COMMENTARY

HOW THE MALPRACTICE CRISIS AFFECTS NUCLEAR MEDICINE PHYSICIANS

Imagine a time when doctors refuse to cover their calls in the emergency room. Imagine many doctors abruptly ending or relocating their practices, despite an urgent demand for their services. Imagine an emergency room director stating in a defeated voice on camera for a national broadcast, "Don't get injured around here," when asked what citizens should do if they require emergency services. What you have imagined is not fantasy. It is here, now, in Florida.

John W. Laude, MD

After immense awards for malpractice plaintiffs in many trials, the major medical malpractice insurers have ceased to do business in Florida or have astronomically increased their insurance premiums. Surgical specialists—particularly neurosurgeons, obstetricians, and orthopedists—have been the hardest hit. The crisis also affects other medical specialists because malpractice insurance premiums have risen for all Florida doctors. What has happened in Florida is extreme but, to a lesser degree, doctors throughout the United States (US) have experienced some impact of more frequent lawsuits and steadily rising malpractice premiums. No medical specialty has been immune to these circumstances.

Why are malpractice insurance premiums increasing? What has been the experience of nuclear medicine physicians regarding malpractice? What can physicians do to seek a better climate for the practice of good medicine? Once these questions have been answered, the Florida experience will at least be better understood. Strong, organized efforts to influence state legislatures will be needed to avoid a Florida-like crisis elsewhere.

The American College of Nuclear Physicians (ACNP) has surveyed the nuclear medicine community three times in the last 10 years regarding malpractice liability insurance premiums and liability suit experience. In 1976, the Professional Liability Insurance Committee of the ACNP, chaired by Oscar M. Powell, MD, reported the results of 565 (61% response rate) survey questionnaires. A more elaborate survey, yielding 1,117 (32%) responses, of ACNP, Society of Nuclear Medicine (SNM), and American College of Nuclear Medicine (ACNM) members was reported in 1979 by a committee chaired by John F. Lindeman, MD. The survey of ACNP members that we conducted in 1986 under the auspices of the ACNP Practice Management and Economics Committee, chaired by Conrad E. Nagle, MD, elicited 267 (24%) responses.

Lee Grindheim

Median malpractice insurance premiums per year were $2,000 in 1976, $2,500 in 1979, and $5,000 in 1986, representing an increase in the 1976 median premium of 25% and 150% for 1979 and 1986, respectively. In contrast to these increases, the Consumer Price Index, published by the US Department of Labor, increased since 1976 by 44% in 1979 and by 86% in 1985 (the last year of record). Although insurance companies often plead that frequent and large claim losses are the major cause of increasing premiums, they fail to acknowledge their own responsibility for this trend through their use of the "cash underwriting" mechanism.

In the liability insurance business there is usually a long lag time between the collection of premiums and losses paid on policies. In standard insurance underwriting, premium payments are typically held as reserves to cover future claims. In periods of high interest rates (as in the early 1980s) underwriters are more willing to write underpriced insurance policies at a possible loss because they can invest the premiums in short-term money market funds or government bonds, and hope that the investment income earned will be enough to offset underwriting losses. When interest rates fall, however, many insurers (who may have locked themselves into lower insurance premium prices for periods of several years) find themselves in trouble because investment income now reflects the lower interest rates, and the locked-in premiums prohibit the raising of premiums to cover expenses. The loss ratio (claims and expenses as a percentage of premiums) for medical malpractice rose from 102.6% in 1978 to 161.1% in 1984. As underwriting losses increase, weaker companies go under and those that remain begin to show profits again. Stronger insurance companies, because they are no longer competing with weaker companies for "market share," will raise their premiums to

(continued on page 1518)

"What is particularly upsetting is the practice of some insurance companies to cut losses by settling frivolous suits out of court."

(continued from page 1517)

cover losses and, thereby, create a more favorable loss ratio.

