

**THE CROSSROAD: AN ANALYSIS OF THE  
INTERSECTION BETWEEN MEDICAL  
MALPRACTICE, HEALTH CARE COSTS,  
AND PROSTATE CANCER**

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*The debate over health care, medical malpractice, and rising costs has been raging in the United States for many years. There are many suspected sources for the high cost of health care, including the medical malpractice system and inefficient spending on end-of-life care. While this issue spans the spectrum of many diseases, prostate cancer in particular illustrates the conundrum of American health care. In this Note, Mr. Hernandez focuses on prostate cancer, because it particularly affects the elderly due to its propensity to strike older men and grow at a slow rate for many years. Mr. Hernandez discusses the prevalence of prostate cancer; current treatments, including the controversial watchful waiting option; end-of-life costs; and the practice of defensive medicine that currently results from physicians' fear of medical malpractice liability. Currently, physicians can face liability by recommending treatment options such as watchful waiting rather than conducting expensive tests and treatments that often do not significantly aid the patient. In conducting this analysis, Mr. Hernandez describes three possible solutions to reform the medical malpractice system to ensure cost-effective treatment for prostate cancer. Mr. Hernandez considers imposition of damage caps in medical malpractice suits, the practice of preventative medicine, and changing the medical standard of care. Ultimately, Mr. Hernandez concludes that a change to the medical standard of care that better reflects the expertise of specialized medical organizations such as the American Urological Association would result in*

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The author would like to dedicate this Note to his father, for his inspiration, and to his mother, for always being there for him.

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decreased fears of medical malpractice liability and adherence to both new and cost-effective treatment options. Mr. Hernandez explains that with this change, doctors will no longer increase costs to the entire system because they made "bad bets" under fear of liability.

## I. Introduction

In the grand circus of the American political arena in 2009, the center ring belonged to the debate over health care. Regardless of which side of the political spectrum one falls upon, there is no getting around the fact that average health care costs in the United States are significantly higher than in the rest of the world,<sup>1</sup> yet the result of all that spending leaves much to be desired.<sup>2</sup> Instead of arguing over whether a problem actually exists, the various participants in this debate are arguing over the source of these inconsistent and inefficient health care spending numbers.<sup>3</sup>

The medical malpractice system is one of the most commonly suggested sources of high health care costs.<sup>4</sup> Doctors suggest that the liability imposed upon them by malpractice law causes them to practice "defensive medicine," the practice of ordering various tests, treatments, and doctor visits, not so much for the benefit of the patient, but rather as a shield and defense to potential malpractice liability.<sup>5</sup> Naturally, the costs of these tests, visits, and treatments get transferred to patients and their insurers, thereby driving up costs.<sup>6</sup>

The amount of spending involved at the end of a person's life is another frequently discussed area of inefficient health care expendi-

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1. *Health Care Spending in the United States and OECD Countries*, KAISER FAMILY FOUND., (Jan. 1, 2007), <http://www.kff.org/insurance/snapshot/chcm010307oth.cfm> ("It is reasonably well known that for some time the United States has spent more per capita on health care than other countries.")

2. *Id.* ("Despite this relatively high level of spending, the U.S. does not appear to provide substantially greater health resources to its citizens, or achieve substantially better health benchmarks, compared to other developed countries.")

3. See discussion *infra* Part II.D-E.

4. Franklin D. Cleckley & Govind Hariharan, *A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live with Inefficient Doctors?*, 94 W. VA. L. REV. 11, 14-16 (1991) ("Along the road to the present crisis in health care costs, some observers, notably health care providers and insurance underwriters, blamed skyrocketing costs on the civil judicial system . . . [and] set out upon . . . dismantling, state-by-state, medical malpractice tort laws.") (alteration in original).

5. Steve LeBlanc, *Health Care Dispute: Costs of Defensive Medicine*, ABC NEWS (Nov. 4, 2009), <http://abcnews.go.com/Business/wireStory?id=8996182>.

