

**SIXTEEN MYTHS OF MEDICINE AND
MEDICAL MALPRACTICE**

Norman G. Tabler, Jr.*

MYTH I: AMERICA HAS THE BEST HEALTH CARE IN THE WORLD	364
MYTH II: YOU GET WHAT YOU PAY FOR (IN HEALTH CARE)	366
MYTH III: THE BEST HEALTH CARE IS THE MOST EXPENSIVE HEALTH CARE	366
MYTH IV: MORE HOSPITAL CARE IS BETTER CARE	367
MYTH V: WE DON'T RATION HEALTH CARE	368
MYTH VI: THE TORT SYSTEM SHOULD WEED OUT BAD DOCTORS	370
MYTH VII: WHEN A CASE GOES TO TRIAL, THERE IS A WINNER (OTHER THAN THE ATTORNEYS).....	371
MYTH VIII: JURIES AWARD MORE MONEY THAN JUDGES	372
MYTH IX: A HOSPITAL-ACQUIRED INFECTION MUST BE THE HOSPITAL'S FAULT	373
MYTH X: UNEXPECTED READMISSION IS EVIDENCE OF POOR TREATMENT	374
MYTH XI: A LOW CAP ON DAMAGES REDUCES PLAINTIFF RECOVERIES.....	375
MYTH XII: THERE IS SUCH A THING AS A NEVER EVENT	376
MYTH XIII: AN INSURER SHOULD HAVE LOW ADMINISTRATIVE COSTS	378
MYTH XIV: THERE'S AN ANSWER TO, "SHOULD PHYSICIANS APOLOGIZE FOR MEDICAL ERRORS?"	379
MYTH XV: AN APOLOGY NECESSARILY INVOLVES ADMISSION OF LIABILITY	380
MYTH XVI: APOLOGIZING FOR MEDICAL ERRORS IS ALWAYS A MISTAKE.....	381
CONCLUSION.....	383

Good morning. I was delighted and flattered to receive Professor Terry's invitation to speak this morning. I was even more delighted when he told me the topic: myths of medicine and medical malpractice. I was delighted because this gives me a rare opportunity to vent in public—to complain about the misconceptions and erroneous beliefs that I have encountered on a daily basis in my forty plus years of representing clients in the health care industry.

With your indulgence, I want to start from a thirty-thousand-foot view of American health care in general and gradually narrow our focus to the tort system of addressing claims of professional liability. If time allows, I would like to devote a few minutes to a special interest of mine: the role of apologies in resolving professional liability issues.

MYTH I: AMERICA HAS THE BEST HEALTH CARE IN THE WORLD

Here is the first myth—one that survives despite mountains of evidence to the contrary. The myth is that the Americans have the best health care in the world. You hear and read this myth every day of the week, from the sophisticated and unsophisticated alike.

Here is the Speaker of the United States House of Representatives, John Boehner, on the July 1, 2012, edition of the CBS Sunday morning staple *Face the Nation*: “Governor Romney understands that Obamacare will bankrupt our country and ruin *the best health care delivery system in the world*.”¹

And on the Senate side of Congress, here's then-Senate Minority (now Majority) Leader Mitch McConnell's take on the matter: the United States has “the finest health care system in the world.”

When Speaker Boehner's office was asked for evidence to back up the claim, a spokesman observed that “there is no

*Counsel, Faegre Baker Daniels LLP; former Senior Vice President & General Counsel, Indiana University Health.

¹ Louis Jacobsen, *'Best Health Care Delivery System in the World'? John Boehner Thinks So*, POLITIFACT.COM (Jul. 5, 2012, 10:30 AM), <http://www.politifact.com/truth-o-meter/article/2012/jul/05/best-health-care-delivery-system-world-john-boehne/> [<https://perma.cc/EC66-HRZX>] (Italics added).

generally accepted measure for quality of care,” but said that there are several measures by which the United States fares well. For example, in 2004 The Commonwealth Fund rated the United States the best in four out of five preventive-care categories when compared to four other advanced industrialized countries. And, he went on, the United States has strong survival rates for patients with cancer.²

Finally, the Speaker’s spokesman invoked the old saw: wealthy foreigners flock to the United States for their care. To me, that’s like saying we know the Dominican Republic has the best housing in the world because rich people have winter homes there.

But let’s pause to analyze this evidence offered on behalf of the Speaker. We’ll start with the statement that “there’s no generally accepted measure for quality of care.” There are two glaring problems with that statement. First, it was the Speaker who claimed that there *is* a generally accepted measure: he said that the United States ranks number one by that measure.