What about malpractice claims against nuclear medicine physicians? The three ACNP surveys did not attempt to limit the time span of claims made alleging malpractice of nuclear medicine. Some claims may have been reported in several or all of the surveys. Thirteen claims were reported in the 1976 survey. Four of these claims had been settled in favor of the plaintiff. Awards ranged from $600 to $5,000, the latter amount awarded in a case of alleged misinterpretation of a brain scan. The 1979 survey noted 38 claims, with three cases settled against the physician-defendant, awarding $5,000–$30,000. An alleged hypoglycemic death in a patient with diabetes two months after iodine-131 therapy for Grave's disease resulted in the highest award at that time. In the 1986 survey, 39 lawsuits were noted; one respondent reported being sued 14 times! Five suits were lost by that physician, with awards of $2,500–$150,000. The latter case involved radionuclide therapy, but further details were not reported. Total claim payouts as a percentage of estimated premiums paid for the single year of a given survey were 1.5% in 1976, 1.3% in 1979, and 28% in 1986.

Predictably, these adverse statistics have modified physician behavior. In the 1986 survey, 56% of respondents indicated that they had practiced nuclear medicine more defensively over the last several years as a precaution against malpractice suits. Even careful, defensive practice (for example, extensive use of written informed consent, careful charting, and timely reporting of results, etc.) will not protect a physician from a malpractice claim. What is particularly upsetting is the practice of some insurance companies to cut losses by settling frivolous suits out of court. One survey respondent noted that his insurer paid $5,000—without the knowledge or approval of the sued physician—to a plaintiff claiming that iodine-131 therapy had worsened her Grave's ophthalmopathy. Although one standard endocrinology text mentions this possible side-effect, the data supporting this claim are somewhat limited, and such an alleged direct cause of worsened ophthalmopathy is deserving of argument in court.

The legal aspects of the malpractice crisis have been recounted in numerous articles and studies. One important study, dated February 1986, was released by the Tort Policy Working Group of the US Department of Justice. This study cited examples of tort (malpractice and other liability) law that have been major causes of increased awards and insurance premiums. In some jurisdictions, it is no longer necessary for the physician to be directly at fault for injury to be considered liable for that injury. Incredible testimony of pseudoscientists has been allowed to persuade juries in some malpractice and liability cases. Awards for noneconomic losses (pain/suffering, loss of consortium) have skyrocketed without any reasonable limit or uniformity from case to case. The Tort Policy Working Group proposed many reforms to address these circumstances: a return to the standard of fault-based liability, limitations of noneconomic damage awards, allowing only credible scientific testimony to establish the cause of an injury, limitations on attorneys' contingency fees charged to plaintiffs, and a potpourri of other reforms. The insurance industry was not left unscathed in this report, taking lumps for the "cash underwriting" practices mentioned above.

What can a nuclear physician do to improve this situation? Involvement with state medical societies in an effort to influence state legislatures to reform tort law is a first step. Physicians lobbied very successfully in Maryland, Michigan, Illinois, and California for major tort reforms, and other states, after prodding by physicians, are also reforming tort law and better regulating the insurance industry. The risk of malpractice claims can be minimized by obtaining written informed consent for all therapeutic nuclear medicine procedures, and actively keeping radiation doses as low as reasonably achievable (ALARA) to children, hospital personnel, childbearing women, and others. Even soothing a hostile patient may help avoid a malpractice claim. Avoiding the quick-buck, low-cost insurance purveyor will also help. Many state medical societies provide malpractice insurance that may be more costly for the physician, but that also may provide better service by vigorously fighting frivolous lawsuits and by having more than a mere profit motive to provide coverage. Lastly, practicing the very best nuclear medicine possible is a very low-cost form of malpractice insurance.

John W. Laude, MD
Elmhurst Memorial Hospital, Elmhurst, Illinois

Lee Grindheim
American Psychiatric Association

(Dr. Laude is a member of the ACNP Practice Management and Economics Committee. Ms. Grindheim is a former staff member of the SNM/ACNP Washington Office.)