MALPRACTICE LITIGATION INVOLVING PATIENTS WITH CARCINOMA OF THE BREAST

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BACKGROUND: We sought to evaluate recent trends in the United States of America regarding malpractice awards for patients with carcinoma of the breast.
STUDY DESIGN: A retrospective review was performed of 118 cases of purported malpractice in the diagnosis and management of patients with carcinoma of the breast and related problems. The information was tabulated from Westlaw Transmission, a computerized database.
RESULTS: Gynecologists were the specialists most often sued and accounted for 47 percent of the physicians involved in lawsuits. Radiologists were cited in only 13 percent of the cases. Health maintenance organizations (HMOs) were cited in 5 percent of the cases. The most common complaint was delay in diagnosis, made by a plaintiff who detected her own breast mass (52 percent). In 15 percent of the cases, the plaintiffs complained that a mammogram was not obtained, and 9 percent complained that other diagnostic tests, such as ultrasound or fine-needle aspiration biopsy, were not performed. The average delay in diagnosis was 14 months. The average award to plaintiffs with carcinoma of the breast was $691,449. The average plaintiff's age was 44 years.
CONCLUSIONS: Most malpractice complaints related to carcinoma of the breast are instituted by women under the age of 50 years who identified the breast mass by themselves and were assumed by their physicians to have fibrocystic disease of the breast. Complaints can be expected to increase regarding failure to order further diagnostic tests, such as ultrasound or fine-needle aspiration biopsy, despite a negative mammogram. Complaints against HMOs are now also being made, citing failure to properly diagnose or treat patients with carcinoma of the breast. *J. Am. Coll. Surg.*, 1995, 181: 315-321.

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MALPRACTICE LITIGATION involving patients with carcinoma of the breast has become an increasing problem for physicians involved in medical care for women in the United States of America (U.S.A.) (1–3). It has been documented to be the second highest cause of indemnity payments by insurance companies in the U.S.A. (4). This estimate is based on the findings of the Physicians' Insurance Association of America (PIAA) data collection, a retrospective review of 273 legal actions, in which payment to the plaintiff was made and was resolved prior to 1989. The total indemnity payments for these cases was $60.5 million, plus an additional $5.3 million in handling expenses.

The PIAA data led to several conclusions, including the findings that women younger than 50 years of age accounted for 84 percent of the total reported paid indemnity claims, carcinoma of the breast was most commonly detected by the plaintiff, and delay in diagnosis was the most frequent complaint of the plaintiff. The study found that mammograms were interpreted as negative in 35 percent of patients in whom carcinoma of the breast was present. Other authors have confirmed that younger patients who discover a mass, and have been clinically diagnosed as having fibrocystic disease of the breast, were most often claimants in malpractice litigation (5, 6). Gynecology has been recognized as the specialty most often involved in these suits (4–6). However, while there were a greater number of gynecologists involved in the lawsuits, cases involving surgeons had the highest indemnity payment per case (5).

Despite the recognition that reform of medical malpractice litigation is indicated, there has been little substantial tort reform to date. In New York, the legislature passed a variety of statutes, effective June 1, 1985, that were aimed at reducing the volume of malpractice suits. The New York statutes include: reducing plaintiffs' lawyers' compensation for malpractice cases, requiring a Certificate of Merit reflecting consultation with a

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physician before bringing the action, abolishing joint and several liability among defendants for noneconomic loss (this applies to damages for pain and suffering and reducing the plaintiff's incentive to bring in a party as a "deep pocket," independent of the true percentage of their liability), and requiring that verdicts be reduced to "present value" and be paid out through the purchase of annuities or structures. A structure, or an annuity, costs less than the actual verdict amount.

California's Medical Injury Compensation Reform Act (MICRA) was a tort reform package which included a $250,000 cap placed on noneconomic damages and decreased the statute of limitations to one year from discovery in most cases and to three years maximum (7, 8). Additionally, the plaintiff's attorney was required to have the case reviewed by a physician and file a Certificate of Merit with each lawsuit. As a direct result, California has been successfully moderating the cost of malpractice insurance premiums.

