

Midwest Surgical Association Presidential Address: August 2003
*Does No Good Deed Go Unpunished? Notes to a
Young Surgeon*

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FIRST, ALLOW ME to express my appreciation and gratitude to the members and supporters of this organization for its continued survival and prosperity. My family and I have treasured these August meetings and the many new and renewed friendships they have brought us. I have also learned much from the presentations. Where else can you learn of buggy injuries and Notch signaling at the same meeting? Thanks also to the Nominating Committee for appointing me as your president for the past year. It has been an interesting and unique undertaking.

Today we are beset by all sorts of change: decreased remuneration, increased fragmentation and specialization, lawsuits increased in number, awards and craziness, and consequently increased malpractice fees, particularly in my home state of Pennsylvania. As probably your oldest president, approaching the top of the hill and seeing the other side, I have been acutely aware that this society was founded for the benefit of young surgeons. So, I thought I should focus my talk to the youngsters among us. I was initially troubled that perhaps our society has been aging, but in fact the median age of 72 new members over the past 5 years has been 39 years, so the median age of the group cannot be too much higher. Also, every senior surgeon in this group is extremely generous and unselfish with her or his wisdom, and as such, provides an excellent source of counsel for our younger colleagues. I also tried to counterbalance my white hair and presenility by inviting our youngest Harridge lecturer.

Malpractice and Tort Reform

In Pennsylvania, malpractice insurance for a general surgeon just out of residency or fellowship is at least \$120,000 per year. For a young orthopedist, it is \$160,000. You can bet that there are not nor will there

be societies in that state for younger surgeons. While malpractice insurance in the Midwest is not so onerous, remuneration per case has waned and expenses have increased, so no younger surgeon is overly wealthy. I believe we have been mindful of this in offering free registration to our new members for their first year of membership. We shall need to consider venues for our future meetings that can be afforded by younger members in order to be faithful to the group's charter.

I'm aware that a few of the states in the Midwest already have what I would consider intelligent mechanisms to reduce legal folly such as judicial review of the validity of a medical liability case. Even so, there is probably no state invulnerable to the kind of travesty we've seen in Pennsylvania as long as juries decide the guilt or innocence of a physician defendant and set the amount of awards without ceiling.

To give you a flavor of what we're facing, I'll broadly describe a case wherein a heavy smoker was admitted to an ER in full cardiac arrest in one of Pennsylvania's prestigious hospitals. An aortic balloon was inserted transfemorally, and cardiac function was restored. The patient was taken to surgery where aortocoronary bypasses were performed. Shortly thereafter, the left leg was found to be ischemic and a femoral graft was inserted by the vascular surgeon. The graft then clotted several hours later, and the patient eventually was found to have heparin-induced thrombocytopenia. The leg was not salvageable and therefore amputated. The result? A multimillion-dollar verdict in favor of the plaintiff against the vascular surgeon. This was before the recent law passed, which requires the expert witness to be boarded in the specialty of the defendant. The expert here was a general practitioner.

The AMA now describes 19 states in crisis over medical liability issues. Only Indiana and Wisconsin are free from a medical liability crisis in the Midwest, but Ohio has just passed legislation with a cap on noneconomic damages. There are now over 1000 hospitals throughout the country that cannot staff Emergency Rooms. Fifty-eight per cent of malpractice payouts now go to lawyers and over 70 per cent of all

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medical liability claims result in no payouts to claimants. In 2000, medical liability rates increased over 30 per cent in eight states and multimillion-dollar verdicts increased 45 per cent from 1998 to 1999. In 1997, only two medical liability verdicts topped \$20 million. In 2001, at least 12 went above \$20 million and three exceeded \$100 million, including a \$269 million judgment.

Nationally there are \$28 billion in direct costs of the medical liability system and between \$75 billion and \$125 billion in costs of defensive medicine.^{1,2} There are many examples of medical under-service directly relating to physician retirement or movement because of the malpractice insurance crisis. However, the recent defeat in the U.S. Senate of S.11, a bill offering caps in noneconomic jury awards and shifting more of the jury awards to the plaintiff and away from the lawyer brought the following statement in the Association of American Trial Lawyers of America website. "In a great victory for the civil justice system, the medical malpractice bill went down to defeat July 9 by a vote of 48-49. This is a major victory in the fight to preserve the legal rights of American families."

It seems that the current legal system often and increasingly assumes a perpetrator whenever there's a victim. When the natural consequences of an illness or a surgical procedure are viewed as malpractice, a surgeon cannot survive. Furthermore, even if a verdict is rendered in favor of the surgeon, the trial and its attendant time and anguish have dealt a heavy blow to confidence and well-being. Many in high-risk states have taken the approach of avoiding all situations with potentially tragic outcomes, which passes the problem directly on to the patients in those underserved areas. Agents of the state governments of Pennsylvania and New Jersey are already warning that leaving the states could evoke lawsuits for abandonment.

