

Special Article

The Medical Malpractice Problem, and Some Possible Solutions

William H. L. Dornette, M.D., J.D.*

The solutions to the problems of medical malpractice and malpractice insurance coverage are primarily in the hands of state legislatures. Legislation enacted has been primarily palliative, to assure continued availability of professional liability insurance. Unfortunately, no limit can be placed on the costs of such coverage. Unfortunately, too, no long-term solution has been forthcoming. Any long-term solution must encompass some method or methods of reducing injuries to patients and at the same time changing the system from defense of the physician to compensation of the patient. If such changes are not forthcoming, physicians will become uninsurable and the private practice of medicine as we now know it will disappear in this country. (Key word: *Medicolegal*.)

ANESTHESIOLOGISTS are well aware of the medical malpractice problem and attendant professional liability insurance crisis. The increase of the number of lawsuits against physicians and the progressive magnitude of awards stem from a variety of factors, the numerous roots of which lie deep in the legal framework of this country. These factors fall into two basic categories—those that make the patient more willing to sue the health care provider, and those that form the grounds for the allegations of the lawsuit itself.

Etiology of the Problem

In the former category are four fundamental problems. The first is specialization. Con-

sidering the many advances in medicine and the large volume of scientific knowledge required by health-care providers to offer total patient care, specialization has merits and advantages. Specialization has, nevertheless, resulted in minimization of physician-patient contact. Busy specialists also became impersonal, and there is a major loss of rapport.

Second, the American public has been imbued with consumerism. Americans expect perfection in the goods and services they purchase, and medical care is no exception. They expect a cure, and if that cure is not forthcoming the average patient suspects that something went amiss in the quality of care rendered. This attitude has been fostered by the now famous "Marcus Welby syndrome," by which the American health-care provider regularly produces a cure for every disease. Unfortunately, the publicity given the advances of American medicine has not been tempered by a parallel presentation of side effects of the often miraculous agents and methods, developed in the last several decades, that are responsible for the advances.

The third factor is the litigious nature of the American. Being brought up in a society that offers a right for every wrong, and being made aware almost daily of the sometimes highly remunerative judgements rendered against health-care providers and others, the average American often feels it is incumbent upon him to pursue a course of action in the courts if a therapeutic result is not to his total satisfaction. This attitude may be enforced by a "something for nothing" philosophy, as well as by current inflationary trends.

The final factor that fosters the patient's willingness to sue the health-care provider is the tarnished image of the American physician. The physician who runs afoul of

* Director of Education and Research, Division of Anesthesiology, The Cleveland Clinic, Cleveland, Ohio. Editor, *Journal of Legal Medicine*, 9500 Euclid Avenue, Cleveland, Ohio 44106.

Accepted for publication December 1, 1975. Presented as a scientific exhibit at the Annual Meeting of the American Society of Anesthesiologists, Chicago, Illinois, October 12-15, 1975.

Address reprint requests to Dr. Dornette.

the law, or who is disabled emotionally or by drug or alcohol abuse, receives wide publicity. Even though few of his own patients may sue him, patients of other physicians become aware of his notoriety. A general distrust of all health-care providers may develop.

Given a background in which consumers of health care are more willing than ever before to sue for injuries, real or imagined, it is easy to envision how the patient who suffers an iatrogenic complication not adequately explained by the physician will consult a personal-injury lawyer. It is presently very difficult to undertake a course of therapy that does not have at least the potential for producing some side effect. When one considers the volumes of medications that patients purchase over the counter, and the variety of pharmaceutical agents prescribed by members of the health-care team, it is easy to see that drug interactions are a real possibility. Modern therapy is in truth a two-edged sword. We cannot achieve therapeutics, including the allying of pain for operative procedures, except at a price. Unfortunately, and in spite of our best efforts, that price may be too high, in terms of morbidity and even mortality.

Given a result less than perfect in the eyes of the patient, coupled with the average patient's willingness to file a lawsuit, litigation is a real possibility. It also is easy to understand how the large number of patient contacts and days of hospital stay have led to a proliferation of lawsuits. With this proliferation has come an increase in costs of defending the health-care provider and paying judgements or settlements. All these factors have escalated liability insurance costs to the point that they are rapidly exceeding the budget of the average health-care provider, be he physician or hospital.