Second, with the apparent exception of the Speaker, everyone knows that generally accepted measures of quality do, in fact, exist. And, again with the apparent exception of the Speaker, everyone knows what some of the measures are and where to find them. I suggest that the Speaker google this phrase: “Medicare AND quality measures.” He’ll find a lifetime of reading material, all of it focused on generally accepted quality measures.

And notice the hasty retreat by the spokesman from the Speaker’s sweeping claim to *overall* superiority to the infinitely narrower and more modest claim of best in four out of five preventive-care categories when compared to four other countries and “strong survival rates” for patients with cancer. Those are admirable rankings, if accurate, but they are nowhere near to proving the unqualified overall superiority the Speaker claimed.

The spokesman cited a 2004 survey by The Commonwealth Fund. However, the Speaker might be interested in a study released by the same organization just last summer. The headline of the press release accompanying sums up the findings nicely: “U.S. Health

² See *id.*

System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives.”³ Not best: *worst*. Not first: *last*.

MYTH II: YOU GET WHAT YOU PAY FOR (IN HEALTH CARE)

The Commonwealth Fund study provides a great segue to the next myth: that you get what you pay for in health care. That study, while ranking the United States eleventh out of eleven in quality, also ranked us as the most expensive of the eleven countries. And the contest was by no means close. The average annual cost in the United States was over *twice* the cost in the United Kingdom, which, incidentally, ranked first in quality: \$8,500 in the United States versus \$3,400 in the United Kingdom.

The study puts the lie to the you-get-what-you-pay-for myth in two different ways. The more obvious of the two is that the worst health care has the highest cost, and the best health care has the lowest cost. The second of the two ways deserves its own section. Here it is.

MYTH III: THE BEST HEALTH CARE IS THE MOST EXPENSIVE HEALTH CARE

To the surprise of no one, with the possible exceptions of Speaker Boehner and Senator McConnell, the 2014 study by The Commonwealth Fund revealed that the factor that most significantly dragged the United States down in the rankings was a wide-spread lack of access to primary care, especially access by the poor.

Primary care—almost by definition—is the least expensive care. It is much less expensive than specialty care and, of course, vastly less expensive than hospital care. But the unavailability of that inexpensive primary care has the inevitable result of increasing the need for, and consumption

³ Press Release, The Commonwealth Fund, U.S. Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives, (Jun. 16, 2014), *available at* <http://www.commonwealthfund.org/publications/pressreleases/2014/jun/us-health-system-ranks-last> [<https://perma.cc/ZXF5-33CV>].

of, more expensive specialty and hospital care. So the best quality care is the least expensive care. It is primary care.

If you ask experts in the relevant fields—say, population management and disease prevention and control—to name the best investments for improving health, they do not cite multi-million dollar robotic equipment or subspecialist physicians in exotic fields. They cite investments that are very—even shockingly—inexpensive. They suggest sending social workers and dental hygienists into the inner city. They suggest sending drivers to assure that people have transportation to their doctors' offices and clinics.

So the best care is not the most expensive. The best care is, relatively speaking, dirt cheap. The myth is not just wrong. It is the precise opposite of the truth. What is more, the myth is harmful because it is so misleading.

MYTH IV: MORE HOSPITAL CARE IS BETTER CARE

Somehow this myth survives—the myth that more hospital care is better care. Think how often you read about a celebrity who has checked into a hospital because he “needs the rest.” Rest? In a hospital? With all the busy nurses and aides working around the clock? With the sounds of carts wheeling through the halls twenty-four hours a day? Not to mention the comings and goings of people who are really sick—the ones who are in the hospital because they are sick rather than because they want to rest.

If the celebrity wants rest, he would be better off in a Ritz-Carlton Hotel. It would be a lot quieter—a lot more restful. And it would cost only a fraction of a hospital stay.

And the Ritz-Carlton would be *safer* than a hospital. Those of us in the industry or who serve the industry don't like to acknowledge it in public, but a hospital is not a particularly safe place to be. Why? Because it is full of sick people. And the acuity—the degree of sickness—increases every year. There is a reason we have a term called “hospital-acquired infections” but not a term called “hotel-acquired infections.” It is because people regularly get sick, or sicker, from exposure to infections present in hospitals. That does not happen in hotels to any significant degree.

Federal law and some state laws do not seem to take this factor into consideration when they impose mandatory

minimums on length-of-stay benefits in health insurance plans. The best known of such laws is the Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act),⁴ enacted as an amendment to the Employee Retirement Income Security Act of 1974 (ERISA),⁵ which generally mandates coverage of a minimum of forty-eight and ninety-six hours, respectively, for vaginal and cesarean births, and prohibits incentives that would encourage earlier discharges.

