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REVIEW ESSAY

LIKE A SURGEON

Steven Lubett†

COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE. By Atul Gawande. New York: Metropolitan Books, 2002. Pp. x, 269. \$24.00.

I

PAY CLOSE ATTENTION TO THAT MAN BEHIND THE CURTAIN

Dr. Atul Gawande believes that too much information about medical practice has been “hidden, behind drapes and anesthesia and the elisions of language.”¹ He should know. As a senior surgical resident at Boston’s Brigham and Women’s Hospital, the Harvard-trained Gawande has had plenty of opportunities to observe the delivery of medicine in the trenches—from the remarkable successes to the tragic mishaps. It is our good fortune that he has decided to share his observations in the form of a truly exceptional book, *Complications: A Surgeon’s Notes on an Imperfect Science*.

Gawande’s theme is that medicine is subject to the same limitations as are all human enterprises. Even in an age of high technology and rigorous science, errors are inevitable. While physicians are often candid among themselves when it comes to confronting and correcting errors, they are far less forthcoming with their patients and the public. Gawande’s great insight is that the medical profession will only be strengthened by increased communication and candor, even when the truth is awkward or uncomfortable. As he put it in a recent interview, his goal is to “‘convey a sense that medicine is less perfect than people might think it is, but more extraordinary than they understand.’”²

The essays that comprise *Complications* (many of which originally appeared as articles in *The New Yorker*) are divided into three sec-

† Professor of Law, Northwestern University. I am grateful to the physicians and lawyers who provided me with helpful suggestions, comments and assistance on earlier drafts of this essay: Peter Budetti, Shari Diamond, Jack Heinz, Marcia Lehr, Jim Lindgren, Michelle Oberman, and Ann Warner.

¹ Atul Gawande, *The Learning Curve*, NEW YORKER, Jan. 28, 2002, at 58.

² Stephanie Schorow, *Writer in Residence: Doctor Explores His Profession in Collection of Incisive Essays*, BOSTON HERALD, June 3, 2002, at 29.

tions—"Fallibility," "Mystery," and "Uncertainty"—each dealing with a different sort of imperfection or difficulty in medical practice. Gawande thus explores the many ways that medicine can fall short of expectations. Humans err, despite their best efforts. Scientific knowledge remains incomplete, leaving many questions unanswered and unanswerable. And some situations are simply ambiguous, calling for the exercise of judgment in the face of maddeningly incomplete information, often with no good solution available.

There is a straightforward elegance in Gawande's writing. He clearly respects and admires the physicians with whom he works, but he is nonetheless unsparing in his critique—beginning with himself. In his very first chapter—"Education of a Knife"—he explains in achingly detail one of his own failures as a first-year resident, without omitting the consequences for his patient.³ The tricky procedure in question was the insertion of a "central line" into the vena cava, the main blood vessel into the patient's heart. This is a routine matter for an experienced surgeon, but when performed incorrectly it can result in a punctured lung.

I felt for landmarks on the patient's chest. *Here?* I asked with my eyes, not wanting to undermine my patient's confidence any further Next, I took the three-inch needle in hand and poked it through the skin. I advanced it slowly and uncertainly, a few millimeters at a time, afraid to plunge it into something bad. This is a big goddam needle, I kept thinking. I couldn't believe I was sticking it into someone's chest. I concentrated on maintaining a steep angle of entry, but kept spearing his clavicle instead of slipping beneath it.⁴

A senior resident eventually had to intervene, but not before the patient was subjected to some unnecessary pain, discomfort, and uncertainty. It was not until later, when he was able to review an x-ray, that Gawande reassured himself that he had not harmed the patient.

Later, in the most moving and revealing section of the book, Gawande describes at length his participation in a botched tracheostomy that almost caused the death of his patient.⁵ As the surgical resident on duty, Gawande was sent to oversee the admission to the hospital of a trauma victim. Discovering that her airway was obstructed, he realized that a breathing tube had to be inserted, but he did not wait for help from a more senior surgeon. This proved to be the first of a series of nearly disastrous mistakes. After several minutes of fumbling, the patient's throat proved too swollen to accept the tube. Gawande

³ See ATUL GAWANDE, *COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE* 11–15 (2002).

⁴ *Id.* at 14.

⁵ *Id.* at 48–55.

realized that she risked brain damage or death without an emergency tracheostomy, a procedure that he had never previously attempted on his own. Again, however, he did not summon help. Instead, he made the incision in the wrong place, unnecessarily severing a vein and causing so much bleeding that it was impossible for him to see what he was doing—even if he had known how to do it. It was only the provident arrival of a senior anesthesiologist that saved the day, as he ultimately was able to slip a pediatric breathing tube down the patient's throat, completely bypassing Gawande's mangled incision.⁶

This incident illustrates a "central truth in medicine," he explains at the end of the story: "[A]ll doctors make terrible mistakes."⁷ From another, less thoughtful writer, that revelation might seem like either an exposé or an accusation. Coming from Gawande, it is simply the beginning of an unusually frank discussion of the realities of contemporary medicine, usually inspiring, but sometimes troubling as well.

This is a book that everyone—critics, admirers, and, most of all, patients of physicians—ought to read. By openly confronting medicine's inherent shortcomings, Gawande creates not skepticism or wariness, but rather a renewed and enlightened respect for the concept of medical "practice."

Although Gawande is unflinching in identifying flaws in the delivery of medical services, many of his solutions tend to be physician-centric, with little room for the intervention of outsiders, especially attorneys. As an important new voice in medicine, his views are bound to be influential in medical schools, hospitals, and beyond. Consequently, three aspects of *Complications* should be of special interest to lawyers and legal academics: the discussions of professional education, patient autonomy, and, of course, malpractice litigation.