Once a lawsuit is filed, a costly and time-consuming process lies ahead. Since professional liability insurance is intended to protect the physician, the insurance carrier will hire the best legal counsel available, and spare no expense. The plaintiff's lawyer will also do his best to develop and pursue his case. This, too, takes time and money. Legal fees and other costs of litigation add to the burgeoning expense of determining whether a health-care provider was at fault. An analy-

sis of the expenditures of the professional liability insurance premium dollar in 1968¹ revealed that fees to plaintiff's counsel and cost of prosecuting claims consumed 29 per cent, investigation and defending the health-care provider, 24 per cent. These two factors comprise the cost of determining fault, and amounted to 53 per cent of the insurance dollar. In contrast, injured plaintiffs received only 27 per cent. Solicitation of the carrier's business (20 per cent) and overhead of the insurance carrier (13 per cent) increased the total expenditures to 113 per cent of the premium dollar. Thus, carriers in 1968 operated at an adverse loss ratio. These expense ratios have changed but little since then. In fact, recoveries by patients have reportedly decreased to as little as 18 per cent. In the meantime, according to insurance carriers at least, the adverse loss ratios have continued, causing some carriers to raise their rates significantly and others to be forced out of the market.

Simply stated, the malpractice insurance problem is one of losses, through payments to injured patients and cost of defense, that far exceed the monies generated by the premiums paid for this type of coverage.

The past several years have seen several large carriers withdraw from the field completely, creating major gaps in coverage in certain states. Carriers who remain in the business have generally become reluctant to take on these additional risks, and in one state after another crises have developed as health-care providers have found themselves able to obtain only inadequate coverage or none at all, or have been unable to afford that which was offered.

Insurance rates have always varied with the specialty as well as with the area of the country in which the insured practices. The problem has come to sharp focus in states such as New York and California, where the incidences of litigation and dollar values of damages paid have been the highest. Anesthesiologists have been at the forefront of this problem. They have always been rated at the highest risk level, not because of a high incidence of lawsuits but because of the severe nature of some of the injuries sustained by their patients (*e.g.*, severe neurologic injuries following circulatory arrest). Today, the pre-

miums asked of anesthesiologists are consuming a far greater portion of their gross incomes than is the case with other high-risk specialists (e.g., neurosurgeons and orthopedists) whose gross incomes are much higher. This disparity of income compared with expenses has resulted in anesthesiologists' being in the forefront of those who have temporarily retired from practice (labeled "strikes" or "slowdowns" by the news media) because of inability to afford adequate protection.

Short-term Legislative Solutions

Legislators in various states, faced with the problem of constituents unable to obtain adequate medical care, have responded by enacting legislation of various types.²⁻⁶ In general, legislative approaches attempt to solve the problem by one or more of a variety of methods—reducing the cost of determining fault, reducing awards, reducing liability, mitigating the cause of action, reducing injuries to patients, and assuring availability of insurance through the creation of a joint underwriting authority. A detailed review of the provisions adopted or pending in each state is not possible. The following discussion is concerned with typical provisions various state legislatures have enacted in their attempts to cope with the problem.

Perhaps foremost among the methods used to attempt to reduce the cost of determining fault is the establishment of pretrial screening panels or arbitration proceedings. Such proceedings will reduce the cost of defense in the nonmeritorious case.⁷ Unfortunately, if the plaintiff does have a case, albeit a small one, the results of the arbitration or panel discussion may go by the boards if the parties do not agree to be bound by this decision. Hence, defense costs may even be increased if a subsequent trial is necessary.

Another effort to reduce the costs of determining fault is to limit the fees paid to defense counsel. While this step may prove to be of some benefit, there is no way to limit the amount of time that the lawyer spends on a case. For example, if the hourly charge were limited by statute, insurance carriers might find that the lawyers were spending more time than previously on the average case.

The second group of proposals attempts

to conserve malpractice insurance funds by reducing or placing a limit on awards to patients. One such proposal is to modify the *collateral source* rule. This rule states that any monies the patient receives from pre-existing health care insurance (i.e., collateral sources) in payment of any health-care costs occasioned by medical malpractice may not be deducted from the special damages† that he receives from a jury or in settlement (i.e., he receives double recovery). If the collateral source rule is abolished, any health-care costs covered by pre-existing insurance would be deducted from the award made the patient at the end of the trial. It would have a meritorious effect in reducing damages, and hence malpractice insurance losses.

