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# Malpractice Suits and Physician Apologies in Cancer Care

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Consider the following case:

The patient is a 44-year-old woman who presents for radiation treatment of an isolated locoregional recurrence of breast cancer in her chest wall, 3 years after undergoing mastectomy. At the time of diagnosis, she had T2N2M0 disease, with four of 15 lymph nodes involved with tumor. She received a mastectomy with negative margins and appropriate chemotherapy, but none of her physicians talked to her about postmastectomy radiation therapy, which would clearly have been indicated to reduce her risk of locoregional failure and would have been expected to improve her likelihood of survival. She asks the radiation oncologist who sees her whether this recurrence could have been prevented, and she notes that when she was diagnosed with the recurrence, a nurse asked her why she had not received radiation before. She states that she is thinking of retaining an attorney. The radiation oncologist says, “Dwelling on what could have been done isn’t productive—let’s just focus on how we can fight this cancer now.”

This case reveals some of the dilemmas oncologists face when treating patients who have suffered from substandard medical care. It also highlights some of the shortcomings of the existing tort system, both in addressing the legitimate claims of the patient who has been harmed by negligent care and in promoting quality improvement. In this article, we survey the US medical malpractice system and assess the effectiveness of tort law at achieving its goals. We then consider how physicians and health care organizations could better assist negligently harmed patients and simultaneously reduce future mistakes. Specifically, we describe how the hypothetical case presented might have been handled if it had occurred at our own institution, which has adopted a novel approach to promote transparency and remedy through disclosure and apology by negligent providers to injured patients. This program was designed to compensate patients swiftly and fairly when there is evidence of harm caused by unreasonable care, as well as to decrease future errors through continuous quality improvement and an open exchange with injured patients about medical mistakes.

In this article, we use the term “negligent” specifically to denote the legal standard of care for medical malpractice liability. Although the precise contours vary by state, negligent typically refers to a level of treatment below that which would be provided by physicians with “the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing,” under the circumstances.<sup>1(p187)</sup> We use the term “unreasonable” when discussing the Michigan program because that is the relevant threshold established by the pro-

gram. These need not be synonyms, nor need they be exclusive or even exhaustive categories of medical error. For example, iatrogenic injuries may result for reasons unrelated to negligent or unreasonable treatment; it may be that a course of treatment comes to be seen as the wrong course *ex post* when the decision to follow the course was appropriate and reasonable *ex ante*. Some might consider these reasonable decisions as not errors at all. Others might consider them errors in a broader, abstract sense, but only classify them as unfortunate or regrettable, not negligent or unreasonable. We use the term “substandard” more generally to denote care that fails to meet a certain threshold or standard.

## The Tort-Based Medical Malpractice System in the United States

In the United States, situations like the example case are typically administered by the tort-based system of medical malpractice, which requires negligent defendants to redress their wrongful conduct by paying financial compensation to successful plaintiffs. In addition to corrective justice, the most frequently articulated goals of this system are compensating for negligently caused harms (including payments for medical bills, lost wages, reduced future employment, and pain and suffering) and deterring poor medical treatment.

The tort-based, malpractice system, however, does not always function as intended. There have been three “malpractice crises” over the past 30 years, and considerable evidence demonstrates that the system often fails to achieve its goals.<sup>2</sup> Although many patients are injured by substandard medical care each year, only a small percentage of them are compensated through the tort system. The Harvard Medical Practice Study I reviewed the records of 30,121 patients treated in New York State in 1984 to determine the incidence of adverse events.<sup>3</sup> They demonstrated that adverse events occurred in 3.7% of hospitalizations, and of these adverse events, 27.6% were due to negligence. Extrapolating these data, they estimated that 27,179 adverse events in New York State in 1984 were the result of negligence. Furthermore, they found that the more serious the adverse event, the more frequently negligence occurred, with 51.3% of adverse-event deaths caused by negligence. A more recent study by the Congressional Budget Office estimates that in 2003, 181,000 severe medical injuries in US hospitals were the result of negligence.<sup>4</sup>

