Perspective: **Malpractice in an Academic Medical Center: A Frequently Overlooked Aspect of Professionalism Education**

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Abstract

Understanding how medical malpractice occurs and is resolved is important to improving patient safety and preserving the viability of a physician’s career in academic medicine. Every physician is likely to be sued by a patient, and how the physician responds can change his or her professional life. However, the principles of medical malpractice are rarely taught or addressed during residency training. In fact, many faculty at academic medical centers know little about malpractice.

In this article, the authors propose that information about the inciting causes of malpractice claims and their resolution should be incorporated into residency professionalism curricula both to improve patient safety and to decrease physician anxiety about a crucial aspect of medicine that is not well understood. The authors provide information on national trends in malpractice litigation and residents’ understanding of malpractice, then share the results of their in-depth review of surgical malpractice claims filed during 2001–2008 against their academic medical center. The authors incorporated those data into an evidence-driven educational intervention as a model for helping residents better understand the events that lead to malpractice litigation, as well as its process and prevention.

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Editor’s Note: A commentary on this article appears on page 282.

Every physician is likely to be sued by a patient, and how the physician responds to a lawsuit can change his or her professional life. Medical malpractice has a significant impact on patient safety and the manner in which physicians practice medicine, but even many faculty at academic medical centers know little about malpractice despite the attention paid by the media to escalating malpractice insurance rates and settlement payouts. Although the issue is important to physicians and patients alike, residency programs’ professionalism curricula rarely cover the incidence of medical malpractice or behaviors to avoid it. Residents in training, therefore, have limited exposure to the principles of malpractice law and, as a result, have little understanding of how malpractice will affect their careers.

We believe that information about the inciting causes of malpractice claims and their resolution should be incorporated into education both to improve patient safety and to decrease physician anxiety about a crucial aspect of medicine that is not well understood. In this article, we highlight national trends in malpractice litigation and residents’ understanding of malpractice, then share our research concerning malpractice claims at the NYU Langone Medical Center/Bellevue Hospital (NYU/Bellevue). Finally, we describe the malpractice seminar we developed for surgical residents using those data and propose that such an evidence-driven educational intervention for surgical resident learners can significantly improve their understanding of the causes of malpractice and its resolution through the legal system.

**National Trends in Malpractice Claims**

Since 1975, medical liability costs have risen an average of 11.1% per year, outpacing increases in overall U.S. tort costs, which have risen an average of 8.4% annually. Liability insurance rates for general surgeons, for example, reflect an average physician defense cost of more than $90,000 for a claim that goes to trial in which the surgeon prevails. Median settlement payouts and jury awards are also growing. From 1997 to 2006, they increased from $100,000 to $204,500 and $157,000 to $487,500, respectively.

Despite state and federal action, frivolous malpractice claims continue to contribute to this growth. The number of malpractice suits far exceeds the number of “true negligence” claims: As many as 37% of malpractice claims do not involve an error, and as few as 1 in 35 cases of actual negligence results in a lawsuit. It has been suggested that the majority of medical malpractice suits may not be driven by clinical quality of care but rather by other factors, such as the physician’s level and manner of...
communication with the patient, the plaintiff’s degree of disability, and patients’ lower levels of confidence in physicians due to negative experiences with managed care.

A study of actual technical errors in surgical procedures—which surgeons would characterize as negligence—found that the majority were not committed by newer surgeons or experienced surgeons performing challenging procedures but rather by experienced surgeons doing routine procedures. Thus, operating room procedures aimed at patient safety (e.g., marking the surgical site, confirming the operation and side of the body orally with the patient prior to anesthesia, the timeout) are most important for routine procedures. Residents need to understand that mistakes occur more frequently in simpler procedures, when their guard may be down.

Studies have shown that a significant proportion of residents commit medical errors during the course of their training and suffer considerable emotional distress as a result. Residents coping with their mistakes have been shown to be encouraged by reassurance and the opportunity to learn from mistakes as facilitated by their training programs and faculty. This suggests that residents may benefit from understanding how medical errors affect them personally and are handled by attendings in the context of their practice and the legal system.

Residents’ Understanding of the Malpractice Process

Residents’ lack of knowledge of the causes and resolution of malpractice actions in their roles as trainees has been highlighted by a number of studies. Singh et al. reviewed five insurance companies’ databases for malpractice claims naming trainees from 1979 to 2001. Among the 240 claims identified, remarkably 70% were due to “teammate failures,” such as hand-off problems/miscommunications and lack of supervision by more senior residents or attendings. Rodriguez et al. found that the fear of malpractice markedly decreased emergency medicine intern’s enjoyment of their emergency room responsibilities. However, this fear decreased as they progressed through their residencies.

