The Impact of Medical Malpractice Suits Upon the Patterns of Medical Practice.

Masud Ahmad Mufti
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THE IMPACT OF MEDICAL MALPRACTICE SUITS UPON THE PATTERNS OF MEDICAL PRACTICE

A Dissertation

Submitted to the Graduate Faculty of the Louisiana State University and Agricultural and Mechanical College in partial fulfillment of the requirements of the degree of Doctor of Philosophy in The Department of Sociology

by Masud Ahmad Mufti
B. A., University of the Panjab, 1966
M. A., University of the Panjab, 1968
August, 1976
Dedicated to my dear wife, Marcia, and our first born
The author would like to express his profound gratitude to the medical community of East Baton Rouge Parish for their immense cooperation and help with the project. Thanks are also due to the professionals in the medical, legal, and insurance fields in the State of Louisiana who went out of their way to lend support in order to make this project a success.

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Dr. David Smith and Thornton Cofield of the Department of Experimental Statistics helped the author put the data together and make sense out of it. The author is highly grateful to them for doing so much without being obligated to do anything at all.

Most of all the author would like to thank his wife, Marcia, who never got tired of doing anything and everything to make this undertaking see completion.
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td></td>
<td>viii</td>
</tr>
<tr>
<td>Chapter 1: INTRODUCTION</td>
<td>Medical Malpractice: An Overview...</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A Review of the Relevant Literature..</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>General Characteristics of Malpractice Litigation Problem....</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Presumed Contributory Causes of Medical Malpractice Litigation Problem</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Perceived Implications of Medical Malpractice Litigation Problem...</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Proposed Solutions to Medical Malpractice Litigation Problem....</td>
<td>34</td>
</tr>
<tr>
<td>Chapter 2: STATEMENT OF THE PROBLEM</td>
<td>Conceptual Framework</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Patterns of Practice of Medical Practitioners</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Significance of the Study...</td>
<td>55</td>
</tr>
<tr>
<td>Chapter 3: RESEARCH PROCEDURE</td>
<td>The Study Population</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Sampling Design...</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Operationalization of the Concepts...</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>The Background and the Professional Value Orientation Variables</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>The Situational Variables...</td>
<td>66</td>
</tr>
<tr>
<td>Table</td>
<td>Description</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1</td>
<td>Distribution of Amounts Paid on Medical Malpractice Claims Closed in 1970</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>Percentage of Claim Files Closed in 1970 Relative to Year File Opened</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>Unrotated and Rotated Factor Matrices With Final Communality Estimates of the Stress-full Patterns of Medical Practice</td>
<td>80</td>
</tr>
<tr>
<td>4</td>
<td>Abridged Analysis of Variance Table For Factor 1 With Situational Variables Introduced First</td>
<td>87</td>
</tr>
<tr>
<td>5</td>
<td>Abridged Analysis of Variance Table For Factor 1 With the Background and Professional Value Orientation Variables Introduced First</td>
<td>88</td>
</tr>
<tr>
<td>6</td>
<td>Abridged Analysis of Variance Table For Factor 2 With the Situational Variables Introduced First</td>
<td>90</td>
</tr>
<tr>
<td>7</td>
<td>Abridged Analysis of Variance Table For Factor 2 With the Background and Professional Value Orientation Variables Introduced First</td>
<td>90</td>
</tr>
<tr>
<td>8</td>
<td>Abridged Analysis of Variance Table For Factor 3 With the Situational Variables Introduced First</td>
<td>91</td>
</tr>
<tr>
<td>9</td>
<td>Abridged Analysis of Variance Table For Factor 3 With the Background and Professional Value Orientation Variables Introduced First</td>
<td>91</td>
</tr>
</tbody>
</table>
### LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Relative Number of Claims By Speciality</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>State to State Differences in Number of Claims Closed in 1970 Per 100 Active Practitioners</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>Severity of Injuries Alleged in Medical Malpractice Claim Files Closed in 1970</td>
<td>20</td>
</tr>
</tbody>
</table>
ABSTRACT

The present study attempts to determine the impact of medical malpractice litigation upon the patterns of practice of self-employed medical practitioners in East Baton Rouge Parish, Louisiana.

The conceptual framework for the study was provided by the "social structure" approach of Freidson, who asserted that a significant amount of human behavior is in response to the organized pressures of the situation the person is in at any particular time rather than his individual attributes and value orientations.

A review of relevant literature indicates that medical malpractice litigation and the malpractice insurance crisis has resulted in varied degrees of strains and stresses for medical practitioners. The hypothesis tested is that situational factors pertaining to medical malpractice litigation would have more stressful impact upon the patterns of practice of medical practitioners than would their individual attributes and value orientations, both personal and professional.

The basic data for the study were collected by the author by interviewing 103 randomly selected practitioners...
from a total of 310 self-employed physicians in the parish with the help of an interviewing schedule. The analysis of data upheld the hypothesis and revealed that the situational variables were responsible for explaining the stressful patterns of medical practice more significantly than the background and professional value orientation variables, thus supporting Freidson's "social structure" approach. The findings also supported the perceived implications found in the literature that both malpractice suits and the fear of being sued have forced providers of healthcare to resort to defensive or conservative medicine, especially those belonging to the higher risk fields of medical practice.
"Medical malpractice" is basically a medico-legal concept for which there is no specific, universal definition. This fact makes the understanding, analysis, and the interpretation of the phenomenon highly ambiguous and complex.

The inception of the concept is mainly the result of litigation between the health-care providers and the health-care recipients. In law, such litigation is covered under torts. "Torts or tort law is a branch of civil law which applies when a person sues another for personal recompense or for some other wrong he feels has been done to him." Malpractice, in general, is defined as "any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct." In the field of medicine, its application "chiefly concerns the legal problems arising when a physician, in the course of treatment, does or fails to do something that the patient can claim is not up to the standards of the profession."

A relatively more specific definition of medical malpractice was brought out in an Ohio case:

Malpractice in relation to the care of the human body has been defined as the failure of a member
of the medical profession, employed to treat a case professionally, to fulfill the duty which the law implies from the employment, to exercise that degree of skill, care and diligence exercised by members of the same profession, practicing in the same or similar locality, in the light of the present state of medical science.

These and numerous other legal definitions arising out of medical malpractice litigation are vulnerable to the relativity of legal interpretations of the concepts involved. This differential interpretability of the concepts is responsible for a great deal of variability in medical malpractice litigation and its outcome from one place to another and/or from one point in time to another. For the purpose of this study, the following tentative definition is offered:

Medical malpractice may be defined as negligent behavior on the part of a medical practitioner during the course of the delivery of health-care services involving the processes of prevention, diagnosis, therapy, prognosis, and rehabilitation which may result in real or imagined adverse physical or psychosocial effects to the patient.

Negligent behavior in the present context refers not only to the adoption of medically "unjustifiable" preventive, diagnostic, therapeutic, prognostic, or rehabilitative procedures but also failure to adopt appropriate procedures--intentionally or unintentionally. Adverse physical or psychosocial effects may refer to any damage, injury, disability, or discomfort of physical, psychological, or socio-economic nature inflicted upon the patient which is directly or indirectly attributable to negligent behavior on the part of
a practitioner during the course of health-care processes of prevention, diagnosis, therapy, prognosis, and rehabilitation.

Medical Malpractice: An Overview

The occurrence of medical malpractice is as old as the practice of medicine itself, but public awareness of, and challenge to it, is quite recent. Until the dawn of the present century, hazards to public health were accepted either as the outcome of disease or simply the "will of God". Very rarely did anyone question the knowledge, expertise, and most importantly, the integrity of medical practitioners. Medical knowledge itself was relatively limited, and public knowledge about medicine was almost negligible. Malpractice suits were almost unheard of.

The first "significant change began in the 1930's. California, then ranking only sixth in population, suddenly surpassed all other states in the number of malpractice suits. Similar jumps were soon noted in Ohio, Texas, Minnesota, and the District of Columbia."6 Thereafter, the number of malpractice suits has continued to grow except for a temporary decline during World War II, when the number of such cases declined. Not only has the number of malpractice suits been on the increase, but also the damages awarded to the patients, and the premiums paid by the practitioners for medical mal-
practice insurance. The decade has seen the greatest increase in the number of medical malpractice suits to date. Ninety percent of all medical malpractice suits ever filed in the United States were filed during this period. With filing increasing ten percent a year, one physician in three might expect to be sued during his career. The average amount granted by a jury has risen from $62,151 in 1965 to nearly $350,000 in 1975 (Excluding awards of $1 million or more). "Settlements for large sums of money have become commonplace. In California, for example, there were three malpractice settlements of $300,000 or more in 1969; in 1974 there were more than 30. In the nation as a whole there have been between 30 and 35 malpractice awards of $1 million or more....."

Insurance companies responded to this situation by tremendous increases in premiums. In January of 1975, the Argonant Insurance Company, one of the nation's largest insurers, raised their average annual premiums for high risk specialties in California, for example, from $5,377 to $22,704, an increase of 322.24 percent. While practitioners were still trying to seek legal and public support against this unprecedented increase, the Argonant and other medical malpractice insurance carriers all over the nation, in early spring of 1975, sought yet another round of increases in some states and discontinued malpractice coverage altogether in other
states starting in July of 1975. These actions on the part of the insurance companies created a crisis for over "50,000 physicians in New York, California, Illinois, and other states" who were left without any coverage for the forthcoming year.

As a protest against the soaring costs of malpractice insurance in some, and total non-availability of insurance coverage in other states, doctors went on strike. On May 1, 1975, almost all anesthesiologists in California walked out and refused to render services except for dire emergencies. As a result, operating rooms were shut down "in virtually every major city in the state."

The malpractice insurance crisis, a new crisis in medicine, brought doctors and lawyers at loggerheads. Their age-old professional rivalry and competitive ferocity was bitterly expressed in an exchange of articles in professional journals and other magazines and newspapers. Doctors blamed "unscrupulous, money-hungry" lawyers who "have turned to malpractice litigation to make up for business lost to the trend toward no-fault automobile insurance in the U.S." They also criticized the contingency fee system often used in malpractice cases; wherein lawyers take up to half the award if they win, but no fee if they lose. Some doctors believed that nine out of ten medical malpractice suits were frivolous, and just bids to make money. Lawyers retorted, "Don't blame
lawyers for malpractice mess... Blaming lawyers... for the medical malpractice crisis is like blaming firemen for forest fires and arson... Malpractice suits are symptoms... not the cause of it." The rationale for lawyers' increased interest in malpractice litigation and contingency fee was that, "Lawyers must make a living too, and when the economy declines, no-fault auto insurance looms on the horizon and law schools continue to spawn graduates in a competitive job market, it is not surprising that attorneys are lured to a potentially lucrative field of practice." The contingency fee, according to Low, is a red herring. Jury verdicts can not and do not take them into account. Contingency fees are the ordinary man's ticket to the courthouse. It is the only way he can obtain a talented and hardworking attorney to represent him. Abolition of the contingency fee would significantly cut down the number of meritorious malpractice lawsuits.

Patients and insurance companies are not a part of doctor-lawyer professional rivalry, but they are an indispensible part of the medical malpractice insurance crisis. Patients are accused of being "overexpectant, suit-minded." When their high degree of expectations are not met, they are readily inclined to blame the doctor and take legal action. Defenders of consumer interests claim that there are a large number of injuries to patients which have been barely tapped by legal process. Many cases go undetected, for medicine
is the most arcane of all the professions and the patient is usually the last to know that he has been ill-served by his physician.  

Insurance companies are blamed for unwisely investing in the stock market and losing some of their reserves. Doctors claim that their premiums have "doubled, even trebled", in some states while the aggrieved patient receives only 16 cents out of every dollar paid for liability insurance. This point is supported by HEW statistics, according to which, insurers are estimated to have collected approximately $500 million while they paid out approximately $100 million in claims and legal fees. If the estimates are reasonably dependable, then one wonders as to what happened to the remaining $400 million? Insurance industry profit and cost data are difficult to obtain, with most malpractice data buried in the "miscellaneous liability" files of state records.

Insurers assert that the expected ultimate claims payout for carriers of this insurance for a five year period ending December 31, 1972 (latest data available), will be more than $150 for each $100 of collected premiums; adding company expenses and sales costs would boost this to $180 for each $100 of premiums. Traphagan claims that insurance companies are experiencing severe losses in writing professional liability insurance that they need even higher
rates if they are going to be able to continue to provide insurance. White believes that no company is losing money by writing malpractice insurance; they simply are not making as much as they want to. They have invested unwisely in the stock market, and lost some of their reserves. While such losses are really their problem, they want the doctors to pay for it; insurance companies have been able to force the doctors to do so, since they have strong influence with many state insurance commissioners.

The insurers blame their plight on the extraordinary time they are liable for claims—the 'tail' in industry parlance—under laws relating to malpractice. In most states, a suit can be brought within three years of the alleged wrong doing. But in case of a foreign object left in the body, however, the statute of limitations begins at the time the problem is discovered—possibly years after the operation. Because of the long tail period, therefore, insurance companies believe that it is actuarially impossible to estimate what their future liability will be when setting a premium for a given year.

While it is almost impossible to ascertain the validity of the convictions of each party in this conflict of interests, it is relatively simpler to observe the consequences of growing dissatisfaction of medical practitioners with the existing medico-legal conditions. By the time the walk-
out of the anesthesiologists and the surgeons entered its straight fifth week in California, many of the area's 150 hospitals had missed payrolls and "were on the brink of bankruptcy and shutdown. Fully 4,000 of San Francisco's hospital workers had been laid off.... In four counties (of California), including Los Angeles, 22,000 beds in 113 hospitals were unoccupied, and hospital officials were putting their economic losses at $1.1 million a day." Similar conditions can be observed in other states.

Some state like Indiana, Idaho, and Maryland responded to the medical malpractice insurance crisis sooner than the others. Indiana's Governor Otis Brown, who is himself a physician, "created a state insurance fund, established a panel to screen malpractice claims and weed out nuisance suits, and set a ceiling on malpractice awards." Idaho and Maryland enacted similar measures.