Although the absolute numbers of adverse events caused by medical negligence are high, few patients file legal claims. The Harvard Medical Practice Study III examined the relationship

between malpractice claims and adverse events caused by negligence in New York in 1984. It found that claims occurred only 13% as often as injuries resulting from malpractice. Moreover, only 1.5% of adverse events caused by negligence led to claims.<sup>5</sup> Numerous explanations are possible for the low number of medical malpractice claims in the setting of so many cases of injuries related to negligence. Patients may view many injuries as minor or may have adequate disability or health insurance benefits to cover the costs of their injuries. They may not wish to jeopardize relationships with their caregivers by suing, they may have difficulty securing legal representation, or they may not trust lawyers. Injured patients may also be unaware that they received substandard medical care, particularly in areas as complex as cancer care. With the practice of medicine becoming increasingly specialized, few patients can be expected to know when a medical decision has injured them unless a medical professional informs them. Despite state law and accreditation body rules that require providers to report serious adverse events,<sup>6</sup> there is considerable evidence that providers frequently fail to disclose their own errors.<sup>7-10</sup>

In the hypothetical case above, only a nurse's incidental comment alerted the patient to a problem with prior care. Furthermore, despite not participating in the substandard treatment, the consulting physician was reluctant to discuss it. Physicians often feel uncomfortable assigning blame to other physicians, perhaps out of a sense of collegiality or a desire to preserve referral networks. Moreover, many physicians object to the malpractice system in general or dislike admitting their own errors or calling attention to those of others. Some may fear that exposing errors will trigger malpractice claims that will compromise their own ability to practice or maintain malpractice insurance coverage. Furthermore, in many cases, other caregivers may not have access to enough details about a situation to comment responsibly about whether an error occurred. Thus, many patients may not file viable claims because they never discover they have cause to do so.

Whatever the reason, few patients pursue medical malpractice claims, and an even smaller number of claims proceed to a final judgment. The vast majority are settled before trial. Only approximately 30% of filed claims go to trial, 7% of which are decided by juries, with plaintiffs (the injured party) prevailing in 27% of these jury trials.<sup>11,12</sup> Even when there is strong evidence of medical negligence, as determined by independent physician reviewers, plaintiffs are successful in only about half of the cases that go to trial.<sup>13,14</sup>

One of the difficulties in winning a medical malpractice case is proving causation, that is, proving that the physician's negligence rather than chance resulted in an injury. In the hypothetical case above, the chance of a local recurrence after postmastectomy radiotherapy might still be as high as 10%, as compared with 30% without radiotherapy.<sup>15,16</sup> Trying to determine whether the failure to refer for radiation caused the local recurrence or whether the local recurrence would have occurred even with proper treatment is quite difficult. Although some jurisdictions allow suits for "loss of chance"—a doctrine that permits malpractice suits on behalf of patients who were

deprived a significant probability of survival and died as a result—this doctrine has not been adopted uniformly.<sup>17</sup> In Michigan, for example, the law states that "in an action alleging malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%."<sup>18</sup> Because acts or omissions may cumulatively increase or decrease the risk of recurrence and death for patients with cancer, applying the doctrine to any one particular act or omission can be particularly difficult.

Thus, although one of the main goals of the tort system is to compensate injured patients, the data suggest that many injured patients may not be compensated in the current medical malpractice system. In addition, even when patients successfully win medical malpractice lawsuits, variability in jury awards and tort reform measures such as damage caps have economically significant effects on payments to successful plaintiffs.<sup>19</sup> Although there is a positive relationship between "independent assessments of liability and of injury cost and outcomes of legal disputes alleging malpractice,"<sup>20(p17)</sup> the best evidence suggests that the system is inefficient at compensating patients.<sup>3</sup>

In addition to compensation, the malpractice system is meant to improve quality by deterring negligent care. Accordingly, the threat of costly litigation as well as having to report to the National Practitioners Data Bank offers health care providers the necessary incentives to take the appropriate level of safety precautions. Unfortunately, there is little evidence that this process works well either.