More worrisome are Helms and Helms’ findings from their review of 136 malpractice actions that involved residents and proceeded to litigation. Residents were on the side of the prevailing party in only 44% of cases, meaning that in 56% of the cases residents bore some responsibility in the judicial result. Residents need to understand that one’s status as a trainee does not confer immunity from being named as a malpractice defendant.

Patterns of Malpractice at a Large Academic Medical Center

As we began to develop our malpractice professionalism seminar in the summer of 2008, we decided that it would be important to share concrete examples drawn from actual malpractice claims. Working with the NYU/Bellevue Risk Management Department, we collected data from the malpractice claims management database. We identified and reviewed all claims involving the Department of Surgery (including ambulatory, cardiothoracic, general, pediatric, transplant, vascular, and trauma surgeries) from July 2001 through May 2008.

During the seven-year study period, 18,753 surgical procedures were performed and 101 malpractice actions (formally known as “notices of claims”) were brought against the Department of Surgery, representing 0.5% of all operations performed. At the time of data collection, 60 of the cases had been resolved (closed cases) and 41 were still in litigation.

Of the 60 closed claims, 33 (55%) progressed to a formal lawsuit. Thus, 27 (45%) of the notices of claims did not result in a filed lawsuit. Of the 33 cases in which a lawsuit was filed, 23 (70%) were settled for a monetary amount and 10 (30%) were closed without a financial settlement. Only 1 (3%) of the 33 resolved cases progressed to trial, and it was settled prior to verdict.

Consequently, there were 23 malpractice monetary settlements resulting from the 18,753 surgical procedures performed. This yields a risk of 0.12%—in other words, roughly 1 of 1,200 surgical procedures at NYU/Bellevue results in an adverse legal action. This is an extremely low incidence of malpractice settlements and verdicts—a much lower rate than, in our experience, practicing academic physicians generally believe to exist.

Among the 23 settled malpractice cases, 10 (43%) involved improper documentation, 7 (30%) cited inadequate informed consent, 8 (35%) involved a technical error, 6 (26%) were related to a system failure, and only 1 (4%) cited inadequate resident supervision. (Some of the 23 cases were associated with deviations in more than one of these areas.) Specific issues leading to a malpractice action included bowel perforation during laparoscopy, retained foreign bodies, arterial injury during resection of a neck mass, improper positioning during surgery, failure to follow up on a lung nodule revealed on a routine X-ray, and malfunction of a heart–lung machine.

One Model for Resident Professionalism Education in Malpractice

On the basis of our review of both national trends in malpractice claims and malpractice claims against NYU/Bellevue from 2001 to 2008, we prepared an evidence-driven, interactive professionalism seminar on malpractice. The target learners were 16 NYU surgical residents (spanning postgraduate years 1–5). Immediately before the seminar (which we delivered in October 2008), we asked them to complete a 13-question, written multiple-choice survey to determine their baseline level of malpractice understanding (Table 1). This study of deidentified surgical residents was approved by the New York University School of Medicine institutional review board.

Our resident learners’ baseline knowledge was quite poor. Analysis of the pretest data revealed that the surgical residents correctly answered an average of 52% (SD 15%) of the 13 questions.

Immediately after the pretest, we delivered an interactive, hourlong seminar in which the surgical education team discussed the events that prompt patients to file malpractice claims and applicable malpractice law. The PowerPoint-based seminar included the definition of malpractice, statistics on the financial and emotional tolls of medical malpractice on physicians, examples of commonly cited forms of
medical malpractice, the legal steps of a malpractice suit, discussion of how malpractice law affects residents, and the characteristics of surgical malpractice claims at this academic medical center. The seminar also included in-depth case reviews of seven specific claims, which were analyzed as examples of issues that can lead to a patient’s filing a lawsuit. We concluded the seminar with recommendations and instruction on proper documentation (with examples of appropriate ways to correct errors when writing in a patient’s chart), key aspects of informed consent and the language that should be used in obtaining it, and what residents should do (and not do) if they are sued.

At the conclusion of the seminar we asked the 16 residents to complete the questionnaire again. Analysis of residents’ posttest responses showed improvement to 81% (SD 10%) correct answers ($P < .001$, paired $t$ test $= 6.46$). Before the seminar, the topics about which residents were least informed ($\leq50\%$ answered correctly) were the basic tenets of malpractice law, the frequency of malpractice actions and settlements, plaintiff legal fees, the time until resolution of a malpractice claim, and important aspects of informed consent. Residents showed improvement in all these areas except one (initial step in a lawsuit) on the posttest. Additionally, on posttesting, the residents continued to struggle ($\leq75\%$ answered correctly) with questions related to legal fees generated by malpractice actions, the time frame from the filing to resolution of a malpractice lawsuit, and the legal steps in the initiation of a lawsuit.