The New York law, a compromise between medical and legal interests, was enacted to reduce the possibility of total breakdown of the health-care system. It establishes "a Medical Malpractice Underwriting Association made up of the 300 private insurance companies writing personal-liability insurance. The association would assure doctors of coverage when the Argonaut Insurance (Company) of Menlo Park, (California), hitherto the major malpractice insurer in the state, withdraws from underwriting in New York June 30 (1975).
The law also sets up a special state fund to provide insurance (in case) the new association becomes insolvent.\textsuperscript{35}

Equally important in the New York law are the new limitations placed on the rights of patients to sue doctors. The statute of limitations for the initiation of malpractice actions was reduced from three to two and a half years for adults with a maximum of ten years for infants. The law also prohibits the application of the doctrine of informed consent, which makes doctors liable in case they failed to tell patients of the risks as well as benefits of a procedure in emergency cases. The prohibition of the application of the doctrine does not apply in cases of non-emergency treatment and certain diagnostic procedures, such as cardiac catheterization, that involve "invasion" of the body. Finally, the New York law permits facts relating to compensation the plaintiff has received from such sources as insurance or social security to be admitted as evidence and taken into consideration by the judge and jury in the formulation of damages awards.\textsuperscript{36}

The New York law did not stop the medical malpractice problem from erupting into "a full-scale doctors' revolt."\textsuperscript{37} Protesting that an emergency law enacted to alleviate the malpractice burden did not go far enough, fifteen thousand physicians, around the end of May of 1975, held a howling, jeering demonstration outside the headquarters of the New
York State Medical Society. Against this background, the society's House of Delegates ignored the advice of many of its leaders and voted 143 to 82 to reject the law. In eight counties, including Queens, Nassau and Suffolk, angry physicians declared that they would close their offices, depriving patients of necessary medical care. But further, if deprived of their usual number of inpatients, said a spokesman for the Greater New York Hospital Association, as many as 25 hospitals might go bankrupt within two weeks.38

The strike actions in California and New York brought bitter recriminations from legislators. California assemblymen, who were slowly wading through some thirty bills aimed at improving the situation, charged that "many anesthesiologists had been inordinately rude during visits to the legislature to plead their case."39 One doctor noted a wry irony in the plight of his colleagues which might reflect on the degree of truthfulness of the charges of assemblymen: "'In a lot of respects, (it is) the doctors' own fault', said San Francisco obstetrician Dr. Frederick Ostermann. 'For years doctors went around telling government to leave them alone. And then the first time (they are) in real trouble, they start yelling for government to help them'. At one point, Bronx Assemblyman Thomas Culhane introduced a bill to revoke the license of any doctor who refused to treat a patient."40
Dissatisfied with the perceived slow pace of effective actions taken by various public and private agencies to improve the medical malpractice litigation scene and soaring medical malpractice rates, doctors in California instituted slowdown on January 1, 1976, involving some 23,000 physicians - most of them specialists. The slowdown continued for 35 days. On February 4, 1976, The United Physicians of California, "which spearheaded the protest, voted to end the slowdown even though all major issues in the controversy remained unresolved." The doctors, however, warned that unless the state legislature acted quickly to resolve the problem, "next time everyone will go out."

At the point of this writing, hundreds of bills are being considered by the state legislators all over the United States. Thus far, very few measures, recommended or adopted by state legislative bodies, go beyond stopgap arrangements. Attempts are being made to devise relatively more workable solutions to the medical malpractice problem.

A Review of the Relevant Literature

A review of the literature thus far has indicated that there is no dearth of material on medical malpractice, but most of it approaches the problem primarily from the medico-legal point of view. Since our primary concern here is sociological, reliable statistical data are necessary. Unfortunately
they are scarce. Piecemeal data, put out by medical, legal, insurance or public interest sectors is unreliable in most cases due to lack of comparability, inter-sectoral variability, and inaccessibility to sources of data for verification.

In the field of medical malpractice insurance, for example, a few carriers have good but limited internal data available to them. However, comprehensive data on malpractice insurance in even the most elementary form is sadly lacking because most malpractice writers do not file their data with the Insurance Services Organization (ISO), the only designated statistical filing agency for malpractice data. For the policy year ending December 31, 1969, physicians and surgeons malpractice premiums reported to ISO (all states) were less than $33 million, which is less than 25 percent of the estimated market. Even if all possible sources of relevant data could be tapped, information may still be inaccessible because of professional, legal, moral, or ethical implication involved. These, among others, may be the reasons why there are not many studies conducted by social scientists in this field. The only sociological study conducted to date on medical malpractice used data collected by the Law Department of the American Medical Association. This nationwide study utilized available data in a multiple regression analysis and correlation to identify legal or structural variables significantly associated with high rates of medical malpractice claims. The
study treated professional liability as the dependent variable and found that two structural variables, education and general hospital expense per patient day; and two legal variables, the legal doctrine of res ipsa loquitur and the statutes of limitation collectively explained 55 percent of the variation in claim experience from state to state.

While Berman treated claim liability rate (or malpractice suit rate) as a dependent variable, the present study treats it as an independent variable, directly and/or indirectly affecting the patterns of practice of medical practitioners, the dependent variable. To provide a clearer understanding of malpractice litigation problem for the present study, information has been gathered from a wide variety of sources and presented below under four major headings:

1) General characteristics; 2) Presumed contributory causes; 3) Perceived implications; and 4) Proposed solutions.

1. General Characteristics of Malpractice Litigation Problem

According to the latest estimates available, approximately 20,000 malpractice claims are brought against some of nearly 380,000 doctors every year, meaning thereby that one out of every nineteen doctors are charged with negligence, or worse each year.

The risks of being sued for malpractice are not shared equally among all practitioners. Those most likely to be
sued are surgeons, since malpractice is easier to prove when a mistake in an operation is made—e.g., leaving a fairly obvious evidence of an error or mishap in the form of an instrument or a swab in the patient's body. The surgeon is also liable to be sued if a patient is not satisfied with the outcome of his surgery. General practitioners, by contrast, are less likely to be sued. At times they may make errors of judgement and fail to prescribe the right medicine, but such errors are relatively less evident, therefore less susceptible to professional or legal reproach. Figure 1 shows the relative number of claims by specialty. It is evident

**FIGURE 1**
**RELATIVE NUMBER OF CLAIMS BY SPECIALTY**
**INDEX = 100 (AVERAGE)**

Source: Commission Study of Claim Files Closed in 1970, Freeland, W. G. (1973-A), Figure 3, p. 9.
that surgical specialties are more susceptible to claims than medical specialties.

Among surgeons, orthopedists and anesthesiologists "by the very nature of the high risk procedures they undertake are subject to claims more frequently." This point is further strengthened by the fact that state loss experience and personal loss experience of individual practitioners remaining the same, medical malpractice rates for doctors are generally determined by specialty and the amount of surgery they perform. In 1966, ISO used a five-category classification system for actuarial purposes. Class 5 has been seen as having five times the loss experience of Class 1, and the differentials have remained stable through the years until 1972 (the latest data available). The ISO class definitions are:

Class 1. Physicians who do not perform or ordinarily assist in surgery;

Class 2. Physicians who perform minor surgery or assist in major surgery on their own patients;

Class 3. Physicians who perform major surgery or assist with major surgery on patients other than their own, i.e., ophthalmologists and proctologists;

Class 4. General surgeons and others, i.e., cardiac surgeons, urologists, etc.;

Class 5. Surgeons who specialize in anesthesiology, orthopedics, etc.

There is variation in the number of claims that are brought
against active practitioners from state to state. Figure 2 shows state to state differences in the number of claims closed in 1970 per 100 active practitioners. This figure shows a range of 0-14 closed claims per 100 active practitioners with the overwhelming majority of states (84 percent) between 3-8. Alaska had no closed claims while Nevada

FIGURE 2
STATE TO STATE DIFFERENCES
IN NUMBER OF CLAIMS CLOSED
IN 1970 PER 100 ACTIVE PRACTITIONERS
AVERAGE U.S. = 6.54

CLAIMS CLOSED PER 100 PRACTICING PHYSICIANS

Source: Commission Study of Claims Closed in 1970; Distribution of Physicians in the United States, 1970, American Medical Association; Freeland, W. G. (1973-A), Figure 2, p. 8.
led the nation with 14 closed claims per 100 active practitioners. Both states had less than a hundred closed files that year. California, with 3,071 closed files (with 9 files closed per 100 active practitioners) led the nation in this category.

The patterns of claims settlement indicate that of the 16,000 claim files closed in 1970, 50 percent were closed without the claims resulting in lawsuits, and the claimant or his legal representative received some payment in about 25 percent of these closed files. The other half of the claim files closed by insurance companies in 1970 resulted in lawsuits. Eighty percent of them never went to trial; they were settled by negotiation and mutual agreement, with the claimant receiving some payment 60 percent of the time. The remaining 20 percent of the suits filed were resolved by jury trials with the verdict in favor of the plaintiff 20 percent of the time. In sum, there was payment in approximately 45 percent of all claims, whether or not a lawsuit was filed.

In Table 1, an analysis of claims paid reveals that more than half of the claimants who received payments got less than $2,000. "Less than one out of every 1,000 claims paid for $1 million or more, and there are probably not more than seven such payments each year." The trend however is on the increase. According to one source, 30 to 35 awards
TABLE 1
DISTRIBUTION OF AMOUNTS PAID ON MEDICAL MALPRACTICE CLAIMS CLOSED IN 1970

<table>
<thead>
<tr>
<th>Total settlement costs of incidents, in dollars</th>
<th>Percent of incidents</th>
<th>Cumulative percent of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-499</td>
<td>21.1</td>
<td>21.1</td>
</tr>
<tr>
<td>500-999</td>
<td>16.0</td>
<td>37.1</td>
</tr>
<tr>
<td>1,000-1,999</td>
<td>12.3</td>
<td>49.4</td>
</tr>
<tr>
<td>2,000-2,999</td>
<td>10.1</td>
<td>59.5</td>
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<td>3,000-3,999</td>
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<td>13.4</td>
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<td>1.3</td>
<td>95.2</td>
</tr>
<tr>
<td>60,000-79,999</td>
<td>1.0</td>
<td>96.2</td>
</tr>
<tr>
<td>80,000-99,999</td>
<td>0.8</td>
<td>97.0</td>
</tr>
<tr>
<td>100,000 and up</td>
<td>3.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

100.0


of $1 million have been handed down since 1970.

It takes a long time to close a malpractice case. Table 2 indicates that on the average, "only half are closed within 18 months after they are opened; ten percent remain open 6½ years after they are opened."59

A profile of alleged injuries in Figure 3 shows that out of 12,000 injuries alleged in the survey of claim files closed in 1970, 19 percent suffered permanent physical and/or psychological damage and 18 percent resulted in death. At the other
<table>
<thead>
<tr>
<th>Time, incident to closing</th>
<th>Year of first incident</th>
<th>Percent of cases where known</th>
<th>Cumulative percent of cases where known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>1970</td>
<td>18.6</td>
<td>18.6</td>
</tr>
<tr>
<td>1 year</td>
<td>1969</td>
<td>23.3</td>
<td>41.9</td>
</tr>
<tr>
<td>2 years</td>
<td>1968</td>
<td>15.9</td>
<td>57.8</td>
</tr>
<tr>
<td>3 years</td>
<td>1967</td>
<td>11.7</td>
<td>69.5</td>
</tr>
<tr>
<td>4 years</td>
<td>1966</td>
<td>10.9</td>
<td>80.4</td>
</tr>
<tr>
<td>5 years</td>
<td>1965</td>
<td>7.1</td>
<td>87.5</td>
</tr>
<tr>
<td>6 years</td>
<td>1964</td>
<td>5.5</td>
<td>93.0</td>
</tr>
<tr>
<td>7 years</td>
<td>1963</td>
<td>3.1</td>
<td>96.1</td>
</tr>
<tr>
<td>8 years</td>
<td>1962</td>
<td>1.7</td>
<td>97.8</td>
</tr>
<tr>
<td>9 years</td>
<td>1961</td>
<td>0.7</td>
<td>98.5</td>
</tr>
<tr>
<td>More than 9 years</td>
<td>1960 or earlier</td>
<td>1.5</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>


**FIGURE 3**
SEVERITY OF INJURIES
ALLEGED IN MEDICAL MALPRACTICE
CLAIM FILES CLOSED IN 1970

![Severity of Injuries Graph]

Source: Commission Study of Claim Files Closed in 1970, Medical Malpractice, (1973), Figure 4, p. 11.
end, 12 percent of the alleged injuries were primarily psychological. Excluding patients who died, two-thirds of the alleged injuries were temporary in nature. 60

Age and sex distribution of claimants in 1970 showed that a majority of claimants were females (58 percent) and fifty-three percent of the claimants were over 40 years of age, whereas only one-third of the population was over 40. This may be due to the fact that older people utilize more medical and hospital facilities than the younger ones do. 61

2. Presumed Contributory Causes of Medical Malpractice Litigation Problem

In recent years, the presumed causes of an increase in medical malpractice litigation have been a subject of great controversy. Each party involved has been blamed by other parties for allegedly contributing to the problem. The truth of the matter, however, is that there is only one cause of medical malpractice litigation and that is the occurrence of medical malpractice itself--real or imagined. Without the necessary cause of real or imagined injury, damage, harm, or discomfort experienced by patients attributable to negligence on the part of medical practitioners, malpractice litigation cannot come into existence. All the other presumed "causes" are simply contributory or precipitating factors which, in interaction with other factors, may or may not result in
negligence on the part of the practitioners, and that negligence may or may not lead to an injury. And of course an injury is not a guarantee that a liability claim will be filed. The willingness of a patient to hold his or her doctor responsible for it and seek recompense are intervening variables between an injury and liability claim. In other words, no one presumed cause has anything inherent in it that is liable to create the same effect in all cases.

With this preface, the author will list some of the factors that have been cited as contributory causes of medical malpractice litigation problem in the present-day United States.

The first and the foremost factor is the change in the structure and the process of medicine. Developments in science and technology during the present century have brought about concomitant changes in the organization of medical practice, the most dominant trend being the increasing complexity and professionalization of the delivery of health-care system. "Parallel to the development of a technically or scientifically adequate foundation of medical work was the development of a sociological foundation to create an occupation so well established in its society as to become a true consulting profession--in comand of the criteria that qualify men to work at healing, of exclusive competence, to determine the proper content and effective method of performing medical work, and freely consulted by those thought to need its help."

