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### Q. & A.

#### Bad Medicine

Atul Gawande talks with Daniel Cappello about the costs and consequences of medical malpractice.

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This week in the magazine, Atul Gawande writes about who pays the price when patients sue doctors. Here, with Daniel Cappello, he talks about the costs and consequences of medical malpractice.

#### **DANIEL CAPPELLO: Is the number of malpractice cases in this country on the rise?**

ATUL GAWANDE: There has been a rise, especially if you look at the past forty years. There's been an increase in malpractice claims all over the world. In the past ten or fifteen years, what has really increased is not the number of cases but the number that are settled in the million-dollar-plus range. And that's what has helped bring it into the headlines more and more. I'm not convinced that this is different from other kinds of litigation involving products and services in our country—we're a litigious society, and this is part of a larger debate about responsibility for mishaps, especially in high-risk activities.

#### **How do most malpractice suits arise?**

They run the gamut, but, generally, they start with a bad outcome and at least a question of whether an error caused it. There have been a number of studies showing that, the worse the outcome, the more likely a lawsuit is to happen. It's not necessarily closely tied to whether that outcome was the result of a clear mistake. Obstetrics is probably the most notable example of a field in which controversy over causation arises. For instance, it seems more and more likely that cerebral palsy is not likely to be related to a catastrophic delivery but occurs gradually over the course of a pregnancy. In Senator John Edwards's book, "Four Trials," for example, he talks about a cerebral-palsy malpractice case that won his client seven figures, but elsewhere acknowledges that there are now doubts about whether cerebral palsy is caused by errors.

#### **You are a general surgeon. How often can you anticipate being sued in your career?**

The statistics say that I should expect to be sued about once every six years. Now, there is some evidence that if you're a nice guy and communicate well with your patients you get sued less. It's not because you're a better doctor; it seems to be because patients feel more loyal to you.

#### **You write that many doctors have become extremely forthright with patients about mistakes, because doing this might make them less likely to sue.**

There was a study in Kentucky which suggested that apologizing to patients would reduce the likelihood of their suing. I'm a little troubled by this idea, because the attraction of it to physicians is that maybe, even if a patient is badly hurt by an error, he won't seek money if you're more straightforward about the fact that an error occurred. To me, the scenario brings up all the problems with our current system. The malpractice system makes error almost automatically an adversarial matter, a battle separating doctor and patient. It discourages honesty. At the same time, if a devastating error has occurred, then patients deserve assistance, too.

#### **What are the effects of malpractice on the quality of medical care?**

There's a huge debate about the effect of defensive medicine, meaning that doctors may be treating patients differently because of fear of a lawsuit. And there is, indeed, evidence that physicians are more likely to order scans or biopsies or other kinds of procedures that may be of borderline value. But the debate gets complex pretty quickly. For example, if a young woman comes to me with a breast lump, and a mammogram and an ultrasound show that things look normal, the chances of breast cancer are very low. Researchers point to the fact that physicians now routinely do biopsies as an example of defensive medicine, because biopsying is an expensive, invasive procedure with little likelihood of finding cancer. Yet, I find that my patients, when I give them the options, prefer my being aggressive. I go through the statistics. I say, "You have a one in five hundred chance that this can turn out to be a breast cancer. Do you want to go through a biopsy or follow this for a while?" I've never had a patient say no. And, so far, I have actually caught a breast cancer this way, in a twenty-three-year-old patient. I think "defensive medicine" does make us more paranoid about errors, but that may be what the public wants.

### **What is the toll of malpractice on doctors?**

The financial toll is under one per cent of our expenses. The real toll, I think, is in two places. One is in hindering our ability to honestly address injuries to patients from complications. There are two or three per cent of patients who will be hurt by serious complications in care; about half of those will be the result of error. And because these cases have the potential to become all-out battles in court, we often lose our human instincts to apologize, to grieve, to still be doctors for our patients.

The other cost is in our ability to improve. Almost every case, when it's settled, is sealed, and it can become hard to know what the patterns of failure in medicine are. In the airline industry, if there's an accident, they can do an investigation and share information and figure out when there are certain patterns that suggest what things can be done to improve safety. We really haven't been able to do that.

### **You say that in nearly seventy per cent of the cases the outcome favors doctors. Is this because many suits tend to be without merit, or do doctors have some sort of advantage?**

It's both. The common situation is that there's a bad, perhaps devastating outcome for a patient, the patient goes to a lawyer to try to seek compensation, and the lawyer then investigates the records. Along the way, the lawyer often finds information that tells him he's on the wrong track. I've seen this happen lots of times. The lawyer will name every physician who might be involved, but then half of them will turn out to be people who were responding to the complication and helping, rather than being a cause. Or the complication may emerge as having been unavoidable anyway. A good percentage of cases require digging to find out what really happened, and then the suits get dropped. If a suit isn't dropped, juries tend to be sympathetic to physicians, even in the cases of deserving patients. Once it goes to jury trial, physicians win eighty per cent of the time.