### Recommendations

Residents’ poor understanding of medical malpractice may be due to its omission from professionalism curricula. We believe the time has come to add an understanding of the causes and resolution of malpractice to the core resident curriculum. The increasing costs of medical malpractice litigation, the emotional toll of the malpractice process, the ordering of excessive tests for “defensive” medical purposes, and, most important, malpractice’s impact on patient safety warrant improved residency education in malpractice law and issues. On the basis of our findings, we have added our malpractice seminar to the required professionalism curriculum for NYU/Bellevue surgical residents. It is important to prepare residents for this challenge which they

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**Table 1**

<table>
<thead>
<tr>
<th>Question</th>
<th>Correct answer</th>
<th>Pretest</th>
<th>Posttest</th>
<th>No. (%) of residents giving correct answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to establish medical malpractice has been committed, an attorney must prove:</td>
<td>A physician breached the local community standard of care</td>
<td>5 (31)</td>
<td>14 (88)</td>
<td></td>
</tr>
<tr>
<td>A formal lawsuit begins with:</td>
<td>Filing of a complaint</td>
<td>5 (31)</td>
<td>2 (13)</td>
<td></td>
</tr>
<tr>
<td>In the eyes of the law, resident physicians of all levels are expected to conform to the standard of care expected of attending physicians in their specialty field.</td>
<td>True</td>
<td>12 (75)</td>
<td>16 (100)</td>
<td></td>
</tr>
<tr>
<td>A physician is only subject to civil penalties for alterations made to a patient’s chart after the fact.</td>
<td>False</td>
<td>14 (88)</td>
<td>13 (81)</td>
<td></td>
</tr>
<tr>
<td>What are the chances that you will be sued for malpractice in your career?</td>
<td>100%</td>
<td>7 (44)</td>
<td>16 (100)</td>
<td></td>
</tr>
<tr>
<td>Disclosure of information about a medical error increases the risk of a lawsuit being filed and of a larger settlement.</td>
<td>False</td>
<td>16 (100)</td>
<td>16 (100)</td>
<td></td>
</tr>
<tr>
<td>What is the percentage of surgical procedures that result in a malpractice action at your home institution?</td>
<td>0.3%</td>
<td>8 (50)</td>
<td>14 (88)</td>
<td></td>
</tr>
<tr>
<td>Most malpractice lawsuits proceed to trial and are decided by a jury verdict.</td>
<td>False</td>
<td>14 (88)</td>
<td>16 (100)</td>
<td></td>
</tr>
<tr>
<td>The most common root cause of surgical malpractice actions at your home institution is:</td>
<td>Improper documentation</td>
<td>11 (69)</td>
<td>16 (100)</td>
<td></td>
</tr>
<tr>
<td>What percent of a settlement typically goes to the malpractice attorney?</td>
<td>33%</td>
<td>5 (31)</td>
<td>12 (75)</td>
<td></td>
</tr>
<tr>
<td>What is the average time to resolution of a malpractice claim at your home institution?</td>
<td>3 years</td>
<td>3 (19)</td>
<td>7 (44)</td>
<td></td>
</tr>
<tr>
<td>What is the percentage of surgical cases at your home institution that result in a malpractice monetary settlement?</td>
<td>0.1%</td>
<td>8 (50)</td>
<td>15 (94)</td>
<td></td>
</tr>
<tr>
<td>The single most important aspect of informed consent to protect the surgeon is:</td>
<td>A doctor note in chart</td>
<td>2 (13)</td>
<td>14 (88)</td>
<td></td>
</tr>
</tbody>
</table>

* Sixteen surgical residents across all levels of training at New York University Langone Medical Center/Bellevue Hospital responded to a 13-question multiple-choice test before and immediately after a one-hour interactive seminar on malpractice led by surgical education faculty in October 2008.
will surely encounter during their careers. Both residents and patients will be the beneficiaries.

Acknowledgments: The authors wish to thank Julianne Cameron for her coordination of and data collection for this project.

Funding/Support: This study was funded in part by generous grants from the Josiah Macy, Jr. Foundation, the Arnold P. Gold Foundation, and the NYU Program in Medical Education Innovations and Research.

Other disclosures: None.

Ethical approval: This research on deidentified residents-in-training was approved by the institutional review board of the New York University School of Medicine.

Previous presentations: The abstract of an earlier version of this article was presented at the 29th Annual Meeting of the Association for Surgical Education; April to May 2009; Salt Lake City, Utah.

References