When he files his petition or complaint initiating the lawsuit, the plaintiff states the amount of damages he is seeking, called the *ad damnum* clause. If this amount is significant, reporters who cover the courts for the news media often will find the lawsuit newsworthy, and create needless and unfortunate publicity for the defendant. Additionally, the amount of damages asked will become known to the jurors when they take the pleadings (including the complaint) with them to the jury room. Abolishing the *ad damnum* clause would keep from the jurors the dollar value of damages requested, and might tend to keep awards more realistic. Additionally, a significant amount of publicity adverse to health-care providers would be eliminated. The overall effect on malpractice insurance losses would be slight, however.

Some states have placed limits on the amounts of awards to injured patients. This provision may limit the total award or the award for general damages only. Since the average award in a malpractice case is far less than the total award limit placed by some state legislatures, such limits will prevent catastrophic losses but have no overall effect on malpractice losses. General damages, for pain and suffering, are computed by the plaintiff to be twice the special damages. Limiting general damages would be very effective in cases involving serious injuries

† The awards to patients consist of *special damages* (for loss of income and health care costs, past, present and future) as well as *general damages* (damages awarded for pain and suffering).

and significant special damages, but would have little effect on the average malpractice case, in which the award for general damages is moderate.

Another effort to reduce awards, being made in a number of states, is to restrict the amount of the contingent fee agreed to between the plaintiff and his lawyer at the time the lawyer takes the case. Unquestionably, the contingent fee is subject to abuse, and limiting its amount would enhance the recovery of damages by the patient. This provision would have no overall effect on the total amount awarded for damages, however.

There are other reasons why the contingent fee should remain as long as the need for the fee is present, *i.e.*, as long as the fault determination process is used to effectuate or deny compensation for iatrogenic complications. Physicians do not expect lawyers to tell them how they should charge their patients, and we physicians should not, by the same token, attempt to dictate to lawyers the financial arrangements they make with their clients. If the contingent fee were eliminated completely (an avowed goal of many physicians), the poor or medically indigent would lose what little means they have for pursuing a meritorious case; injustice would result. The alternative to the contingent fee system is socialized legal services. For example, in Great Britain, where lawyers cannot charge a contingent fee, an indigent person can obtain the services of a lawyer paid by the Crown. His fee is set by the court. Physicians do not want socialized medicine, and we should not be asking for changes that will result in socialized legal services.

Physicians who would abolish the fee do not realize that it discourages nonmeritorious claims. Medical malpractice litigation requires a high degree of expertise, and a considerable expenditure of time, on the part of a lawyer pursuing a case on behalf of an injured patient. If the lawyer does not feel that the patient's case has clear-cut merit, he generally will not accept him as a client. If his client loses his case, the lawyer collects no fee. If all patients had access to pre-paid legal services, it is very likely that even more cases would be filed against health-care providers. Finally, the contingent fee system functions in other tort law situations. If persons injured in automobile, industrial

or product's liability accidents have access to the courthouse through the contingent fee, there is no reason why patients injured in medical malpractice cases should not have similar access.

A third group of statutory proposals or enacted legislation attempts to reduce liability. One of these proposals shortens statutes of limitation of actions in pediatric and foreign-body cases.¹ Reducing the statutes of limitation for pediatric patients and in foreign-body cases will aid in insurance underwriting (by making losses more predictable) but will have no overall effect on reducing losses.

Other proposals relate to the confidentiality of reports of peer review, credentials and utilization committees. Plaintiffs' lawyers have repeatedly tried to obtain the reports of these committees in order to gain access to valuable information for the development of their cases. While the enactment of a statute protecting the confidentiality of these reports will eliminate a thorn in the side of the medical profession, it will have little effect on malpractice losses. Practically all courts by common law decisions have held such reports to be privileged information. The reason for this holding is based upon the need for frank disclosure during such meetings, in order to promote the effectiveness of the action of these committees.

Another proposal provides statutory immunity for activity of professionals serving on these committees. This step will eliminate a source of potential liability between professionals (the professional who is unhappy with the review may have a tendency to sue his reviewers, members of the credentials committee) but will have no effect whatever on the overall malpractice problem.