Limiting awards for pain and suffering such as have been in place in California for 25 years is one partial remedy to frivolous lawsuits, but even in a Republican-controlled senate S.11 could not even be opened for discussion. A more ideal system of justice is advocated by an organization called Common Good.¹ They believe that the tort system in medical justice is "so broken that just tinkering around the edges of it, or simply trying to cap damages without making other reforms, isn't going to solve the problems." They find that large jury awards correlate almost perfectly with bad outcomes and severity of injury, but not necessarily with bad care or what any of us would consider malpractice. Thus, "since jury awards and lawsuits don't correlate with . . . bad behavior, you have a legal system sending out totally random deterrence signals that don't make any sense." They advocate either "an administrative system or special medical court that has

expert decision-makers who can draw on expertise and medical science to make law about the standard of care and about what's negligence and what's not." What exists now is "really no law. . . . It just changes from jury to jury." In other words, we have no standards of care in the current legal system. Obviously, such a system would limit legal remuneration and is therefore probably doomed. An Illinois senator arguing against S.11 remarked that if we can trust a jury of people to determine the death penalty for a defendant, they should be able to determine a financial award for a plaintiff in a medical liability case. I notice he didn't assert their ability to distinguish medical error from medical complications. Any retired surgeon (or even a retired dermatologist or general practitioner in some states) can take the stand for thousands of dollars and declare malpractice in a situation he or she may not even understand, and a jury of nonphysicians and non-scientists has no way to differentiate this from scientific truth. If the focus of the jury is primarily on the sad state of the plaintiff and not on the scientific evidence, huge awards may be granted without medical malpractice. Sadly, the fact remains that, as a politician patient of mine once put it, when one has the lawyers and the politicians in league against the doctors, all the doctors can hope for is that a number of the lawyers and politicians get sick and need medical treatment. Hopefully he was wrong, and new political awareness on the part of patients and physicians will allow effective reform to emerge.

All of this cannot be comforting to the young surgeon. Having just completed an expensive and arduous residency, she or he should be expecting a grateful welcome from prospective sufferers. Instead, patients are suspicious and there is a lawyer around every corner watching the doctor's every move and every patient event. Malpractice premiums are ballooning and reimbursements are flat or decreasing. What's a young doc to do?

Suggested Responses

Other than to move to states with medical liability tort reform and low insurance premiums, my advice would be a three-pronged approach: become active and angry politically, be the best you can be surgically, and try not to let the current medico-legal and economic binds divert your attention from your goal.

First the political. Doctors have never been very active politically as a group and have never acted together as a profession. It seems competition within and between specialties and hospitals is the natural condition. Pessimism abounds. Obviously, nothing can be accomplished politically without large numbers of the

entire medical community acting cohesively. Then perhaps politicians will listen and treat us fairly and appropriately. There are a number of new groups formed specifically in reaction to the medical liability issue, and established groups such as the American College of Surgeons and the AMA have demonstrated good leadership. We each should become as involved as possible in these issues, both locally and nationally. We are all at risk here. The ACS website is a good start.

Secondly, the competency issue. No matter where the liability crisis takes us, it is clear that we are under more scrutiny and suspicion than ever from our patients, lawyers, and hospital workers. It is natural to feel hurt, angry, misunderstood, and underappreciated in these conditions. I don't think they will change for quite some time, so we need to deal with them. Although quite natural, responses out of anger and hurt feelings will not help in the hospital, in the office, or the home. These are best used, if at all, in the nonhospital political setting. We clearly need to be as competent and caring as possible to our patients. This is nothing new. The only thing new is that there is a virtual lawyer behind the shoulder of every patient. We need to continue our reading and thirst for knowledge throughout our surgical lives. We will be more and more required to accrue CME credits and to retest for competency. We should take these requirements on with acceptance, and attend many fine meetings such as this.

All sorts of work and family demands plus the desire to keep our incomes steady push us to hurry and to multiply our work and decisions, but more mistakes are made in this kind of rush, and it's not enjoyable. Corporations may increase productivity with new technology, as we probably have somewhat with staplers and harmonic scalpels, but any good operation still requires care and nearly as much time as it did 20 years ago. We need to try to slow down and practice surgery, as it ideally should be; to spend time enough with patients to know their complete health pictures. We and our families need to remain healthy, happy, and well-rested. The only way to do all this is to manage time well. Even then, you will be pressured to do much more than is comfortable. Sometimes you'll need to take a week off just to catch up. If you need more money, instead of extreme multitasking, try investing in property or the stock market *with expert help*. You will never make as much income as the cardiac surgeons and ophthalmologists. A broker friend told me that as a group, doctors were the worst investors. Probably for the same reason we're the worst airplane pilots, trying to fit the flight into our own needs rather than into what the environment/situation calls for. Spending may also need curtailing.

You may need to drive an American car rather than a fancy import.

