

Malpractice lawsuits help only a tiny fraction of injured patients, but medicine has offered no genuine alternative.

THE MALPRACTICE MESS

Who pays the price when patients sue doctors?

BY ATUL GAWANDE

It was an ordinary Monday at the Middlesex County Superior Court in Cambridge, Massachusetts. Fifty-two criminal cases and a hundred and forty-seven civil cases were in session. In Courtroom 6A, Daniel Kachoul was on trial for three counts of rape and three counts of assault. In Courtroom 10B, David Santiago was on trial for cocaine trafficking and illegal possession of a deadly weapon. In Courtroom 7B, a scheduling conference was being held for *Minihan v. Wallinger*, a civil claim of motor-vehicle negligence. And next door, in Courtroom 7A, Dr. Kenneth Reed faced charges of medical malpractice.

Reed was a Harvard-trained dermatologist with twenty-one years of experience, and he had never been sued for malpractice before. That day, he was being questioned about two office visits and a phone call that had taken place almost nine years earlier. Barbara Stanley, a fifty-eight-year-old woman, had come to see him in the summer of 1996 about a dark warty nodule a quarter-inch wide on her left thigh. In the office, under local anesthesia, Reed shaved off the top for a biopsy. The pathologist's report came back a few days later, with a near-certain diagnosis of skin cancer—a malignant melanoma. At a follow-up appointment, Reed told Stanley that the growth would have to be completely removed. This would require taking a two-centimetre margin—almost an inch—of healthy skin beyond the lesion. He was worried about metastasis, and recommended that the procedure be done immediately, but she balked. The excision that he outlined on her leg would have been three inches across, and she couldn't believe that a procedure so disfiguring was necessary. She said that she had a friend who had been given a diagnosis of cancer erroneously, and underwent unnecessary surgery. Reed pressed, though, and by the end of their discus-

sion she allowed him to remove the visible tumor that remained on her thigh, only a half-inch excision, for a second biopsy. He, in turn, agreed to have another pathologist look at all the tissue and provide a second opinion.

To Reed's surprise, the new tissue specimen was found to contain no sign of cancer. And when the second pathologist, Dr. Wallace Clark, an eminent authority on melanoma, examined the first specimen he concluded that the initial cancer diagnosis was wrong. "I doubt if this is melanoma, but I cannot completely rule it out," his report said. Reed and Stanley spoke by phone on August 10, 1996, to go over the new findings.

None of this is under dispute; what's under dispute is what happened afterward. According to Barbara Stanley, Reed told her that she did not have a melanoma after all—the second opinion on the original biopsy "was negative"—and that no further surgery was required. That's not how Reed recalled the phone conversation. "I indicated to Barbara Stanley . . . that Dr. Wallace Clark felt that this was a benign lesion called a Spitz nevus, and that he could not be a hundred per cent sure it was not a melanoma," he testified. "I also explained to her that in Dr. Clark's opinion this lesion had been adequately treated, that follow-up would be necessary, and that Dr. Clark did not feel that further surgery was critical. I also explained to Barbara Stanley that this was in conflict with the previous pathology report, and that the most cautious way to approach this would be to allow me to [remove additional skin] for a two-centimetre margin." She told him, he said, that she didn't want more surgery. "At that point, I reemphasized to Barbara Stanley that at least she should come in for regular follow-up." Unhappy with the care she received, she didn't return.

After two years, the growth reappeared. Stanley went to another doctor,

and the pathology report came back with a clear diagnosis: a deeply invasive malignant melanoma. A complete excision, she was told, should probably have been done the first time around. When she finally did undergo the more radical procedure, the cancer had spread to lymph nodes in her groin. She was started on a yearlong course of chemotherapy. Five months later, she suffered a seizure. The cancer was now in her brain and her left lung. She had a course of brain and lung radiation. A few weeks after that, Barbara Stanley died.

But not before she had called a lawyer from her hospital bed. She found a full-page ad in the Yellow Pages for an attorney named Barry Lang, a specialist in medical-malpractice cases, and he visited her at her bedside that very day. She told him that she wanted to sue Kenneth Reed. Lang took the case. Six years later, on behalf of Barbara Stanley's children, he stood up in a Cambridge courtroom and called Reed as his first witness.

Malpractice suits are a feared, often infuriating, and common event in a doctor's life. (I have not faced a bonafide malpractice suit, but I know to expect one.) The average doctor in a high-risk practice like surgery or obstetrics is sued about once every six years. Seventy per cent of the time, the suit is either dropped by the plaintiff or won in court. But the cost of defense is high, and when doctors lose, the average jury verdict is half a million dollars. General surgeons pay anywhere from thirty thousand to two hundred thousand dollars a year in malpractice-insurance premiums, depending on the litigation climate of the state they work in; neurosurgeons and obstetricians pay upward of fifty per cent more.