Under the common law, physicians have been required to divulge confidential informa-

¹ Minors are under a legal disability and need not file a lawsuit until they reach majority. Thus the statute of limitation of actions is tolled for the minor until he reaches legal age. The anesthesiologist administering obstetric anesthesia thus could be exposed to a lawsuit 19 to 20 years after the delivery if the neonate was injured through the alleged negligence of the anesthesiologist. Additionally, courts in some states have tolled the statute in a foreign-body case until the patient discovered the foreign body. In one case* this resulted in a successful lawsuit's being filed more than ten years after the patient left the hospital.

tion gained by them within the physician-patient relationship when ordered to do so by a court of law. A number of states have adopted statutes restricting the use of such information in non-malpractice cases, but allowing it to be entered into evidence if the patient sues the health-care provider and thus places his physical condition at issue. Statutory protection of such privileged information, and freedom of its use to defend a physician, thus will be helpful in the defense of malpractice cases as well as in the protection of the physician in non-malpractice cases. This step would have no effect on malpractice losses, however.

Arbitration is intended to reduce losses by eliminating nuisance claims, shortening the costly fault-determination process, and making awards more realistic. The effectiveness of arbitration depends upon the neutrality and competence of the neutral arbitrator and whether the parties are bound to the findings. Arbitration can serve its intended purpose if all issues are settled and all parties bound. It would be an exercise in futility if the parties did not agree to the findings. Injustice would result if the neutral arbitrator were biased or less than competent.

Certain provisions attempt to reduce exposure to liability. One of these involves placing limitations on who may give expert-opinion evidence in a medical malpractice case. Ohio has limited the medical-expert witness to one who practices medicine at least three fourths full time.⁹ A proposal before the Washington state legislature would restrict medical experts to those licensed to practice in that state. While it is true that there are some "professional witnesses" who will testify regularly for plaintiffs, it is not likely that such individuals perjure themselves. To restrict the experts available to the plaintiff may promote injustice, and may even force appellate courts to utilize novel legal theories to afford justice in cases in which it is obvious that, even in the presence of negligence, a plaintiff was unable to obtain a qualified medical expert to testify.

Along the same lines are efforts to abolish the use of the doctrine *res ipsa loquitur* in medical malpractice cases. This doctrine is applied in cases in which the act of negligence was so obvious that even a lay person could understand it (leaving a foreign body in a patient or operating on the wrong part

of the body). It is my opinion that the doctrine of *res ipsa loquitur* is not generally subject to abuse, and its statutory abolition in medical malpractice cases would appear to have little overall effect on reducing losses in this area.

Other provisions attempt to mitigate the cause of action. Many physicians are concerned about the question of what constitutes informed consent. Some states have defined what informed consent should consist of, and have actually set out by statute the wording of an informed consent form, the signing of which would create a *legal presumption* that informed consent was obtained.¹⁰ I believe that the large majority of American physicians do inform their patients of the risks of the proposed treatment. The question of lack of informed consent is an issue in only a very few jurisdictions,¹¹ and attempts to legislate informed consent are in general crude and may further reduce rapport between patients and health-care providers. Because informed consent is not a major issue, one would not expect the use of such forms to reduce malpractice insurance losses.

Another effort to mitigate the cause of action is to restrict breach-of-contract actions against the health-care provider with regard to promises made in writing and signed by the health-care provider. Breach-of-contract actions are relatively rare in the medical treatment area. If the physician is foolhardy enough to promise he will produce a result, he should be held to that promise. Because of the relative rarity of suits alleging breach of contract, statutory restriction of actions of this type would have little effect on the overall medical malpractice problem.

Of significant importance in maintaining a market for professional liability insurance is the establishment of a joint underwriting authority (JUA). The legislatures in a majority of the states that have enacted remedial malpractice legislation have established such underwriting authorities. These authorities amass the assets of the casualty underwriters doing business in the state in question, a process similar to that employed for insuring the high-risk automobile driver. The joint underwriting authority also surcharges each professional who purchases insurance in the state, whether insured under a JUA policy or by private carrier. The economic basis for

this type of underwriting may be explained by the total volume of business underwritten by casualty insurers as compared with the volume of professional liability insurance. Table 1 gives these data for 1968. Unquestionably, the dollar volume of malpractice insurance has increased significantly, but other insurance volumes have also increased. Thus, while the percentage of all casualty insurance represented by malpractice insurance may be somewhat more than three tenths of a per cent as it was in 1968, it unquestionably still is relatively low.