To further evaluate malpractice litigation concerning patients with carcinoma of the breast and to identify recent trends, we reviewed 118 cases. Most of these were instituted since 1989.

METHODS AND MATERIALS

A computerized database of voluntarily reported cases, the majority of which came to trial since 1989, is available from Westlaw Transmission (Hoscham, Pennsylvania). Westlaw Transmission obtains their information from Jury Verdict Research, Inc., an organization that collects data regarding purported medical malpractice cases that come to trial. They conduct surveys by individual state and estimate that they obtain information concerning approximately 60 percent of cases (9). To date there is no way to determine the completeness of this registry, as there is not yet a uniform compulsory listing of malpractice cases in each state. Settled cases are probably underestimated, as some settlements have "no publicity" clauses and, therefore, no report of these cases is issued.

The information provided by this database includes the state in which the case occurred, the trial date, the outcome, the primary injury claimed, and the damages awarded. Specific details of the cases were not included in some instances. The information was then tabulated and analyzed according to the type of liability, specialty of the physician, specific complaint, length of delay in diagnosis claimed, outcome, and social data relevant to these awards.

RESULTS

The ages of the patients were available in 90 of 118 instances and ranged from 20 to 73 years, with an average age of 44 years. Relevant social data and monetary awards for 53 of the 118 instances in which awards were decided in favor of the plaintiff, or there was a monetary award before trial, are listed in Table I. There were 33 cases decided in favor of the plaintiff and an additional 20 were settled with a monetary award before the trial. (The 65 cases that were decided in favor of the defense are not included in this table). Of the 11 instances in which age was available and the monetary awards were equal to or greater than $1,000,000, all but one of the patients were less than 50 years of age. Of the 17 instances in which the awards ranged from $500,000 to $999,999, all but four were given to patients younger than 50 years of age. The average award was $691,449. The highest monetary awards given by state were in New Jersey ($3,000,000), Georgia ($2,000,000), and New York ($1,900,000). No trend was noted according to the state in which the case was instituted or in the outcome of the award. There were 12 patients who died from carcinoma of the breast; the average award in those cases was $639,101. For the 14 cases with documented metastatic disease, the average award was $749,208.

The specialties of the physicians involved in the litigation were available for 90 of the 118 cases. Gynecologists were most commonly cited (47 percent), followed by surgeons (18 percent), internists or general practitioners (13 percent), and radiologists (13 percent). There were four plastic surgeons cited (4 percent). In three of these four cases, the patients complained that unnecessary surgery was performed, e.g., bilateral subcutaneous mastectomy for benign disease. The fourth case involved a complaint against a plastic surgeon for disfigurement and loss of function of the plaintiff's arm following mastectomy. The two complaints involving radiation oncologists (2 percent) were for cellulitis and severe scarring following treatment. A single anesthesiologist (1 percent) was claimed to have caused quadriplegia by improper administration of anesthesia during mastectomy. One osteopath was sued.

While most complaints were against individual physicians, there were 13 institutions or organizations cited: seven hospitals, four health main-