Before
the Middle Ages, there was hardly any unification among healers. They came from different occupational and social backgrounds, and went through different formal or informal training, if at all. There were no standardized measures for regulating the training or the practice of medicine. During the Medieval Period in England and Western Europe, for example, separate bodies of physicians, barber-surgeons, and apothecaries developed. "The physicians were educated men, mostly graduates of universities; in England, of Oxford and Cambridge. The barber-surgeons were unlettered craftsmen whose skills were often handed on from father to son. The apothecaries, who made their physics from herbs, were usually members of the Grocers' Company. With the passage of time, the distinction between physicians, surgeons, and apothecaries broke down. Most medical men, by the Nineteenth Century, became general practitioners, working mostly in isolation and primarily catering to the needs of the elite.

In the United States, skepticism by the public about the remedies of bleeding and purging offered by the physicians as their educated scientific treatment of choice in the Eighteenth and Nineteenth Centuries, led to the support of a variety of more palatable healing movements and, in the Nineteenth Century particularly, to a thriving alcohol and opium-laden patent medicine trade. Egalitarianism led to the feeling that no man's freedom to heal others should be hampered
by medical licensing laws, and the expansion of the frontier precluded the enforcement of any elaborate set of rules about who may heal. Only in the Twentieth Century was licensing widely established in the United States, based on uniform standards for medical education. With a sound technical basis for their training, rigorously enforced licensing laws, and political maneuvering by their medical association, practitioners managed to gain not only public confidence but also official control over their work, enabling them to maintain their professional and social preeminence.\textsuperscript{64}

This professional and social preeminence of the physicians may have been one of the major causes of a peculiar rivalry between doctors and lawyers. In the areas of prestige, power, credibility, and income, their competitive ferocity has been expressed in ways varying from bitter exchanges in professional journals to impugning each other's integrity, morality, and competence in litigation.\textsuperscript{65}

As noted earlier, this is still true today. The rivalry has psychological more than legal or professional repercussions upon the patterns of professional performance of medical practitioners. "Even the doctor who has never been sued is ever conscious of the sword of Damocles hanging over his head."\textsuperscript{66} Practitioners have often expressed dissatisfaction with the prevailing medical-legal system which, according to them, is unfair not only to the practitioners but also to the
....as a physician, I live in an aura of fear--fear of suit. And fear contributes to hostility and rarely contributes to constructive action.

Medicine has some bad doctors and some bad health-care institutions. We are not proud of them nor do we defend them. We are concerned with the correction and elimination of that element of the health-care community. Some do not believe that we have this concern, but we do have it. It is my opinion that if these bad health-care providers were removed from the medical community overnight, the malpractice problem, or better stated, the professional liability problem, would remain.....

The House of Medicine, however, feels belabored. Medical organizations are trying their best to overcome their deficiencies, but in my opinion medical malpractice litigation is not the best incentive to improvement. It places medicine in an adversary position from which hostilities too often result.....

It may be hard to believe, but we are a frightened profession. The doctor feels put upon. He feels nude on the corner of the Main Street of life. He often tries to cover himself with pride and even occasional arrogance, only to find himself being castrated. He really doesn't want to believe the hostility he feels...The faith of the patient is important to the patient and his physician. Faith is a power and the physician continually feels it is being eroded by sometimes justified, but, frequently unjustified, attacks.

A review of relevant literature has indicated that such statements are quite uncommon in medical literature. The feelings expressed in the statement, however, may not be limited to a few practitioners only. How far are they shared by the medical practitioners around the country, remains to be empirically verified.
Changes in the medical field that contributed to the complexity of the health-care system are highly interrelated and centered around increasing demand of health-care facilities without a corresponding increase in the number of health-care providers. This has resulted in a shortage of doctors and a proportionate increase of patients per doctor thus reducing the time a doctor could devote to each patient. Longer waiting hours and fuller waiting rooms may have caused some doctors to make rapid decisions. Today, "experts calculate that there are 70,000 fewer doctors than there should be." The most acute shortage of all is among the 'primary' physicians-G.P.'s, internists and pediatricians—who are usually the first point of contact between the ailing individual and the health-care system. They have declined from 59 for every 100,000 to 40 for the same number of patients during the past decade. There is increasing trend towards specialization. In 1972, only one-fifth of the physicians who provided patient care were general practitioners. The remainder have specialized in one of the 33 fields recognized by the medical profession.

With increasing specialization and sub-specialization, the locus of practice moved from office and home to clinic and hospital, and from personal treatment to impersonal treatment by groups and teams. Since most practitioners could not afford sophisticated diagnostic and therapeutic equipment,
utilization of common facilities enhanced interdependence among practitioners resulting in inadequate patient care and fragmented responsibility.

One side-effect of the increasing demands on practitioners' time is that it makes it difficult for them to keep up with the latest developments in the field. Chalmers claims that to prevent miscarriages, many doctors continued to prescribe diethylstilbestrol, a synthetic estrogen, for fifteen years after six well documented studies proved the drug to be ineffective. A bland diet for ulcer patients and bed rest for patients with infectious hepatitis are still widely used, in spite of the available evidence that these measures have little effect.

Sensational breakthroughs in the field of medicine have made sensational headlines in the news media, resulting in higher expectations on the part of patients. When patients expect miracles and miracles do not happen according to their mental picture, disappointments often result. Such feelings are liable to serve as a precipitating factor for a claim. Another related aspect of sensational headlines is that they have increased public knowledge about medicine. When people were generally "ignorant" about medical phenomena, they rarely challenged the "authority". As Moore and Tumin noted "Ignorance on the part of a consumer of specialized services (for example, medical or legal advice) helps to preserve the priv-
ileged position of a specialized dispenser of these services." But now when they do have better knowledge, they tend to expect at least some explanation as to what is being done to them and why. The growing awareness of personal rights has added another dimension to it. Now if they suspect that they have not received what they are entitled to, they turn to the courts to seek redress. "Client revolt", as it is sometimes called in the mass media, is an attack on the basic legitimacy of the occupational and institutional claims to power of the professional.

Finally, such demographic factors as urbanization and mobility may have some contributory influence upon creating the general environment of impersonalization, contractual nature of relationships, and mutual mistrust. "Insurance companies report that in growing suburban areas, malpractice suits tend to rise in some direct proportion to the population growth." Higher rates of mobility among the American people does not let them develop the feeling of neighborliness. The feeling of community and mutual trust is difficult to develop in present-day urban areas giving rise to lack of faith in interpersonal relationships, including those in the medical sector. It is just a presumption. There are no concrete data to support this argument.

Concluding the discussion on the presumed causes of malpractice litigation problem, it may be added that undoubtedly,
the "miracles" of medicine are not without price. Some diagnostic and therapeutic procedures, along with highly potent drugs, are potentially more risky than others; often, at least, they are two-edged swords.

These factors, along with many others, may have contributed to the breakdown in harmony and mutual trust between the providers and the consumers, thus paving the way for legal battles over controversial courses of action, misaction, or inaction by practitioners in treating the patients.

3. Perceived Implications of Medical Malpractice Litigation

The most obvious and recent impact of medical malpractice litigation is the rise in malpractice premiums, non-availability of malpractice insurance for some doctors, and professional and legal tension between lawyers, doctors, and insurance carriers.

As the situation stands today, the parties affected most by the malpractice problem are patients and doctors, in that order. Whenever there is a rise in malpractice premiums, either the doctors raise the cost of medical care and employ extra diagnostic tests and therapeutic procedures to protect themselves against a possible liability suit, or stop rendering high-risk services thus reducing the availability of such services to patients. At a time when there are 70,000 fewer
doctors then there should be, a loss of another 50,000 because of this problem can be disastrous not only for patients, but for the entire health-care delivery system. Doctors already have a great work-load. Any decrease in the number of doctors, or the services they provide, is bound to increase the work-load of available practitioners to an extent which may negatively affect both the quality and the quantity of available health-care.

In economic terms, "health is the second largest industry in the United States. In 1971, the total costs of direct health services provided to Americans was $75 billion..... With increase in doctors' bills, the cost experience of public health insurance would go up, which in turn, would increase their premiums. Since the Federal Government pays about 23 percent of the bills (for medicaid, and other programs), the cost would be borne by the general public through taxation.

The most significant impact, however, is upon the organization of medical practice. Both malpractice suits and the fear of being sued has forced providers of health-care to resort to defensive medicine. Defensive medicine may be defined as "the alteration of modes of medical practice, induced by the threat of liability, for the principal purpose of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such
lawsuits are instituted."  

Three different kinds of defensive medicine may be identified: 1) active defensive medicine; 2) passive defensive medicine; and 3) maverick defensive medicine.

Active defensive medicine is the performance of unnecessary tests or the use of certain diagnostic or therapeutic procedures which are medically "unjustifiable" but are carried out simply to prevent the threat of medico-legal liability. Although statistics are not available as to what proportion of the total medical expenses is spent on such practices, it has been estimated by some sources to be as high as one-fourth of the total expenses, not counting the loss of earnings of patients due to unnecessary hospitalization or absence from jobs for tests, and the like.

Passive defensive medicine takes place when a practitioner refrains from the use of certain diagnostic or therapeutic procedures, which while not absolutely necessary, could be beneficial if used simply out of fear of uncertain side effects. This may also result in delay in recovery, unnecessary hospitalization and suffering.

Another form of passive defensive medicine is the reluctance on the part of practitioners to dispense services in non-clinical situations. Nadler observed that on-the-spot or pre-hospital emergency medical care for a number of
disorders can increase the probability and speed of recovery, and decrease the chances of temporary or permanent damage, or in certain cases, mortality. In other words, with no change in scientific knowledge or medical technology, death, disability and discomfort attributable to various causes can be reduced by increasing the speed with which effective initial care is delivered. But in spite of Good Samaritan Statutes in effect, according to which a practitioner is not liable for delivering emergency or on-the-spot care, 50 percent of the practitioners surveyed in 1963 responded that they would not render such care. Now that the malpractice situation is much worse, it is likely that even a greater percentage of doctors are unwilling to render such services.

The waste of knowledge and expertise of allied health personnel is yet another aspect of passive defensive medicine. There are some specially trained allied health personnel who can perform tasks which are customarily performed by a physician. A number of physicians have expressed reluctance to employ these new kinds of allied health personnel or give them authority to perform needed tasks without their permission because they are uncertain about the effect it might have on their professional liability insurance premiums and on the chances that they might be sued for the harmful acts of their new assistants.

Maverick defensive medicine refers to the reluctance on
the part of medical providers to publish in medical journals reports on cases with adverse effects of diagnostic or therapeutic procedures. This practice involves one of the most critical issues of modern medicine, since it serves as a major deterrent to the dissemination of important medical knowledge. When adverse effects are not shared with the professional community for fear of litigation, other patients could be placed in greater risk.

The medical malpractice litigation problem of the present-day United States has increased the ever-present friction between doctors and lawyers, and increased the public's suspicion of the medico-legal system because of the discrepancies existing in the awards for the same injuries from place to place and from time to time. In certain cases, attorneys take only those cases which offer the greatest awards, since most malpractice cases are handled on a contingency fee basis. In many cases consumers do not file any claims because attorneys will not take the case because the slight chance for the consumer to recover anything substantial is not worth the risk and trouble.

And finally, litigation over malpractice insurance has necessitated some drastic legislative measures. This has brought various agencies of the government along with doctors, lawyers, and insurers into a rather tense situation. State and federal legislative bodies are in active pursuit of some
workable solution to this problem, that has now reached a critical stage.

4. Proposed Solutions to Medical Malpractice Litigation Problem

There are primarily two kinds of proposed solutions that are being considered on various levels. Some measures are directed towards a stop-gap arrangement of medical malpractice liability coverage for those physicians who are now without coverage due to the withdrawal of insurers from certain states, or where doctors cannot meet the enormous increases in premiums demanded by insurance companies. For the short-term, the American Medical Association has proposed that reinsurance pools, similar to those developed by automobile insurance carriers to cover high-risk drivers, be formed. These pools would spread the risk among several carriers so that no one company would bear the brunt of a crippling settlement. Similar actions of self-supporting coverage plans have been proposed in California, New York, Wisconsin, and other states where doctors are now without coverage. All these short-term measures are only stop-gap solutions to the problem. All sectors agree that long-term reforms are needed to fight this problem. The proposed solutions, however, are of varying nature. They can be classified under the following heads: 1) proposed reforms concern-
ing the practice of medicine; 2) proposed reforms concerning the legal procedures; 3) proposed reforms concerning the compensation procedures; and 4) proposed reforms concerning the insurance industry.

Proposed reforms concerning the practice of medicine are based upon the assumption that incompetent and inept medical practitioners are responsible for a great number of medical malpractice suits. The measures suggested are, in general, aimed at improving the quality of health-care providers. In an article titled "MDs Share Malpractice Fault For Not Expelling Inept Doctors", White blames the professionals for the present conditions:

In considerable measure, we are to blame for this mess. We have put off doing anything about it until too late. We have, from sloth and loyalty, taken only token action against those physicians who practice negligent medicine, and none against those who accumulate the majority of the malpractice suits, for most of the lawsuits are filed against the same small number of physicians year after year.

When our Medical Society has tried to get action from the State Board of Medical Examiners, the only body which can suspend or revoke a license to practice, we have obtained little response or action. However, we have left the matter there and failed to go to the legislature to demand a chance to give the Board more power.

In an effort to control the cost and the quality of health-care, the Federal Government has finally stepped in with sweeping legislation. Under the law "doctors are being asked to set up Professional Standards Review Organizations
(PSRO's) across the country to monitor the care given under federally supported programs--including any national health insurance plan that may eventually become law. "PSRO's," Dr. Henry E. Simmons, Deputy Director of the Department of Health, Education and Welfare, told a group of doctors recently, "may be our last, best chance as an independent profession to do the job."\(^8\)

The discussion thus far about proposed medical practice reforms suggests that there is a small percentage (2 percent)\(^8\) of "incompetent" physicians who are responsible for the majority of suits. This calls for stricter peer review and control, which may have been rather lenient in the past.

Among other proposals for medical reforms, continuing education programs are widely recommended. There are presently quite a few such programs in operation. Their main objective is to keep practitioners abreast of the latest developments in the field. Patterson\(^9\) claims that communications with members is the key to upgrading medical practice, and that good medical practice cannot be separated from liability insurance.