Every doctor, it seems, has a crazy-lawsuit story. My mother, a pediatrician, was once sued after a healthy two-

month-old she had seen for a routine checkup died of sudden infant death syndrome a week later. The lawsuit alleged that she should have prevented the death, even though a defining characteristic of SIDS is that it occurs without warning. One of my colleagues performed lifesaving surgery to remove a woman's pancreatic cancer only to be sued years later because she developed a chronic pain in her arm; the patient blamed it, implausibly, on potassium that she received by I.V. during recovery from the surgery. I have a crazy-lawsuit story of my own. In 1990, while I was in medical school, I was at a crowded Cambridge bus stop and an elderly woman tripped on my foot and broke her shoulder. I gave her my phone number, hoping that she would call me and let me know how she was doing. She gave the number to a lawyer, and when he found out that it was a medical-school exchange he tried to sue me for malpractice, alleging that I had failed to diagnose the woman's broken shoulder when I was trying to help her. (A marshal served me with a subpoena in physiology class.) When it became apparent that I was just a first-week medical student and hadn't been treating the woman, the court disallowed the case. The lawyer then sued me for half a million dollars, alleging that I'd run his client over with a bike. I didn't even have a bike, but it took a year and a half—and fifteen thousand dollars in legal fees—to prove it.

My trial had taken place in the same courtroom as Reed's trial, and a shudder went through me when I recognized it. Not all Americans, however, see the system the way doctors do, and I had come in an attempt to understand that gap in perspectives. In the courtroom gallery, I took a seat next to Ernie Browe, the son of Barbara Stanley. He was weary, he told me, after six years of excruciating delays. He works for a chemistry lab in Washington State and has had to take vacation time and money out of his savings to pay for hotels and flights—including for two trial dates that were postponed as soon as he arrived. "I wouldn't be here unless my mother asked me to, and she did before she died," he said. "She was angry, angry to have lost all those years because of Reed." He was glad that Reed was finally being called to account.

The dermatologist sat straight-

backed and still in the witness chair as Lang fired questions at him. He was clearly trying not to get flustered. A friend of mine, a pediatric plastic surgeon who had had a malpractice suit go to trial, told me the instructions that his lawyer had given him for his court appearances: Don't wear anything flashy or expensive. Don't smile or joke or frown. Don't appear angry or uncomfortable, but don't appear overconfident or dismissive, either. How, then, are you supposed to look? Reed seemed to have concluded that the only choice was to look as blank as possible. He parsed every question for traps, but the strenuous effort to avoid mistakes only made him seem anxious and defensive.

"Wouldn't you agree," Lang asked, "that [melanoma] is very curable if it's excised before it has a chance to spread?" If a patient had asked this question, Reed would readily have said yes. But, with Lang asking, he paused, uncertain.

"It's hypothetical," Reed said.

Lang was clearly delighted with this sort of answer. Reed's biggest problem, though, was that he hadn't kept notes on his August 10th phone conversation with Barbara Stanley. He could produce no corroboration for his version of events. And, as Lang often reminded the jury, plaintiffs aren't required to prove beyond a reasonable doubt that the defendant has committed malpractice. Lang needed ten of twelve jurors to think only that it was more likely than not.

"You documented a telephone conversation that you had with Barbara Stanley on August 31st, isn't that correct?" Lang asked.

"That is correct."

"Your assistant documented a discussion that you had with Barbara Stanley on August 1st, right?"

"That is correct."

"You documented a telephone call with Malden Hospital, correct?"

"That is correct."

"You documented a telephone conversation on September 6th, when you gave Barbara Stanley a prescription for an infection, correct?"

"That is correct."

"So you made efforts and you had a habit of documenting patient interactions and telephone conversations, right?"

"That is correct."

Lang began to draw the threads together. "Exactly what Barbara Stanley needed, according to you, [was] a two-centimetre excision, right?"

"Which is what I instructed Ms. Stanley to do . . ."

"Yet you did not tell Dr. Hochman"—Stanley's internist—"that she needed a two-centimetre excision, right?"

"That is correct."

"But you want this jury to believe you told Barbara Stanley?"

"I want this jury to believe the truth—which is that I told Barbara Stanley she needed a two-centimetre excision."

Lang raised his voice. "You *should* have told Barbara Stanley that . . . isn't that correct?" He all but called Reed a perjurer.

"I did tell Barbara Stanley, repeatedly!" Reed protested. "But she refused." As the examination continued, Reed tried to keep his exasperation in check, and Lang did all he could to discredit him.

"In your entire career, Doctor, how many articles have you published in the literature?" Lang asked at another point.

"Three," Reed said.

Lang lifted his eyebrows, and stood with his mouth agape for two beats. "In twenty years' time, you've published three articles?"

Without documentation, Reed was in a hard spot, and Lang's examination made my skin crawl. I could easily picture myself on the stand being made to defend any number of cases in which things didn't turn out well and I hadn't got every last thing down on paper. Lang was sixty years old, bald, short, and loud. Spittle flew in droplets. He paced constantly, and rolled his eyes at Reed's protestations. He showed no deference and little courtesy. He was almost a stereotype of a malpractice lawyer—except in one respect, and that was the reason I'd come to watch this particular trial.