6. *Id.* ("Doctors say the hidden costs of the tests along with malpractice insurance and lawsuit awards are major drivers behind the soaring cost of care.")

tures,<sup>7</sup> commonly seen in instances of elderly patients and patients with chronic disease.<sup>8</sup> Tremendous amounts of money go towards treating patients in these categories, yet the results, in a direct reflection of the national health care crisis, leave much to be desired.<sup>9</sup> In terms of pure economic efficiency, a cost-benefit analysis might lead to more efficient results with these types of patients, but there are many personal and human dignity factors to consider that tend to disrupt “economically rational” behavior.<sup>10</sup>

Where in this grand debate filled with numbers, statistics, and political agendas can we begin to search for answers or even solutions? This Note suggests that the beginning of this search lies at a crossroad. Specifically, a narrow, yet unique area where the topics of end-of-life spending, medical malpractice law, and defensive medicine converge: prostate cancer. The nature of prostate cancer and the various methods employed for its treatment implicate each aspect at issue mentioned above. It is a chronic disease that primarily affects the elderly and is the subject of much medical malpractice litigation due to its treatments, thereby leading to a significant practice of “defensive medicine” by physicians who specialize in this area.<sup>11</sup>

This Note is not intended to solve the health care cost crisis nor does it seek to solve the entire medical malpractice problem. Rather, this Note is a focused look at the problem area of prostate cancer malpractice and various proposed solutions. Part II of this Note explains why prostate cancer is such a helpful place to start the search for a solution to rising health care costs. Part II also offers helpful background information on prostate cancer and its treatments, end-of-life costs, and the practice of defensive medicine. Part III analyzes several proposed solutions for medical malpractice reform, their strengths and weaknesses on solving the prostate cancer malpractice problem,

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7. See Russell Turk, *Reform Health Care Now: End-of-life Costs Are Too High*, DAILY FIN. (July 3, 2009, 12:00 PM) <http://www.dailyfinance.com/2009/07/03/reform-health-care-now-end-of-life-costs-are-too-high/>.

8. See Julie Appleby, *Debate Surrounds End-of-Life Health Care Costs*, USA TODAY, (Oct. 19, 2006), available at [http://www.usatoday.com/money/industries/health/2006-10-18-end-of-life-costs\\_x.htm](http://www.usatoday.com/money/industries/health/2006-10-18-end-of-life-costs_x.htm).

9. *Id.* (“Across the nation, some patients spend much of their final weeks seeing specialists, having tests, trying new drugs. Many die attached to machines, such as ventilators, in hospitals.”).

10. See generally Ezekiel J. Emanuel & Linda L. Emanuel, *The Economics of Dying – The Illusion of Cost Savings at the End of Life*, 330 NEW ENG. J. MED. 540 (1994) (discussing the various difficulties in saving money at the end of life).

11. See discussion *infra* Part II.E.

and their effects on doctors and elderly patients. Part IV offers a recommendation that will best help to resolve the current situation.

## II. Background

Prostate cancer represents a crossroad of many issues relevant to the health care cost debate. The question remains as to why this is the case. The answer lies in the nature of the disease and its treatments.

### A. The Nature of Prostate Cancer

Quite simply, prostate cancer is similar to other cancers and follows the same pattern. Cells in the male prostate gland grow uncontrollably, leading to the growth of tumors.<sup>12</sup> Like other cancers, the malignant cells can then be deposited in the body's lymphatic system and transferred to other areas of the body where they can become lodged, allowing for the growth of secondary tumors, a process known as metastasis.<sup>13</sup> However, prostate cancer is unique because it develops slowly relative to other types of cancer.<sup>14</sup> As a result, prostate cancer takes longer to progress to the point where it could metastasize,<sup>15</sup> which is bad in the sense that it also often takes a long time to grow large enough to be detected.<sup>16</sup>