II

EDUCATION OF A KNIFE

Unlike the legal academy, the medical profession regards clinical education as a fundamental necessity. The third and fourth years of medical school are devoted almost exclusively to clinical rotations, followed in most cases by a lengthy post-graduate residency (at least five years for surgery) in which poorly paid neophytes continue to train under the supervision of their elders.

The residency system has been much criticized, chiefly because of the staggeringly long hours it demands of the residents themselves,⁸

⁶ *Id.* at 53–54.

⁷ *Id.* at 55–56.

⁸ The American Medical Association and the Accreditation Council for Graduate Medical Education both recently adopted recommended limits for the number of hours that medical residents can work. But even the new, "limited" hours would seem punishing

but there can be no doubt that it has also produced some of the best trained physicians in the world. As a mode of professional education, it is far superior to anything developed by the legal profession, either during or following law school. The exacting apprenticeship required of most physicians has no real equivalent in law practice, where formal education is overwhelmingly theoretical and on-the-job training is spotty at best. Even at large law firms, where the flow of work and long hours bear some resemblance to teaching hospitals, the assignment of associates is almost exclusively profit-driven, with little similarity to the methodical exposure of medical residents to cases and the steady, incremental development of their individual responsibility.⁹ Physicians are purposefully taught to practice their profession in a way that attorneys are not.

The philosophy of clinical training in medicine is often summarized as “see one, do one, teach one,” meaning that residents are expected to learn quickly as they begin practicing on real patients. Gawande admirably confronts the central dilemma of this system. Beginners can never be as good as their more experienced colleagues, and many medical procedures (unlike, say, legal briefs) cannot simply be redone if the first effort is inadequate. In medicine, especially in surgery, there is no such thing as a rough draft. Patients sometimes pay a price for novice mistakes; such are the perils of the learning curve.¹⁰ And although teaching hospitals adhere to a protocol of patient consent, many of the most meaningful disclosures are, shall we say, glossed over when the resident actually seeks the patient’s permission to proceed.

Gawande calls this “[t]he moral burden of practicing on people,” which is never fully spelled out for patients.¹¹ “Not to worry. I just assist,” says the surgical resident to the occasional balky patient. “The attending surgeon is always in charge.” None of this is “exactly a lie,” Gawande explains, but it is “a kind of subterfuge.”¹² In fact, the residents do far more than assist in most teaching hospitals. They perform crucial stages of the surgery—“hold the knife,” in Gawande’s words—while the attending physician watches and offers advice. Sometimes extra steps are added, not because it is better for the pa-

by any other measure, as they merely restrict residents to an average of eighty hours a week, with no more than twenty-four hours on a single shift. Even these limits can be expanded under “special circumstances.” See *AMA Backs Limits on Residents’ Hours*, N.Y. TIMES, June 21, 2002, at A18.

⁹ See generally David B. Wilkins & G. Mitu Gulati, *Reconceiving the Tournament of Lawyers: Tracking, Seeding, and Information Control in the Internal Labor Markets of Elite Law Firms*, 84 VA. L. REV. 1581 (1998) (describing the institutional structure of large law firms).

¹⁰ See GAWANDE, *supra* note 3, at 25–34.

¹¹ *Id.* at 23.

¹² *Id.*

tient, but because the resident needs the practice.¹³ That is the “uncomfortable truth about teaching.”¹⁴

It is hard to imagine doing it any other way. Doctors have to be trained, and the residency system provides both opportunity and supervision. Medicine itself advances through trial and error; there is no perfection without practice. As an undifferentiated group, patients obviously benefit enormously from the existence of clinical training (eventually there would be no skilled surgeons without it), even if individuals may often receive sub-optimal treatment. The societal benefit is clear, though the individual cost is intentionally hidden. “Given the stakes,” Gawande reminds us, “who in their right mind would agree to be practiced upon?”¹⁵

Gawande leaves us puzzling the conundrum that there is an unresolvable “conflict between the imperative to give patients the best possible care and the need to provide novices with experience.”¹⁶ Left to their own devices, physicians will ensure that the necessary knowledge is “stolen” from unsuspecting patients, “taken as a kind of bodily eminent domain.”¹⁷ Except, of course, when the patient is a physician or other insider, in which case the resident’s educational needs will be deferred in favor of more seasoned hands. Gawande tells us of a colleague who refused even to allow residents in the delivery room when his child was born.¹⁸ And Gawande himself insisted that a senior cardiologist treat his son, to the disappointment of an eager resident who was actually more familiar with the case.¹⁹

To his credit, Gawande is willing to raise the tough issue. Choices are given to “the doctor’s child but not the truck driver’s. If choice cannot go to everyone, maybe it is better when it is not allowed at all.”²⁰ The reason is obvious, though Gawande does not advert to it. Choices are given to doctors’ children because doctors make the rules. That will continue to be the case so long as hospitals are autonomous institutions (setting procedures and assigning personnel), which is to say, indefinitely.

The suggestion that insiders’ choice should be prohibited in the name of social equality is, in fact, a plea for law. Gawande’s own experience makes it plainly evident that virtually no parent or patient would ever willingly renounce access to superior medical care for the

¹³ *Id.*

¹⁴ *Id.* at 24.

¹⁵ *Id.* at 30.

¹⁶ *Id.* at 24.

¹⁷ *Id.* at 32.

¹⁸ *Id.* at 31.

¹⁹ *Id.* at 31–32.