Some have recommended recertification of physicians every year, as are airline pilots, and the inclusion of lay members and several lawyers on state boards of medical examiners.\(^9\) These proposals are not widely shared by any sector.

Proposed reforms concerning legal procedures are based
upon the assumption that the present system of medical malpractice is very complicated, time consuming and unfair to some parties. The most widely proposed recommendation is the formation of voluntary but binding arbitration bodies which would involve informal procedures, comparatively private hearings and use of text-book evidence to make malpractice cases faster, more economical and less strained than court trials. This kind of arbitration has not been tried on a large scale, but the California legislature has been urged to make it mandatory, and the Medical Society of New York has proposed it as one of their long-term solutions instead of a stop-gap program of reinsurance pools.

Another proposal of significance is the use of a sliding fee scale, the kind adopted by New Jersey's Supreme Court, as a method of reimbursement of attorneys who take cases on a contingency basis. Under this system, the greater the reward, the smaller the percentage an attorney gets for a fee, though the absolute amount of the fee would always go up with the size of the award. Some states might limit the contingency fee paid to the attorneys; several have already done so.

The formation of screening panels for malpractice has been proposed by some, which calls for a panel to be comprised of a judge, doctors, and lawyers. According to the proposal, malpractice suits would go to the panel where
an informal hearing, without a record, would be held to reach a settlement if possible. In other words, a panel would decide the merit of the claim. If the panel were to find it meritorious, a settlement would be sought, if possible. This would screen out a number of cases before going to trial, especially if they were frivolous.

Reform of the collateral source rule is another proposed legal reform. Present law in some states prevents a jury from being told of other, so called "collateral", sources of funds an injured party receives to compensate injuries, including health insurance and governmental compensation. The California legislature has been urged to change the law and permit admission of this evidence to offset double recovery and thus reduce the amount of awards for damages.

Proposed reforms concerning compensation procedures are primarily based upon two assumptions: 1) the very nature of present medical practice is such that some injuries are bound to occur in spite of the utmost care of the practitioners; and 2) the aggrieved patient should not have to prove negligence to be compensated for treatment induced injuries. Patients should be compensated for treatment injuries even if there is no negligence on the part of the doctor.

The proposal is widely recommended by almost every sector.
U.S. Senators Kennedy and Inouye have filed legislation that would set up a workman's compensation style malpractice program. Patients would be compensated for treatment induced injuries--without having to prove negligence--according to a schedule of payments for medical expenses, physical suffering and loss of income.

Proposed reforms concerning the insurance industry are based primarily upon the assumption that the present medical malpractice premium system based on the doctor's type of practice and specialty, as well as the compensation award system, need to be revised. Nelson suggested that the method of classifying doctors needs to be changed so that the cost of insurance is spread more evenly over all types of practitioners. At the present time, some specialists pay far more than the others. This proposal, however, does not recognize the fact that some specialists earn more than others with the same amount of work, nor does it take into account the differential rates of malpractice suits and liability awards.

Another proposal concerns structured life care awards under which a defendant doctor, through his insurer would fund an injured patient's care with periodic, rather than lump-sum payments. The proposal is aimed at saving money and stabilizing an insurance industry allegedly crippled by large awards.
Presently, one company usually writes most of the medical malpractice insurance in a state. This gives them a monopoly over the market. It is proposed that policies should be available from competing companies so that physicians and hospitals would have the benefit of competition.\textsuperscript{103}

The insurance industry has been accused by Low of being "woefully lacking in any recognition of the fact that their business must be geared to public interest.....It cannot be given license to underwrite losses and then get out of the less profitable areas....."\textsuperscript{104} He also suggests that all "insurance companies' underwriting practices should be reviewed and made public. Newspapers should print full details of the premiums collected, the reserve setup, the investment of reserves, the companies' investment portfolios and the ratio of premiums collected to payout."\textsuperscript{105}

Insurance industry's proposals\textsuperscript{106} to ease their problem is to develop a new policy. The traditional policy covers claims reported any time in the future resulting from professional services rendered during the time a particular policy was in force. The proposed policy would be designed to cover claims for incidents reported only during the time the policy is in force. In other words, the insurance industry proposes to cut the "tail" in industry parlance.

At the time of this writing, numerous legislative and other efforts are being made to fight what has time and again
been called a "crisis" in the profession of medicine.

FOOTNOTES

5. What is medically "unjustifiable is a controversial issue in the field of medicine. In Chapter 2, this point is elaborated.
8. Ibid.
16. M. Clark and M. Gosnell, Ibid.
17. F. vom Saal, op. cit.
22. Scientific American, op. cit.
26. Ibid.
27. G. Nelson, op. cit.
28. Ibid.
30. Ibid.
32. M. Clark and M. Gosnell, op. cit.
35. Ibid.
36. Ibid.
38. Ibid.
39. Ibid.
40. F. Ostermann (1975), as cited in Ibid.
41. "California Doctors' Slowdown Causing Crisis in Hospitals" (1976).
43. Ibid.
44. Ibid.
46. Ibid. (Footnote 53).
48. Latin for "the thing speaks for itself." In medical malpractice suits, the doctrine of res ipsa loquitur is an evidentiary rule that is permitted to be invoked when: 1) an injury occurs which is of a type that ordinarily does not occur except for someone's negligence; 2) the conduct or mechanism which caused the injury was within the exclusive control of the person from whom the damages are sought; and 3) the complaining party was free of any contributory negligence. Given these circumstances, the law permits an inference of negligence on the part of the physician and liability will accrue unless the physician (to whom the burden is shifted) proves he was not negligent. (W. G. Freeland (1973-A), p. 28.
49. For a detailed discussion of the dependent and independent variables of the present study, please refer to the subsequent chapters.
50. M. Clark, op. cit., p. 50.
52. M. Kendall and J. Haldi, op. cit., p. 553.
53. Ibid.
55. Ibid.
56. Ibid., p. 10.
57. Ibid.
58. Scientific American, op. cit.
60. Ibid.
61. Ibid.
64. E. Freidson, op. cit., pp. 20-23.
65. E. D. Luby (1972).
68. M. Clark, op. cit., p. 48.
69. Ibid.
71. T. C. Chalmers, as quoted in M. Clark, op. cit., p. 49.
74. M. Clark, op. cit., p. 48.
75. L. Shearer, op. cit.
77. Ibid.
78. Ibid.
79. Based on Ibid. The idea was taken from this source but the categories were developed by the present author.
80. R. E. McGarrah, as cited in M. Clark, op. cit., p. 47.
83. Ibid., p. 17.
84. M. Todd, op. cit.
85. L. P. White, op. cit.
86. Ibid.

87. A survey of professional liability incidence in Maryland indicated that the number of physicians involved in only one claim is expected to be 337, much greater than the number observed to have one claim (267). The number expected to have more than one claim is only 21, in sharp contrast to the 46 observed. (W. R. Pabst, Jr., in W. G. Freeland (1973-B), p. 634.).

88. H. E. Simmons, as quoted in M. Clark, op. cit., p. 47.
89. American Medical News (1975), p. 11.
90. Ibid. (Patterson is the Executive Secretary of the Alabama Medical Association.)
92. F. J. Heistand, op. cit.
93. Ibid.
95. F. J. Heistand, op. cit.
96. Ibid.
98. F. J. Heistand, op. cit.
99. Ibid.
100. M. Clark and M. Gosnell, op. cit.
102. F. J. Heistand, op. cit.
103. J. B. Spence, op. cit.
104. E. Low, op. cit.
105. Ibid.
106. W. M. Traphagan, op. cit.
CHAPTER 2

STATEMENT OF THE PROBLEM

The present study is a cross-sectional survey analysis aimed at determining the impact of medical malpractice litigation upon the patterns of practice of self-employed medical practitioners in East Baton Rouge Parish, Louisiana. The general perspective for the study is provided by the sociological conception of professions.

Sociologists draw a general distinction between "professions" and other "occupations." Professions are occupations which have assumed a dominant position in the division of labor, and are in control of the substance of their work. Unlike most occupations, professions are autonomous and self-directing. They sustain their special status by regulating the trustworthiness of their members in terms of ethicality and knowledgeable skill.¹

Goode² gives two "core characteristics" of professions from which ten other frequently cited characteristics are derived. They are: 1) prolonged specialized training in a body of abstract knowledge; and 2) a collectivity of service orientation. The derived characteristics, which are presumably "caused" by the core characteristics are:³

1) The profession determines its own standards
of education and training.

2) The student professional goes through a more far-reaching adult socialization experience than the learner in other occupations.

3) Professional practice is often legally recognized by some form of licensure.

4) Licensing and admission boards are manned by members of the profession.

5) Most legislation concerned with the profession is shaped by that profession.

6) The occupation gains in income, power, and prestige ranking and can demand higher caliber students.

7) The practitioner is relatively free of lay evaluation and control.

8) The norms of practice enforced by the profession are more stringent than legal controls.

9) Members are more strongly identified and affiliated with the profession than are members of other occupations with theirs.

10) The profession is more likely to be a terminal occupation. Members do not care to leave it, and a higher proportion assert that if they had to do it over again, they would again choose that type of work.

Goode claims that these characteristics "are closely interdependent. More important, they are all social relationships; they assert obligations and rights between client and professional, professional and colleagues, or professional and some formal agency. Consequently, an important part of the process by which an occupation becomes a profession is the gradual institutionalization of various role relation-
ships between itself and other parts of the society. These clients or agencies, or the society generally, will concede autonomy to the profession only if its members are able and willing to police themselves; will grant higher fees or prestige only when both its competence and its area of competence seem to merit them; or will grant an effective monopoly to the profession through licensure boards only when it has persuasively shown that it is the sole master of its special craft, and that its decisions are not to be reviewed by other professions.\textsuperscript{4}

Medicine is a practicing and consulting profession and "is usually considered the prototype of the professions."\textsuperscript{5} The physician is its key professional. He is "the most prominent among the members of the generally recognized professions. He is seen by the public as possessing a higher standard than any other professional and by the sociologist as the virtual prototype of his kind."\textsuperscript{6} Economic or political autonomy may vary from country to country but technological or scientific autonomy of a profession is the same everywhere. In every country, be it the United States, Soviet Union, or the United Kingdom, the profession of medicine is left fairly free to develop its special area of knowledge and to determine what are "scientifically acceptable" practices. Thus, while the profession may not be free to control the terms of its work, it is free to control the content
of its work.

In the United States, "the profession through its private associations has very largely been given the right to determine how political and legal power bearing on medicine shall be exercised." This is primarily because of the nature of medical work. In spite of precision in medical science, Carr-Saunders and Wilson argue that medicine requires not a set of routine but the exercise of complex judgement and instead of caution it sometimes requires the taking of risks. Furthermore, judgement as such cannot be objectified because it is, at least in part, a matter of opinion. Since the focus of medical practice is on the solution of concrete problems, it is obliged to carry on even when it lacks a scientific foundation for its activities: it is oriented toward intervention irrespective of the existence of reliable knowledge. Furthermore medical practice is typically occupied with the problems of individuals rather than aggregates or statistical units. Probabilities can only guide the determination of whether a patient does or does not have a disease. Thus, even when general scientific knowledge may be available, the mere fact of individual variability poses a constant problem for assessment that emphasizes the necessity for personal firsthand examination of every individual case and the difficulty of disposition on some formal abstract scientific basis.
Conceptual Framework

There are two theoretical perspectives that are generally used to interpret patterns of practice of medical practitioners. One emphasizes individual attributes and value orientations as determinants of practitioners' patterns of performance independently of their environment, while the other explains it as the product of the pressures of their environment independently of their individual attributes and value orientations. Although both aspects are equally significant, far too much emphasis has been placed on individual attributes and value orientations in sociological literature. "Deficient behavior on the part of a professional tends to be explained as the result of being a deficient kind of person, or at least inadequately or improperly 'socialized' or educated in the professional school."10 Solutions to such problems are seen in recruiting better motivated and more capable entrants to school, in improving their professional education, and in generally 'raising standards'. "All these devices are predicated on the aim of changing the quality of individuals, the assumption being first that social pathologies connected with medical care, like illnesses connected with mankind, are 'caused' by the characteristics of the individuals providing the care rather than by the environment in which those individuals provide care, and second that they are best treated by treat-
ing individuals rather than the environment."

No one can deny the importance of "socialization" or education and training in the medical profession. It is, without any doubt, "of great significance, not only for establishing formal criteria for licensing but also for establishing within individual members of the profession a core of knowledge and attitude." Nevertheless, Freidson argues, "that education is a less important variable than work environment. There is some very persuasive evidence that 'socialization' does not explain some important elements of professional performance half so well as does the organization of the immediate work environment." He cites a few studies that have reinforced this viewpoint. Seeman and Evans, for example, found that the same individual physicians in a hospital behaved differently when the quality of supervision varied. Peterson and his associates could find little relation between variations in professional education and the technical performance of general practitioners some years after graduation. In a similar study, Clute came up with approximately the same results in Canada. A quite different study, but relevant to the line of argument here, conducted by Price found no relationship between grade-point average in medical schools and performance in practice. And in a longitudinal study of rather unusual nature, Gray and his associates found that a group of equally "cynical"
medical school graduates differed in their later "cynicism\" according to the type of practice in which they engaged. Freidson claims that these studies provide evidence that quite critical elements of professional behavior--the level of technical performance, the approach to the client, "cynicism" and ethicality--do not vary so much with the practitioners' formal professional training as with the social setting in which they work after their education. These observations reinforced his belief "that it is at once attractively parsimonious and adequately true to assume that a significant amount of behavior is situational in character--that people are constantly responding to the organized pressures of the situations they are in at any particular time, that what they are is not completely but more their present than their past, and that what they do is more an outcome of the pressures of the situation they are in than of what they have earlier "internalized". This belief led him to suggest the "social structure" approach as an alternative mode of thinking about medical care. The major assumptions of the structural approach, according to him are: 1) that whatever motives, values or knowledge people have come into contact with and have "internalized", they do not guide the behavior of most individuals unless they are continually reinforced by their social environment; 2) that the environment can, by reinforcement, lead people to forsake one set
of motives, values, or knowledge in favor of another; and
3) given the first two, the average behavior of an aggre­
gate of individuals can be predicted more successfully by
reference to the pressures of the environment than by re­fer­ence to the motives, values, and knowledge they had be­fore entering the social environment. The basis of pre­
diction is from the requirements for social "survival"
posed by the social environment and refers to the func­
tional adaptations of the individuals who survive.

