Learning from Medical Litigation

Clara Forrest [a] (Orcid ID 0000-0002-0251-4967)
Deirdre Madden [b] (Orcid ID 0000-0001-9752-6110)
Martin J O'Sullivan [c] (Orcid ID 0000-0002-0899-6661)
Seamus O'Reilly [d, e] (Orcid ID 0000-0002-2887-7336)

[a] Academic Track Intern Programme, Intern Network Executive, School of Medicine, University College Cork, Ireland
[b] School of Law, University College Cork, Cork, Ireland
[c] Department of Surgery, Cork University Hospital, Ireland
[d] Department of Medical Oncology, Cork University Hospital, Ireland
[e] Cancer Research@UCC, University College Cork, Ireland

In the book 'We Need to Talk About Kevin' the author, Lionel Shriver, recounts the fictional tale of her son whose deteriorating behaviour ultimately results in tragedy, despite many unheeded warning signs (1). In clinical medicine, we face a similar issue of a deteriorating medico-legal climate with overlooked warning signs and potential tragic consequences for many. Like the protagonist in the novel, we also need to talk about the impact and opportunity cost of our current situation.

Medical negligence claims are increasing in both quantity and subsequent cost in all continents. In the United Kingdom (UK), $2.78bn was spent by the National Health Service (NHS) on negligence claims in 2021-2022, representing an 8.7% annual increase due to a 12.9% increase in claims and costs (2). In Ireland, the number of clinical claims increased by 46.7% and associated costs by 297% between 2010 and 2020 (3, 4). These worrying trends are being seen across Europe (5, 6). For instance, the costs of closed claims in the Netherlands has quadrupled between 2007 and 2021 (7), while in Poland, the average amount of compensation paid increased by 70% between 2014 and 2017 (8).

In contrast to the UK and many European countries, the United States (US) operates a public-private healthcare system and is governed by common law. In the US, the average amount paid per claim has been increasing year on year as has the percentage of payments over $1m (9). The National Practitioner Data Bank reported that $17.19bn had been paid for 36,050 medical malpractice claims between 2017 and 2021. These numbers notably include only payments made on behalf of a physician and exclude the increasing number of cases

settled on behalf of institutions, and the costs of unsuccessful claims (10). It has been estimated that the medical liability system in the US costs more than $55 billion a year (11).

Similar tends are being seen in China where medical malpractice claims in grade-A tertiary hospitals have increased since 2008, a trend which accelerated in 2014 and was mirrored by a continuously rising average payment per claim (12).

How are these trends impacting on cancer care? A number of specialities are often seen as classically ‘high-risk’ for malpractice claims, obstetrics and gynaecology, surgery and emergency medicine (13, 14). Relatively low medical malpractice insurance premiums for oncologists in the US reflects the belief that they are less likely to be sued than their counterparts in other specialties (15). However, on average 9% of oncology physicians in the US faced a malpractice claim annually, which was higher than the 7.4% average rate for physicians, and ranked third after gastroenterology and pulmonary medicine, both of which are procedure based (16). Despite oncology not being classed as a stereotypically ‘high-risk’ field of medicine, surgical oncology disciplines have high medicolegal exposures with 19.1% of neurosurgeons,18.9% of cardiothoracic surgeons and 15.3% general surgeons facing malpractice claims annually (16).

Breast cancer is the most common malignancy involved in malpractice claims in the US (17). Breast cancer claims have been found to arise most often from delay in diagnosis, most commonly involve radiologists followed by general surgeons and median award amounts varied from $978,858 to $1,800,000 (17-20). A 20 year review of US colorectal cancer cases highlighted that diagnostic error was the commonest cause for litigation. Primary care physicians were most commonly named followed by gastroenterologists and general surgeons (21). In dermatological, head and neck, oral, and oropharyngeal malignancies failure to diagnose was again the most commonly alleged reason for litigation (22, 23).

While under or delayed diagnosis is a significant medicolegal risk equally fear of litigation can lead to defensive medical practices. Surveys of pathologists have shown that concerns regarding malpractice increased their likelihood of diagnosing malignancy in equivocal lesions such as breast or pigmented skin lesions (24, 25). Defensive medicine is hypothesised to be a major cause of unnecessary diagnostic testing and subsequent overdiagnosis of thyroid cancer (26). A review of malpractice in pancreaticoduodenectomy cases found the most common cause of alleged negligence was unnecessary surgery and often also alleging misdiagnosis (27).