I think it's also prudent to refer patients rather than do one kind of case rarely. We all do more of certain procedures than others. That's one of many reasons why groups such as this and the ACS are so valuable, bringing us back to our roots and fundamentals, learning about advances in other subdisciplines as well as our own. It's normal and essential that we differentiate. The advantage of specialization is just that: we regard what we do as special and have more confidence when we've done many rather than few cases. Look around you and you'll see those specializing in laparoscopy, endocrine, trauma, vascular, colorectal, transplant, breast, bariatric, upper GI, pancreatic, esophageal, pediatric, liver, inflammatory bowel disease, endoscopy—and surgical oncology. And those in surgical oncology have become further specialized into different tumor and organ systems. There's just no way one person can possibly do it all and expertly.

I provide just one example to illustrate the advantages of patient referral. Four years ago, Dr. Chao presented at this meeting a series of cases with operations at other hospitals wherein a pancreatic cancer was judged unresectable. They then presented to me; most were treated with neoadjuvant chemoradiotherapy and then had resections.³ Three of those 22 patients have now survived beyond 5 years, of their initial procedures, and one is alive and well 15 years after the first exploration. Median survival is as good as any series of resections for pancreatic adenocarcinoma. If you are not comfortable doing pancreatic resections for tumors close to the superior mesenteric vessels, then perform laparoscopy to rule out distant metastases and refer the patient to someone who is comfortable. We have now performed resections for 51 patients with at least significant superior mesenteric vein narrowing or short segment occlusion (Ishikawa III to V). Two-year survival is 42 per cent and 3-year survival 23 per cent in those with preresectional chemoradiotherapy. Three years is a long time, not to be reached without resectional surgery.

Lastly, how to deal with these harsh times. If I had addressed you 5 years ago, I know I wouldn't have had any good advice as to how to deal with the stresses of your situation. I would have seen you working harder and bringing in less, among more and more demands, obstacles, and dangers. Throw in a medical liability system out of control, and it would have seemed desperate. So, I went out to the golf course to ponder what I could say. My experiences there and my reading on golf have produced a few ideas. I don't know that it has helped my game that much, but it has certainly helped my attitude and enjoyment of the game, and in turn, it has helped me more easily tolerate the vicissi-

tudes of modern-day surgery. Like a golfer surrounded by onlookers and about to make a shot of great importance, we all need to try to relax, remember the fundamentals of our craft, and not let any annoyance force us into making mistakes and bad decisions.

I'm not advising you to take up the game of golf, but it does have much to teach about how to approach life and stress. Furthermore, when you become as decrepit as I am, it's about the only game available. Walter Curtis once said, "Golf develops the good qualities of a man's nature and softens the poor ones. It is the developer and builder of character without a peer. It is a leveler of rank and class, where rich and poor meet on common ground. It cultivates patience under adversity and yet keeps alive the fires of hope."⁴ Peter Jacobsen said, "One of the most fascinating things about golf is how it reflects the cycle of life. No matter what you shoot, the next day you have to go back to the first tee and begin all over again and make yourself into something."⁵ Not bad advice for a surgeon.

I found an important message in *Zen Golf*, where we are reminded that in each of us is a wonderful, natural golfer with an excellent swing.⁶ All of the mistakes we make come from inattention, worry, lack of confidence, anger, and frustration. It's the few (in my case) near perfect shots that bring us back to the next round always hopeful. We are advised to conduct ourselves impeccably, joyfully, and with great care at all times, as if a 5-year old were watching us. Yes, we will sometimes arrive in difficult situations. We will deal with them better by approaching the situations with curiosity, practice, and confidence rather than anger and inattention.

Finally, words to remember for a well-trained surgeon: "Confidence is a change in attitude that makes the seemingly unworkable workable. This doesn't mean that all of a sudden everything is going to go our way. But it does mean that we can appreciate life even when things don't go our way. We have the resources to live in the challenge."⁶

In closing, I ask you to imagine the country doctor out here in the heartland before medicine became a business, before health insurance and Medicare. He had much less knowledge and therapeutic power, but

he understood what patients needed and had time to be a sympathetic listener. Modern doctors will never again be able to spend as much time listening and relating—it's just too expensive for both. One hears that most of the increased costs of medical liability insurance and decreased remuneration will be passed on to the patient. True, medical insurance costs will rise, but probably the greater cost is emotional: voice-mail rather than a human voice, longer waiting times and less time with the doctor, who has less time to be fully human. Even so, we should try to retain as much of that Midwest country doctor's spirit and sense of humor and humanity as possible. Without it, our surgeon-patient relationship is impoverished. We are privileged to see anatomy, disease, the wonders of the human body and its healing power rather than just seeing pictures or words in a book. We are all very lucky to be surgeons. No other profession can save or palliate as many lives so immediately. Our tasks are simple: to keep an eye on the ball and our heads down each time we approach an encounter in the medical world; to strengthen ourselves politically, professionally and personally. The goal: to do our very best to protect our patients and our families, who of course will share any burden placed upon us.

Does no good deed go unpunished? If a good deed is viewed as a punishable offense, then a system is seriously flawed and tragic. Don't let it happen.

Being your president for the past year has been a great pleasure and honor. Thank you.

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