EDITORIAL

MALPRACTICE: A PUBLIC HEALTH EMERGENCY

A smoldering problem in our health system in the United States has suddenly erupted into a full-blown conflagration in the Spring and Summer of 1975: It is medical malpractice litigation and insurance.

The major casualty insurance companies of the country have suddenly given notice that they are either withdrawing from the field entirely, or are raising their rates in multiples of from 4 to 10 times current, already sky-high levels.

We now have physicians, hospitals, and other health professions, including public health personnel, in a panic about what is going to happen in July or September when these companies threaten to pull out. State legislatures are reacting to the panic with hastily drawn legislation intended to cope with the emergency by forcing the companies to continue to write insurance and by enacting financial limitations on court awards and settlements. Many of these proposals are of questionable Constitutional validity.

What are the public health implications of this crisis? It seems to me that the role of public health is to observe the patterns of the problem, the epidemiology of the outbreak. None of the current forces, none of the loud voices crying "Do something!" care much about the study of the epidemic itself. They simply want a quick and complete cure by July 1, 1975; no later, please.

What, then, are some of the epidemiological problems?

First of all, malpractice insurance is very badly organized. The companies sell policies on a state-by-state basis and for different rates by specialty, depending on how many claims and suits are generated or vaguely threatened in that field. This system results in very small risk pools with very high rates, not based on quality of care assessment, but on the inherent dangers of the medical procedures performed. For example, most malpractice claims arise from hospital care, not community care, and from surgery and anesthesia. With the huge inflation in our national economy, this method of "insurance" is bound to fail. It cannot be supported by the physicians and hospitals in this "small pool-large risk" pattern.

The second major factor I would point out is that there is a strong suspicion that the incidence of medical malpractice (or of "therapeutic misadventure" as it is called in medicine) is under-reported, not over-reported. The ratio between "incidents" of injury, infection, and adverse drug reactions in hospitals and the reported awards and settlements are far from equilibrium. Very few incidents result in claims. At the insurance companies, the picture is the same. A large percentage of claims files opened because of reported incidents never get any further. The patients either do nothing about them, or are satisfied with further medical care to alleviate the problems. This indicates that malpractice litigation bears limited unpredictable resemblance to the "epidemic" itself; i.e., injuries to patients at risk. Therefore, remedies aimed at improving quality of care are an unreliable and remote attack on malpractice litigation. Also, it indicates that if the "reform" in this field makes it easier for patients to sue without proving negligence under a "no-fault insurance" scheme, the incidence of claims is bound to rise very precipitously, not fall. Current methods of insurance could not possibly support these increases. The workmen's compensation system of this country, our primary "no-fault" method, is itself in very poor shape. Benefit levels in most states are at or below welfare payment levels for all workers, no matter what their previous earnings were at the time of injury. The delay in recoveries in workmen's compensation is often up to 4 years after the injury. Is this what we want to sponsor as a "reform" in medical malpractice recoveries?

I suggest that the field of medical malpractice litigation, compensation, and insurance needs a public health approach. It may not contribute much to solving this summer's crisis, but it could help immeasurably to develop some long term solutions.

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LETTERS to the editor

ON ABORTION AND NEONATAL MORTALITY

In the article "Effects of Legalized Abortion on Neonatal Mortality and Obstetrical Morbidity at Harlem Hospital Center" (Glass et al., 64:717, 1974), I see no constructive conclusions reached.

The authors state that a marked decrease occurred in the neonatal mortality rate. If you kill the fetus before birth then you are bound to reduce the possibility of death after birth because you never gave the child a chance.

They proclaim a 50 per cent decline in maternal mortality. The only figure given is 2 maternal deaths in 1970. In 1970 maternal mortality rate for the U.S.A. was 20 per 100,000 live births. Harlem Hospital Center had 2 per approximately 2,222 deliveries (one of which was abortion-associated).

Abortion remains a matter of convenience, not necessity. The effects you show do not indicate an improvement in health. I see no constructive effect for the child if you reduce his potential for morbidity by killing him prenatally.

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