Freidson's "social structure" approach provides the
conceptual framework for the present study which, in its
own right, serves as the empirical verification of his
assumptions in the medical professional organization in
East Baton Rouge Parish, Louisiana.

A review of the literature has indicated that the mal­
practice litigation problem has reached "crisis" proportions
calling for both short-range emergency measures as well as
long-range legislative and other reforms. It has resulted
in varied degrees of strains and stresses to the medical prac­titioners which are manifested through their patterns of prac­tice. Patterns of practice mainly involve three major cate­gories of relationships that are of primary significance in
their professional milieu: 1) practitioner-patient rela­tionships; 2) practitioner-colleague relationships; and 3) practitioner-allied health personnel relationships.
Patterns of Practice of Medical Practitioners

Becker and his associates\textsuperscript{21} in their study at the University of Kansas Medical School in the 1950's found that the values of "medical responsibility" and "clinical experience" were strongly emphasized during the training of medical students. Medical responsibility is responsibility for the patients' well-being. It is personal and direct, in that it belongs to the physician who is working directly with the patient. And it is consequential in that it requires the physician to accept the outcome of a certain treatment, whether negative or positive.

Clinical experience refers to "actual experience in dealing with patients and disease....(which) even though it substitutes for scientifically verified knowledge, can be used to legitimate a choice of procedures for a patient's treatment and can even be used to rule out use of some procedures which have been scientifically established."\textsuperscript{22} Freidson contends that in part, "the idea depends upon the fact that contemporary medical diagnosis still requires the direct use of several of the physician's senses, which by the nature of the case can only be schooled by direct practice at using them. The idea also seems to depend in part upon the inadequacy of 'book' and scientific knowledge in the face of the practical contingencies and complexities of the individual case."\textsuperscript{23} The Kansas study\textsuperscript{24} showed that at
times students found their answers based on a textbook or a journal rejected by the questioning faculty member, whose own experience happened to be incongruent with the established knowledge. On such occasions, "argument from experience was quite commonly used and considered answerable.... The only counter-argument that can prevail is..... By someone who can claim greater experience in the area discussed."25

This value orientation of "medical responsibility" and "clinical experience" can be seen as the basic and probably the most consistent determinant of a practitioner's patterns of practice, with a certain degree of variability, of course, "because not all do the same work with the same demands."26 Value orientation of practitioners, and action oriented nature of medical work, helps formulate a composite view of idealistic patterns of medical practice observable through "the clinical mind" conceptualized by Freidson.27 According to idealistic patterns of practice, the aim of the practitioner is action. "Successful action is preferred, but action with very little chance for success is to be preferred over no action at all."28 Perhaps because of this action orientation, a practitioner "is prone to rely on apparent 'results' rather than on theory....."29 It may be because of this reason that practitioners in time come to trust their own first hand experience in preference to abstract principles, particularly in assessing and managing
those aspects of their work that cannot be treated routinely. 30 This aspect makes practitioners' work mostly subjective and indeterminate rather than regular and lawful scientific behavior. Thus, by the very nature of their work, practitioners have to assume responsibility for practical action, and in doing so, they must rely on their concrete clinical experience. In assuming responsibility for virtually any concrete action, they also assume a risk which makes them vulnerable to professional or legal reproach.

The emphasis on particularism and subjectivity in practitioners' work should not lead us to conclude that their work is not based on rationality. "Much of medical man's activity can be represented by the process of differential diagnosis: a succession of diagnoses in the form of hypotheses is tested against the available signs and symptoms. Rationality is a significant attribute of the physician... (which) is particularized and technical; it is a method of sorting the enormous mass of concrete detail confronting him in his individual cases. The difference between clinical rationality and scientific rationality is that clinical rationality is not a tool for the exploration or discovery of general principles, as is the scientific method, but only a tool for sorting the interconnections of perceived and hypothesized facts." 31

In the present context, it is the clinical rationality
which helps practitioners evaluate the odds they are working against in different situations and modify their patterns of practice accordingly. In other words, patterns of practice of medical practitioners are determined by situational variables.

The primary aim of the present study is to empirically determine the impact of a set of situational variables pertaining to medical malpractice litigation as opposed to background and professional value orientation variables upon the patterns of practice of medical practitioners. The situational as well as background and professional value orientation variables have been treated as independent variables and the patterns of practice as the dependent variable. It is hypothesized that the situational variables will be responsible for explaining greater variation in the stressful patterns of medical practice than the background and the professional value orientation variables.

Significance of the Study

It is the first empirical study which is aimed at determining the impact of medical malpractice litigation upon the patterns of practice involving medical practitioners in their professional work relationships with their patients, colleagues, and allied health personnel. It is an empirical verification of Freidson's "social structural" approach as
it applies to the patterns of medical practice in East Baton Rouge Parish, Louisiana.

A review of the relevant literature has indicated that the problem of medical malpractice litigation is a very critical issue in the profession of medicine at the present time. But, unfortunately, there are not enough significant sociological studies available that could shed light on the nature, magnitude, and impact of this problem upon the health-care delivery system in particular and the social structure in general. Since every member of a society is a potential consumer of health services, a thorough and clear understanding of every related aspect is crucial for viable solutions. The present study deals with one of the most important aspects of health-care delivery system, i.e., the patterns of practice of medical practitioners. It has already been noted that medical practitioners are the key figure in the profession of medicine. Any variation in their professional performance is bound to affect the entire spectrum of health-care delivery system. Although the scope of the present study is quite limited, both in the conceptual as well as the geographical sense, it is hoped that it will be in a position to provide answers to a few questions, and most importantly, raise a few pertinent sociological questions which may serve as guidelines for any further study.
FOOTNOTES

1. E. Freidson (1973), p. xvii. Also see M. I. Cogan (1953), for a classical review of the definitions of professions.


3. Ibid.

4. Ibid.


10. Ibid., p. 88.


13. Ibid., p. 89.


16. K. F. Clute (1963), as cited in Ibid.

17. P. B. Price (1963), as cited in Ibid.

18. R. M. Gray, et al., as cited in Ibid.

19. E. Freidson (1973), p. 90. (Footnoted: This position has been put more abstractly by Howard S. Becker, "Personal Change in Adult Life", Sociometry, XXVII (1964), pp. 40-53.).

27. Ibid., pp. 168-172.
28. Ibid., p. 168.
29. Ibid., p. 169.
30. Ibid.
31. Ibid., p. 171.
The Study Population

The population for the present study consisted of the self-employed M.D's practicing in East Baton Rouge Parish, Louisiana.

The listings of medical practitioners in the yellow pages of the Telephone Directory of Greater Baton Rouge provided the sampling frame.¹ There are two different kinds of listings in the Directory: 1) general listings, and 2) listings according to the fields of practice. This cross-listing of the practitioners, however, was not complete. Some practitioners were listed only in the general listings, or only in the listings according to the field of practice. From these two listings, a comprehensive list of 310 practitioners was compiled.

The rationale for using the telephone directory as the sampling frame was that it was the most comprehensive and up-to-date list available from any source. This statement is based on the fact that the Louisiana State Board of Medical Examiners does not keep such records and not every practitioner in the Parish is a member of the East Baton Rouge Parish Medical Society, or the East Baton Rouge Parish Med-
ical Association. Since doctors are prompt in installing a telephone and listing their number for both professional and business reasons, it was decided that the listings in the Directory of Greater Baton Rouge will serve as an adequate sampling frame. The appropriateness of the sampling frame was justified by the fact that changes in the listings between 1974 and 1975 directories were found to be insignificant.2

Sampling Design

A simple random sample was selected; all physicians were numbered and 103 were chosen by employing the table of random numbers. The sample size was set at 103, one-third of the total number of self-employed medical practitioners in the area; this was the maximum that could be interviewed with the resources available. Anticipating non-responses due to various reasons, a sample of 177 was drawn. The actual number of respondents interviewed was 104. One interview conducted on the telephone was discarded, resulting in a final sample size of 103.

Operationalization of the Concepts

The general hypothesis of the study is that the situational variables will be responsible for explaining greater variation in the stressful patterns of medical practice than
the background and the professional value orientation variables.

There are two sets of independent variables: 1) the situational variables, and 2) the background and the professional value orientation variables. The dependent variable in the general hypothesis consists of a set of 12 variables designed to indicate the degree of stress in the patterns of practice of medical practitioners. The sets of both independent and dependent variables are described below.

The Background and the Professional Value Orientation Variables

The following variables pertain to the personal characteristics, interests, and activities concerning the profession of medicine. All variables are at the interval level of measurement; some are discrete rather than continuous.

1) Age (Question 1 in the data collection instrument, p. 116).

2) Certification by the national boards of limited fields of practice; measured in terms of the number of boards by which a practitioner is certified. (Question 4 in the data collection instrument, p. 116).

3) Board certification classification; measured by summing up the number of years of certification of a practitioner by each national board of limited field. (Question 4 in the data collection instrument, p. 116).
4) Number of years of formal medical training. (Question 6 in the data collection instrument, p. 116).

5) Estimation of hours of formal refresher or continuing education course-work during the past 5 years. (Question 7 in the data collection instrument, p. 117).

6) Number of years of medical practice experience including the internship and the residency. (Question 8 in the data collection instrument, p. 117).

7) Estimation of current memberships in local, state, regional, national, and/or international medical associations. (Question 9 in the data collection instrument, p. 117).

8) Estimation of offices or positions held in medical associations during the past 5 years. (Question 10 in the data collection instrument, p. 117).

9) Estimation of hours spent attending medical association meetings during the past 5 years. (Question 11 in the data collection instrument, p. 117).

10) Estimation of papers presented at medical association meetings during the past 5 years. (Question 12 in the data collection instrument, p. 117).

11) Estimation of paid subscriptions to medical journals during the past 5 years. (Question 13 in the data collection instrument, p. 117).

12) Estimation of articles published in medical journals during the past 5 years. (Question 14 in the data collection instrument, p. 118).

13) Estimation of medical journal editorial positions held during the past 5 years. (Question 15 in the data collection instrument, p. 118).
The Situational Variables

The situational variables are designed to measure those conditions which either increase the probability of a liability suit or the fear of it; or reduce it, directly or indirectly. All variables are at the interval level of measurement; some are discrete rather than continuous.

1) Post-interview observations, measured in terms of the degree of congeniality observed by the author in the professional work-settings of medical practitioners. Included in the work-settings are the material objects which characterized the clinical environment; and the nature of both intra and interrelationships among the patients, the staff, and the practitioners.

2) Waiting time in minutes, recorded in terms of the difference between the scheduled time and the actual time when the interview started.

3) The risk-factor of the fields of medical practice, ranging between low (1), moderate (2), high (3), to very high (4). The classification is based on the ISO classification system used for actuarial purposes. Low risk fields of medical practice include Allergy, Cardiology (excluding Catherization), Dermatology, Family Practice, Gastroenterology, General Practice, Internal Medicine, Neurology, Pathology, Pediatrics, Psychiatry, Radiology, and Rheumatology. Moderate risk fields of medical practice include Cardiology (including Catherization but not including cardiac surgery), Ophthalmology, and Proctology. High risk fields of medical practice include Cardiac Surgery, General Surgery, Thoracic Surgery, and Vascular Surgery. Finally, very high risk fields of medical practice include Neurology, Obstetrics and Gynecology, Orthopedics, Otolaryngology, and Plastic Surgery. (Question 4 in the data collection instrument, p. 116).
4) Kinds of professional work-settings, ranging from solo practice (1), simple partnership in terms of sharing of clinical facilities, etc. (2), strict partnership in terms of sharing the office facilities as well as the remunerations (3), a limited, unitary-field professional medical corporation (4), to a limited, multiple-field professional medical corporation (5). (Question 5 in the data collection instrument, p. 116).

5) Number of partners in the group. (Question 5a in the data collection instrument, p. 116).

6) Number of medical malpractice suits filed against the medical practitioner during the past 5 years. (Question 16 in the data collection instrument, p. 118).

7) Number of medical malpractice suits resulting in unfavorable decision for the practitioner. (Question 16 in the data collection instrument, p. 118).

8) The evaluation and control by the Professional Standards Review Organization (PSRO's); measured in terms of the degree of stress observed in the responses of medical practitioners due to medical malpractice litigation involving the opinion about PSRO's. (Question 29 in the data collection instrument, p. 120).

9) The availability of expert testimony from outside of the community in malpractice suits; measured in terms of the degree of stress observed in the responses of medical practitioners due to medical malpractice litigation involving the availability of expert testimony in medical malpractice suits. (Question 30 in the data collection instrument, p. 120).

10) No-fault or workman's compensation type compensation to the patients for treatment induced injuries regardless of physicians negligence; measured in terms of the physician's attitude towards no-fault type compensation. (Question 35 in the data collection instrument, p. 121).
Stressful Patterns of Medical Practice Variables

A higher degree of stress in the patterns of medical practice is indicated by the following indicators:

1) A higher bracket of basic medical malpractice insurance coverage. (Question 17 in the data collection instrument, p. 118).

2) Additional medical malpractice insurance coverage. (Question 18 in the data collection instrument, p. 118).

3) Refraining from dispensing on-the-spot or pre-hospital emergency care; measured in terms of the degree of stress observed in responses of medical practitioners due to medical malpractice litigation involving the rendering of emergency care. (Question 19 in the data collection instrument, p. 118).

4) Explaining the patients' condition and the treatment procedure to them or their family members/friends for the purpose of acquiring informed consent (sound legal support); measured in terms of the degree of stress observed in the responses and the reasons for the responses concerning explaining the patients' condition and the treatment procedure. (Question 20 in the data collection instrument, p. 118).

5) Taking serious note of the complaints of the patients even though the complaints may seem trivial; measured in terms of the degree of stress observed in responses and the reasons for the responses to the patients with apparently trivial complaints. (Question 21 in the data collection instrument, p. 119).