The deterrence theory for medical liability assumes that providers know the law, behave in an economically rational manner by weighing the costs and benefits of their actions, and internalize the costs of their choices.<sup>11</sup> Yet these assumptions are often unfounded. For example, physicians who carry liability insurance are largely shielded from the financial burden of their own negligent acts.<sup>21</sup> They are protected because, although physicians found liable for malpractice may be dropped from their insurance carriers, premiums are not typically based on individual physician liability experience but are set according to the location and specialty of the physician.<sup>21</sup>

Moreover, the incentives do not always work as intended. Although the tort system attempts to encourage physicians to order necessary tests and procedures, it also encourages them to order unnecessary tests and procedures.<sup>22</sup> The system may also deter the reporting of negligent actions that might otherwise be used as examples to educate other physicians and improve the quality of medical care. The net effects of the tort system on the quality of care are uncertain.

### A Better Way?

Given the shortcomings of the medical malpractice system detailed above, it is natural to wonder whether there might be alternative approaches to achieving the important goals of compensation for injury and reduction of poor quality medical care. Although many possibilities exist, from first-party insurance to state-funded compensation funds, physicians at the University of Michigan are fortunate to practice in an institution that has

devoted a great deal of attention to creating a less adversarial approach that attempts to compensate patients harmed by unreasonable care while also improving care. Indeed, had the hypothetical case above occurred at our institution, the story might have unfolded differently.

The University of Michigan has a program, predicated on honesty, that provides both a mechanism for acknowledging medical mistakes and a means to compensate injured patients.<sup>23</sup> This system is distinct from reforms to the tort law system such as caps on rewards for noneconomic damages,<sup>24</sup> elimination of the collateral source rule, and limitations on contingency fees to attorneys. Rather than changing tort law, this program offers an alternative. In doing so, it attempts to change the institutional culture to promote honest assessment, open communication, and apologies for unreasonable care. Of note, many organizations have advocated disclosure of mistakes to patients, and disclosure is even one of the patient safety standards required by the Joint Committee on Accreditation of Health Care Organizations.<sup>6</sup> Although the principle of disclosing medical errors to patients is not new,<sup>25,26</sup> acknowledging mistakes and offering apologies and remedies for unreasonable care is a relatively recent development.

The University of Michigan program was designed as a part of an integrated quality improvement initiative, one component of which is a mechanism for compensating patients harmed by unreasonable care. The program has also had the incidental effect of reducing the University's liability expenses; the program avoids the costs of litigation because when the University makes payments within the structure of the program (which are presumably lower than those that would have been awarded at trial), those payments are typically predicated on obtaining a full release of potential legal claims.<sup>27</sup> Nonetheless, cost saving is not the program's ultimate goal. The program's leaders hope that by creating an environment in which physicians are not penalized for acknowledging their mistakes and are encouraged to do so, they may be more willing to openly discuss medical errors and develop strategies to prevent similar mistakes in the future. The program attempts both to reassure providers that disclosure will not lead to legal or organizational penalties and to destigmatize admissions of error.<sup>28</sup> Ultimately, the whole program is predicated on the notion that honesty is the first prerequisite to patient safety improvement.

According to the current program administrators, "Fears that impede individual physicians from open disclosure are the fear of losing malpractice coverage, the fear of compromising a future malpractice case, and the fear of financial ruin. Some of these fears can be assuaged with a little knowledge, courage, a change in culture, and planning."<sup>23(p148)</sup> As noted by the leaders of the Michigan program, a barrier to disclosure and apology has been the concern by health providers that their statements will be used as admissions of fault in a legal proceeding. Indeed, lawyers and insurers have advised doctors to avoid apologies, and various commentators have advocated careful disclosure of medical errors without explicit acknowledgment of wrongdoing to avoid incriminating statements.<sup>29,30</sup> A tension exists between the moral duty to disclose a mistake to a patient and the