²⁰ *Id.* at 33.

sake of egalitarianism. Concerning his decision to invoke the doctors' privilege, Gawande acknowledges that

this was not fair. My son had an unusual problem. The [resident] needed the experience. Of all people, I, a resident, should have understood. But I was not torn about the decision. This was *my child*. Given a choice, I will always choose the best care I can for him. How can anybody be expected to do otherwise?²¹

Absolutely. No one could possibly be expected to do otherwise. Consequently, any reform in this unfair system would have to come from the outside. And to make the reform stick, to ensure that it would not simply be evaded with a wink and a nudge, it would have to be enforceable with meaningful sanctions. Otherwise, physicians would happily continue to provide preferred care to their friends and colleagues, while the children of truck drivers would continue to be practiced upon.

Note, please, that it is Dr. Gawande—not me—who raises the question of fairness in medical practice, and who wonders whether familial favoritism should be forbidden. I am not suggesting a regulatory scheme to govern the assignment of patients to physicians. I am merely pointing out that physicians cannot be expected to make such changes—however socially beneficial—by themselves, especially when it comes to relinquishing life-and-death prerogatives. Such a change would take serious intervention. In other words, it would take some form of law, which is the democratic vehicle that allows the general public to constrain powerful elites.

Gawande does not really acknowledge that creating and enforcing social policy is not the job of doctors. The distribution of benefits is the territory of other specialists—philosophers, ethicists, legislators, journalists, administrators, and, yes, lawyers. Though he holds a Master's degree in public health, and though his mission is to reveal the deep nature of medicine to the public, Gawande retains a bit of the physician's disdain for these other professionals—lawyers, not surprisingly, being chief among them. That mistrust surfaces obliquely in his discussion of professional training, but it is more direct when he addresses legal concepts such as informed consent and malpractice.

III

WHOSE BODY IS IT, ANYWAY?

Medicine is both an art and a science, but it is also a social practice involving a complex set of communications and interactions between physicians and patients. This relationship has changed dramatically in the last two decades. In the not-too-distant past, "doc-

²¹ *Id.* at 32.

tors' orders" were considered inviolable. Patients were simply expected to comply, often without the benefit of the most basic information about their own prognoses. As Gawande puts it, patients "were regarded as children: too fragile and simple-minded to handle the truth."²² It was once considered good practice, for example, to withhold diagnoses from terminally ill patients, so they would not become disheartened (never mind the impact on their lives and relationships). Patients were subjected to powerful drugs and invasive surgeries without knowledge of the potential side effects or other consequences. Those were the bad old days, as Gawande recognizes, when women were routinely rushed into radical mastectomies without being given the possible alternatives.²³

Things are better today. The patient autonomy movement has taken hold in medical schools and hospitals, with most doctors "taking seriously the idea that patients should control their own fates" and, therefore, laying out the "options and the risks involved."²⁴ Gawande credits this change to the 1984 publication of Dr. Jay Katz's important book, *The Silent World of Doctor and Patient*,²⁵ but this attribution is yet another example of physician-centrism. Katz, a Yale psychiatrist and ethicist, was surely influential in his critique of the traditional model for medical decision making. But as Katz himself readily acknowledges, the idea of informed consent began as a legal doctrine, developed by lawyers and judges in the context of medical malpractice litigation, during the period 1957–1972.²⁶

Gawande agrees that patients suffered under the old paternalism, but, along with many doctors, he remains skeptical of what he calls the "new orthodoxy."²⁷ He observes that patients often make "bad decisions" and "grave mistake[s],"²⁸ and that it is therefore the job of good doctors to protect patients from their own poor choices. He is willing to respect autonomy, but mostly when it leads to the right result.

Lawyers will immediately recognize this as the familiar tension between process and outcome. Sometimes rights and procedures have inherent value, entirely independent of results. In law, the presumption of innocence is one such principle, essential to a free society even though it sometimes leads to terrible verdicts by juries. More broadly, individual autonomy is the foundation of democracy—everyone gets to vote, even if many ballots are capriciously cast and ill-informed. Pursuing happiness, people may make all sorts of bad decisions—to

²² *Id.* at 210.

²³ *See id.* at 211.

²⁴ *Id.* at 212.

²⁵ *See id.* at 210–11.

²⁶ *See* JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 48–84 (1984).

²⁷ GAWANDE, *supra* note 3, at 219.

²⁸ *Id.* at 212.

smoke, to drop out of school, to procreate as teenagers, or to fail to diversify their 401(k) portfolios—with no superior authority to intervene.

No doubt, Gawande would agree that individual autonomy, in the general sense, is an important principle. After all, one of his primary goals is to educate the public concerning the fallibility of physicians and the great amount of “plain old guessing”²⁹ that often goes into medical treatment. He obviously expects his readers to use this knowledge to make their own medical choices.

When it comes to his patients, however, he wavers. “[A] good physician,” according to Gawande, “cannot simply stand aside when patients make bad or self-defeating decisions.”³⁰ But this, of course, merely begs the question. What conceivable method exists for separating the good doctors (who push appropriately in the right direction) from the bad doctors (who may be influenced, as Gawande notes, “by money, professional bias . . . and personal idiosyncrasy.”³¹)? Alas, Gawande offers no clear way of distinguishing good physicians from others. For example, he is in full accord with Jay Katz that bad physicians were inappropriately overbearing in their assessment of the now-famous case of the pseudonymous “Iphigenia Jones.”³²

Iphigenia Jones was a twenty-one year old woman who was found to have a serious breast malignancy. The prevailing treatment at the time was radical mastectomy, though a less-disfiguring lumpectomy was also available. Survival rates were comparable, but the lumpectomy was thought to carry a greater risk of recurrence. Jones’s surgeon was certain that a mastectomy was needed, but, as the morning of surgery approached, he had second thoughts about removing the breast of a woman so young. He therefore took the then-heretical approach of presenting the options to his patient and allowing her to choose the treatment. She elected for the less intrusive surgery. Some time later, Jones participated in a panel discussion at a medical conference. Confronted with the idea that Jones had chosen her own treatment, the surgical establishment was appalled. “‘If doctors have such trouble deciding which treatment is best, how can patients decide?’” complained one surgeon. Gawande points out, however, that “the decision involved not technical but personal issues: Which was more important to Iphigenia—the preservation of her breast or the security of living without a significant chance that the lump would

²⁹ *Id.* at 7.