### **Are doctors prepared while they're still in medical school to deal with the malpractice issue, or does it hit them on the job?**

You're not trained in any real way about medical malpractice. But, if you look at surveys of physicians, anger about the malpractice system is the No. 1 concern that physicians cite. It's above income worries, above the frustrations of managed care. Malpractice has deep effects on doctors, and that inevitably affects students' perceptions of medical practice.

### **In your article, you follow Barry Lang, a malpractice attorney. Lang is unusual in that he was once a doctor and a malpractice defendant, and now he's suing doctors. What made him change? Did you get a sense that he's on some sort of mission?**

He wasn't on a mission, but he was unusual in a certain way. In this piece, I really wanted to find a way of getting beyond the vitriol of the doctors on one side and the lawyers on the other. And Barry

Lang, having been a successful, well-respected pediatric orthopedic surgeon for twenty-three years, and then becoming a plaintiff's attorney, gave me one way of getting past all the anger. What was interesting about Lang was that, even in the midst of lawsuits against him, he could be philosophical about malpractice. He was just as devastated as any of us would be, and yet he had the ability to step back and say, "I have to remind myself, this is the cost of doing business." The same way a grocer has insurance against someone getting hurt in his store, the same way you have insurance to protect you if you're in your car and you run a red light and hit somebody—we have insurance to help with the cost of our failures. Lang's point is not that there are lots of bad doctors out there, or that he has the solution to eliminate errors, but that physicians have a moral responsibility to patients they have hurt through a mistake. And that responsibility includes compensation to help them. His question for those of us who oppose the malpractice approach is, what alternative system might we propose to help injured patients?

**In one of the suits against Lang, he was attempting to repair a severely injured set of nerves in a man's wrist. Knowing that such a delicate surgery could lead to further complications, should he have stopped and simply sewn up the man's wrist? How often does the question of malpractice come across your mind during surgery?**

Malpractice doesn't come across my mind during surgery. But I am always worrying about whether I could be doing, at any given moment, more harm than good. Looking at Barry Lang in that situation—well, yes, there comes a point when you have to choose to back out. But it's usually unclear where that point is. It is no less an error to give up when you shouldn't. This past week, I backed out of an operation halfway through, which was a painful decision, and I can tell you that it's rarely black and white whether that is the right thing to do. Lang's insurers certainly worried that a jury would disagree with his decision to proceed. They settled that case for three hundred thousand dollars.

**Your article raises the question of what doctors believe should be done for patients who have been harmed. What's your impression of what doctors generally think about this?**

Almost every physician I know feels deep responsibility for the cases in which patients have had a bad outcome, especially one that we can't fix. The first thing that we feel responsibility for is, O.K., if there's bleeding, let's go back and stop the bleeding. Let's take care of it. We have a tougher time with the cases we can't do anything about, especially if a patient has a serious permanent injury. You want to be able to help, but, short of telling the patient to sue you, our system does not offer many options. Some hospitals are willing to consider early settlement offers, meaning an offer to provide compensation for a patient's losses. This doesn't happen often, though.

**Are American doctors in a tougher position than those in, say, Great Britain or Canada?**

The major difference between malpractice here and in Great Britain and Canada turns out not to be in the number of lawsuits. At this point, the U.K. and Canada seem to be catching up with our rate of lawsuits. The big difference is that the awards are far smaller. This is partly because of the traditions of their court systems, but it's also because they have universal health coverage. Patients in those systems already have their medical expenses covered for their lifetime, as well as some disability benefits. So malpractice awards are restricted to other costs—lost wages, or compensation for suffering, for example—and these are much smaller costs on the whole.

**At the end of your article, you touch upon some potential reforms, such as a congressional cap on financial damages. What are some other alternatives to the current malpractice system?**

The trouble with the caps on damages is that, for the deserving patient, it's not clear how that's a sensible policy at all. It's mainly a policy geared toward keeping the premiums low enough that we don't drive physicians in high-risk specialties in some parts of the country out of business. It may

work temporarily, but even that's open to debate. The alternative that seems most appealing is essentially something like the vaccine compensation fund. Children who are vaccinated can, on rare occasions, have injuries from their vaccines, and lawsuits related to those injuries ended up producing awards so high that vaccine manufacturers started to get out of the business. So Congress created a fund that would take those cases out of the courts and provide automatic and remarkably quick compensation. There are parallels to this in New Zealand and in Sweden, where, if you have serious complications, there's no need to go to court—there's a fund that provides money not only for medical expenses but also for lost income and even to some extent for suffering from the injury. The striking thing is that the vaccine compensation fund, just like the program in New Zealand, is very popular. Families are lobbying to have the vaccine fund cover a broader range of injuries than are currently covered, because they don't feel like the courts are nearly as responsive or as good at being able to help them.

### **Is there a downside to such a compensation-fund system?**

These kinds of compensation funds are, generally, popular and more successful in helping a broader range of people, but without strict limits they quickly become extraordinarily expensive. Those limits can become politically unpopular, because the lines drawn inevitably seem arbitrary and severe. We saw this with the compensation fund for the families of 9/11 victims. But, given our current system, where fewer than one per cent of people who are injured by medical errors are going to be helped, it's easy to imagine a system that can do a lot better for less money. ✦