There is no doubt that the intentions behind the Newborns' Act were entirely benign. (Besides, given the name of the act, who would dare oppose it?) But if the mother and child do not *need* forty-eight or ninety-six hours, is it always a great idea to keep them in the hospital? Might it not be better, cheaper, and safer to allow them to spend the last night in the Ritz-Carlton? Or, more realistically, how about providing a home care nurse for a day or two?

MYTH V: WE DON'T RATION HEALTH CARE

This is the most fascinating of all the myths: that in America we do not *ration* health care. It is as though, at birth, every American swears an oath to deny that we ration health care and to agree that rationing health care would be a mortal sin.

So, whenever anyone opposes a health care program, he condemns it as a plan to *ration* health care. It happened with the Affordable Care Act, and it happened with various state Medicaid programs, most notable Governor John Kitzhaber's Oregon Health Plan.⁶

But what is even more fascinating is the response of program proponents to the accusation. They do not say, "Of course, it's rationing health care. There's a limit on how

⁴ Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. aw104-204 (1996).

⁵ Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406 (1974).

⁶ For a discussion, see Jonathan Oberlander, *Health Reform Interrupted: The Unraveling of the Oregon Health Plan*, HEALTH AFF., (Dec. 2006), available at <http://content.healthaffairs.org/content/26/1/w96.full?sid=5e5f6332-5a32-41a8-adbb-d376bde2b65d> [https://perma.cc/H9XK-AY6P].

much we'll spend on health care. So we ration it. And we try to do it rationally."

Instead, they tacitly agree with the premise that rationing health care would be unthinkable. So they defend the program by denying that it involves rationing health care.

America has always rationed health care. Before the inception of Medicare in the mid-sixties, we rationed it primarily through the free market system. Providers decided where to locate and not locate and how much to charge. Members of the public who had geographic access and financial capability got health care; those without access and capability went without. That's how we rationed it.

Of course, even before Medicare, there were various governmental assistance programs for the needy. They *rationed* health care in an even more explicit way than through the free market system. They set budgets and eligibility requirements. Then they rationed available health care, within the limits imposed by those budgets and eligibility requirements. Medicaid now plays that role, and in a big way. Medicaid is the largest health insurance program in the United States.

But let's stick with health care as it applies to those who don't qualify for Medicaid or other programs for the needy. For those tens of millions, Medicare is without a doubt *the* primary force in American health care. Interestingly, though, Medicare exerts all its power *indirectly*.

How? By setting reimbursement rates and policies that then determine how health care providers (most of them private) deliver (or don't deliver) care. If Medicare rates are high in certain specialties and low in others, the result is an overall increase in the availability of the former specialty care and decrease in the latter. The chronic shortage in primary care is a conspicuous example.

Remember The Commonwealth Fund study finding that Americans have less access to health care than any other industrialized nation?⁷ It showed that about 40% of

⁷ Press Release, The Commonwealth Fund, U.S. Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives (June 16, 2014), *available at* <http://www.commonwealthfund.org/publications/press->

respondents with below-average income reported that during the previous twelve month they had foregone health care due to cost.⁸ Try telling them that we do not ration health care.

Let's be clear, though: this may (and probably does) mean that we do a poor job of rationing. But it doesn't mean that rationing is in itself bad.

MYTH VI: THE TORT SYSTEM SHOULD WEED OUT BAD DOCTORS

Now let's narrow our focus to the tort claim system for resolving professional negligence disputes in the medical area. In this context, we often hear the complaint that the tort system is ineffective in weeding out incompetent physicians. And Professor Hyman has very persuasively demonstrated that the system is, indeed, ineffective in doing that.⁹ The tort system does *not* weed out bad doctors.

But I'd like to go one step deeper in the analysis and ask, "Why *should* the tort system weed out bad doctors. Why should we have that expectation?"

I can think of three different ways to address the question, and by all three of them, the answer is the same: we should *not* rely on the tort system for that purpose. The first of the three comes from Professor Hyman's study: such reliance is misplaced because the system is unreliable for that purpose.

The second way is by analogy to other industries and other walks of life. Imagine that you ask the Federal Aviation Authority how it weeds out bad pilots. The FAA responds that if there is a crash and someone sues and proves the cause was pilot negligence, the pilot gets fired. How would you feel about that as a method for weeding out bad pilots?

Or say you ask a local hospital executive about medical staff credentialing, and he says, "Oh, we rely on malpractice

releases/2014/jun/us-health-system-ranks-last [https://perma.cc/GP4Y-H47J].