³⁰ *Id.* at 216.

³¹ *Id.* at 211.

³² *See id.* at 211–12.

grow back? No doctor was the authority on these matters. Only Iphigenia was.”³³

On the other hand, as a good physician, Gawande believes that he must “push” his patients when the “stakes are this high, and a bad choice may be irreversible,”³⁴ though no doubt this was the same rationale used by the physicians who wanted to control Iphigenia Jones’s treatment. Interestingly, Gawande’s illustration of this point is one of his own breast cancer cases.

Gawande tells the story of an unnamed patient—the mother of two and a partner in a downtown law firm, as it happened—whose mammogram reveals “a faint group of punctate, clustered calcifications . . . that were not clearly present on the prior examination.”³⁵ This worrisome feature could mean breast cancer, which calls for a biopsy. Gawande tells his patient the news. “Despite the circumstances, and the flimsy paper gown she’s in, she manages to maintain her composure.”³⁶ But she is not pleased and does not want a biopsy. It seems that she has had three biopsies for similar readings in the past five years, each time with a benign result. “You just don’t know when enough is enough, . . . I’m not getting another goddam biopsy. . . .”³⁷

This is a terrible decision on her part, Gawande believes. The calcifications are not equivocal, and three negative biopsies do not indicate that the fourth will be negative as well. He wants to push her, for her own good, into agreeing to a fourth biopsy, even though the first three have already taken out so much tissue “that the left breast is distinctly smaller than the right one.”³⁸ A good doctor would not let her go, autonomy notwithstanding.

“Here’s what I’ve seen good doctors do,” Gawande explains. “They step out for a minute and give the woman time to get dressed.” (Another begged question: Why did she have to endure the initial consultation dressed only in a flimsy paper gown? Why should only recalcitrant patients be granted the dignity of real clothing?) Then the doctor holds an extended conversation with the patient, validating her concerns but slowly breaking down her resistance. “Before a

³³ *Id.* at 211. Many years later, it turns out that Iphigenia indeed may have made the wiser choice, even though it was contrary to her physician’s professional judgment. See Gina Kolata, *Lumpectomies Seen as Equal in Benefit to Breast Removals*, N.Y. TIMES, Oct. 17, 2002, at A1 (“After monitoring more than 2,500 breast cancer patients for 20 years, researchers have concluded that women fare just as well with an operation that removes the cancerous lump as they do by having the entire breast removed.”).

³⁴ GAWANDE, *supra* note 3, at 218.

³⁵ *Id.* at 217.

³⁶ *Id.*

³⁷ *Id.* at 217–18.

³⁸ *Id.* at 218.

thoughtful, concerned, and, yes, sometimes crafty doctor, few patients will not eventually 'choose' what the doctor recommends."³⁹

Writing in *The New York Review of Books*, Dr. Sherwin Nuland, a professor of surgery at Yale, describes this as one of Gawande's "rare lapses."⁴⁰ Although statistics for large numbers of patients supported Gawande's advocacy of an urgent biopsy, the history of his individual patient did not. Gawande convinced himself that his judgment was correct, but in fact it was open to question. In the face of medical uncertainty (on this, I take Dr. Nuland's word), why should the patient not have declined the fourth invasion of her breast? Was Gawande simply being a good doctor as he craftily persuaded her to relent, or was he approaching her just as the old-timers would have treated Iphigenia Jones (though more politely)?

The point of this is not that Gawande made a mistake—he would be the first to concede that possibility—but rather, that he has consistently undervalued the importance of patient autonomy. To him, patient consent forms bear "the mark of lawyerdom and bureaucracy,"⁴¹ and ethicists can be "heartless"⁴² in their insistence on patient decision making. Instead, Gawande believes patients frequently do not want the freedom they have been given,⁴³ and that it can be cruel to impose choices upon them.

He illustrates his position with another personal story, this time involving his youngest child. Born five weeks premature and weighing only four pounds, his daughter, Hunter, suffered respiratory failure when she was only eleven days old. Admitted to intensive care, her condition deteriorated and a decision had to be made. "Should she be intubated and put on a ventilator? Or should the doctors wait to see if she could recover without it? There were risks either way."⁴⁴ So who should make the decision: the physicians or the parent (who, in this case, was himself a doctor)?

In the event, Gawande deferred to the judgment of the treating physicians. "I wanted them to decide," he says, "doctors I had never met before." It is not that they were necessarily more competent, but that, as he movingly explains, "[t]he uncertainties were savage, and I could not bear the possibility of making the wrong call. Even if I made what I was sure was the right choice for her, I could not live with the guilt if something went wrong. . . . I needed Hunter's physicians

39 *Id.* at 218–19.

40 Sherwin B. Nuland, *Whoops!*, N.Y. REV. OF BOOKS, July 18, 2002, at 10, 11.

41 GAWANDE, *supra* note 3, at 213.

42 *Id.* at 221.

43 *Id.* at 219.

44 *Id.* at 221.

to bear the responsibility: they could live with the consequences, good or bad."⁴⁵

Gawande made the right choice for himself and his family. Hunter was kept off the ventilator and recovered, though she spent two more weeks in intensive care. But not every patient, or parent, would have done the same. Certainly, other individuals would prefer to make their own decisions, shouldering the burden themselves rather than deferring it to others. Would that be wrong? Would it be heartless?