Barry Lang used to be a doctor. For twenty-three years, he had a successful practice as an orthopedic surgeon, with particular expertise in pediatric orthopedics. He'd even served as an expert witness on behalf of other surgeons. Then, in a turnabout, he went to law school, gave up his medical practice, and embarked on a new career suing doctors. Watching him, I wondered,

after all his experience did he understand something that the rest of us didn't?

I went to see Lang at his office in downtown Boston, on the tenth floor of 1 State Street, in the heart of the financial district. He welcomed me warmly, and I found that we spoke more as fellow-doctors than as potential adversaries. I asked why he had quit medicine to become a malpractice attorney. Was it for the money?

He laughed at the idea. Going into law "was a money disaster," he said. Starting out, he had expected at least some rewards. "I figured I'd get some cases, and if they were good the doctors would settle them quickly and get them out of the way. But no. I was incredibly naïve. No one ever settles before the actual court date. It doesn't matter how strong your evidence is. They always think they're in the right. Things can also change over time. And, given the choice of paying now or paying later, which would you rather do?"

He entered law practice, he said, because he thought he'd be good at it, because he thought he could help people, and because, after twenty-three years in medicine, he was burning out. "It used to be 'Two hip replacements today—yeah!'" he recalled. "Then it became 'Two hip replacements today—ugh.'"

When I spoke to his wife, Janet, she said that his decision to change careers shocked her. From the day she met him, when they were both undergraduates at Syracuse University, he'd never wanted to be anything other than a doctor. After medical school in Syracuse and an orthopedics residency at Temple University, he had built a busy orthopedics practice in New Bedford, Massachusetts, and had a fulfilling and varied life. Even when he enrolled in night classes at Southern New England School of Law, a few blocks from his office, his wife didn't think anything of it. He was, as she put it, "forever going to school." One year, he took English-literature classes at a local college. Another year, he took classes in Judaism. He took pilot lessons, and before long was entering airplane aerobatics competitions. Law school, too, began as another pastime—"It was just for kicks," he said.

After he finished, though, he took the



"This one to your liking, sir?"

bar exam and got his license. He was fifty years old. He'd been in orthopedics practice long enough to have saved a lot of money, and law had begun to seem much more interesting than medicine. In July, 1997, he handed his practice over to his startled partners, "and that was the end of it," he said.

He figured that the one thing he could offer was his medical expertise, and he tried to start his legal practice by defending physicians. But, because he had no experience, the major law firms that dealt with malpractice defense wouldn't take him, and the malpractice insurers in the state wouldn't send him cases. So he rented a small office and set up shop as a malpractice attorney for patients. He spent several thousand dollars a month for ads on television and in the phone book, dubbing himself "the Law Doctor." Then the phone calls came. Five years into his new career, his cases finally began going to trial. This is his eighth year as a malpractice attorney, and he has won settlements in at least thirty cases. Eight others went to

trial, and he won half of them. Two weeks before the Reed trial, he won a four-hundred-thousand-dollar jury award for a woman whose main bile duct was injured during gallbladder surgery, forcing her to undergo several reconstructive operations. (Lang got more than a third of that award. Under Massachusetts state law, attorneys get no more than forty per cent of the first hundred and fifty thousand dollars, 33.3 per cent of the next hundred and fifty thousand, thirty per cent of the next two hundred thousand, and twenty-five per cent of anything over half a million.) Lang has at least sixty cases pending. If he had any money troubles, they are over.

Lang said that he gets ten to twelve calls a day, mostly from patients or their families, with some referrals from other lawyers who don't do malpractice. He turns most of them away. He wants a good case, and a good case has to have two things, he said. "No. 1, you need the doctor to be negligent. No. 2, you need the doctor to have caused damage." Many of the callers fail on both counts.

"I had a call from one guy. He says, 'I was waiting in the emergency room for four hours. People were taken ahead of me, and I was really sick.' I say, 'Well, what happened as a result of that?' 'Nothing, but I shouldn't have to wait for four hours.' Well, that's ridiculous."

Some callers have received negligent care but suffered little harm. In a typical scenario, a woman sees her doctor about a lump in her breast and is told not to worry about it. Still concerned, she sees another doctor, gets a biopsy, and learns that she has cancer. "So she calls me up, and she wants to sue the first doctor," Lang said. "Well, the first doctor was negligent. But what are the damages?" She got a timely diagnosis and treatment. "The damages are nothing."

I asked him how great the prospective damages had to be to make the effort worth his while. "It's a gut thing," he said. His expenses on a case are typically forty to fifty thousand dollars. So he would almost never take, say, a dental case. "Is a jury going to give me fifty thousand dollars for the loss of a tooth? The answer is no." The bigger the damages, the better. As another attorney told me, "I'm looking for a phone number"—damages worth seven figures.