⁸ *Id.*

⁹ See David A. Hyman & Charles Silver, *Five Myths of Medical Malpractice*, 143 CHEST J. 222 (Jan. 2013), available at http://www.americanbar.org/content/dam/aba/administrative/medical_liability/five_myths_of_medical_malpractice.authcheckdam.pdf [https://perma.cc/FRS4-4RVL].

case outcomes to weed out the bad doctors.” I assume you would not be checking into that hospital any time soon.

Or think about your own experience and observations when it comes to driving. We have a tort system for resolving negligence issues arising out of driving automobiles and trucks. Does it weed out bad drivers?

The third way is by taking a hard look at the reality of the tort system as it applies to medical negligence. The myth appears to envision something like this: doctor commits malpractice, gets sued, loses, makes malpractice insurer pay, becomes uninsurable, and has to leave practice—all in short order.

Contrast that with reality. If there is any hope for a financial recovery by the patient, *all* of the following factors must be present: negligence is provable; damage to the patient is provable; the patient has the knowledge and the will to pursue the matter; the patient has a lawyer willing and able to pursue the case; the doctor has insurance; the patient and lawyer have the patience *and the financial resources* to pursue the matter for what may well be many years; a judge or jury finds negligence and awards damages; and the doctor becomes uninsurable and therefore retires from practice.

How likely is all of that?

MYTH VII: WHEN A CASE GOES TO TRIAL, THERE IS A WINNER (OTHER THAN THE ATTORNEYS)

That parenthetical is not meant to demean the role of attorneys in professional negligence cases. I put it in because I want to focus on the plaintiffs and defendants.

We typically talk as though there is a winner and a loser in a negligence trial. Even we lawyers use those terms. But I contend that, in practical terms, there generally *are not* any true winners.

Let's start with a plaintiff's Platonic ideal. Assume that a patient is damaged by a doctor's professional negligence, that \$1 million is an accurate measure of the damage, that the judge or jury finds liability and awards precisely that amount, that the doctor has insurance or resources to cover the award, and that the plaintiff is promptly paid in full.

The next morning's newspaper would report that the patient had "won" the case and was \$1 million richer. But is that really the case? Let's look a little deeper. We know that his damage was \$1 million, and so was the award. Chances are overwhelming that the patient owes his lawyer anywhere from \$300,000 to \$400,000, plus expenses in the five figures. And the process has likely taken years—maybe as many as ten.

So in this best (for the plaintiff) case scenario, the plaintiff has debits of at least \$300,000 in legal fees, say \$25,000 in costs, and say \$60,000 in loss of use of the money (at 6% a year). In other words, in the best case scenario, the so-called winner receives \$615,000 in return for a \$1 million loss. He can't afford many more such "wins."

Now let's look at the best case scenario for a doctor. He wasn't negligent and a judge or jury says so after years of effort, distraction, embarrassment, and anxiety. What does he get at the end of the ordeal other than an end to it?

It is true, I will acknowledge, that if a patient takes home more of a damage award than the combined value of his actual damage and the cost of pursuing the matter, he is in a sense a "winner." Conversely, the doctor who is vindicated, regardless of his negligence actually harming a patient, may have won something. Although the tort process is in itself a heavy price for a defendant.

But the reality is that these extremes rarely occur. The hurdles for plaintiffs are simply too numerous and too high to allow very many instances when they truly come out ahead of the game.

And the doctor whose malpractice seriously harms a patient? If the patient pursues a civil action, chances are small that the doctor will survive the ordeal without *some* finding of liability. If the doctor avoids liability, it's probably because the patient didn't—or couldn't—pursue the matter. If the patient sticks with it, the doctor will in all likelihood be held to *some* degree of liability.

MYTH VIII: JURIES AWARD MORE MONEY THAN JUDGES

I have to start discussion of this myth with the acknowledgment that I have no experience and little

information about medical malpractice awards outside the state of Indiana. All I have to say is based on Indiana.

Let's start by stating the myth. The myth persists that juries generally award more than judges—that juries become enflamed by emotion and outrage and award enormous, jaw-dropping sums. Remember the climactic scene in *The Verdict*, starring Paul Newman? So enflamed was the jury by the perfidy of the defendant hospital (represented by a sneering James Mason) that they asked the judge, “Are we allowed to award more than the plaintiff asked for?”

That happens in Hollywood. It doesn't happen in Indiana. In Indiana juries tend to be very conservative—even stingy—in calculating awards. And that's when they find the malpractice defendant liable. I know of cases where the jury found the doctor or hospital liable and then awarded damages equal to the patient's medical bill—not a penny more.