Upon reflection, Hunter's ordeal illustrates the virtue of autonomy, not its drawbacks. Her father was, in fact, given the option of deciding or deferring. He made his choice for compelling emotional reasons ("I could not live with the guilt if something went wrong," he said) that had nothing to do with the likely medical outcome. As the person who had to live with the result (his wife is not mentioned, though one assumes she concurred), he was best suited to understand its impact. Jay Katz would call this a "value judgment," of the sort that may, depending on the circumstances, rest upon "a combination of medical, emotional, aesthetic, religious, philosophical, social, interpersonal, and personal" factors. Different patients, Katz notes, "bring different values to bear on their ultimate choice."⁴⁶

Still, Gawande asserts that "many ethicists go wrong . . . in promoting patient autonomy as a kind of ultimate value in medicine rather than recognizing it as one value among others."⁴⁷ As an alternative, he posits an ethic of "kindness [that] will often involve respecting patients' autonomy" but that may also mean "taking on burdensome decisions when patients don't want to make them, or guiding patients in the right direction when they do." Even when patients prefer to make their own decisions, "there are times when the compassionate thing to do is to press hard."⁴⁸

Here, Gawande is wrestling with a straw person. What he characterizes as the "new orthodoxy" is actually an extreme view that has, at most, a handful of adherents. No mainstream ethicist believes that these wrenching decisions should be foisted upon unwilling patients, or that physicians should be barred from strongly urging their recommended treatments once the options have been explained. Autonomy only implies respect for the individual's preferences, including the very common preference that doctors make the decisions. Of course, patients must first be advised of the risks and alternatives, even

⁴⁵ *Id.* at 221–22.

⁴⁶ KATZ, *supra* note 26, at 96.

⁴⁷ GAWANDE, *supra* note 3, at 223–24.

⁴⁸ *Id.* at 224.

if that seems lawyerly. Ultimately, process makes a difference. It is the conversation that matters.

IV

WHEN DOCTORS MAKE MISTAKES (AND WHEN GOOD DOCTORS GO BAD)

You would not expect a surgeon to have anything positive to say about medical malpractice litigation. And you would be right. Gawande regards malpractice cases as worse than useless. They punish doctors,⁴⁹ interfere with physician-patient communications, and do nothing to improve care.⁵⁰

Gawande served as a health policy advisor during the Clinton Administration,⁵¹ so the derogation of malpractice litigation might be the only issue on which he agrees with President Bush, who recently called for national legislation to limit malpractice liability.⁵² For the President, of course, the issue is intensely political—Bush announced his proposal at a campaign rally for a Senate candidate. Gawande's objections are more humane, and therefore more interesting. Uncharacteristically, though not unpredictably, he mostly adopts the standard positions of his profession which, from a lawyer's perspective, do not tell the whole story.

Gawande's primary objection to malpractice litigation is that it sweeps too broadly, failing to distinguish between dangerous doctors and good doctors who simply make mistakes. Malpractice lawyers do not concentrate on the few bad apples, he believes, given that "malpractice cases [are not] concentrated among a small group, but in fact they follow a uniform, bell-shaped distribution."⁵³ A bell curve, however, might indicate nothing more than a statistically random distribution of incompetence among physicians: it reports a small number of doctors at the extreme end of the malpractice axis, meaning that their incidence of lawsuits is exceptionally high as opposed to those in the fattest part of the curve, and extraordinarily high compared to the physicians at the opposite extreme.⁵⁴ If there is indeed a bell curve

⁴⁹ See *id.* at 55.

⁵⁰ See *id.* at 57.

⁵¹ John Freeman, *An Inside Look at Practicing Medicine*, PLAIN DEALER, May 5, 2002, at J12.

⁵² Sheryl Gay Stolberg, *Bush Urges a Cap on Medical Liability*, N.Y. TIMES, July 26, 2002, at A16 (quoting President Bush as stating that "[h]ealth care costs are up because docs are worried about getting sued," and that the liability system is "broken and riddled with bad, bad law").

⁵³ GAWANDE, *supra* note 3, at 56.

⁵⁴ It could also mean that other litigation-generating variables are randomly distributed among physicians. For example, few lawyers will file lawsuits in the absence of extreme injuries and potentially high financial losses, circumstances that could be randomly distributed even if incidents of underlying malpractice are not. Additionally, it is well

(Gawande does not cite his source), then it would appear at least plausible to conclude that some bad doctors are in fact being singled out for litigation while some very careful (or perhaps very lucky) physicians successfully avoid suit.⁵⁵

Statistical inferences aside, Gawande is concerned that “[m]ost surgeons are sued at least once in the course of their careers,”⁵⁶ which he regards as evidence that “repeat offenders are not the problem.”⁵⁷ It is certainly easy to sympathize with those physicians who find themselves on the receiving end of such lawsuits, many of which are no doubt unnecessary or ill-founded. As a social phenomenon, however, the high incidence of malpractice litigation is not shocking.

In 2000, the Institute of Medicine published a report entitled *To Err is Human: Building a Safer Health System*⁵⁸ that was intended to provide “a comprehensive approach for reducing medical errors and improving patient safety.”⁵⁹ The report concluded that “[p]reventable adverse events are a leading cause of death in the United States,” and that “at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors.”⁶⁰ These numbers would be far higher if the report included serious but non-fatal injuries. The much cited Harvard Medical Practice Study, for example, concluded that serious adverse events (resulting in prolonged hospitalization or disability) occurred in 3.7% of hospitalizations, over half of which were preventable and over a quarter of which were due to negligence.⁶¹

With numbers like these, it cannot be considered surprising that most surgeons—who are in a high risk field by any standard—might face litigation at least once in their careers. Gawande himself observes “that virtually everyone who cares for hospital patients will make serious mistakes, and even commit acts of negligence, every year.”⁶² In-

known that factors such as poor interpersonal skills and inept record keeping often encourage litigation.