desire to protect oneself from the legal repercussions of that admission. These concerns have persisted despite longstanding and widespread adoption of shield laws that forbid the admission of statements of apology or grief by medical practitioners as evidence of negligence. Some statutes go farther and protect against the admission of apologies that include statements of fault, mistakes, error, or liability.<sup>31</sup> Massachusetts passed the first protective law in 1986,<sup>32</sup> and by 2010, 34 more states and the District of Columbia had adopted apology laws (typically precluding evidence of a physician's expression of sympathy from being introduced in a malpractice claim) and nine had adopted disclosure laws (typically requiring or encouraging providers to inform patients of unintended outcomes).<sup>33</sup> Of note, until 2011, Michigan had neither type of statute, but Michigan recently enacted legislation that prohibits statements of sympathy from being admitted as evidence in medical malpractice claims.

As a quality improvement initiative, the University of Michigan's program discloses substandard care to injured patients and compensates patients harmed by unreasonable medical care<sup>23</sup> even if they could not have brought a successful malpractice suit. In fact, in three instances, the University informed patients that a medical error had occurred and compensated them even though the statute of limitations for bringing a suit had expired.<sup>34</sup> Moreover, because the hospital policy encourages open dialogue without repercussions, physicians and staff may be more likely to admit to their errors, partly because the existence of such a program helps to destigmatize the commission of errors, and partly because it indicates that the hospital will support them in the event of a mistake. Early understanding of the source of errors has allowed the institution to implement system-wide changes to improve patient safety, without waiting for the final results of litigation. To be sure, many factors that contribute to providers' reluctance to expose error such as embarrassment or the remaining risk of suit persist, but the shift in culture promoted by the program helps providers recognize that an admission of error is an integral contribution to long-term quality improvement. Other programs that have been successful in similar efforts have also tended to emphasize the critical connection between error reporting and quality improvement.<sup>35</sup> Indeed, the Agency for Healthcare Research and Quality has initiated the Medical Liability Reform and Patient Safety Initiative, the goals of which include to "foster better communication between doctors and their patients"<sup>36</sup> and which has funded papers studying disclosure of errors.<sup>37</sup>

By linking disclosures of medical errors with compensation, the University of Michigan program might thus satisfy two aims of medical malpractice tort, compensation and error-prevention, without the intervention from the courts. The program may also save costs. Since instituting the program, the hospital has decreased its malpractice insurance cash reserve from \$70 million to \$13 million.<sup>34</sup> Because patients may sue to extract an apology from the defendant or to prevent similar incidents from happening in the future,<sup>38,39</sup> one possible explanation for the decrease in cash reserve is that by receiving apologies and witnessing a demonstrated commitment to quality



improvement, fewer patients wish to sue the University. Alternatively, by addressing mistakes early on, the policy may have facilitated settlements and reduced overall malpractice costs.<sup>25</sup> It is, however, difficult to isolate the impact of this particular program in the wake of numerous other secular trends.

The striking experience at our institution may not generalize to all hospitals. Unlike many smaller hospitals, the University of Michigan self-insures and completely indemnifies its employed physicians. This arrangement reduces conflicts of interest among the physicians, hospital, and insurer. The program may not be as effective where different carriers insure the hospital and physicians, or when indemnification is absent, introducing strategic behavior where it may benefit one party if another admits liability.

Although the program may neither succeed as well at other institutions as it has at ours nor eliminate all legal claims, it offers an alternative resolution to difficult situations in which substandard care has caused injury. Unlike the case we presented at the outset of this article, the only case of medical error one of us has personally seen (a case of wrong-site incision) was addressed by a prompt apology by the offending surgeon, along with immediate compensation of the patient by the institution. She chose to pursue adjuvant therapy at our institution and appears to continue to hold her physicians and our hospital in high esteem. Although anecdotal, the examples reported above show how embracing a culture of provider disclosure and learning from errors through such a program can both compensate patients and facilitate long-term reductions in medical errors—goals that the medical malpractice system has not been particularly effective or efficient in meeting. Oncology providers at

institutions that do not have such programs should consider contacting their risk management professionals to determine their institution's view (and applicable state laws) regarding the role of provider apology when mistakes occur. They may also wish to encourage consideration of similar cultural changes at their own institutions, where possible.

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