In cases like that no judge would have awarded less than the jury. That's why in certain kinds of medical malpractice cases, experienced plaintiffs' lawyers prefer that a judge rather than a jury calculate the damages.

MYTH IX: A HOSPITAL-ACQUIRED INFECTION MUST BE THE HOSPITAL'S FAULT

As we've discussed, the term “hospital-acquired infection” is well accepted and well-known. But the term isn't always well *understood*.

The definition of the term is self-evident. A hospital-acquired infection is an infection that the patient acquired in the hospital. It is distinguished from a community-acquired infection, which is acquired somewhere outside the hospital. Hospitals are required to track and report their hospital-acquired infection rates. The rates are published and hospitals are punished financially for high rates.

But are hospital-acquired infections always the hospital's fault? Not necessarily. First, let us look at the distinction between hospital- and community-acquired infections. Most Indiana counties have only one hospital, and that hospital may be among the largest employers in the county. It is not unusual for a hospital cafeteria to be a popular community gathering place at mealtime, especially lunch. When the

cafeteria is full of local residents at lunchtime, is there a clear difference between the hospital and the community? I am not sure there is.

Now let us turn to fault. And let us exclude the lunchtime crowd from the calculus. A typical patient has visitors, generally relatives and sometimes others. In pediatric area, it is almost a given that family members will visit a patient, frequently staying around the clock. And especially with the youngest children, the family has a significant role in caring for the child, providing comfort and assisting with eating and toilet needs.

If a patient acquires an infection from contact with a family member or other visitor, is it always the hospital's fault? Doesn't the family member or other visitor share at least some part of the responsibility?

MYTH X: UNEXPECTED READMISSION IS EVIDENCE OF POOR TREATMENT

This myth not only persists, but gains momentum every day: the myth that the unexpected readmission of a patient to the hospital is proof that the care during his earlier stay must have been inadequate. So in recent years insurance programs, led by Medicare, have begun to refuse to pay for the readmission stay. The theory is that the readmission would have been unnecessary if the treatment had been adequate first time around.

A hospital suffers from readmissions in two different ways. First, as noted above, it may not get paid for the second stay. Second, its readmission rate is published online, and it suffers from the adverse publicity.

But let's examine the myth. It is based on the premise that no factor other than poor hospital treatment could possibly contribute to the need for readmission. That premise defies common sense and general experience. What if the patient did not take the medicine prescribed by the doctor? What if he could not afford it? What if he could not get to the pharmacy? What if he did not keep his incision wound clean? What if he ate or drank things his doctor warned him against? In short, are there not countless factors outside the hospital's control that might have contributed to the need for readmission?

You have probably noted that many of these factors outside the hospital's control are related to a patient's financial resources—or, more precisely, a patient's *lack* of financial resources. So you will not be surprised to learn that studies of the issue invariably reveal that the unexpected readmission rates for hospitals in low-income areas is higher than the rates in high-income areas.¹⁰

You might say that in certain areas and with certain population groups, unexpected readmissions are not unexpected.

Yet the myth persists that an unexpected readmission is proof of poor hospital care. It is a little like saying that an undernourished child is proof of a poor school cafeteria.

MYTH XI: A LOW CAP ON DAMAGES REDUCES PLAINTIFF RECOVERIES

When we talk about tort reform, we generally make the uncritical assumption that a cap on damages—that is, a legal limitation on the amount—will necessarily result in lower recoveries by plaintiffs. And, of course, it is undeniably true that a cap will result in lower recoveries in *some* cases. What is a myth, though, is the belief that a cap will result in lower recoveries in *all* cases. In fact, as we shall see, there is evidence that a cap will actually result in *higher* recoveries in some cases—and higher *average* recoveries overall.

Let's take a look at Indiana's cap. Indiana has long had the lowest cap of all states. That's what happens when a state elects a physician as its governor, as Indiana did in 1972 with the election of Dr. Otis Bowen, later United States Secretary of Health & Human Services.

Indiana's cap currently limits a health care provider's liability for an incident of medical malpractice to \$250,000; and it limits a plaintiff's recovery to \$1,250,000.¹¹ You are wondering, "If the doctor's liability is limited to \$250,000, how can the plaintiff receive \$1,250,000?" The explanation

¹⁰ See, e.g., Joel S. Weissman et al., *The Impact of Patient Socioeconomic Status & Other Social Factors on Readmission: A Prospective Study in Four Massachusetts Hospitals*, 31 JSTOR 163, 169 (1994).

¹¹ Ind. Code § 34-18-14-3 (2016).

lies in the Indiana Patient Compensation Fund (“the Fund”): a state-run insurance program that can pay the difference between the defendant’s obligation and the \$1,250,000 limit.