TABLE I.—SOCIAL DATA RELEVANT TO SETTLEMENTS OR AWARDS TO PLAINTIFFS

Outcome	*Pt. No.*	*Age, y*	*State*	*Monetary award**	*Metastatic disease*	*Deceased*	*Occupation*	*No. of children*
S	1	42	TX	200,000	+			
S	2	32	TX	351,000		+	Homemaker	6
P	3	31	MO	756,355	+		Manager	
S	4	45	MA	935,000		+		
P	5	65	CA	25,000			Homemaker	
S	6	44	ND	265,000				
P	7	49	CA	736,000				
P	8	45	MI	667,000			Executive	
S	9	62	GA	2,000,000			Homemaker	
S	10	54	CA	325,000	+		Bookkeeper	
P	11	73	OH	50,000			Homemaker	1
P	12	36	KY	1,500,000				
S	13	55	NY	300,000		+		
P	14		MN	212,000				
S	15			400,000				
P	16	37	NJ	3,000,000				
S	17		CA	190,000	+			
P	18	43	WA	970,000	+		Food presenter	
P	19	35	MD	911,700	+		Teacher	
P	20	44	RI	1,307,000	+		Legal secretary	1
S	21	68	CA	100,000		+	Retired	2
P	22		CA	425,236		+		
S	23	54	NY	325,000		+	Homemaker	
P	24	30	WA	1,300,000			Bank teller	
P	25		WV	1,000,000			Homemaker	
P	26	47	NY	223,000		+		
P	27	42	CA	420,600				
P	28	58	KA	900,000				
P	29	52	NY	504,000			Lunchroom helper	
P	30	26	CO	325,000		+	Computer programmer	
S	31	35	CA	200,000				
P	32	54	VA	775,000	+		Administrative assistant	
P	33	49	NY	1,900,000				
P	34	58	PA	200,000			Retired	
S	35		MN	120,000				
P	36	27	NJ	850,000		+		1
P	37	53	WA	195,000				
P	38	58	VA	250,000			Manager television station	
P	39	57	MI	875,000				
P	40	42	VA	750,000			Teacher	
S	41	48	MA	640,000	+			
S	42		IL	45,000				
S	43	34	CA	29,999				
P	44	30	NV	1,600,000	+		Insurance officer	
P	45	43	NJ	765,000				
P	46	49	NJ	1,000,000	+			
P	47		NJ	1,284,980		+		
P	48		CT	700,000		+		
S	49	40	IL	1,850,000		+		
P	50	50	VA	179,090				
S	51		MA	815,000	+			
S	52	64	MN	242,500	+			
P	53	32		756,355	+		Homemaker	

*Monetary awards are given in dollar amounts.
Pt. No., Patient number; y, years; S, settlement before a trial; P, plaintiff award; and +, positive.

tenance organizations (HMOs), and two insurance companies. The HMOs were cited for improper treatment as follows: denial of patient request for a follow-up six-month mammogram resulting in delay of diagnosis of the carcinoma of the breast, improper treatment with bilateral subcutaneous mastectomy for benign disease, delay in diagnosis of carcinoma of the breast by failure to perform diagnostic tests, and delay in diagnosis of carcinoma of the breast by failure to refer to a specialist for biopsy. The two complaints against insurance companies were for failing to pay benefits.

Delay in diagnosis claimed by the patient is

TABLE II.—DELAY IN DIAGNOSIS CLAIMED BY PLAINTIFF, No.=41

Delay, mo	*No.*	*Percent*
1 to 3	4	10
4 to 6	10	24
7 to 12	14	34
13 to 24	8	20
25 to 36	3	7
>36	2	5
Total	41	100

Average, 14 months.
No., Number, and mo, months.

given in months in Table II. As noted, there was a delay of 12 months or less in 68 percent of cases in which this information was available. Ten percent of plaintiffs claimed a delay of only one to three months, all of these claims had outcomes in favor of the defense. The average delay claimed was 14 months.

The specific complaints of the plaintiffs involved in these lawsuits are listed in Table III. Since in some cases there were multiple complaints, the total number was 167. The most often cited reason for a lawsuit was that the patient detected a lump and the physician failed to refer her to a specialist for biopsy (Category 1; 53 percent). In these instances, the patient was most often assumed to have fibrocystic disease. In one instance, the mass was attributed to the plaintiff's pregnancy.

The next most common complaint was that the physician failed to order either a mammogram (15 percent) or other diagnostic test, such as fine-needle aspiration biopsy or ultrasound (9 percent) if the mammographic findings were negative. These two complaints often accompanied Category 1 complaints. Inaccurate interpretation or performance of diagnostic tests was cited in 10 percent of cases, and a delay in diagnosis of carcinoma of the breast accounted for a total of 90 percent. Treatment-related complaints accounted for 7 percent, while failure to pay benefits and the denial of diagnostic or treatment services accounted for the remaining 3 percent.