Malpractice litigation has a profound impact on the feasibility of cancer screening programmes. Wilson & Jungner's 1968 principles of screening remain the foundation of many global screening programmes. One of the ten principles states that 'the cost of case-finding (including a diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole' (28). Balancing this cost is difficult and the growing financial burden of malpractice claims threaten the viability of cancer screening programmes.

Mammography is one of the most common areas of medical litigation among adults and this is impacting breast cancer screening negatively due to its increasing costs and its deterrent impact on recruitment of radiologists. Survey-based studies have found that one in three radiologists are considering withdrawing from mammogram interpretation due to medical malpractice concerns (29-32). In Ireland, there have been over 360 claims filed against the National Cervical Cancer Screening Programme, CervicalCheck (33). Consequently, due to concerns that both erosion of public trust and litigation pose a threat to the viability of screening services globally, the International Agency for Research on Cancer, is conducting a review into Ireland's cancer screening programmes (34).

Aside from the financial consequences of medical litigation on cancer care, the adversarial nature of the legal process can have profound effects on both the plaintiff and medical practitioner. For the former, the process can cause upset, distress, pain, anger, disappointment and anxiety. One Irish lawyer commented that they had never seen "a plaintiff [celebrate] when they win… I don't think I've ever seen a plaintiff come out and say 'That was really worth it'" (35). For the medical professional, the emotional and psychological impact can progress from initial shock and worry to profound numbness, guilt and isolation (35).

In theory, examining the characteristics of malpractice claims can improve our understanding of the current medico-legal climate and provide a foundation from which further risk management and prevention strategies can be developed. However, in practice there are limited examples of studies' findings translating to tangible improvement of care, reduction of error and subsequent litigation. (36). Anaesthetics, arguably the leading speciality in patient safety improvement, has been the most successful. A prime example is the findings of the American Society of Anaesthetists Closed Claims Project which contributed significantly to the formulation of standards regarding endotracheal intubation, ulnar nerve injury, spinal cord injury and airway trauma (37).

In the UK in May 2021, 'Learning from Litigation Claims: The Getting It Right First Time (GIRFT) and NHS Resolution best practice guide for clinicians and managers' was released as part of the drive for better patient safety (38). As pointed out by John Machin, co-leader of GIRFT's litigation workstream, 'historically, claims learning has not had the attention it needs to maximise the potential improvements for patient care.' (39). Since then, the GIRFT litigation workstream has improved access to claims data and provided a structured, standardised way of analysing claims which in turn has allowed practical recommendations to be applied to clinical practice (40-42).

Central to the GIRFT litigation workstream is practicality, structure and standardisation. Furthermore, there is guidance on disseminating learnings at local and national levels to facilitate data-driven improvements patient safety and care (38). Only through facilitating system-wide improvements can harm be reduced, safer care provided and spending on clinical negligence minimised (43, 44). Cancer care could benefit from integration of a similar model of reflective practice.

An initial step would be the development of a best practice guide for clinicians and managers to aid learning from cancer claims. Areas it could address include how to best access comprehensive and reliable claims-related data which may present varying levels of bureaucratic challenge depending on the type of healthcare system, confidentiality agreements in claims, and indemnity structures. It could recommend how to assess the data in a standardised manner by relevant senior clinicians and with the assistance of experienced medical lawyers so actionable recommendations can be made. It might comment on how to establish a workforce team to implement and monitor the progress of these recommendations. Finally, it may suggest how best to disseminate and discuss findings and proposed changes such as integration with existing fora such as surgical morbidity and mortality meetings or department-wide journal clubs. Integration of such reflective learning should also be integrated into oncology conferences (44).

Cancer care involves a continuous cycle of learning from the inputs of clinical trials and evidence-based medicine. This cycle of information integration doesn't routinely include learnings from medical litigation but each claim represents a modifiable, teachable moment. Lest we fail to heed the warning signs to talk about the current challenges medicolegal poses for clinical practice, our actions will come too late much like with Kevin.

References:

1. Shriver L. We Need to Talk About Kevin. United States: Counterpoint Press; 2003.

2. NHS Resolution. Annual report and accounts 2021/2022. July 2022. https://resolution.nhs.uk/wp-content/uploads/2022/07/NHS-Resolution-Annual-report-and-accounts-2021_22_Access.pdf [Accessed October 30 2022].