In 1991 Professors Eleanor Kinney and William Gronfein published the results of an exhaustive study of the first ten years of experience under the Indiana cap on malpractice liability. The results were eye-opening. Indiana plaintiff recoveries in large-claims cases (defined back then as \$100,000 or more) actually *exceeded* large-claim recoveries in neighboring Ohio and Michigan—larger states with no caps.¹²

What is the explanation? How can a damage cap cause recoveries to go *up*? The answer appears to be that in large-claim cases the limit on a provider’s liability (currently \$250,000, but only \$75,000 at the time of the Kinney-Gronfein study) encourages an insurer to effectively concede liability for an amount up to, or exceeding the limit on, the insured’s liability, leaving the excess for the Fund to pay and saving the insurer from further costs of defense.

So, paradoxically, a cap can—and does—often *increase* plaintiff recoveries.

MYTH XII: THERE IS SUCH A THING AS A NEVER EVENT

Most of the myths we are discussing are old. They have been around as long as anyone can remember. This is a new one. It sprang up almost overnight, and it spread like wildfire. In fact, it is still spreading, with more and more events classified as “never events.”

The term was introduced in 2001 by Ken Kizer, M.D., former chief executive officer of the National Quality Forum.¹³ The term was meant for truly shocking events—*e.g.*, surgery on the wrong patient—that should never occur. Over time, the list of events has expanded. Medicare now lists 29 “never events” and often declines to pay for care that

¹² Eleanor D. Kinney & William P. Gronfein, *Indiana’s Malpractice System: No-Fault by Accident?*, 54 LAW & CONTEMP. PROBS. 169, 182 (1991).

¹³ See, *e.g.*, *Never Events*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY (Dec. 2014), <http://psnet.ahrq.gov/primer.aspx?primerID=3> [<https://perma.cc/E72T-ARAH>].

involves such events.¹⁴ Other insurance carriers have joined in, also declining to pay for never events. Many states have adopted requirements that hospitals report events of the sort that appear on never event lists.

There is no doubt that every event on the list is unfortunate and regrettable. None of them *should* occur, and hospitals should do their utmost to prevent them. But I maintain that it is wrong to claim that all of them are always avoidable or that a good hospital—even an excellent hospital—can always avoid all of them.

Let us consider a few examples: physical assault of a patient or staff member in the hospital or on the hospital grounds, serious injury of a patient from a fall, certain pressure ulcers acquired in the hospital, and serious injury from a medication error.

All of these are regrettable. But can a good hospital *always* avoid them? Let us start with physical assault. If a hospital is open to the public for 24 hours a day, how can it assure that no patient or staff member will ever be physically assaulted in the hospital or on the hospital grounds? If it can, why have all institutions in all industries not taken the same steps?

Or patient falls. People fall down. Old, sick, and medicated people are particularly susceptible to falls. Hospitals are forbidden to apply physical restraints to patients. How, then, can *all* falls be prevented?

Or pressure ulcers bed sores in common parlance. Some studies show that when a mature adult lies motionless for two hours or more skin breakdown starts to occur.¹⁵ So what happens when a seventy-year-old lies motionless on an operating table for four or more hours? You guessed it.

Take a look at the Mayo Clinic's published list of factors contributing to bed sores. It describes a large proportion of Medicaid and Medicare patients who find themselves in the

¹⁴ *Id.*

¹⁵ See *Factsheet: Skin Breakdown and Pressure Ulcer Prevention in Persons with SCI*, REHABILITATION RESEARCH AND TRAINING CENTER ON SECONDARY CONDITIONS IN THE REHABILITATION OF INDIVIDUALS WITH SPINAL CORD INJURY (2012), <http://sci-health.org/RRTC/publications/PDF/Skincare-Factsheet.pdf> [<https://perma.cc/ZEP6-FKDV>].

hospital: old age, weight loss, poor nutrition, incontinence, smoking, and dry skin.¹⁶

Let's complete our review with medication errors. Two primary factors assure that even excellent hospitals will experience medication errors. One is the emergency, not-a-moment-to-spare, nature of some hospital work. That kind of situation is most likely to occur in the emergency department. It also occurs, however, in inpatient areas when emergencies arise. Sometimes hospital personnel need to act first and carefully consider the matter later. That may be unfortunate, but it is reality in a hospital.

The other factor contributing to medication errors is the *sheer number* of times medications are administered. It may simply be impossible for humans to do anything a million times without an error. Does a million sound like too high a number? Just consider a hospital with 200 beds. Assume each of the 200 patients needs medications five times a day. That's $200 \times 365 \times 5$, or 365,000 doses a year.