Prostate cancer is quite prevalent. In men, prostate cancer is the most common cancer and the second leading cause of cancer-related deaths.<sup>17</sup> Due to its slow development, prostate cancer is known to attack men later on in their lives. According to the Prostate Cancer Foundation, only one in ten thousand men under the age of forty will be diagnosed with the cancer.<sup>18</sup> However, this rate increases dramatically to one diagnosis out of every thirty-eight men between the ages of forty and fifty-nine, reaching a high water mark of one diagnosis

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12. *What is Prostate Cancer?*, PROSTATE CANCER FOUND., [http://www.pcf.org/site/c.leJRIRORepH/b.5802045/k.6D36/What\\_Is\\_Prostate\\_Cancer.htm](http://www.pcf.org/site/c.leJRIRORepH/b.5802045/k.6D36/What_Is_Prostate_Cancer.htm) (last visited Oct. 30, 2010).

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

17. José M. Hernández-Gräulau, *What You Should Know About the Diagnosis of Prostate Cancer*, PEORIA MED., Winter 2009, at 4, 4.

18. *Prostate Cancer Risk Factors*, PROSTATE CANCER FOUND., [http://www.pcf.org/site/c.leJRIRORepH/b.5802027/k.D271/Prostate\\_Cancer\\_Risk\\_Factors.htm](http://www.pcf.org/site/c.leJRIRORepH/b.5802027/k.D271/Prostate_Cancer_Risk_Factors.htm) (last visited Oct. 30, 2010).

out of every fifteen men for ages sixty to sixty-nine.<sup>19</sup> In fact, “sixty-five percent of all prostate cancers are diagnosed in men over the age of sixty-five,” making the threat of prostate cancer most significant for elderly men.<sup>20</sup>

Prostate cancer, while not hereditary per se, has a strong tendency to run in families.<sup>21</sup> Individuals with one immediate relative who has been diagnosed with prostate cancer are twice as likely to develop the cancer themselves.<sup>22</sup> Individuals with three immediate relatives who have been diagnosed are almost nine times as likely to develop prostate cancer.<sup>23</sup>

## B. Diagnosis of Prostate Cancer

As mentioned above, prostate cancer grows slowly, which makes detection difficult before it reaches a certain size.<sup>24</sup> One of the most significant tools in the diagnosis of prostate cancer is a blood test known as the Prostate-Specific Antigen Test (PSA).<sup>25</sup> The test measures the amount of a specific protein produced by the prostate gland found in a patient’s blood.<sup>26</sup> The protein is used as a biological marker and high levels can indicate the presence of cancer.<sup>27</sup> The diagnosis rates of prostate cancer rose dramatically following the introduction of the PSA.<sup>28</sup>

While the PSA is the most common detection method, it is not the only method available to urologists. First, there is the Digital Rec-

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19. *Id.*

20. *Id.*

21. Hernández-Gräulau, *supra* note 17, at 4 (“Hereditary prostate cancer is usually defined as multiple affected family members and a distribution along several generations. Approximately 20% of patients may have a familial association with another individual with prostate cancer.”).

22. *Id.*

23. *Id.*

24. *What is Prostate Cancer?*, *supra* note 12.

25. See Hernández-Gräulau, *supra* note 17, at 4.

26. *Fact Sheet: Prostate-Specific Antigen (PSA) Test*, NAT’L CANCER INST., 1 (Mar. 18, 2009), [http://www.cancer.gov/images/documents/4d0e8a1a-5770-4a6f-baac-ded5595d97df/Fs5\\_29.pdf](http://www.cancer.gov/images/documents/4d0e8a1a-5770-4a6f-baac-ded5595d97df/Fs5_29.pdf).