Another consideration is how the plaintiff will come across to jurors. Someone may have a great case on paper, but Lang listens with a jury in mind. Is this person articulate enough? Would he or she seem unreasonable or strange to others? Indeed, a number of malpractice attorneys I spoke to confirmed that the nature of the plaintiff, not just of the injury, was a key factor in the awarding of damages. Vernon Glenn, a highly successful trial attorney from Charleston, South Carolina, told me, "The ideal client is someone who matches the social, political, and cultural template of where you are." He told me about a case he had in Lexington County, South Carolina—a socially conservative, devoutly Christian county that went seventy-two per cent for George W. Bush in the last election and produces juries unsympathetic to malpractice lawyers. But his plaintiff was a white, Christian female in her thirties with three young children who had lost her husband—a hardworking, thirty-nine-year-old truck mechanic who loved NASCAR, had voted Repub-

THE OWL'S NIGHT

Here is a present
that yesterday doesn't touch.
When we reached
the last of the trees we noticed that we
were no longer able to notice.
When we looked at the trucks
we saw absence heaping up its selected things,
and pouring out its eternal tent around us.

Here is a present
that yesterday doesn't touch.
Silk thread slips between the mulberry trees,
letters on the night's notebook.
Only moths light our boldness
descending to the hollow of strange words:
Was this miserable man my father?
Perhaps I'll consider my situation here. Perhaps
I'll give birth, now, to myself, with myself,
and choose for my name vertical letters.

Here is a present
sitting in time's emptiness staring
at the trace of those who pass on the river's stalk
polishing their flutes with air . . . Perhaps speech
will become transparent, so we'll see windows in it, open.
Perhaps time will hurry, with us
carrying our tomorrow in its luggage.

lican for the past twenty years, and had built the addition to their country home himself—to a medical error. During routine abdominal surgery, doctors caused a bowel injury that they failed to notice until, days later, he collapsed and died. The woman was articulate and attractive, but not so good-looking as to put off a jury. She wasn't angry or vengeful, but was visibly grieving and in need of help. If the family hadn't spoken English, if the husband had a long history of mental illness or alcoholism or cigarette smoking, if they'd been involved in previous lawsuits or had a criminal record, Glenn might not have taken the case. As it was, "she was darn close to the perfect client," he said. The day before trial, the defendants settled for \$2.4 million.

Out of sixty callers a week, Barry Lang might take the next step with two, and start reviewing the medical records for hard evidence of negligent care. Many law firms have a nurse or a nurse practitioner on staff to do the initial re-

view. Lang himself gathers all the records, arranges them chronologically, and goes through them page by page.

There is a legal definition of negligence ("when a doctor has breached his or her duty of care"), but I wanted to know his practical definition of the term. Lang said that if he finds an error that resulted in harm, and the doctor could have avoided it, then, as far as he is concerned, the doctor was negligent.

To most doctors, this is an alarming definition. Given the difficulty of many cases—unclear diagnoses, delicate operations—we all have serious "complications" that might have been avoided. I told Lang about a few patients of mine: a man with severe bleeding after laparoscopic liver surgery, a patient who was left permanently hoarse after thyroid surgery, a woman whose breast cancer I failed to diagnose for months. All were difficult cases. But, in looking back on them, I also now see ways in which I could have done better. Would he sue me? If he could show a jury how I might

Here is a present
without time.

He didn't find anyone here, anyone who remembered
how we left the door, a gust of wind. Anyone who remembered
when we fell off yesterday. Yesterday
broke over the floor, shrapnel gathered together
by others, like mirrors for their image, after us.

Here is a present
without place.

Perhaps I'll consider my situation, and scream at
the owl's night: Was that miserable man
my father, who makes me carry the burden of his history?
Perhaps I'll change my name, and choose
my mother's expressions and her customs as they ought
to be: This way she'll be able to joke with me
whenever salt touches my blood. This way she'll be able to
take care of me whenever a nightingale bites my mouth.

Here is a present
fleeting.

Here strangers hang their guns on
the branches of an olive tree, prepare dinner
quickly, from tin cans, and leave
quickly, for their trucks.

—*Mahmoud Darwish*

(*Translated, from the Arabic, by Jeffrey Sacks.*)

have avoided harm, and if the damages were substantial, he said, "I would sue you in a flash." But what if I have a good record among surgeons, with generally excellent outcomes and conscientious care? That wouldn't matter, he said. The only thing that matters is what I did in the case in question.

Lang insists that he is not engaged in a crusade against doctors. He faced three malpractice lawsuits himself when he was a surgeon. One involved an arthroscopy that he performed on a young woman with torn cartilage in her knee from a sports injury. Several years later, he said, she sued because she developed arthritis in the knee—a known, often unavoidable outcome. Against his wishes, the insurer settled with the patient for what Lang called "nuisance money"—five thousand dollars or so—because it was cheaper than fighting the suit in court.

In another case, a manual laborer with a wrist injury that caused numbness in three fingers sued because Lang's attempted repair made the numbness

worse and left him unable to work. Lang said that he'd warned the patient that this was a high-risk surgery. When he got in, he found the key nerves encased in a thick scar. Freeing them was exceedingly difficult—"like trying to peel Scotch tape off wallpaper," he said—and some nerve fibres were unavoidably pulled off. But the insurer wasn't certain that it would prevail at trial, and settled for three hundred thousand dollars. Both cases seemed unmerited, and Lang found them as exasperating as any other doctor would.