6) Over-utilization of hospital and various diagnostic and therapeutic procedures to forestall the possibility of lawsuits, and in case of suits, to provide a good legal defense in a medical malpractice suit. This includes hospitalization for diagnostic tests which may be done as out-patients; hospitalization for border-line conditions which could be treated
at home; keeping patients in the hospital for extra days to avoid the possibility of premature discharge and possible complications at home; and over-prescription of x-rays and other routine diagnostic procedures to provide legal protection; measured in terms of the degree of stress observed in responses of medical practitioners due to medical malpractice litigation involving the utilization of hospital facilities and the prescription of diagnostic tests. (Questions 22, 23, and 24 in the data collection instrument, p. 119).

7) Restraint in use of new medical and other diagnostic or therapeutic procedures if there is potential for faster and better recovery but the possible adverse effects have not been completely determined at the time; measured in terms of the degree of stress observed in the responses of medical practitioners due to medical malpractice litigation involving the use of new medical "armament". (Question 25 in the data collection instrument, p. 119).

8) Restraint in sharing observed adverse effects or therapeutic failures with one's colleagues in the work-setting due to fear of legal or professional reproach; measured in terms of the degree of stress observed in the responses of medical practitioners due to medical malpractice litigation involving the sharing of therapeutic failures and observed adverse effects. (Question 26 in the data collection instrument, p. 119).

9) Restraint in publishing accounts of therapeutic failures due to fear of legal or professional reproach; measured in terms of the degree of stress observed in responses of medical practitioners due to medical malpractice litigation involving the publishing of case histories depicting therapeutic failures. (Question 27 in the data collection instrument, p. 120).

10) Restraint in using one's clinical judgement if the scientific foundations for certain
diagnostic and therapeutic procedures are problematic or incongruent with one's firsthand experience; measured in terms of the degree of stress observed in the responses of medical practitioners due to medical malpractice litigation involving choice between clinical judgement and the standard procedure according to the medical literature. (Question 28 in the data collection instrument, p. 120).

11) Restraint in employing specially trained allied health personnel to do the routine jobs independently, since the ultimate responsibility lies with the practitioner. Also, restraining in delegating responsibility to dependable allied health personnel to do routine jobs independently or to deal with minor emergency complaints of patients without permission of the practitioner; measured in terms of the degree of stress observed in the responses of medical practitioners due to medical malpractice litigation involving the employment of certain specially trained allied health personnel and delegating powers to dependable allied health personnel to do routine jobs independently. (Questions 31 and 32 in the data collection instrument, p. 120).

12) The use of extra precautionary measures for "suit prone" patients; measured in terms of the degree of stress observed in the responses of medical practitioners due to medical malpractice litigation involving the perception and the handling of unhappy patients. (Question 33 in the data collection instrument, p. 121).

The indicators given above are designed to measure practitioners' attitudes which are organized dispositions to think, feel, perceive, and behave toward strains and stresses posed by the medical malpractice litigation problem and its many ramifications.
Data Collection

All interviews were conducted by the author during the period of June 5 to August 20, 1975, in a face to face situation with medical practitioners in their professional work-setting. Hand-written notes were taken and at the same time, all but six interviews were recorded on a cassette tape which was erased after transcription.

The instrument used for data collection purposes was an interview schedule with 35 open-ended questions. The final format was arrived at after modifications necessitated by the pretest of the interviewing schedule on 10 physicians conducted early in May, 1975.

All respondents were male - 97 White and 6 Black. An overwhelming majority of them were specialists (85 percent) in one or more limited fields of medical practice; the remainder were general practitioners. Among the specialists, 8 percent were neither certified by their limited field of practice nor were they qualified or eligible to be certified. Board eligible or board qualified limited practitioners constituted 19 percent of the specialists; 16 percent certified by one board of limited field of practice and 7 percent were certified by two boards of limited fields of practice.

A significant majority of medical practitioners (62 percent) were engaged in group practice and 38 percent were
solo practitioners. Among the group practitioners, 11 percent simply shared the office and/or clinical facilities; 36 percent shared the office and clinical facilities as well as the workload and remunerations; 37 percent belonged to a limited, unitary-field professional medical corporation and 16 percent were members of a limited, multiple-field professional medical corporation. The number of partners ranged from 1 to 27 with an average of 7 partners.

The practitioners ranged in age between 32 and 76 with an average age of 50 years. Their number of years of medical practice experience including the internship and the residency ranged between 7 and 50 years, averaging about 24 years. The sample was represented by all levels of risk categories of medical practitioners.

The fieldwork was implemented by writing requests for interviews to 126 randomly selected physicians with an enclosed endorsement letter from the chairman of the dissertation committee. The response was generally favorable. However, there was some concern expressed by some practitioners in connection with the purpose of the research. The president of the local medical society contacted the chairman of the dissertation committee asking the nature and purpose of the project. He was assured of the purely academic nature of the project and a meeting was arranged
for the author to see him in person and discuss the matter. There was a delay in arranging some of the interviews. After the successful meeting with the medical society president, these practitioners were contacted and interviews were secured. The response pattern improved in general after the meeting.

In the meantime, the author had been experiencing two interrelated problems which persisted throughout the fieldwork. They were: 1) in general, access to physicians was through a receptionist, secretary, or nurse who often blocked direct contact with the doctors, and 2) rescheduling of interview appointments by medical practitioners due to emergency calls. To improve accessibility, the author tried two methods, both of which failed. The first method was to contact the practitioners in the evening at home. The problem here was that each call at home went through the medical exchange. The nature and purpose of the call was noted by the operators and conveyed to practitioners who either conveyed it through the operator to call back at the office, or were not in a position to receive the call at that time. Most often, they were not at home. After several attempts without success, the author made a point not to continue that course of action. The second method that also proved to be unsuccessful was to go to the offices of the individual practitioners and send in a note of request
for an interview appointment. Here again, the author was told either to call again or come back because the practitioner was busy with patients.

The method that proved to be most successful was to leave the message with the staff member, record that person's name in the interviewee's file, and request him to get an appointment for the author. When the author called the next time, he asked for that person and usually got the appointment or reply after one or more attempts. When it seemed impossible to make an appointment through a staff member who sounded unsympathetic toward the project, the author insisted on talking to the doctor and held the line as long as necessary.

The problem of emergencies and rescheduling could not be helped because the occurrence of emergencies was impossible to be anticipated.

Finally, the problem of leaving the author's telephone number with the staff member often proved to be futile because either the call was not returned, or if it was, the author was out interviewing or at home making calls to other practitioners thus keeping the phone busy. This problem was solved by getting another line. This helped the author to receive the incoming calls while he was on the phone making calls. In the absence of the author from the base for interviewing, the author's wife took the messages
but she could not answer the questions that the doctors wanted answered before granting an interview. Such cases were handled by the author when he got back.

Since most appointments were made well in advance, sometimes over a month prior to the scheduled interview session, in the first week of July, 1975, it was discovered by the author that the target may not be achieved if more interview request letters were not sent out. Thus on July 10, 1975, an additional 51 letters were sent. The format of the letter of request was modified and no letter of endorsement was enclosed. 16

At the end of the data collection phase, the author had personally interviewed 103 practitioners. Five practitioners had moved out of East Baton Rouge Parish; the remaining were either unable to grant an interview appointment due to various personal or professional reasons, or were ineligible because of retirement or granting of the interview on the phone. The fieldwork came to an end without any serious problems.

FOOTNOTES


3. Appendix A, Table A1.

4. Appendix D.

5. There were a few female medical practitioners chosen in the sample but they were unable to grant an interview due to various reasons.

6. Appendix A, Table A2.

7. Appendix A, Table A3.

8. Appendix A, Table A4.


10. Appendix A, Table A7.

11. Appendix A, Table A8.


13. Appendix A, Table A10.

14. Appendix A, Table A5.

15. Appendix B-1 and B-2.

16. Appendix C.
The general hypothesis of the study is that the situational variables will be responsible for explaining greater variation in the stressful patterns of medical practice than the background and the professional value orientation variables.

In the hypothesis, there are two sets of independent variables: 1) situational variables, and 2) the background and the professional value orientation variables. The dependent variable consists of a set of 12 variables designed to indicate the degree of stress in the patterns of practice of the medical practitioners.

In order to test the hypothesis, the procedures used are discussed below.

**Factor Analysis**

A principal component factor analysis of the set of dependent variables was performed to determine the number and the nature of underlying factors. The rationale for using the factoring method was to produce a set of loadings that will resolve the common-factor variance and determine the correlations among the variables. The method of princ-
ipal component extracts a maximum of variance as each factor is calculated. It requires the first factor to reduce "as much as possible the total common-factor variance; the second factor, the common-factor variance left unresolved by the first factor; the third factor, the common-factor variance left unexplained by the first two factors, and so on, until the common-factor variance is completely resolved."

In order to meet the condition that the factors be uncorrelated (orthogonal), the varimax rotation method was used. Factor scores were computed to be statistically independent, using the Statistical Analysis System. The first factor was responsible for .446 common-factor variance; the second for .101; and the third for .092. The subsequent factors were relatively low on extracting common-factor variance. As a result the first three factors, responsible for cumulative .638 common-factor variance, were retained.

Table 3 presents the unrotated and rotated factor matrices with final communality estimates for the stressful patterns of medical practice variables (the set of dependent variables).

In Table 3, the variables listed are as follows:

DV 1: Basic medical malpractice insurance coverage.

DV 2: Additional medical malpractice insurance coverage.
DV 3: On-the-spot or pre-hospital emergency care.
DV 4: Matters concerning informed consent.
DV 5: Handling of trivial complaints.
DV 6: Utilization of hospital facilities and other health-care procedures.
DV 7: Use of new health-care procedures.
DV 8: Verbal disclosure of therapeutic failures.
DV 9: Written disclosure of therapeutic failures.
DV 10: Dilemma of clinical judgement versus established procedure.
DV 11: Employment of allied health personnel and delegation of powers to them.
DV 12: Handling of "suit prone" patients.

The three factors are conceptualized as follows:

Factor 1: Defensive medicine factor.
Factor 2: Conservative medicine factor.
Factor 3: Insurance factor.

The defensive medicine factor deals with actions or the omissions of actions for the primary purpose of forestalling the possibility of a liability claim or lawsuit. In general, these actions or omissions are not primarily to improve the health-care process, but are attempts to provide a good legal defense in case of a medical malpractice suit.

The conservative medicine factor is very closely related to the defensive medicine factor but differs distinctly
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<th>Communalities</th>
<th>Rotated Factor Matrix</th>
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<td>DV 2</td>
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<td>0.15386</td>
<td>0.87999</td>
</tr>
<tr>
<td>DV 3</td>
<td>0.71624</td>
<td>0.27133</td>
<td>-0.27133</td>
</tr>
<tr>
<td>DV 4</td>
<td>0.80329</td>
<td>0.14194</td>
<td>-0.19533</td>
</tr>
<tr>
<td>DV 5</td>
<td>0.75684</td>
<td>0.11500</td>
<td>-0.14042</td>
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<tr>
<td>DV 6</td>
<td>0.76673</td>
<td>-0.11551</td>
<td>0.07936</td>
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<tr>
<td>DV 7</td>
<td>0.72126</td>
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<td>DV 8</td>
<td>0.77979</td>
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<td>0.04521</td>
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<td>DV 9</td>
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<td>-0.34996</td>
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<tr>
<td>DV 10</td>
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<td>-0.29879</td>
<td>0.21470</td>
</tr>
<tr>
<td>DV 11</td>
<td>0.65540</td>
<td>0.28722</td>
<td>0.16972</td>
</tr>
<tr>
<td>DV 12</td>
<td>0.59690</td>
<td>0.27364</td>
<td>-0.27008</td>
</tr>
</tbody>
</table>
in terms of equal emphasis placed on the protection of the practitioners by reducing the chances of the occurrence of medical malpractice, which may have lead to a medical malpractice suit, as well as protecting the patients from complications arising from the health-care process. In general these actions or omissions are helpful in improving the quality and the efficiency of the delivery of health-care.

The insurance factor involves basic medical malpractice insurance coverage, additional medical malpractice insurance coverage, and related matters that affect the insurance coverage of the practitioners.

The communalities given in Table 3 are the final communality estimates which are simply the sums of squares of the rotated factor loadings of a variable. The figures indicate the common-factor variance explained by each variable.

Looking at the table closely, it is easily observable that factors 1 and 3 remained very consistent in terms of extracting common-factor variance from the variables both before and after the varimax rotation. All but one variable that showed significance (.4 or above value) on the unrotated factor matrix fell below the arbitrary measure of significance in the rotated matrix (DV 12 decreasing from 0.59690 to 0.32492). DV 2 showed a significance of 0.87999
on the unrotated factor 3 matrix, and 0.89324 on the rotated
matrix. No other variable showed significant factor 3 load-
ings in either the unrotated or rotated matrix.

The most salient feature observable from the table is
the change in factor 2 loadings after rotation. In most
cases they became significant while they were below signif-
icance level in the unrotated matrix. Second, in most cases,
where the significance of the factor loadings for variables
increased after rotation in factor 2, it showed a correspond-
ing decrease in factor loadings after rotation in factor 1
for the same variables and vice versa. Variables DV 3, DV 4,
DV 5, DV 6, DV 11, and DV 12 showed a decrease in factor 1
and an increase in factor 2 after rotation, while the fol-
lowing variables showed exactly the opposite trend: DV 8,
DV 9, and DV 10. This trend may be easier to comprehend by
looking at the nature of the two factors as well as the var-
iables concerned.

As mentioned earlier, the difference between factors
1 and 2 is that of degree rather than of kind. DV 1 (basic
medical malpractice insurance coverage) is highly saturated
on factor 2, the conservative medicine factor. The explana-
tion for this is that medical malpractice insurance coverage
of the practitioners not only protects the doctors but also
the patients. If the practitioners were not insured against
the occurrence of medical malpractice, the patients would
not be able to seek compensation which may be of a great importance to them for recovery and rehabilitation.

DV 3 (on-the-spot or pre-hospital emergency care) has significant loadings on both factor 1 and 2. The reason for this is that while refraining from dispensing such service may keep the practitioners from getting involved and thus open oneself to a liability claim, it also goes to the advantage of the patient who may be protected from the intervention of practitioners who may not be fully qualified to handle his case due to a limited field of practice or other reasons. The significant loadings on factor 2 in this case appeared after rotation and with a corresponding decrease of factor loadings on factor 1, from 0.71624 (unrotated) to 0.46357 (rotated).