⁵⁵ Gawande gives us the example of one “bad apple,” an orthopedic surgeon who repeatedly and inexcusably injured his patients. It appears, however, that this doctor was indeed singled out by repeated malpractice complaints, becoming one of the most frequently sued physicians at his hospital and, at least anecdotally, refuting Gawande’s claim of random distribution. See GAWANDE, *supra* note 3, at 90–91, 97.

⁵⁶ *Id.* at 56.

⁵⁷ *Id.*

⁵⁸ INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 2000).

⁵⁹ *Id.* at 17.

⁶⁰ *Id.* at 26.

⁶¹ *Id.* at 30. Other studies have found even higher rates of preventable adverse events. See, e.g., Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET 309, 309 (1997) (finding that at least 17.7% of patients had at least one preventable adverse event).

⁶² GAWANDE, *supra* note 3, at 56.

deed, he goes further. Discussing the prevalence of physician burnout, and its potentially dangerous effect on unsuspecting patients, Gawande notes that “‘problem doctors’” are not aberrations. In fact, “[t]he aberration may be a doctor who makes it through a forty-year career without at least a troubled year or two.”⁶³ He adds, “estimates are that, at any given time, 3 to 5 percent of practicing physicians are actually unfit to see patients.”⁶⁴

Whatever the cause, there is obviously plenty of malpractice to go around, although that does not necessarily mean that the current litigation system is the best way to deal with it. Lawsuits are expensive, time consuming, and uncertain. They distribute resources badly, with too much money going to attorneys and not enough to victims. Even if litigation works as intended (on any level), its primary objective is compensation, not systemic improvement.

No physician looks at the current litigation system without longing for a better way to address medical mistakes. Gawande offers the alternative model of the Morbidity and Mortality Conference (M & M conference), where doctors can talk candidly about their errors, if only among themselves. Usually held once a week at most teaching hospitals, the M & M conference allows doctors to “gather behind closed doors to review the mistakes, untoward events, and deaths that occurred on their watch, determine responsibility, and figure out what to do differently next time.”⁶⁵ As Gawande sees it, the M & M conference is everything that a malpractice lawsuit is not. Most importantly, it focuses on future improvement rather than past recrimination, thus motivating physicians to expose their errors in order to do better rather than hide them in the hope of avoiding responsibility.

M & M conferences are exceptionally good at helping responsible doctors locate and rectify their problems without fear of liability. That is why forty-nine states have enacted statutory medical peer review privileges (the sole exception is New Jersey), which protect communications in settings such as M & M conferences.⁶⁶ As Gawande extolls it,

[T]he M & M is an impressively sophisticated and human institution. Unlike the courts or the media, it recognizes that human error is generally not something that can be deterred by punishment. The M & M sees avoiding error as largely a matter of will—of staying sufficiently informed and alert to anticipate the myriad ways that things can go wrong and then trying to head off each potential

⁶³ *Id.* at 94.

⁶⁴ *Id.*

⁶⁵ *Id.* at 57–58.

⁶⁶ See INSTITUTE OF MEDICINE, *supra* note 58, at 119.

problem before it happens. It isn't damnable that an error occurs, but there is some shame to it.⁶⁷

Alas, the M & M conference is no panacea. Gawande himself, fewer than thirty pages later, gives us a chilling account of a dangerous doctor who simply ignored the weekly M & M conferences, and whose colleagues stood by for years while patients were crippled and disfigured. The doctor, whom Gawande calls Hank Goodman, was an orthopedic surgeon whose early career showed great promise. His techniques were up to date, he reveled in his work, he won teaching awards at the hospital, and he performed more procedures than anyone else in his group practice. After several years, however, things began to go wrong. He started to cut corners and ignore patients, making poor decisions time and again.

In one case, Dr. Goodman refused even to examine a patient who appeared to be suffering from a painful infection following knee surgery. "Ah, she's just a whiner," he told his assistant. By the time the patient finally sought the opinion of another doctor, the infection had consumed all of the cartilage in her knee, destroying the entire joint. The bone was so severely damaged that even a knee replacement was impossible; the only viable option was to fuse her knee.⁶⁸ In another case, Goodman put the wrong size screw in a patient's broken ankle and refused to change it when the patient complained of pain. In a similar case, he used an improperly long screw that actually eroded through the flesh and skin in the patient's arm. In a fourth case, he mishandled the surgery for an elderly man's broken hip, resulting in almost complete dissolution of the bone. A horrified surgeon who reviewed the case had this to say about it: "[Goodman] just wouldn't do anything. He literally wouldn't bring the patient into the hospital. He ignored the obvious on X rays. He could have killed this guy the way things were going."⁶⁹

If ever there was a doctor who needed urgent, effective peer review, it was Hank Goodman. But it did not happen. Although Goodman's "botched cases became a staple of his department's Morbidity and Mortality conferences,"⁷⁰ nothing was actually done to prevent him from continuing to operate on unsuspecting patients. There were a few "Terribly Quiet Chats," in which Goodman was urged to seek help, but matters simply drifted along for "an unconscionably

67 GAWANDE, *supra* note 3, at 62.

68 *Id.* at 90.

69 *Id.* at 91.

