especially cross examination. The chapter on expert witnesses is important for those who may act as an expert and even more important for anyone who is a defendant in order to understand the preeminent role an expert plays on behalf of a plaintiff or a defendant. The chapters on the ophthalmic subspecialties and related fields are intended to cover those problems that most commonly lead to litigation and the means by which to maximize risk management.

Being sued for malpractice is a significant psychological trauma for any physician no matter the circumstance or the outcome. It will definitely alter the
physician’s self-image and the way he or she regards patients and enjoys the practice of medicine. Following any lawsuit, even if it is dropped without payment or successfully defended, it will be difficult thereafter not to view patients as potential adversaries. To this end a chapter has been included to assist physicians in coping with the psychological effects of litigation. Furthermore, because most physicians are not trained businessmen, a chapter is devoted to simplifying the evaluation and selection of medical malpractice insurance policies and companies, which can be a daunting process to the uninformed physician. Duplication of effort in discussing some subjects has been minimized wherever possible, but it is difficult to avoid completely because of the multiplicity of authors and the overlap of some subjects. Therefore, some topics (i.e., informed consent) are appropriately discussed in more than one chapter.

The current system of malpractice litigation is at best inadequate, inefficient, unfair, and wasteful. “Canadian physicians are only one-fifth as likely to be sued as are American doctors.” Does this mean that American doctors are only 20% as caring or competent as their Canadian counterparts? Too many frivolous claims are initiated in the United States. “Eighty-three percent of the 2,827 claims closed in the United States in 2005 resulted in no payments.” These nonmeritorious claims cost the physicians’ insurance companies money to defend whether they were eventually dropped by the plaintiff or successfully defended in court by the physician, and it is the physician who must unfairly bear this financial burden, which would seem more appropriately placed on the plaintiff. On occasion, a nonmeritorious claim may need to be settled because the medical details are too complicated for a jury to comprehend. “The use of malpractice awards for social justice is frequently prominent in the thinking of juries. This is a most inefficient method of accomplishing . . . redistribution of wealth. Much of this wealth is redistributed to the legal profession.” Only a fraction of the money awarded in meritorious claims goes to patients. Although the number of medical liability lawsuits is stabilizing the severity of claims and the cost of defending them continues to rise (17% in 2005). The trial bar avers that the jury is the best and most impartial judge of evidence. If juries are in fact the most impartial “triers of fact,” why do attorneys “venue shop” for locations with jury pools that are notoriously more favorable to one side or the other? Does the fact that malpractice insurance premiums in those venues that are currently hotbeds of litigation, such as South Florida, West Virginia, parts of Texas, and three counties in Illinois, can be over 26 times more expensive than premiums in other less litigious parts of the country mean that those local physicians are less competent? General surgeons in Dade County, Florida, paid an average of $299,420 for malpractice insurance in 2006, while the average premium in Minnesota was $11,306.7 “Furthermore, in litigated cases, it is the severity of the patient’s disability, not the occurrence of an adverse event due to negligence, which best predicts the payment of claims to plaintiffs.” Government and private insurers are presently considering “pay for performance” incentive systems in which the quality of care by physicians is evaluated through physician clinical performance assessment (PCPA). “There is concern that PCPA may increase litigation risks if plaintiff attorneys are able to use the data as evidence to bolster malpractice claims.”
“According to a new nationwide survey, six in ten doctors have considered leaving medicine because they are discouraged by the health care system. The medical liability environment is one of the top six reasons.” The outcome options for a physician defendant in medical malpractice litigation are uniformly poor. In today’s hyperlitigious environment, insurance companies tend to add every lawsuit to the physician’s claim total and increase the premium for coverage accordingly. This is usually the case not only in the event of a jury verdict for the plaintiff but even if the claim is voluntarily dropped, dismissed by the court, or after a defense verdict, because in each instance the insurance company incurs expenses. The net result is, therefore, if the physician is sued he or she loses regardless of the outcome. It is truly a no-win situation. Attorneys often file “shotgun” lawsuits aimed at every physician who provided any services to a patient. This is to protect the attorney as well as the patient. If an attorney fails to name the appropriate physician prior to expiration of the statute of limitations, that physician can theoretically never be sued for the malpractice. This puts the attorney at risk for a malpractice lawsuit by the patient. If one or more physician defendants are later dropped from the suit, the claim will still be added to their lawsuit total by the insurance company, thus affecting their premium. Thus the physician has literally paid the price of protecting the attorney.

Another bias of legislation that is prejudiced against physicians is the statute of limitations for filing a medical malpractice lawsuit on behalf of a minor. In many states the statute runs until the child’s twenty-first birthday and even a year or two beyond. For example, in the 1960s, the only ophthalmologist practicing in a suburban city volunteered to evaluate the retinas of premature newborns before discharge from the hospital. The service was essentially pro bono, because at that time it was not the rule for newborns to be covered by medical insurance. In 1981, the ophthalmologist was sued by the parents of a child he had seen 20 years earlier and who was blind from retrolental fibroplasia (as it was called at the time). The limits of the ophthalmologist’s malpractice insurance policy in 1961, the year he saw the patient, were the typical $10,000/20,000 that practically every physician had at that time. The 1981 lawsuit was for $3 million, and the ophthalmologist, aged 62 years and near retirement, was concerned about depleting his financial resources. Two years later the lawsuit was dismissed by the court. Unfortunately, the physician had already lost 30 pounds and practically all of his hair. Jury awards have escalated at an alarming rate in recent years. It is not difficult to imagine an award for retinopathy of prematurity 20 years from now to be in the range of $30 million, thus threatening the retirement funds of today’s ophthalmologists, who are typically covered by $2–$5 million. This threat explains why so many vitreoretinal specialists are presently unwilling to see premature infants.

In 2007, the President of the American Medical Association wrote:

Medical liability is one area in which we seem to make little progress as long as we “soldier on” and live with the terror of the tort system. There is no question that as long as we continue to allow ourselves to be subjected to the inequities of this system, we will never see meaningful change. It is clearly time that we face this undeniable fact. The day will most certainly come when we must say ENOUGH.
The questions are when do we say it, and in what manner do we express this sentiment? The unfortunate situation is presently that among any 100 physicians in a room there will be 200 opinions. Until and unless we are willing to act as one, we have no choice but to suffer and endure. In the current political setting any chance physicians have for favorable, meaningful reform of the tort system in the near or intermediate term is remote at best. Although political activism for tort reform presents hope for the future, under the present circumstances it is essential that physicians recognize the inequities and limitations of the system and learn how best to deal with them. The optimal solution is effective risk prevention, enabling the physician to stay out of court and avoid putting his or her fate in the hands of any jury. To this end I offer the following chapters.

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References

6. Rose JR. Is your state a haven for “litigation tourists”? Med Econ 2006;Feb:10.
Risk Prevention in Ophthalmology
Kraushar, M. (Ed.)
2008, XVII, 282 p., Softcover