Rotation also brought about significant factor loadings for DV 4 (matters concerning informed consent), bringing about a significant decrease in factor 1 loadings. This signifies that although informed consent is primarily for the practitioners' legal defense, it is not entirely without its fruitfulness for patients. Patients, their families and friends, if informed about the health-care process, can be of great help in making it more effective and avoid certain maloccurrences that require the knowledge that the patients or their families or friends have which may not be known to the physicians. This is also the case
with DV 5 (handling of trivial complaints), where the factor loadings reached a significant level on factor 2 only after rotation and with a decrease in the loadings on the first factor. Here the explanation is definitely in favor of factor 2 because handling patients seriously and taking careful note of their complaints, even if they apparently seem trivial, is advantageous to both parties. The party which is more likely to be benefited in the long run in this context is the patient, whose life may be saved due to an extremely unexpected but vital discovery.

Although DV 6 and DV 7 exhibited the same trend of increased factor loadings for factor 2 and decrease for factor 1 after rotation; the change was rather insignificant, however, and not enough to raise the factor loadings in factor 2 above the significance level. The variables concerned are utilization of hospital facilities and other health-care procedures, and use of new health-care procedures, respectively. Over-utilization of hospitalization and other health-care processes, and refraining from using new health-care procedures which may be more helpful to the patients, contribute more to a good legal defense rather than better patient care. In fact, in certain cases, such over-utilization and over-cautiousness may even harm the patient although it may be medically justifiable. The same is true with DV 8 (verbal disclosure
of therapeutic failures), DV 9 (written disclosure of therapeu tic failures), and DV 10 (dilemma of clinical judgement versus established procedure). The factor loadings remained consistently significant on factor 1, even improving after rotation at the expense of a decrease in loadings on factor 2. This strongly indicates that refraining from verbal and written disclosure of therapeutic failures, which can be of very critical value to other subsequent patients, can result in a great deal of damage to the entire medical field, which could benefit from such information and save numerous lives and tremendous amount of suffering on the part of the patients. Similarly, following the established procedure only even in face of the fact that the clinical judgement of the practitioner calls for different action; can lead to unnecessary suffering on the part of the patients but definitely keeps the practitioners out of trouble.

DV 11 (employment of allied health personnel and delegation of powers to them) again showed an increase above the significance level on factor 2 with a decrease on factor 1 after rotation. This is because if allied health personnel were delegated powers to handle certain cases independently, they may not only jeopardize the practitioner's insurance but may also harm the patients, since such personnel are not qualified to practice medicine. Therefore, refraining from delegating powers to them goes equally in favor of both
parties concerned. This is the case also with DV 12 (handling of "suit prone" patients). The factor loadings reached a highly significant level on factor 2 after rotation. This indicates that if over anxious or otherwise "problem patients" are given extra attention, there is a better chance for them to recover faster, going again in favor of both parties.

Factor 3, the insurance factor, remained consistent in terms of loadings on DV 2 (additional medical malpractice insurance coverage). The only two other variables that came close to being significant are DV 1 (basic medical malpractice insurance coverage: 0.34866), and DV 11 (employment of allied health personnel and delegation of power to them: 0.26928). Both DV 1 and DV 11 are directly related to insurance factor. The basic medical malpractice insurance coverage variable hardly needs any explanation while DV 11 may need clarification. It is contended here that when allied health personnel are given such powers, they directly nullify the practitioners' insurance because the ultimate responsibility lies with physicians and not allied health personnel.

In the general hypothesis of the study, there are two sets of independent variables: 1) the situational variables, and 2) the background and professional value orientation variables. All variables are at interval level of measure-
ment; some are discrete rather than continuous.

The next procedure used was the analysis of variance for each factor, alternately introducing each set of independent variables first.\(^5\)

**Analysis of Variance**

Table 4 is an abridged analysis of variance table for factor 1, with situational variables introduced first.

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sequential SS</th>
<th>Mean Square</th>
<th>F</th>
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<tr>
<td>Total</td>
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<td>49.28431374</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational Variables</td>
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<td>42.23164723</td>
<td>2.48421454</td>
<td>3.4099049*</td>
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<tr>
<td>Background and Professional Value Orientation Variables</td>
<td>14</td>
<td>7.05266652</td>
<td>0.50376189</td>
<td>0.69147817</td>
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<tr>
<td>Error</td>
<td>71</td>
<td>51.72555792</td>
<td>0.72852898</td>
<td></td>
</tr>
</tbody>
</table>

**Significant at .01 level (A. Haber and R. P. Runyon (1973), pp. 342-345.**

The F value required for the situational variables to be significant (with 17 & 71 degrees of freedom) was 1.79 for the .05 level and 2.28 for the .01 level. Table 4 shows
that the F value for the situational variables was found to be 3.41, considerably above the significance level of .01. The F value for the background and the professional value orientation variables did not show significance at either level. The F value observed in the table was .69 whereas at 71 & 14 degrees of freedom, an F value of 2.21 and 3.14 for .05 and .01 levels was required. Even when the background and the professional value orientation variables were introduced first (Table 5), the situational variables showed significant F value at both .05 and .01 levels whereas the background and the professional value orientation variables did not show significance at either level.

TABLE 5: ABRIDGED ANALYSIS OF VARIANCE TABLE FOR FACTOR 1 WITH THE BACKGROUND AND PROFESSIONAL VALUE ORIENTATION VARIABLES INTRODUCED FIRST

<table>
<thead>
<tr>
<th>Source</th>
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<th>Mean Square</th>
<th>F</th>
</tr>
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<tbody>
<tr>
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<td>49.28431374</td>
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<tr>
<td>Background and Professional Value Orientation Variables</td>
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<td>18.06676165</td>
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<td>Situational Variables</td>
<td>17</td>
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<td>1.83632660</td>
<td>2.5205951**</td>
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<tr>
<td>Error</td>
<td>71</td>
<td>51.72555792</td>
<td>0.72852898</td>
<td></td>
</tr>
</tbody>
</table>

**Significant at .01 level (A. Haber and R. P. Runyon (1973), pp. 342-345.)
orientation variables failed to reach either significance level. This led to the conclusion that the situational variables were responsible for explaining the defensive medicine factor (factor 1) more significantly than the background and the professional value orientation variables.

The most interesting observation in the analysis of variance of factor 1 was that variable SV 3, the risk-factor of the fields of medical practice, showed greatly consistent and significant explanatory power than any other variable in either set of variables. In both cases of each set of variables introduced first, SV 3 was responsible for over half the sequential sums of square for the situational variables. This indicates that the risk-factor of the fields of practice is the strongest determinant of variation in the stressful patterns of medical practice.

In the analysis of variance tables for factor 2, the conservative medicine factor (Tables 6 and 7), only the situational variables introduced first showed and F value that was significant at .05 level, meaning thereby that the situational variables were responsible for explaining the conservative medicine factor more significantly than the background and the professional value orientation variables.
TABLE 6: ABRIDGED ANALYSIS OF VARIANCE TABLE FOR FACTOR 2 WITH THE SITUATIONAL VARIABLES INTRODUCED FIRST

<table>
<thead>
<tr>
<th>Source</th>
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<th>F</th>
</tr>
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<tr>
<td>Total</td>
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<td>Situational Variables</td>
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<td>Orientation Variables</td>
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<tr>
<td>Error</td>
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<td>69.54827445</td>
<td>0.97955316</td>
<td>0.85869641</td>
</tr>
</tbody>
</table>

*Significant at .05 level (A. Haber and R. P. Runyon (1973), pp. 342-345.

TABLE 7: ABRIDGED ANALYSIS OF VARIANCE TABLE FOR FACTOR 2 WITH THE BACKGROUND AND PROFESSIONAL VALUE ORIENTATION VARIABLES INTRODUCED FIRST

<table>
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<th>F</th>
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<tr>
<td>Orientation Variables</td>
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<tr>
<td>Situational Variables</td>
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<tr>
<td>Error</td>
<td>71</td>
<td>69.54827445</td>
<td>0.97955316</td>
<td></td>
</tr>
</tbody>
</table>
In factor 3, the insurance factor, both sets showed significance at the .01 level (Tables 8 and 9) with each

**TABLE 8: ABRIDGED ANALYSIS OF VARIANCE TABLE FOR FACTOR 3 WITH THE SITUATIONAL VARIABLES INTRODUCED FIRST**

<table>
<thead>
<tr>
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<td>Situational Variables</td>
<td>17</td>
<td>34.96801425</td>
<td>2.05694201</td>
<td>3.2933513**</td>
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<tr>
<td>Background and Professional Value Orientation Variables</td>
<td>14</td>
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<td>2.4813865**</td>
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<tr>
<td>Error</td>
<td>71</td>
<td>44.34476263</td>
<td>0.62457412</td>
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</tbody>
</table>

**Significant at .01 level (A. Haber and R. P. Runyon (1973), pp. 342-345.**

**TABLE 9: ABRIDGED ANALYSIS OF VARIANCE TABLE FOR FACTOR 3 WITH THE BACKGROUND AND PROFESSIONAL VALUE ORIENTATION VARIABLES INTRODUCED FIRST**

<table>
<thead>
<tr>
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<tr>
<td>Total</td>
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<td>56.66535196</td>
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<td>Background and Professional Value Orientation Variables</td>
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<td>3.2756902**</td>
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<tr>
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</table>

**Significant at .01 level (A. Haber and R. P. Runyon (1973), pp. 342-345.**
set introduced first, but the situational variables showed the highest sequential sums of squares when introduced first. In conclusion, the testing of the hypothesis with the situational variables showing responsibility for explaining the stressful patterns of practice more significantly than the background and the professional value orientation variables, the general hypothesis was upheld.

FOOTNOTES

1. For the operational definitions, please refer to Chapter 3.


3. Statistical Analysis System has been designed and implemented by Anthony James Barr and James Howard Goodnight, Department of Statistics, North Carolina State University, Raleigh, North Carolina, August, 1972.

4. Please refer to Appendix E for the Prior Estimates of Communality Table.

5. Appendix E, Tables E2, E3, E4, E5, E6, and E7.

6. For situational variables, with 17 & 71 degrees of freedom, an F value of 1.79 and 2.28 was required for .05 and .01 levels respectively. For the background and the professional value orientation variables, observed F value was 1.77 whereas the required values were 1.84 for .05 and 2.35 for .01 levels with 71 & 14 degrees of freedom.

7. Appendix E, Tables E2, E3, E4, E5, E6, and E7.

8. Appendix E, Tables E2 and E5.

9. Situational variables introduced first and with 17 degrees of freedom needed an F value of 1.79 to be significant at .05 level while the F value observed
for it was 1.82. For the background and the professional value orientation variables, the F value required for significance (71 & 14 degrees of freedom) at .05 was 2.21 while the observed value was .86. With background and professional value orientation variables introduced first, the significant F value for the situational variables (71 & 17 degrees of freedom) was 2.04 at .05 level while the observed value was .82. For the background and the professional value orientation variables, the significant F value with 14 & 71 degrees of freedom at .05 level was 1.84 while the observed value was 1.30.

10. The situational variables introduced first and with 17 & 71 degrees of freedom needed an F value of 1.79 and 2.28 for .05 and .01 levels of significance and showed 3.29. The background and the professional value orientation variables required 1.84 and 2.35 for .05 and .01 levels significance respectively (14 & 71 degrees of freedom) and showed 2.48. With background and professional value orientation variables introduced first, the situational variables with 17 & 71 degrees of freedom needed 1.79 and 2.28 F values for significance at .05 and .01 levels respectively while it showed an F value of 2.64. The background and the professional value orientation variables with 14 & 71 degrees of freedom needed an F value of 1.84 and 2.35 for significance at .05 and .01 levels respectively while showing 3.28.
SUMMARY AND CONCLUSIONS

The present study is an attempt to determine the impact of medical malpractice litigation upon the patterns of medical practice of self-employed medical practitioners in East Baton Rouge Parish, Louisiana. The general perspective of the study is based on the sociological conceptions of professions.

The conceptual framework for the study was provided by the "social structure" approach of Freidson who asserted that "a significant amount of behavior is situational in character--that people are constantly responding to the organized pressures of the situations they are in at any particular time, that what they are is not completely but more their present than their past, and that what they do is more an outcome of the pressures of the situation they are in than of what they have earlier "internalized".¹ A review of relevant literature indicated that medical malpractice litigation problem has reached "crisis" proportions calling for both short-range emergency measures as well as long-range legislative and other reforms. It has resulted in varied degrees of strains and stresses to medical practitioners which are manifested through their patterns of practice.
The primary aim of the present study was to empirically determine the impact of a set of situational variables pertaining to medical malpractice litigation as opposed to the background and the professional value orientation variables upon the patterns of practice of the medical practitioners. The situational as well as the background and the professional value orientation variables were treated as the independent variables, and the patterns of practice as the dependent variables. It was hypothesized that the situational variables will be responsible for explaining greater variation in the stressful patterns of medical practice than the background and the professional value orientation variables.

A random sample of 103 was chosen from a total of 310 self-employed medical practitioners. The practitioners were interviewed by the author with the help of an open ended interviewing schedule. The information collected through these interviews served as the basic data for the testing of the main hypothesis.

The dependent variable consisted of 12 indicators designed to project the organized despositions of the practitioners to think, feel, perceive, and behave toward strains and stresses posed by the medical malpractice litigation problem and its various implications.

There were two sets of independent variables: 1) the
background and the professional value orientation variable set consisting of 13 variables pertaining to the personal characteristics, interests, and activities concerning the profession of medicine, and 2) the situational variable set consisting of 10 variables designed to project those conditions which were either increasing the probability of a liability suit or the fear of it, or reducing it—directly or indirectly.

In order to develop the dependent variables, a principal component factor analysis was employed on a set of 12 stressful patterns of practice variables. The first three factors explained .638 cumulative factor variance and were thus retained. These three factors were conceptualized as: 1) defensive medicine factor, 2) conservative medicine factor, and 3) insurance medicine factor.

The defensive medicine factor dealt with the actions or the omissions of actions for the primary purpose of forestalling the possibility of a liability claim or a lawsuit. Conservative medicine factor, on the other hand, placed equal emphasis on the protection of the practitioners by reducing the chances of the occurrence of medical malpractice, which may have led to a medical malpractice suit, as well as protecting the patients from complications arising from the health-care process. Finally, insurance factor was mainly concerned with basic
medical malpractice insurance coverage, additional medical malpractice insurance coverage and related matters that are liable to affect the insurance coverage of the practitioners.