70 *Id.*

long time,”⁷¹ from 1990 until late 1995. For all of the damage he was doing, his colleagues remained “uncomfortable about judging him.”⁷²

In fact, Goodman even stopped attending the M & M conferences, though who could blame him? “Various people warned him, with increasing sharpness, that he would be in serious trouble if he didn’t start showing up at M & Ms,” but he ignored them.⁷³ Here is how Gawande describes the efficacy of the Mortality and Morbidity system in reining in a bad doctor: “After a year of [skipping M & Ms], the hospital board put him on probation. Through it all, he was operating on more patients and generating ever more complications. Another whole year went by” before Goodman’s operating privileges were finally suspended.⁷⁴

Gawande sees both dishonorable and honorable reasons for this lax attitude toward dangerous colleagues. The “dishonorable” reason is disengagement. It is easy to do nothing, and much harder to summon the energy and commitment to take stern measures. No doubt. But Gawande’s so-called “honorable” reason is even less satisfying. He says that “no one really has the heart for it.” Indeed, “[w]hen a skilled, decent, ordinarily conscientious colleague, whom you’ve known and worked with for years, starts popping Percodans, or becomes preoccupied with personal problems, and neglects the proper care of patients, you want to help, not destroy the doctor’s career.”⁷⁵

These words may not fit everyone’s definition of an honorable reason for ignoring life-threatening problems, but it is undoubtedly an accurate description of the reality at most hospitals. It is also the reason that injured patients consult malpractice lawyers, rather than wait for the M & M system to provide a comprehensive solution. Attorneys (and their clients) recognize, if surgeons do not, that it is usually unreasonable to expect institutions to police themselves—and it may simply be irrational to do so when lives are at stake.

Consider the problem of preventable post-surgical infections, which, according to an estimate from the Centers For Disease Control, may needlessly kill as many as 75,000 Americans annually (other estimates are even higher).⁷⁶ One might think M & M conferences could effectively address this issue, since an astonishingly high percentage of deadly infections appear to be “the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses.”⁷⁷

⁷¹ *Id.* at 97.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *See id.* at 97–98.

⁷⁵ *Id.* at 95.

⁷⁶ *See* Michael J. Berens, *Infection Epidemic Carves Deadly Path*, CHH. TRIB., July 21, 2002, at 1.

⁷⁷ *Id.*

Sadly, the opposite seems to be true. Even with full knowledge that improved sanitation would reduce mortality, many hospitals and physicians have failed to take simple remedial steps. “For years, we’ve just been quietly bundling the bodies of patients off to the morgue while infection rates get higher and higher,” said Dr. Barry Farr, the president of the Society for Healthcare Epidemiology of America.⁷⁸

The *Chicago Tribune* reports that Bridgeport Hospital, a major trauma center and teaching hospital in Connecticut, experienced an infection rate of 22% among cardiac surgery patients during the late 1990s. An investigation revealed that “up to half of doctors, primarily surgical residents from Yale University, did not wash their hands before entering the operating room.”⁷⁹ Other doctors wore their surgical scrubs home and returned to the hospital the next day, without changing their dirty scrubs before entering the operating room. This conduct was clearly observable to others, but it went unchanged even as infection rates soared. At one point, in fact, the hospital’s doctors voted against testing all patients for infection because it was not “cost effective.”⁸⁰

This information came to light, and corrective measures were employed, only after the hospital was sued. Post-litigation, infection rates have been reduced to near zero.⁸¹ This is not to say that lawyers should get undue credit for the improved hospital sanitation, but rather to observe that the hospital (and its surgeons) failed to respond to a life-threatening crisis, M & M conferences notwithstanding.⁸²

Gawande’s other complaint about malpractice litigation is that it corrupts the physician-patient relationship:

The deeper problem with medical malpractice suits is that by demonizing errors they prevent doctors from acknowledging and discussing them publicly. The tort system makes adversaries of patient and physician, and pushes each to offer a heavily slanted version of

78 *Id.*

79 *Id.*

80 *Id.*

81 *Id.*

82 Thousands of internal records documented the extent of the problem, but the hospital strenuously resisted their disclosure. The information was made public only by virtue of an order from the Connecticut Supreme Court. *See id.* But even that was not quite the end of the secrecy. The *Chicago Tribune* article discussed the cases of two women who contracted post-surgical infections at Bridgeport Hospital—one died after over 400 days of hospitalization, and the other was effectively crippled for life. Bridgeport Hospital responded by suing the surviving woman and the widower of the deceased for breach of the confidentiality provisions in their malpractice settlements. The lawsuit sought damages and an injunction against publicly discussing “the terms, conditions and existence of any and all settlement agreements regarding Bridgeport Hospital.” After two days of bad publicity, however, the lawsuit was dropped. *See* David M. Herszenhorn, *Hospital Drops Legal Action to Stem Tide of Bad Publicity*, N.Y. TIMES, July 27, 2002, at B5.

events. When things go wrong, it's almost impossible for a physician to talk to a patient honestly about mistakes.⁸³

Forgive me if I appear cynical, but is it really fair to blame malpractice lawyers for physicians' unwillingness to tell patients about mistakes? Was there ever a golden age, before rampant malpractice litigation, when doctors communicated freely with their patients, openly acknowledging errors and confronting mistakes in the spirit of humble cooperation? I don't think so. And neither does Dr. Jay Katz, who wrote *The Silent World of Doctor and Patient* in the 1980s, long before the current flood of malpractice cases. If anything, the days before the malpractice explosion were characterized by *less* communication from doctors, who then routinely refused to acknowledge even the possibility of uncertainty.⁸⁴ The great likelihood, I am afraid, is that doctors, being human, are simply reluctant to admit mistakes to their patients, and instead seize upon any available rationalization. Today, the excuse is malpractice liability. In the old days, it was the patients' own welfare—they would not heal as rapidly, it was said, if they lost confidence in their physicians.⁸⁵

In any event, contrary to Gawande's supposition, there is considerable evidence that malpractice claims actually diminish when doctors are open and candid about their errors. Increased communication is widely seen as reducing malpractice litigation, not inviting it.⁸⁶ The Joint Commission on Accreditation of Healthcare Organizations recently adopted a policy requiring hospitals "to pro-

⁸³ GAWANDE, *supra* note 3, at 57.