But that is not the total number. Each medication has been prescribed by a doctor, prepared or sent by the pharmacy, delivered from the pharmacy area to the nurses' station, and administered by a nurse. That is four separate steps with each involving four or more separate people. If it is four, then we can multiply our initial 365,000 by that number, for a total of nearly 1,500,000. It is hard for human beings to do anything 1,500,000 times a year without a single error. Even with 99.9% accuracy, there would still be 1,500 errors.

So these events cannot really be *never* events. They are unfortunate and hospitals should do all they can to avoid them. But they will continue to occur.

MYTH XIII: AN INSURER SHOULD HAVE LOW ADMINISTRATIVE COSTS

I apologize in advance for this one. It's inside baseball. If you look at a performance report on a liability insurance carrier, one of the factors you always see is a comparison of

¹⁶ See *Bedsore (pressure sores)*, MAYO CLINIC (DEC. 13, 2014), <http://www.mayoclinic.org/diseases-conditions/bedsores/basics/risk-factors/con-20030848> [<https://perma.cc/3KRP-UHLF>].

the amount it pays to resolve liability claims—judgment and settlement payments—to all other expenses, *i.e.*, administrative costs. And the prevailing wisdom is that a high proportion of administrative costs is a bad thing—an indicator of inefficiency.

At first glance, this conventional wisdom sounds right. Let's take a closer look. What if a health system operates its own captive insurance program, spends a high amount on risk management and risk reduction strategies, and as a result pays only a very modest amount in claims settlements? The arithmetic would show a high proportion of administrative costs. But would that be a bad thing? I don't think so.

MYTH XIV: THERE'S AN ANSWER TO, "SHOULD PHYSICIANS APOLOGIZE FOR MEDICAL ERRORS?"

I have spoken and published articles on the subject of the role of physician apologies in resolving cases professional negligence. Often, in discussions of the subject, people ask me the question posed on the screen: "Should physicians apologize for medical errors?" To me, that's a little like asking, "Should parents send a child to a private school?" The only accurate answer is, "It depends."

Let's first discuss why there is not one answer to the question. Later I'll give you my own general view on a matter that is hard to generalize about. Why is there not a one, one-size-fits-all answer? First, consider the most basic variables in any one case. Was there an error? That is harder to answer than you might think. It's common for experts to disagree on that fundamental matter when, say, a case is reviewed by a medical review panel. That is, of course, why in Indiana we use a panel rather than a single expert.

Next, does the error really reflect fault? Or did the error occur despite the provider's adherence to the standard of care appropriate to the circumstances?

Next, was there damage to the patient? It is a fact—fortunately—that most errors in a hospital do not cause any significant harm or any harm at all. Most are never even detected. In my earlier hypothetical about the 200-bed hospital, we found 1,500,000 separate actors annually in

medication administration alone: opportunity for more than a few errors. Most of those errors are never discovered.

Finally, if there *was* damage, what was the extent of it? Did the damage leave the patient disabled for life? Dead? Or was it a bedsore that healed in two weeks?

Now, one more difficult and sensitive question: assuming we can answer all the previous questions the way the plaintiff wants them answered, who was responsible? Was it really the defendant? Remember that in the context of hospital care, medicine is a *team* sport. If, for example, the incident occurred in surgery, team members might have included one or more surgeons, two or more nurses, an anesthesiologist, maybe one or more residents or fellows, one or more technicians, and that always-present team member, the facility itself.

So whose fault was it? Or, in terms of the question on the screen, who should do the apologizing? Do we really want the surgeon to say to the plaintiff, “I want to apologize for the incompetence of the circulating nurse?”

MYTH XV: AN APOLOGY NECESSARILY INVOLVES ADMISSION OF LIABILITY

According to conventional wisdom, a physician can’t apologize for a medical error without admitting responsibility for it. Therefore, a physician shouldn’t apologize for an error because doing so would make him liable for the damage to the patient.

But, as a linguistic matter, an apology *can* be separated from an acceptance of responsibility. And interestingly, some states have adopted rules of evidence that turn on that separation.

Since 2006 our own state, Indiana, has distinguished between a “communication of sympathy” and a “statement of fault.” The former is inadmissible in evidence. The latter is not.¹⁷ Assume, for example, that a surgeon said to a plaintiff, “I am very sorry your husband died on the operating table; I was at fault.” The first independent clause would not be admissible in evidence, but the second one would be admissible.

¹⁷ Ind. Code § 34-43.5-2-4 (2016).