CLAIMS-MADE INSURANCE

Another step to assure availability of coverage is being taken on the initiative of the insurance carriers themselves. Some of these carriers are shifting from occurrence insurance to claims-made insurance.[§] Insurance underwriters prefer claims-made insurance because it makes underwriting actuarially much easier than is the case with occurrence insurance. This facility may be readily explained by the protracted process of fault determination—through trial and possible appeal—plus delays in filing claims because of the sometimes prolonged statute of limitation of actions and the fact that minors need not file until they reach the age of majority. These delays create the "long tail" and make projecting future losses very difficult. Thus, the modern trend is to offer only claims-made insurance.

Claims-made insurance has both advantages and disadvantages. The physician must fully understand these before he purchases a policy. Once he becomes committed to claims-made insurance, the physician will have to continue purchasing this type of insurance until there is no longer the possibility that a claim will be filed against him (which may be a number of years after his retirement), unless he buys up the "tail." Rates for Ohio's first year, and projected second and third years, of claims-made insurance issued by the Joint Underwriting Authority are shown in table 2.

[§] An occurrence policy covers all acts of alleged negligence that may occur during the term the policy is in force. The claims-made insurance policy, in contrast, must be in force at the time the claim is filed as well as at the time the allegedly negligent event took place.

TABLE 1. Volume of Casualty Insurance Underwritten in 1968 by Type of Coverage

Type of Insurance	Premiums, Millions of Dollars	Percentage of All Casualty Insurance
Health and accident	5,432.0	21.8
Automobile bodily injury	4,312.5	17.3
Workmen's compensation	2,584.2	10.4
Homeowners' (incl. some B.I.)	1,747.8	7.0
Bodily injury other than above and other than malpractice	911.9	3.7
Malpractice	75.0	0.3
Total, all casualty insurance	24,899.5	

The advantage of claims-made insurance is that it is available. Unfortunately, there are also numerous and potentially serious drawbacks.¹² There is no guarantee that the rates will remain realistic, even in the immediate future. In point of fact, it is expected that unless the loss experience of all insureds in a given group is salutary, the rates will increase. Even if the rates become excessive, the policy holder is locked into the system unless he buys up the "tail." Calculation of the price of the "tail" is noted in table 2. If an insured physician moves to another state and is required to purchase a policy from a different insurer, he will have to buy up the "tail" of his previous policy. The physician may become personally liable if the carrier goes out of business. If the physician retires or dies, his estate will have to buy up the "tail." Finally, there is no apparent cost control over losses, a key to the continuing use of this type of protection.

Long-range Solutions

Few physicians would disagree with the statement: "No injury, therefore, no claim." Injury prevention does deserve emphasis. Some states have taken steps to reduce injuries directly, by promoting medical injury-prevention programs, and to reduce injuries indirectly by strengthening the powers of medical licensing boards. Unquestionably, the practitioner who is clumsy, lazy or incompetent, has not kept up with the advances in medicine, or is disabled by psychiatric illness or drug abuse should have his practice restricted or terminated by the suspen-

TABLE 2. Rates for Anesthesiologists for Claims-made Insurance under Ohio's Joint Underwriting Authority*

	Primary Coverage Limits		Percentage of Current Occurrence Insurance Rate
	\$100-300 Thousand	\$200-600 Thousand	
First year	7,640	8,888	70
Second year†	9,318	10,793	85
Third year‡	10,086	11,681	92
Cost of "tail"†‡	5,810	6,729	52

* Calculated as percentage of *current* Insurance Service Organization occurrence rates; includes 100 per cent surcharge for funding Ohio's Stabilization Reserve Fund.

† Losses will elevate I.S.O. rate and raise premiums proportionately.

‡ Based upon the total of the percentage differences between the occurrence rate and actual rate charged (right-hand column) for all years of prior coverage, calculated as percentage of the existing occurrence rate at the time the "tail" is purchased; in the above example these percentages (30 for first year, 15 for second year, 8 for third year) total 52 per cent; the "tail" quoted above is based upon 52 per cent of the *current* occurrence rate (Fogo R; Personal communication to the author, November 20, 1975).

sion or revocation of his license. Unquestionably, too, many state licensing boards do not now have either the power or the sharply defined grounds to discipline such individuals adequately. Steps to tighten licensure requirements, to strengthen the powers of the licensing boards, to require continuing education as a prerequisite for continuing licensure, and to create specific grounds for disciplinary action by such boards will help curtail the activities of the incompetent, emotionally ill or educationally obsolescent physician. Whether such individuals play a significant role in today's medical malpractice problem is open to question, however. Restricting their practice will, nevertheless, reduce the unfavorable publicity generated by such physicians, and thus possibly make the American public somewhat less litigious.