3. National Treasury Management Agency. Annual Report & Financial Statements 2010. Dublin, Ireland; 2011.

4. National Treasury Management Agency. Annual Report & Financial Statements 2020. Dublin, Ireland; 2021.

5. di Luca A, Vetrugno G, Pascali VL, Oliva A, Ozonoff A. Perspectives on Patient Safety and Medical Malpractice: A Comparison of Medical and Legal Systems in Italy and the United States. J Patient Saf. 2019;15(4):e78-e81.

6. Toraldo DM, Vergari U, Toraldo M. Medical malpractice, defensive medicine and role of the "media" in Italy. Multidiscip Respir Med. 2015;10(1):12.

7. Klemann D, Mertens H, van Merode F. Trends and Developments in Medical Liability Claims in The Netherlands. Healthcare (Basel). 2022;10(10).

8. Leśniak T, Sierocka A, Kostrzewa D, Kozłowski R, Marczak M. Financial Expenses and "Losses" of the Polish Healthcare System Resulting from the Occurrence of Adverse Events. Int J Environ Res Public Health. 2022;19(13).

9. Schaffer AC, Jena AB, Seabury SA, Singh H, Chalasani V, Kachalia A. Rates and Characteristics of Paid Malpractice Claims Among US Physicians by Specialty, 1992-2014. JAMA Intern Med. 2017;177(5):710-8.

10. Singh H. National Practitioner Data Bank. https://www.npdb.hrsa.gov/analysistool [Accessed 30 October 2022].

11. Mello MM, Chandra A, Gawande AA, Studdert DM. National costs of the medical liability system. Health Aff (Millwood). 2010;29(9):1569-77.

12. Li H, Dong S, Liao Z, Yao Y, Yuan S, Cui Y, et al. Retrospective analysis of medical malpractice claims in tertiary hospitals of China: the view from patient safety. BMJ Open. 2020;10(9):e034681.

13. Studdert DM, Mello MM, Sage WM, DesRoches CM, Peugh J, Zapert K, et al. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. Jama. 2005;293(21):2609-17.

14. Carroll AE, Buddenbaum JL. High and low-risk specialties experience with the U.S. medical malpractice system. BMC Health Serv Res. 2013;13:465.

15. Legant P. Oncologists and medical malpractice. J Oncol Pract. 2006;2(4):164-9.

16. Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. N Engl J Med. 2011;365(7):629-36.

17. Chen G, Huo J, Ghosal V, Daniel S. Characteristics of medical malpractice claims related to cancer in Florida. . Journal of Clinical Oncology. 2020;38(29_suppl):202-.

18. Murphy BL, Ray-Zack MD, Reddy PN, Choudhry AJ, Zielinski MD, Habermann EB, et al. Breast Cancer Litigation in the 21st Century. Ann Surg Oncol. 2018;25(10):2939-47.

19. Lee MV, Konstantinoff K, Gegios A, Miles K, Appleton C, Hui D. Breast cancer malpractice litigation: A 10-year analysis and update in trends. Clin Imaging. 2020;60(1):26-32.

20. Regev GS, Ser AM. Breast cancer medical malpractice litigation in New York: The past 10 years. Breast. 2019;46:1-3.

21. Panuganti PL, Hartnett DA, Eltorai AEM, Eltorai MI, Daniels AH. Colorectal Cancer Litigation: 1988-2018. Am J Gastroenterol. 2020;115(9):1525-31.

22. Lydiatt DD. Medical malpractice and cancer of the skin. Am J Surg. 2004;187(6):688-94.

23. Epstein JB, Kish RV, Hallajian L, Sciubba J. Head and neck, oral, and oropharyngeal cancer: a review of medicolegal cases. Oral Surg Oral Med Oral Pathol Oral Radiol. 2015;119(2):177-86.

24. Carney PA, Frederick PD, Reisch LM, Knezevich S, Piepkorn MW, Barnhill RL, et al. How concerns and experiences with medical malpractice affect dermatopathologists' perceptions of their diagnostic practices when interpreting cutaneous melanocytic lesions. J Am Acad Dermatol. 2016;74(2):317-24; quiz 24.e1-8.