The third case, however, was the result of a clear error, and although it took place two decades ago, it still bothers him. "I could have done more," he told me. The patient was a man in his sixties whom Lang had scheduled for a knee replacement. A few days before the surgery, the man came to his office complaining of pain in his calf. Lang considered the possibility of a deep-vein thrombosis—a blood clot in the leg—but dismissed it as unlikely and ordered no further testing. The patient did have a

D.V.T., though, and when the clot dislodged, two days later, it travelled to his lungs and killed him. Lang's insurer settled the case for about four hundred thousand dollars.

"If I had been on the plaintiff's side, would I have taken that case against me?" he said to me. "Yes."

Being sued was "devastating," Lang recalled. "It's an awful feeling. No physician purposely harms his patient." Yet he insists that, even at the time, he was philosophical about the cases. "Being sued, although it sort of sucks the bottom out of you, you have to understand that it's also the cost of doing business. I mean, everybody at some time in his life is negligent, whether he's a physician, an auto mechanic, or an accountant. Negligence occurs, and that's why you have insurance. If you leave the oven on at home and your house catches fire, you're negligent. It doesn't mean you're a criminal." In his view, the public has a reasonable expectation: if a physician causes someone serious harm from substandard care or an outright mistake, he or she should be held accountable for the consequences.

The cases that Lang faced as a doctor, however, seemed to me to epitomize the malpractice debate. Two of the three lawsuits against him appeared unfounded, and, whatever Lang says now, the cost in money and confidence to our system is nothing to dismiss. Yet one of them concerned a genuine error that cost a man his life. In such cases, what do doctors believe should be done for patients and their families?

Bill Franklin is a physician I know who has practiced at Massachusetts General Hospital, in Boston, for more than forty years. He is an expert in the treatment of severe, life-threatening allergies. He is also a father. Years ago, his son Peter, who was then a second-year student at Boston University School of Medicine, called to say that he was feeling sick. He had sweats, and a cough, and felt exhausted. Bill had him come to his office and looked him over. He didn't find anything, so he had his son get a chest X-ray. Later that day, the radiologist called. "We've got big trouble," he told Bill. The X-rays showed an enormous tumor filling Peter's chest, compressing his lungs from the middle and pushing outward. It was among the



*"You just come home and neglect her at night.
I'm the one who has to neglect her all day."*

largest the radiologist had encountered.

After he had pulled himself together, Bill Franklin called Peter at home to give him and his young wife the frightening news. They had two children and a small house, with a kitchen that they were in the midst of renovating. Their lives came to a halt. Peter was admitted to the hospital and a biopsy showed that he had Hodgkin's lymphoma. He was put on high-dose radiation therapy, with a beam widened to encompass his chest and neck. Still, Peter was determined to return to school. He scheduled his radiation sessions around his coursework, even after they paralyzed his left diaphragm and damaged his left lung, leaving him unable to breathe normally.

The tumor proved too large and extensive for a radiation cure. Portions of it had continued to grow, and it had spread to two lymph nodes in Peter's lower abdomen. The doctors told his father that it was one of the worst cases they had ever seen. Peter was going to need several months of chemotherapy. It would make him sick and leave him infertile, but, they said, it should work.

Bill Franklin couldn't understand how the tumor had got so large under ev-

eryone's eyes. Thinking back on Peter's care over the years, he remembered that four years earlier Peter's wisdom teeth had been removed. The surgery had been performed under general anesthesia, with an overnight stay at M.G.H., and a chest X-ray would have been taken. Franklin had one of the radiologists pull the old X-ray and take a second look. The mass was there, the radiologist told him. What's more, the original radiologist who had reviewed Peter's chest X-ray had seen it. "Further evaluation of this is recommended," the four-year-old report said. But the Franklins had never been told. The oral surgeon and the surgical resident had both written in Peter's chart that the X-ray was normal.

If the tumor had been treated then, Peter would almost certainly have been cured with radiation alone, and with considerably less-toxic doses. Now it seemed unlikely that he'd finish medical school, if he survived at all. Bill Franklin was beside himself. How could this have happened—to one of M.G.H.'s own, no less? How would Peter's wife and children be supported?

Thousands of people in similar circumstances file malpractice lawsuits in order to get answers to such questions. That's not

what Bill Franklin wanted to do. The doctors involved in his son's case were colleagues and friends, and he was no fan of the malpractice system. He had himself been sued. He'd had a longtime patient with severe asthma whom he had put on steroids to ease her breathing during a bad spell. Her asthma had improved, but the high doses resulted in a prolonged dementia, and she had to be hospitalized. The lawsuit alleged that Franklin had been negligent in putting her on steroids, given the risks of the medication, and that he was therefore financially responsible for the aftermath. Franklin had been outraged. She'd had a life-threatening problem, and he'd given her the best care he could.

Now, as an M.G.H. staff member, he decided to see the hospital director. He asked for a small investigation into how the mistake had been made and how it might be prevented in the future; he also wanted to secure financial support for Peter's family. The director told him that he couldn't talk to him about the matter. He should get a lawyer, he said. Was there no other way, Franklin wanted to know. There wasn't.

