Editorial

Malpractice Liability Risk and the Physician-Patient Relationship

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The malpractice liability issue, which reached crisis proportions in US medicine during the mid 1970s, has reemerged again as a national crisis. The magnitude of this problem as illustrated by recent trends is alarming:

1. In the 40-year period between 1935 and 1975, 80 percent of all medical malpractice lawsuits were filed after 1970.[1]
2. The number of annual claims per 100 physicians was 3.3 before 1978; between 1978 and 1983 the number rose to 8 per 100 physicians.[2]
3. More than one quarter of all malpractice claims against physicians arise from surgery-related incidents, while the highest awards for damages involve birth-related problems.[3]
4. As a result of the increasing frequency of suits and the size of awards, malpractice insurers incurred underwriting losses of almost $750 million in 1983.[4]
5. Between 1975 and 1983, medical liability premiums increased by more than 80 percent overall, with insurance losses substantially exceeding premium growth.[5]

There is considerable variation by specialty and by region in the risk of malpractice liability. General/family practice is close to the overall national average for all physicians—8.2 annual claims per 100 physicians between 1978 and 1983 compared with 4.5 for medical specialties and 11.8 for surgical specialties. The risk of malpractice liability in the South is about one half that in the Northeast and North Central regions.[2] On a national basis, the most common allegation in professional liability claims involves an issue of treatment (eg, bad results, delay or omission, bodily injury adjacent to treatment site, incorrect treatment), while incorrect diagnosis leads to many claims.[2]

In response to the escalating medical malpractice liability problem after World War II, a federal Commission on Medical Malpractice was established in 1971 to study the problem and make recommendations for addressing it. In its comprehensive report, the Commission recognized the particular importance of the human element in the malpractice problem. Among the Commission's findings were these observations:[5]

> Improving the human and environmental aspects of patient care can enhance therapeutic outcomes, increase patient satisfaction, and reduce the stimuli to malpractice litigation.
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> The expectations of patients concerning the technical capabilities of medicine are often exaggerated and unrealistic.
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> There is a need to educate all patients concerning the hazards, risks, costs and limitations of medicine, in order to reduce disappointment, frustration and dissatisfaction with the outcome of treatment.

The central importance of the quality of the physician-patient relationship in influencing the extent of malpractice liability risk is captured by Louisell and Williams in their text *Medical Malpractice*[6] as follows: "If understanding between physician and patient is not commensurate with

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the necessary diagnostic and therapeutic activities, there is a strong possibility of a failure of treatment, the collapse of the relationship, or both. If both occur at about the same time, chances for a lawsuit are strong." Additional light is shed on this point by the findings of a large study carried out for the Secretary's Commission on Medical Malpractice in the 1970s.[7] A majority of a representative national sample of more than 1,000 respondents to one-hour personal interviews felt that physician-patient relationships had deteriorated over the preceding 20 years; those with negative views of the physician-patient relationships of today's physicians reported far more incidents of alleged medical malpractice than did those with more positive views of these relationships.

Various approaches are useful in an effort to facilitate optimal physician-patient relationships. In this issue of *The Journal,* Sommers[8] offers a number of specific approaches that can be taken by physicians and their office staffs to foster healthy physician-patient relationships and minimize the risk of malpractice liability. Careful attention to patient education and informed consent provides an opportunity to transform uncertainty about diagnosis or treatment from a threat to the physician-patient alliance into the basis on which an alliance can be built or strengthened.[9] The benefits of this effort are well stated by Gutheil and his colleagues[10] in an excellent recent paper on malpractice prevention through sharing of uncertainty:

> The therapeutic use of informed consent to enlist the patient in an active alliance with the physician discourages overly simplistic blaming and reduces the alienation from the physician that leads the patient to seek legal remedies for dissatisfaction. This is true malpractice prevention, which offers the physician stronger legal protection by allowing both doctor and patient to deepen their understanding while building a supportive and trusting relationship—a relationship based not on unrealistic certainty but on honesty in facing the uncertainty inherent in clinical practice.

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