What may the physician do to help resolve this problem? Clearly, the solution lies in the hands of both legislators and individual physicians. State legislatures must be made aware that none of the proposals before them offers long-term relief. Organized medicine has generally proven ineffective in getting meaningful legislation into law without crippling amendments. While legislators do respond

to lobbying from medical groups, the effectiveness of such action frequently is nullified by lobbyists of other special-interest organizations. Legislators will, however, respond to their constituents. Clearly, it is time for individual physicians to sell their patients and the public at large on the vital importance of obtaining long-term legislative relief at the state level.

Two such solutions are within the power of state legislatures.⁴ Both involve a change from a system based on *fault* to one based on *compensation*. A state could create a patients' compensation board similar to that used for workmen's compensation. Another approach takes the form of medical-injury insurance. This type of coverage, described elsewhere,^{13,14} would be taken out by or on behalf of the patient and cover all iatrogenic complications without the prior necessity of determining fault. The application of such insurance would be coupled with careful risk management and loss control, with active medical injury-prevention programs being developed and implemented on in-hospital, county-wide, or statewide bases. Medical injury prevention is a mandatory companion to medical-injury insurance, as such coverage is never intended to protect the health-care provider against careless practices.

Whether either of the aforementioned methods is adopted is up to the legislatures. Each physician acting on his own can, however, develop and implement his own medical injury-prevention program.^{15,16} The more effective such a program becomes, the less the likelihood of injury and the greater the chances of keeping the costs of his protection within sound economic limits.

SELF-INSURANCE

Should the physician become self-insured? Many anesthesiologists have asked this question. The answer depends upon several factors, including the assets he has accumulated from his years of practice, the complexity of the care he renders, the community in which he lives, and the rules of the hospital in which he practices. It should be obvious that if a large judgment is rendered against him, the physician will have exposed all of

¶ Amendment of a state constitution may be required to abolish trial by jury and place a limit on awards.

his assets to attachment to satisfy the judgement. If the anesthesiologist cares for patients of poor physical status or those who undergo complex operative procedures, there would be a greater chance of his being sued than if he treated only patients of good physical status for relatively "minor" operative procedures. The community is also important. Litigation is much less likely in the smaller town than in the large city. Also, jurors in the smaller town tend to look more favorably on a professional than do those in the big city. Some hospitals will not allow an uninsured physician to continue to treat patients (because the burden of any judgement may fall upon the hospital's own insurance carrier). Finally, the anesthesiologist must remember that he has under his own control the power to maintain solid rapport with his patients, and also to reduce the likelihood of patient injuries by a careful risk-management program.

The anesthesiologist who decides to become self-insured must:

- 1) consult a competent lawyer to learn all of the problems of sequestering one's assets, the bankruptcy laws, and setting aside reserves for possible use in any future litigation;
- 2) initiate a personal risk management and injury-prevention program;
- 3) maintain solid rapport with his patients;
- 4) not care for any patient known to be a trouble-maker;
- 5) practice "heads-up" anesthesia.

Conclusion

The long-term solution to the malpractice problem lies in shifting the emphasis from defense of the physician to *compensating the patient*. The present system of fault determination is inevitably prolonged, sometimes inequitable, and *always too costly*.

This solution can be brought about only by legislative action. Patients injured by negligence have a common law right to sue for damages, unless an alternative method of compensation is afforded them and the health-care provider is at the same time protected by statutory immunity.

The ideal solution lies in the hands of the individual state legislatures. The problems differ among the various states. Any state

action would probably *maximize private initiative* and minimize governmental control.

If the states do not act, the United States Congress will do so. The ever-increasing costs of malpractice insurance are passed on to the patient or third-party provider, adding to an already inflated and overburdened health-care bill for the American consumer and enhancing plans for national health insurance. The premature "retirement" of physicians unable to obtain adequate insurance coverage at reasonable cost will create health-care shortages, *further augmenting sentiments for a national health-care scheme*.

The time to act is now. Physicians in certain states are rapidly becoming uninsurable. A spreading crisis of unavailability of health-care services inevitably will develop.

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