DISCUSSION

This study confirms the findings of previous reports and suggests that additional trends are evolving concerning patients with carcinoma of the breast. The following conclusions are drawn from the current data that confirm previous studies. Malpractice litigation involving patients with carcinoma of the breast most often involves relatively young women (4–6). In the current report, the average age was 44 years. The most common complaint was related to delay in diagnosis of carcinoma of the breast (4–6). We found 90 percent of the claims to involve this specific complaint. The plaintiff most often discovered her own mass, which was often incorrectly interpreted by the physician as not being suspicious of carcinoma of the breast. Since the patients were young, the mass was frequently assumed to be due to fibrocystic disease (5, 6). In this regard, Kern (10) cites a study in which 2 percent of carcinomas of the breast were found in females 15 to 34 years of age and 21 percent were found in women between the ages of 35 and 54 years (10, 11). The role of mammography in diagnostic workup of younger women is, at times, misunderstood (6). Negative mammographic findings should not deter a clinician from further evaluation, particularly in the presence of a palpable mass that is suspicious for carcinoma. Gynecologists are most often the specialists cited in these lawsuits, accounting for 47 percent in the current study (4–6). Patients frequently consider their gynecologist to be the primary physician for evaluating diseases of the breast. Therefore, gynecologists assume the greatest liability in the detection of carcinoma of the breast in young women.

A recent trend that is reflected in the data from the cases in this review is the increasingly recognized importance of diagnostic modalities other than mammography for the detection of carcinoma of the breast. Ultrasound may delineate a carcinoma and be particularly valuable in young patients with dense breasts, those individuals most likely to institute lawsuits for failure to detect their carcinoma (12, 13). Likewise, fine-needle aspiration biopsy or core-needle biopsy are both becoming accepted as useful techniques in the diagnosis of carcinoma of the breast. These methods reduce the need for open surgical biopsy (14–20). Although the failure to use these methods accounted for only 9 percent of the complaints, this number can be expected to increase as the role of these techniques assumes greater acceptance. Even when these diagnostic tests were performed, claims that they were not properly performed or interpreted have generated further legal actions. The recent award of $2.7 million to a 37-year-old woman incorrectly diagnosed as having carcinoma of the breast by fine-needle aspiration biopsy, leading to mastectomy, is an obvious example (21). Ultimately, "standards of care" regarding expectations for performing these tests may well be decided by juries, aided, as

TABLE III.—COMPLAINT OF PLAINTIFF

Category		*No.*	*Percent*
1 . . .	Plaintiff felt a lump; physician failed to obtain a biopsy or refer to a specialist	86	53
2 . . .	Plaintiff felt a lump; physician failed to order mammogram	25	15
3 . . .	Plaintiff felt a lump; physician failed to order other diagnostic tests, such as fine-needle biopsy or ultrasound	15	9
4 . . .	Physician failed to read mammogram properly	12	7
5 . . .	Physician failed to notify patient of abnormal mammogram results or abnórmal palpation	4	2
6 . . .	Physician failed to biopsy or remove correct portion of breast that later proved to be carcinoma	2	1
7 . . .	Failure to perform needle biopsy or ultrasound properly	6	3
8 . . .	Physician or organization denied services	4	2
9 . . .	Failure to pay benefit	2	1
10 . . .	Physician performed unnecessary or incorrect surgery	8	5
11 . . .	Other treatment related complaints	3	2
Total		167*	100

*Complaints total greater than 118 due to multiple complaints of plaintiffs in some instances.
No., Number.

they are, by expert medical witnesses called by plaintiffs' attorneys, who will indicate that the standard of care was indeed the reason to perform these tests, rather than on the basis of their cost to an organization (22). Therefore, clearly delineated guidelines as to when these examinations can be expected to be performed may be helpful in the future. Physicians and the public should appreciate that false-positive and false-negative results, while uncommon, may occur with any diagnostic technique other than surgical excision.