⁸⁴ See KATZ, *supra* note 26, at 165–206. Katz observes:

The history of medicine is the history of physicians' caring but silent devotion to what they believed their patients' best interests dictated. Doctors were rarely heard to invite patients to share the burdens of decision with them. Instead, the voices heard were those of doctors' hopeful and reassuring promises, however truthfully, evasively or deceptively made, of doctors' orders, however gently or harshly uttered, and of patients' compliant assent, however cheerfully or resentfully given.

Id. at 207.

Moreover, in the United Kingdom, where litigation rates are a fraction of what they are in the United States, physicians remain disinclined to discuss medical errors with their patients. See Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1611 (1994).

⁸⁵ Katz tracks the history of this philosophy from ancient times to the present, noting that Hippocrates advised "concealing most things from the patient while you are attending to him." KATZ, *supra* note 26, at 4 (quoting HIPPOCRATES, DECORUM 297 (W. Jones trans., Harv. Univ. Press, 1967)). More recently, physicians have complained that "informed consent endangers patients' mental and physical life." *Id.* at 27. In summary: "The importance that physicians have attributed throughout medical history to faith, hope and reassurance seems to demand that doctors be bearers of certainty and good news. Therefore, the idea of acknowledging to patients the limitations of medical knowledge and of doctors' capacities . . . is opposed by an ancient tradition." *Id.* at 189.

⁸⁶ See Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553, 553–59 (1997).

vide an 'honest explanation' of medical errors to patients and their families."⁸⁷ While patient safety is the primary reason for the new regulation, which went into effect on July 1, 2001, supporters of the rule further note that candor also tends to reduce malpractice claims. "You save money by doing this," said Dr. Dennis O'Leary, head of the Commission, "'and the patient's family is appreciative that people were honest.'"⁸⁸

In this regard, the Commission is following the lead of the Veterans Affairs Medical Center in Lexington, Kentucky, which in 1987 adopted a policy of "extreme honesty" in reporting medical errors. Patients are informed immediately about mistakes and the hospital's office of risk management actually assists patients with filing claims and locating attorneys. "If we're liable, we say so," explained pulmonologist Steve S. Kraman, the hospital's chief of staff.⁸⁹ Kraman further noted that "[i]n the vast majority of cases, people don't stay angry when they realize they're being told the truth and are being treated respectfully."⁹⁰ The implementation of this policy actually resulted in a substantial decrease in malpractice costs, with the hospital's average payment per case now only about one sixth of the average for the entire Veterans Administration system.⁹¹

A study published in the British journal *Lancet* found that as many as 39% of malpractice plaintiffs would not have filed suit if their doctors had sincerely apologized for their errors instead of stonewalling.⁹² The authors noted that lawsuits were prompted when patients "were disturbed by the absence of explanations, a lack of honesty, the reluctance to apologise, or being treated as neurotic."⁹³ A study published in the *Journal of the American Medical Association* likewise reported that at least 24% of malpractice plaintiffs were motivated by perceived cover-ups. In the total sample, 13% of the plaintiffs reported that their physicians "would not listen," 32% said that the doctors had not talked openly, and 48% believed they had been misled.⁹⁴ Yet another study similarly found that patients are more likely to sue if they report "feeling rushed, feeling ignored, [and] receiving inadequate explanations or advice."⁹⁵

⁸⁷ *Politics & Policy—Medical Errors: New Medicare Policy Mandates Disclosure*, American Health Line, Jan. 2, 2001, WESTLAW, Allnews File.

⁸⁸ Janet Wells, *Hospitals Must Disclose Doctor Errors*, S.F. CHRON., Dec. 24, 2000, at A1.

⁸⁹ Mark Crane, *What to Say if You Make a Mistake*, MED. ECON., Aug. 20, 2001, at 26, 28.

⁹⁰ *Id.*

⁹¹ *See id.*

⁹² *See* Vincent et al., *supra* note 84, at 1612.

⁹³ *Id.*

⁹⁴ Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1359 (1992).

⁹⁵ Levinson et al., *supra* note 86, at 554. *See* Gerald B. Hickson et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care*, 272 JAMA 1583, 1583 (1994); *see also*

Ultimately, Gawande's prescription seems to be that medical malpractice litigation should be limited so that the medical establishment can take steps to reduce preventable injuries. Needless to say, there is another way to look at the problem. Perhaps hospitals should enhance patient safety so that malpractice cases will decrease. Heaven knows, there are many things wrong in the world of malpractice litigation, but lawsuits definitely have their place when it comes to addressing, and redressing, medical errors.

V

FINAL CUT

None of this is meant to detract one bit from the considerable virtues of *Complications*. It is a terrific book by any measure. Atul Gawande did not set out to please physicians (he mentions that he expected to dismay many of his colleagues), so it is little surprise that he would not please lawyers either. As an iconoclast, perhaps he might even consider this an additional success.

Hickson et al., *supra* note 94, at 1359, 1583 (noting that “[f]amilies expressed dissatisfaction with physician-patient communication”); LaRae I. Huycke & Mark M. Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 ANNALS OF INTERNAL MED. 792, 798 (1994) (finding that dissatisfaction with modern health care motivates patients to frequently contact law firms); Ann J. Kellett, Comment, *Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients*, 1987 MO. J. DISP. RESOL. 111, 130 (urging an examination of causes leading to medical malpractice lawsuits); Amy B. Witman et al., *How Do Patients Want Physicians to Handle Mistakes?*, 156 ARCHIVES OF INTERNAL MED. 2565, 2567 (1996) (“[A]n overwhelming majority of patients want the physician to acknowledge the error in some way.”).