In order to test the hypothesis, an analysis of variance was performed on each factor by alternately introducing each set of independent variables first. It was found that the situational variables were responsible for explaining the stressful patterns of medical practice more significantly than the background and the professional value orientation variables thus upholding the main hypothesis.

In addition to determining that the situational variables are better predictors of the strains and stresses observable in the patterns of medical practice, the study elicited the following significant findings:

a) The defensive medicine factor accounted for over two-thirds of the cumulative factor variance of the three factors retained. This signifies that most of the stressful patterns of practice variables were saturated with defensive medicine factor.

b) The risk-factor of the fields of medical practice was responsible for over half of the sequential sums of squares of the situational variables on defensive medicine factor meaning thereby that from among the situational variables, the field of medical practice of a medical practitioner is most likely to determine the defensive patterns of practice of a medical practitioner.

c) The factor loadings for the following variables were more significant on defensive medicine factor than any other, meaning thereby, that these variables were primarily determined
by the defensive medicine considerations: handling of trivial complaints; utilization of hospital facilities and other health-care procedures; verbal disclosure of therapeutic failures; written disclosure of therapeutic failures; and dilemma of clinical judgement versus established procedure.

d) Conservative medicine factor was of great significance for the following variables: basic medical malpractice insurance coverage; on-the-spot or pre-hospital emergency care; matters concerning informed consent; employment of allied health personnel and delegation of powers to them; and handling of "suit prone" patients.

From the findings of the research, the conclusions that may follow are discussed below.

The hypothesis was upheld by the findings. This leads to the conclusion that the patterns of practice of medical practitioners are influenced more by the pressures of the work environment and the strains and stresses posed by the situation a practitioner is in rather than his personal characteristics, interests and activities concerning the profession of medicine. This conclusion supports Freidson's "social structure" approach as it applies to the self-employed medical practitioners in East Baton Rouge Parish, Louisiana.

The findings also supported the perceived implications found in the literature that both malpractice suits and the fear of being sued have forced the providers of health-care to resort to defensive medicine: active, passive, or maverick. The over-utilization of hospital facilities and
other diagnostic procedures; refraining from using new diagnostic and therapeutic procedures which may not be absolutely necessary but could be beneficial if used; and reluctance on the part of the providers of health-care to disclose certain case histories describing in detail the noted adverse effects of a certain diagnostic or therapeutic procedure all negatively affect the delivery of health-care system. Some measures which were perceived to be associated with defensive medicine were found to be conservative or protective in nature. A good medical malpractice insurance coverage by the physicians; reluctance on the part of the practitioners to dispense services in non-clinical situations; matters concerning informed consent; and refraining from delegating powers to allied health personnel not only protect the doctor from unnecessary legal complications but also prevent unnecessary medical complications from occurring to the patients.

Finally, the findings support the ISO classification system based on the assumption that risks of being sued for malpractice are higher for some fields of practice than the others. In the present research, it was found that practitioners belonging to higher risk fields of practice showed greater strains and stresses in their patterns of practice and were forced to resort to more defensive and protective medicine than those practitioners who belonged
to lower risk fields of practice.

FOOTNOTE

BIBLIOGRAPHY


APPENDIX A

TABLE A1: TAPE RECORDING RECORD OF MEDICAL PRACTITIONERS

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<thead>
<tr>
<th>Tape Recording</th>
<th>Frequency</th>
<th>Percent</th>
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<tr>
<td>Interviews not recorded</td>
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TABLE A2: RACIAL IDENTITY OF MEDICAL PRACTITIONERS

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</tr>
<tr>
<td>Total</td>
<td>103</td>
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</table>
### TABLE A3: TYPES OF PRACTICE OF MEDICAL PRACTITIONERS

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<tr>
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<td><strong>Total</strong></td>
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### TABLE A4: BOARD CERTIFICATION RECORD OF MEDICAL PRACTITIONERS CERTIFIED BY ONE OR MORE BOARDS OF LIMITED MEDICAL PRACTICE

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<tr>
<th>Board Certification</th>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Non-eligible and non-qualified limited practitioners</td>
<td>7</td>
<td>7.95</td>
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<td>Board eligible or board qualified limited practitioners</td>
<td>17</td>
<td>19.32</td>
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<td>Certified practitioners by one board of limited practice</td>
<td>58</td>
<td>65.91</td>
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<td>Certified practitioners by two boards of limited practice</td>
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### TABLE A5: RISK FACTOR OF FIELDS OF MEDICAL PRACTICE OF MEDICAL PRACTITIONERS

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<th>Risk Factor</th>
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<td>Low</td>
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<td>High</td>
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### TABLE A6: KINDS OF PROFESSIONAL WORK-SETTINGS OF MEDICAL PRACTITIONERS

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<thead>
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<td>Solo Practice</td>
<td>39</td>
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<td>Group Practice</td>
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TABLE A7: GROUP PRACTICE PATTERNS OF MEDICAL PRACTITIONERS NOT IN SOLO PRACTICE

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<thead>
<tr>
<th>Group Practice Patterns</th>
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<td>Sharing of office and/or clinical facilities only</td>
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<td>Sharing of office and clinical facilities as well as work-load and remunerations</td>
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<td>A limited unitary-field professional medical corporation</td>
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TABLE A8: NUMBER OF PARTNERS IN THE GROUP OF MEDICAL PRACTITIONERS NOT IN SOLO PRACTICE

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**Total** 64 100.00
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| Totals | 103 | 100.000 |
### TABLE A10: MEDICAL PRACTICE EXPERIENCE PATTERNS OF MEDICAL PRACTITIONERS

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</tr>
<tr>
<td>Totals</td>
<td>103</td>
<td>100.000</td>
</tr>
</tbody>
</table>
May 30 1975

I am a doctoral candidate in the Department of Sociology at L.S.U. I need your help to complete my research, and thus fulfill my degree requirements.

My research concerns physicians' views on medical malpractice insurance. I shall be most grateful if you will kindly talk with me at your convenience. I shall contact you by phone to make an appointment. I hope you will decide to help me with my project.

The study is based on statistical principles. I assure you of absolute anonymity and strict confidentiality.

Thanking you in anticipation.

Yours sincerely,

Signed

Masud A. Mufti
Graduate Student

Enclosure: Letter of Endorsement from the Chairman, Mufti's Dissertation Committee.
May 21, 1975

TO: Physicians in Baton Rouge

Mr. Masud A. Mufti, a doctoral candidate in this department, is conducting a study on physicians' views on malpractice insurance, which will constitute his dissertation topic. I will greatly appreciate your assistance in this study and thank you in advance for the information you give to him.

Sincerely,

Signed

George S. Tracy
Assistant Professor
Chairman, Mufti's Dissertation Committee
I am a doctoral candidate in the Department of Sociology at L.S.U. I need your help to conduct my research project, and thus fulfill my degree requirements.

My research project is aimed at determining the impact of medical malpractice litigation upon the patterns of medical practice. In this regard, I need to talk with you for about 15 minutes at your convenience. The study is based on statistical principles. I assure you of absolute anonymity and strict confidentiality.

I shall be most grateful if you will kindly direct your receptionist/secretary/nurse to give me a 15 minute appointment. In case you need to talk to me on the phone before you make an appointment for an interview, I shall be more than glad to furnish any information that you may require.

I may add that local and state professional organizations have knowledge that such a study is being conducted. In case you have specific questions in that context, I shall be delighted to answer them.

Thanking you in anticipation.

Yours sincerely,

Signed
Masud A. Mufti
Graduate Student
Dept. of Sociology, LSUBR., and Associate (Research),
Dept. of Psychiatry & Behavioral Sciences, LSU Medical Center
New Orleans, Louisiana
APPENDIX D

DATA COLLECTION INSTRUMENT

<table>
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<th>Field</th>
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<tr>
<td>Place</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Scheduled Time</td>
<td></td>
</tr>
<tr>
<td>Time Interview Started</td>
<td></td>
</tr>
<tr>
<td>Time Interview Ended</td>
<td></td>
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<tr>
<td>General Observations</td>
<td></td>
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</table>
1. Age_______________________________________________

2. Sex_______________________________________________

3. Race_______________________________________________

4. Are you a general practitioner, or is your practice limited to a certain field?
   (If the practice is limited, the following questions are to be asked):
   a) What is your field of practice?
   b) Are you certified by the board?
   c) When were you certified by the board?

5. Do you practice alone, or do you have some kind of partnership?
   (If there is a partnership, the following questions are to be asked):
   a) How many partners do you have?
   b) What is your partnership arrangement?

6. How many years of formal medical training did you go through?
7. How much of formal refresher or continuing education course-work have you done during the past five years?

8. Including your internship and the residency, how many years of medical practice experience do you have?

9. From the local to the international level, how many medical associations are you a member of?

10. During the past five years, what offices or positions have you held in the medical associations?

11. During the past five years, how many medical association meetings have you attended?

12. During the past five years, how many papers have you presented at the medical association meetings?

13. How many medical journals do you subscribe to? (Paid subscriptions only).
14. During the past five years, how many articles have you published in the medical journals?

15. During the past five years, what editorial positions have you held in the medical journals?

16. During the past five years, have you had any medical malpractice suit filed against you? (Probe for the number, the nature, and the outcome of the suit/s).

17. What are your medical malpractice coverage limits?

18. Do you have any medical malpractice coverage other than the basic coverage? (Probe for the nature, the limits, and the reasons for such coverage).

19. If you came across a situation where your services were needed for on-the-spot or pre-hospital emergency care, what would you do? (Probe).

20. What is your opinion about explaining the patients' condition and treatment procedure to them, their immediate family, or their friends? (Probe).
21. How do you respond to the patients who come to you with apparently trivial complaints? (Probe).

22. A number of patients are hospitalized for certain diagnostic tests that might as well be performed without hospitalization. Why do you think it is so?

23. Sometimes patients are hospitalized for not too serious conditions, or they are kept in the hospital for extra few days even after they are ready to go home. Why do you think it is so?

24. There are some x-rays, tests, and other diagnostic procedures that are performed as a matter of routine. Why do you think it is so?

25. Do you think that new medicines and therapeutic procedures should be tried if there is promise for faster and better recovery but the possible adverse effects have not been completely unveiled at the time? (Probe).

26. Do you think that the practitioners should share the observed adverse effects of a certain diagnostic or therapeutic procedure with their colleagues in the work-setting? (Probe).
27. Do you think that the practitioners should publish case histories of noted adverse effects of a certain diagnostic or therapeutic procedure risking a possible medical malpractice suit? (Probe).

28. Do you think that the practitioners should use their clinical experience rather than the standard procedures established in the medical literature? (Probe for the cases where the scientific foundations for certain diagnostic or therapeutic procedures are inadequate or not in concert with one's firsthand experience).

29. What is your opinion about the Professional Standards Review Organizations? (Probe for the efficiency of PSRO's for the patient care).

30. What is your opinion about the availability of expert testimony in the medical malpractice suits from outside of the community? (Probe).

31. There are now specially trained allied health personnel available to do certain routine jobs independently. Have you or your partnership group employed any such personnel and what are their duties?

32. Do you believe in delegating powers to dependable allied health personnel to do routine jobs or take care of minor emergency complaints independently? (Probe).
33. Every practitioner sometimes comes across unhappy patients. What are some of the characteristics of such patients and how do you treat them?

34. What is the general socio-economic status of the majority of your clients?

35. Do you think that no-fault type compensation to the patients for the treatment induced injuries would be a worthwhile solution to the medical malpractice litigation problem? What other measures would you recommend to improve the present medical malpractice scene?

GENERAL COMMENTS:
APPENDIX E

TABLE E1: FACTOR ANALYSIS OF THE STRESSFUL PATTERNS OF MEDICAL PRACTICE VARIABLES: PRIOR ESTIMATES OF COMMUNALITY

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EXPLANATION OF VARIABLES IN TABLES E2 - E7

Situational Variables

SV 1  Post-interview observations.
SV 2  Waiting time in minutes.
SV 3  The risk-factor of fields of medical practice.
SV 4  Kinds of professional work-settings.
SV 5  Number of partners in the group.
SV 6  Number of medical malpractice suits filed against the practitioner.
SV 7  Number of medical malpractice suits resulting in unfavorable decisions for the practitioner.
SV 8  The evaluation and control by the Professional Standards Review Organization (PSRO's).
SV 9  The availability of expert testimony in the medical malpractice suits from outside of the community.
SV 10  No-fault or workman's compensation type compensation to the patient for treatment induced injuries regardless of physicians' negligence.

Background and Professional Value Orientation Variables

BPV 11  Age.
BPV 12  Certification by the national boards of limited field of medical practice.
BPV 13  Board certification classification.
BPV 14  Number of years of formal medical training.
BPV 15  Number of hours of formal refresher or continuing education course-work during the past 5 years.
BPV 16  Number of years of medical practice experience including the internship and residency.
BPV 17  Number of medical association memberships from local to the international level.
BPV 18  Number of offices or positions held in the medical associations during the past 5 years.
BPV 19  Number of hours spent attending medical association meetings during the past 5 years.
BPV 20  Number of papers presented at the medical association meetings during the past 5 years.
BPV 21  Number of paid subscriptions to the medical journals during the past 5 years.
BPV 22  Number of articles published in the medical journals during the past 5 years.
BPV 23  Number of editorial positions held in the medical journals during the past 5 years.
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APPENDIX F-1

A BIBLIOGRAPHICAL GUIDE TO LITERATURE ON MEDICAL MALPRACTICE


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APPENDIX F-2

A BIBLIOGRAPHICAL GUIDE TO LITERATURE ON MEDICAL MALPRACTICE

Supplement 1


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VITA

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EXAMINATION AND THESIS REPORT

Candidate: Masud Ahmad Mufti

Major Field: Sociology

Title of Thesis: The Impact of Medical Malpractice Suits Upon The Patterns of Medical Practice

Approved:

[Signatures]

George A. Tracy
Major Professor and Chairman

James B. Truitt
Dean of the Graduate School

EXAMINING COMMITTEE:

[Signatures]

Perry Alford

Thomas J. Kiefer, Jr.

John A. Hunt

Karen F. Peterson

Date of Examination:

May 3, 1976