In contrast to Indiana, Colorado would make the surgeon's entire statement inadmissible.

The Colorado statute says that in a civil action arising out of an "unanticipated outcome of medical care," all of the following are inadmissible: all statements made by a health care provider "expressing apology, fault, sympathy, commiseration, compassion, or a general sense of benevolence."¹⁸

So in terms of the words on the screen, both states make a distinction between an apology—or at least, an expression of sympathy—and an admission of liability. Indiana makes one inadmissible and the other admissible. Colorado distinguishes between the two but makes both inadmissible.

MYTH XVI: APOLOGIZING FOR MEDICAL ERRORS IS ALWAYS A MISTAKE

You have probably guessed from my last couple of points how I feel about the issue on the screen. Let me start with my conclusion and then explain how I got there. My conclusion is that there's no single, one-size-fits-all answer; but sometimes—even often—an apology can actually be a *good* idea for the physician or the hospital.

There is by no means a wealth of evidence on the effects of disclosure and apology for medical errors. But the evidence that exists points to the conclusion that physician apologies decrease both the incidence of lawsuits and size of awards to patients. In 1987, the Veterans Administration (VA) Hospital of Lexington, Kentucky, instituted one of the earliest formal disclosure policies. A study over a seven-year period (1990—96) revealed that, compared to the other 35 VA hospitals in the eastern United States, the Lexington VA hospital was in the top quartile in the number of claims filed but the bottom quartile in the amount of payments.¹⁹

In 2002 the University of Michigan Health System launched a program that, among other things, called for

¹⁸ Col. Rev. Stat. § 13-25-135 (2016).

¹⁹ Steve S. Kramer & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANN. INTERN. MED. 963, 963 (1999); See also Albert W. Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?* 131 ANN. INTERN. MED. 960 (1999).

prompt acknowledgement of errors and prompt compensation to patients. From August 2001 through August 2005, the average number of open cases declined from 260 to 114. Annual litigation costs dropped from approximately three million dollars to one million dollars.²⁰

We generally assume that the victim of negligence is motivated primarily—even exclusively—by the desire for money. But that's not what the research shows.

According to Lucian L. Leape, M.D., of the Harvard School of Public Health, what the typical patient most wants—more than money—is that the physician (a) acknowledge the error and explain it, (b) take responsibility and apologize, and (c) discover the underlying cause and take steps to prevent recurrence.²¹ Similarly, Professor Carol B. Liebman of Columbia Law School, and Chris Hyman, of the Medical Mediation Group in New York City, report that what patients most want—more than money—are (a) basic information about the incident, (b) an apology, and (c) prevention of recurrence of similar incidents.²²

These two studies are consistent with studies of why patients sue their physicians. The primary reasons are (a) the perception that the physician wasn't honest in addressing the incident, (b) the perception that no one would explain what happened, and (c) the receipt of advice from someone (often another health care provider) to sue.²³

Now consider the several disclosure requirements that already obligate a physician and a hospital to disclose a medical error to the patient. The American Medical Association has long held that a physician has an ethical duty to disclose a harmful error to the patient.²⁴ And The Joint

²⁰ Hillary R. Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205 (2006).

²¹ Lucian L. Leape, *Understanding the Power of Apology: How Saying 'I'm Sorry' Helps Heal Patients and Caregivers*, 8 FOCUS ON PATIENT SAFETY FOUND. 1 (2005).

²² Carol B. Liebman & Chris S. Hyman, *A Mediation Model to Manage Disclosure of Errors and Adverse Events*, 23 HEALTH AFF. 22, 24 (2004).

²³ *Id.* See also *id.* at 23 n. 9, where Liebman & Hyman identify multiple studies on physician mistakes and subsequent behavior that prompt malpractice claims.

²⁴ AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS I-IV (2001); AM. MED. ASS'N, CODE OF MEDICAL ETHICS, OPINION 8.12 (2007).

Commission, the major hospital accreditation authority in the United States, has for years required hospitals to disclose harmful medical errors, including the requirement that the disclosure be made by the “responsible physician (or a designee . . .).”²⁵

So I ask you, in light of the apology statutes, results of these studies, and the disclosure requirements that the AMA and The Joint Commission already impose, isn’t it reasonable to conclude that in many cases an apology is the best course of action?

CONCLUSION

Thank you for giving me the opportunity to identify what I regard as medical myths. I’ve been waiting my entire professional life for the chance to complain about them. You’ve given me that chance.

²⁵ *See, e.g.,* THE JOINT COMM’N, HOSPITAL ACCREDITATION STANDARDS, ETHICS, RIGHTS, AND RESPONSIBILITIES.