Here's where we in medicine have failed. When something bad happens in the course of care and a patient and family want to know whether it was unavoidable or due to a terrible mistake, where are they to turn? Most people turn first to the doctors involved. But what if they aren't very responsive, or their explanations don't sound quite right? People often call an attorney just to get help in finding out what happened.

"Most people aren't sure what they're coming to me for," Vernon Glenn, the South Carolina trial attorney, told me. "The tipoff is often from nurses saying, 'This was just wrong. This should never have happened.'" The families ask him to have a look at the medical files. If the loss or injury is serious, he has an expert review the files. "More often than you would think, we'll say, 'Here's what happened. We don't think it's a case.' And they'll say, 'At least we know what happened now.'"

Malpractice attorneys are hardly the most impartial assessors of care, but medicine has offered no genuine alternative—because physicians are generally unwilling to take financial responsibility for the consequences of their mistakes. Indeed, the one argument that has per-

suaded many doctors to be more forthright about mistakes is that doing so might make patients less likely to sue.

What would most doctors do if someone close to them was hurt by a medical error? In a recent national survey, physicians and non-physicians were given the following case: A surgeon orders an antibiotic for a sixty-seven-year-old man undergoing surgery, failing to notice that the patient's chart says that he is allergic to the drug. The mistake is not caught until after the antibiotic is given, and, despite every effort, the patient dies as a result. What should be done? Unlike fifty per cent of the public, almost none of the physicians wanted the surgeon to lose his license. Medical care requires that a thousand critical steps go right every day, and none of us would have a license if we were punished every time we faltered. At the same time, fifty-five per cent of the physicians said that they would sue the surgeon for malpractice.

That's what Bill Franklin, with some trepidation, decided to do. Lawyer friends warned him that he might have to leave his position on staff if things didn't go well. He loved the hospital and his practice; Peter's oral surgeon was a friend. But his son had been harmed, and he felt that Peter and his young family were entitled to compensation for all that they had lost and suffered. Peter himself was against suing. He was afraid that a lawsuit might so antagonize his doctors that they would not treat him properly. But he was persuaded to go along with it.

At first, the Franklins were told that no lawyer would take the case. The error had been made four years earlier, and this put it beyond the state's three-year statute of limitations. As in most states at the time, one could not file a civil claim for an action long in the past—never mind that Peter didn't learn about the error until it was too late. Then they found a young Boston trial attorney named Michael Mone, who took the case all the way to the Massachusetts Supreme Court and, in 1980, won a change in the law. *Franklin v. Massachusetts General Hospital et al.* ruled that such time limits must start with the *discovery* of harm, and the precedent stands today. The change allowed the case to proceed.

The trial was held in 1983, in the town of Dedham, in the same courthouse where, six decades earlier, the anarchists

Sacco and Vanzetti had been convicted of murder. "I don't remember much about the trial—I've blocked it out," Bev Franklin, Peter's mother, says. "But I remember the room. And I remember Michael Mone saying those words we'd been waiting so long to hear: 'Ladies and gentlemen, this young man had a time bomb ticking in his chest. And for four years—*four years*—the doctors did nothing.'" The trial took four days. The jury found in favor of Peter, and awarded him six hundred thousand dollars.

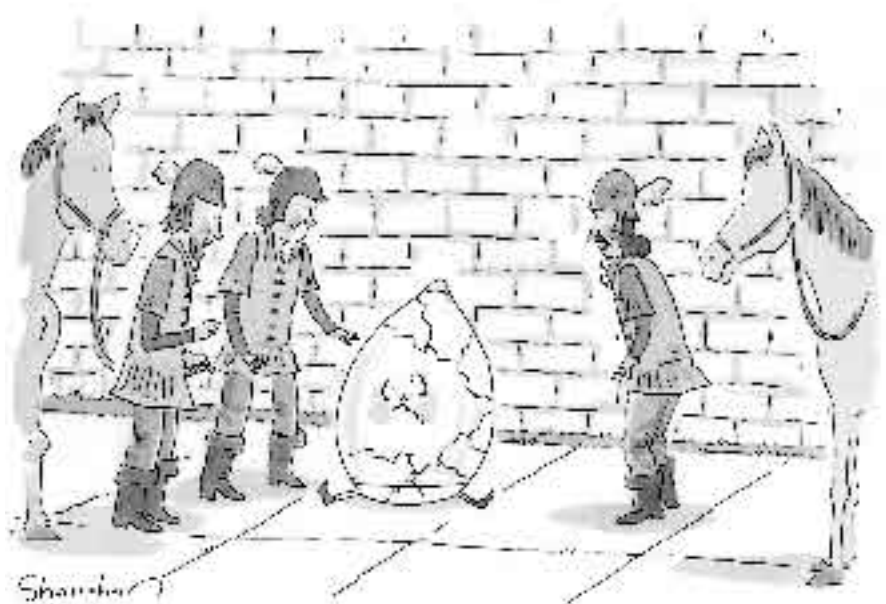
Bill Franklin says that he never experienced any negative repercussions at the hospital. His colleagues seemed to understand, and Peter's doctors did their very best for him. Peter continued to attend medical school. At the end of that long year, after six full cycles of chemotherapy, the lymph nodes in his chest continued to harbor residual cancer. He was given a new chemotherapy regimen, which so weakened his immune system that he almost died of a viral lung infection. He was in the hospital for weeks, and was finally forced to take a leave from school. The virus left him short of breath whenever he did anything more strenuous than climb half a flight of stairs, and with burning nerve pain in his feet. His marriage slowly disintegrated; a disaster can either draw people together or pull them apart, and this one pulled Peter and his wife apart.