25. Reisch LM, Carney PA, Oster NV, Weaver DL, Nelson HD, Frederick PD, et al. Medical malpractice concerns and defensive medicine: a nationwide survey of breast pathologists. Am J Clin Pathol. 2015;144(6):916-22.

26. Warrick J, Lengerich E. Thyroid Cancer Overdiagnosis and Malpractice Climate. Arch Pathol Lab Med. 2019;143(4):414–5.

27. Anandalwar SP, Scholer AJ, Ninan G, Oliver JB, Christian D, Eloy JA, et al. Dissecting malpractice in pancreaticoduodenectomy cases. J Surg Res. 2017;212:48-53.

28. Wilson J, Jungner G. Principles and practices of screening for disease. Geneva, Switzerland: World Health Organization; 1968. Public Health Papers No. 34.

29. Mavroforou A, Mavrophoros D, Michalodimitrakis E. Screening mammography, public perceptions, and medical liability. Eur J Radiol. 2006;57(3):428-35.

30. Reynolds A. Mammography and litigation. Radiol Technol. 2012;83(5):467m-86m.

31. Berlin L. Breast Cancer, Mammography, and Malpractice Litigation: The Controversies Continue. American Journal of Roentgenology 2003;180:1229-37.

32. Elmore JG, Taplin SH, Barlow WE, Cutter GR, D'Orsi CJ, Hendrick RE, et al. Does litigation influence medical practice? The influence of community radiologists' medical malpractice perceptions and experience on screening mammography. Radiology. 2005;236(1):37-46.

33. Scally G. Scoping Inquiry into the CervicalCheck Screening Programme. September 2018. https://assets.gov.ie/9785/9134120f5b2c441c81eeed06808351c7.pdf [Accessed 09 Nov 2022].

34. Murray D. Big Read: Why the WHO is reviewing Ireland's cancer screening and what's at stakeJune 2022. https://www.businesspost.ie/post-plus/big-read-why-the-who-is-reviewing-irelands-cancer-screening-and-whats-at-stake/ [Accessed November 2 2022].

35. Tumelty M-E. Exploring the emotional burdens and impact of medical negligence litigation on the plaintiff and medical practitioner: insights from Ireland. Legal Studies. 2021;41(4): 633-56. .

36. Vincent C, Davy C, Esmail A, Neale G, Elstein M, Firth- Cozens J, et al. Learning from litigation: an analysis of claims for clinical negligence. Manchester Centre for Healthcare Management, University of Manchester, Devonshire House, University Precinct Centre, Oxford Road, Manchester, M13 9PL.; 2004.

37. Cheney FW. The American Society of Anesthesiologists Closed Claims Project: what have we learned, how has it affected practice, and how will it affect practice in the future? Anesthesiology. 1999;91(2):552-6.

38. National Health Service. Learning from Litigation Claims: The Getting It Right First Time (GIRFT) and NHS Resolution best practice guide for clinicians and manager. May 2021. https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/05/Best-practice-in-claims-learning-FINAL.pdf [Accessed 20 November 2021].

39. Doherty S. New guide helps NHS trusts improve patient safety by learning from clinical negligence claims. Manchester.Dac Beachcroft. May 2021. https://www.dacbeachcroft.com/en/gb/articles/2021/may/learning-from-litigation-claims/ [Accessed 20 November 2021].

40. O'Connell RL, Patani N, Machin JT, Briggs TWR, Irvine T, MacNeill FA. Litigation in breast surgery: unique insights from the English National Health Service experience. BJS Open. 2021;5(3).

41. Lane J, Bhome R, Somani B. Urological litigation trends in the UK National Health Service: an analysis of claims over 20 years. BJU Int. 2021;128(3):361-5.

42. Oglesby FC, Ray AG, Shurlock T, Mitra T, Cook TM. Litigation related to anaesthesia: analysis of claims against the NHS in England 2008-2018 and comparison against previous claim patterns. Anaesthesia. 2022;77(5):527-37.

43. Yau CWH, Leigh B, Liberati E, Punch D, Dixon-Woods M, Draycott T. Clinical negligence costs: taking action to safeguard NHS sustainability. Bmj. 2020;368:m552.

44. Clwyd A, Hart T. A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture – Final Report. Williams Lea. October 2013. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf [Accessed 18 July 2022].