Another recent trend noted is that lawsuits against HMOs and insurance companies are appearing with increasing frequency (23). Since cost containment is a basic tenet of an HMO, there may be a disincentive to perform tests, such as fine-needle aspiration biopsy and ultrasound, particularly in young women without a clearly defined mass suggestive of carcinoma. Referral to a specialist, again an additional expense, may not be offered or may occur late. In these instances, lawsuits regarding delay in the diagnosis of carcinoma of the breast may also be expected to increase. The data regarding lawsuits against HMOs are difficult to assess and some HMOs, such as Kaiser Permanente, have been criticized for trying to make this information unavailable (24). However, the Federal General Accounting Office in 1992 reported that information provided by Kaiser Permanente showed that arbitration in California was used in only a relatively small number of malpractice claims annually. Kaiser Permanente estimates that of 3,890 claims which occurred during 1985 and 1989, 40 were resolved through arbitration (24).

The legal implications of a physician's contract with an HMO can be confusing. On August 10, 1976, in the case Madden v. Kaiser Foundation Hospitals, the California Supreme Court ruled that contracts with mandatory arbitration, such as that given by the Kaiser Permanente HMO, are not in violation of an individual's right to trial by jury. This mandatory arbitration led to an efficient and less expensive means of settlement of these malpractice claims in California. Insurance companies largely approve of this process, claiming that there is a significant decrease in cost as a result of mandatory arbitration. Thereafter, in the MICRA, California included binding arbitration for other health care providers and insurance plans (7).

Liability experts warn physicians to consider that, before signing with an HMO, the following specifics should be considered, which might increase physician exposure:

Hold harmless and indemnification clauses. If this is included, the physician pays for settlements against the plan and, in certain instances, the HMO does not retain any liability.

Joint and several liability. If inadequately insured physicians or uninsured physicians are jointly named in an action with another physician, the latter assumes complete responsibility for the award (25).

Regarding hold harmless and indemnification clauses, it should be noted at the outset that one cannot hold another harmless for that other person's negligence. A physician cannot hold a laboratory, even an HMO's laboratory, harmless for negligent processing of a sample, at the very least in New York State, since these agreements have been determined to be violative of public policy. However, hold harmless and indemnification clauses can run from the physician to the HMO, requiring the physician, or in most cases his or her insurance company, to defend not only the physician but the HMO as well.

These clauses can increase the physician's litigation expense. Before entering into such a contract, the physician must contact his or her insurance company to determine the coverage issues that these clauses represent.

As pertains to joint and several liability, of course, the physician who accepts this responsibility always has the right to recover from those "inadequately insured or uninsured physicians," under the rules of indemnification, if indeed they were negligent. However, the fact that they were inadequately insured or uninsured makes the possibility of such a recovery tenuous at best (22).

When a managed care plan and an individual physician disagree regarding medical treatment and the physician complies with the medical plan's treatment, leading to a claim of injury, the physician may be liable. In the case of Wickline v. State of California, the state prevailed in the case. Nevertheless, a warning was issued to physicians (25):

> "However, the physician who complies without protest with the limitations imposed by a third-party payer, when the physician's medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care (26)."

Physicians may not aggressively oppose restrictions to testing or treatment, as this may lead to termination of their contract with an HMO. Control of patient treatment by physicians "dependent upon the plan for the major source of their patients" enables the HMO to control this situation (27).

While commencing lawsuits against HMOs, in contrast to commencing the same against individual physicians, may prove intimidating to patients, the more impersonal character of institutions, such as HMOs, may make them even more acceptable targets for litigation than an individual "family" doctor (22). If the trend toward medical care provided by HMOs increases, added legal protection may be required for physicians practicing in this cost control situation. Some experts predict that the institution of practice guidelines will also increase the malpractice liability of managed care plans as practicing physicians fail to ensure compliance with these guidelines (24).

These 118 lawsuits purporting medical malpractice regarding carcinoma of the breast confirm the findings of previous studies. Additionally, they suggest that the greater public and professional acceptance of other diagnostic modalities, such as fine-needle aspiration biopsy and ultrasound, is becoming increasingly expected in patient evaluation for possible carcinoma of the breast. The failure to perform these tests is the basis of a number of recent lawsuits regarding delay in diagnosis. Recent increasing trends toward managed care and cost containment may pressure physicians involved in the diagnosis of carcinoma of the breast to refrain from costly testing, while public perceptions of carcinoma of the breast treatment success simultaneously compels physicians to pursue an aggressive approach to achieve an early diagnosis.

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