Yet Peter survived. He eventually completed medical school, and decided to go into radiology. To everyone's surprise,

he was rejected by his top-choice residency programs. A dean at Boston University called the chairman of radiology at one of the programs to find out why. "This guy's a maverick! He's suing doctors!" was the reply. The dean told the chairman Peter's story and then asked, "If this was your son, what would you do?" Peter got in after that. He chose Boston University's program and, when he finished, he was asked to join the staff there. Soon, he was made a division chief. He remarried and is now a fifty-six-year-old expert on orthopedic imaging, with a brush mustache, a graying thatch of hair, and chronic lung and liver troubles from his chemotherapy. Four years ago, he started a teleradiology group that now interprets scans for a hundred and fifty centers across the country. He is also a specialist for professional sports teams, including the San Diego Chargers and the Chicago Bears.

He says that his ordeal has made him exceedingly careful in his work. He has set up a review committee to find and analyze errors. Nonetheless, the single biggest budget item for his group is malpractice insurance. As it happens, the most common kind of malpractice case in the country involves allegations that doctors have made the kind of error that Peter once faced—a missed or delayed diagnosis. I asked him how he felt about being responsible for a lawsuit that had made it easier to sue for such claims. He winced and paused to consider his answer.

"I think the malpractice system has run



"Thank goodness he was wearing a condom."

amok," he finally said. "I don't think that my little experience has anything to do with it—the system is just so rampant with problems. But, if you're damaged, you're damaged. If we screw up, I think we should eat it." Wasn't he contradicting himself? No, he said; the system was the contradiction. It helps few of the people who deserve compensation. His case was unusual, and even that involved a seven-year struggle before all the appeals and challenges were dismissed. At the same time, too many undeserving patients sue, imposing enormous expense and misery. The system, as he sees it, is fundamentally perverse.

The paradox at the heart of medical care is that it works so well, and yet never well enough. It routinely gives people years of health that they otherwise wouldn't have had. Death rates from heart disease have fallen by almost two-thirds since the nineteen-fifties. The survival rate among cancer patients is now almost seventy per cent. A century ago, ten in a hundred newborns and one in a hundred mothers died; today, just seven in a thousand newborns and fewer than one in ten thousand mothers do. But this has required drugs and machines and operations and, most of all, decisions that can as easily damage people as save them. It's precisely because of our enormous success that people are bound to wonder what went wrong when we fail.

As a surgeon, I will perform about four hundred operations in the next year—everything from emergency repair of strangulated groin hernias to removal of thyroid cancers. For about two per cent of patients—for eight, maybe ten, of them—things will not go well. They will develop life-threatening bleeding. Or I will damage a critical nerve. Or I will make a wrong diagnosis. Whatever Hippocrates may have said, sometimes we do harm. Studies of serious complications find that usually about half are unavoidable; and, in such cases, I might be able to find some small solace in knowing this. But in the other half I will simply have done something wrong, and my mistake may change someone's life forever. Society is still searching for an adequate way to under-

stand these instances. Are doctors villains if we make mistakes? No, because then we all are. But we are tainted by the harm we cause.

I watch a lot of baseball, and I often find myself thinking about the third baseman's job. In a season, a third baseman will have about as many chances to throw a man out as I will to operate on people. The very best (players like Mike Lowell, Hank Blalock, and Bill Mueller) do this perfectly almost every time. But two per cent of the time even they drop the ball or throw it over the first baseman's head. No one playing a full season fails to make stupid errors. When he does, the fans hoot and jeer. If the player's error costs the game, the hooting will turn to yelling. Imagine, though, that if every time Bill Mueller threw and missed it cost or damaged the life of someone you cared about. One error leaves an old man with a tracheostomy; another puts a young woman in a wheelchair; another leaves a child brain-damaged for the rest of her days. His teammates would still commiserate, but the rest of us? Some will want to rush the field howling for Mueller's blood. Others will see all the saves he's made and forgive him his failures. Nobody, though, would see him in quite the same way again. And nobody would be happy to have the game go on as if nothing had happened. We'd want him to show sorrow, to take responsibility. We'd want the people he injured to be



helped in a meaningful way.

This is our situation in medicine, and litigation has proved to be a singularly unsatisfactory solution. It is expensive, drawn-out, and painfully adversarial. It also helps very few people. Ninety-eight per cent of families that are hurt by medical errors don't sue. They are unable to find lawyers who think they would make good plaintiffs, or they are simply too daunted. Of those who do sue, most will lose. In the end, fewer than one in a hundred deserving families receive any money. The rest get nothing: no help, not even an apology.

There is an alternative approach, which was developed for people who have been injured by vaccines. Vaccines protect tens of millions of chil-

dren, but every year one in ten thousand or so is harmed by side effects. Between 1980 and 1986, personal-injury lawyers filed damage claims valued at more than \$3.5 billion against doctors and manufacturers. When they began to win, vaccine prices jumped and some manufacturers got out of the business. Vaccine stockpiles dwindled. Shortages appeared. So Congress stepped in. Vaccines now carry a seventy-five-cent surcharge (about fifteen per cent of total costs), which goes into a fund for children who are injured by them. The program does not waste effort trying to sort those who are injured through negligence from those who are injured through bad luck. An expert panel has enumerated the known injuries from vaccines, and, if you have one, the fund provides compensation for medical and other expenses. If you're not satisfied, you can sue in court. But few have. Since 1988, the program has paid out a total of \$1.5 billion to injured patients. Because these costs are predictable and evenly distributed, vaccine manufacturers have not only returned to the market but produced new vaccines, including ones against hepatitis and chicken pox. The program also makes the data on manufacturers public—whereas legal settlements in medical cases are virtually always sealed from view. The system has flaws, but it has helped far more people than the courts would have.

The central problem with any system remotely as fair and efficient as this one is that, applied more broadly, it would be overwhelmed with cases. Even if each doctor had just one injured and deserving patient a year (a highly optimistic assumption), complete compensation would exceed the cost of providing universal health coverage in America. To be practical, the system would have to have firm and perhaps arbitrary-seeming limits on eligibility as well as on compensation. New Zealand has settled for a system like this. It has offered compensation for medical injuries that are rare (occurring in less than one per cent of cases) and severe (resulting in death or prolonged disability). As with America's vaccine fund, there is now no attempt to sort the victims of error from the victims of bad luck. For those who qualify, the program pays for lost income, medical needs, and, if there's a

permanent disability, an additional lump sum for the suffering endured. Payouts are made within nine months of filing. There are no mammoth, random windfalls, as there are in our system, but the public sees the amounts as reasonable, and there's no clamor to send these cases back to the courts.

The one defense of our malpractice system is that it has civilized the passions that arise when a doctor has done a devastating wrong. It may not be a rational system, but it does give people with the most heartbreaking injuries a means to fight. Every once in a while, it extracts enough money from a doctor to provide not just compensation but the satisfaction of a resounding punishment, fair or not. And although it does nothing for most plaintiffs, people whose loved ones have suffered complications do not then riot in hospital hallways, as clans have done in some countries.

We are in the midst of a flurry of efforts to "reform" our malpractice system. More than half of the states have enacted limits on the amount of money that juries can award someone who has been injured by a doctor, and Congress is considering a federal cap of two hundred and fifty thousand dollars on non-economic damage awards. But none of this will make the system fairer or less frustrating for either doctors or patients. It simply puts an arbitrary limit on payments so that doctors' insurance premiums might, at least temporarily, be more affordable.

Whether a cap is enacted or not, I will pay at least half a million dollars in premiums in the next ten years. I would much rather see that money placed in an insurance fund for my patients who suffer complications from my care, even if the fund cannot be as generous as we'd like it to be. There's no real chance of this happening, though. Instead, we're forced to make do with what we have.

In Courtroom 7A of the Edward J. Sullivan Courthouse in Cambridge, after seven years of litigation; more than twenty thousand dollars in payments to medical experts; the procurement of bailiffs, court reporters, a judge, and two-hundred-and-fifty-dollar-an-hour defense attorneys; time on an overloaded court schedule; and the commandeered



lives of fourteen jurors for almost two weeks, Barry Lang stood behind a lectern to make his closing argument on behalf of the estate of Barbara Stanley. "Dr. Reed is not a criminal," he told the jury. "But he was negligent, and his negligence was a key factor in causing Barbara Stanley's death."

It was not an open-and-shut case. Even in Lang's account, Reed was faced with a difficult medical problem: pathologists who contradicted each other about whether the first biopsy showed skin cancer; a second biopsy that failed to settle the issue; a distrustful patient who was angry with him, first for doing too much and then for doing too little. But, for the first time during the trial, Lang stopped his constant pacing. He spoke slowly and plainly. The story he told seemed lucid and coherent. In that fateful telephone conversation, he argued, Reed failed to offer Stan-

ley the option of a more radical skin excision that might have saved her life.

Judge Kenneth Fishman then gave the jury its instructions. Stanley's son, Ernie Browe, sat in the front row of the gallery on one side, and Kenneth Reed sat a row back on the other. Both looked drained. When the judge finished, it was late in the afternoon, and everyone was dismissed for the day.

The next morning, the jury began its deliberations. Just before noon, the court officer announced that a verdict had been reached: Dr. Kenneth Reed was *not* negligent in his care of Barbara Stanley. Stanley's son slumped in his seat, looked down at the floor, and did not move for a long while. Barry Lang promptly stood up to put away his papers. "It was a tough case," he said. Reed was not there to hear the verdict. He had been seeing patients in his office all morning. ♦