27. *Id.*

28. Hernández-Gräulau, *supra* note 17, at 4; Mary McNaughton Collins et al., *Medical Malpractice Implications of PSA Testing for Early Detection of Prostate Cancer*, 25 J.L. MED. & ETHICS 234, 234 (1997).

tal Exam (DRE).<sup>29</sup> The DRE is conducted by a physician using a gloved and lubricated finger, inserting it into the rectum of the patient, and physically feeling and examining the prostate gland by touch.<sup>30</sup> By actually touching the prostate gland through the rectal wall, doctors can determine if there are any irregularities in size, shape, or texture.<sup>31</sup> The DRE allows doctors to confirm that an elevated PSA test result is caused by prostate cancer and not by Benign Prostatic Hyperplasia (BPH)<sup>32</sup> (the benign, non-cancerous enlargement of the prostate gland)<sup>33</sup> or Prostatitis<sup>34</sup> (a non-cancerous inflammation and swelling of a bacterially infected prostate gland),<sup>35</sup> both of which can cause elevated PSA results.<sup>36</sup>

A doctor might also use a Transrectal Ultrasound Guided Needle Biopsy (TRUSBx) to diagnose prostate cancer.<sup>37</sup> The TRUSBx is a much more invasive and involved procedure.<sup>38</sup> The TRUSBx involves placing a patient on a multi-day course of fluoroquinolone antibiotics, followed by a procedure where a rectal probe is inserted into the patient and transrectal sonogram images of the prostate are recorded in order to establish the precise location of the prostate gland and any suspicious lesions or growths.<sup>39</sup> The next step in the TRUSBx test is to procure a sample of the suspected lesion by removing a core piece using a biopsy needle loaded into a spring-action automatic bi-

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29. See generally *PSA & DRE Screening*, PROSTATE CANCER FOUND., [http://www.pcf.org/site/c.leJRIRORepH/b.5802071/k.C620/PSA\\_\\_DRE\\_Screening.htm](http://www.pcf.org/site/c.leJRIRORepH/b.5802071/k.C620/PSA__DRE_Screening.htm) (last visited Oct. 30, 2010) (explaining the DRE procedure).

30. *Id.*

31. *Id.*

32. *Id.*

33. *Benign Prostatic Hyperplasia (BHP)*, PROSTATE CANCER FOUND., [http://www.pcf.org/site/c.leJRIRORepH/b.5780045/K.3758/Benign\\_Prostatic\\_Hyperplasia\\_BPH.htm](http://www.pcf.org/site/c.leJRIRORepH/b.5780045/K.3758/Benign_Prostatic_Hyperplasia_BPH.htm) (last visited Oct. 30, 2010).

34. *PSA & DRE Screening*, *supra* note 29.

35. *Prostatitis*, PROSTATE CANCER FOUND., <http://www.pcf.org/site/c.leJRIRORepH/b.5813305/k.A27E/Prostatitis.htm> (last visited Oct. 30, 2010).

36. *PSA & DRE Screening*, *supra* note 29.

37. Peter Carroll & Katsuto Shinohara, *Transrectal Ultrasound Guided Prostate Biopsy*, [http://urology.ucsf.edu/patientGuides/pdf/uroOnc/Prostate\\_Biopsy.pdf](http://urology.ucsf.edu/patientGuides/pdf/uroOnc/Prostate_Biopsy.pdf); *The Transrectal Ultrasound (TRUS) and Prostate Cancer*, PROSTATE CANCER TREATMENT GUIDE, <http://www.prostate-cancer.com/prostate-cancer-treatment-overview/overview-trus.html> (last visited Oct. 30, 2010).

38. See generally Carroll & Shinohara, *supra* note 37 (outlining a detailed discussion of the full TRUSBx procedure).

39. *Id.*

opsy device.<sup>40</sup> The core sample can then be tested for the presence of cancer.<sup>41</sup>

While both the DRE and the TRUSBx are frequently used,<sup>42</sup> they are considered not to be specific or sensitive enough by themselves to diagnose prostate cancer.<sup>43</sup> The DRE relies solely on the tactile ability of the physician which can be imprecise; therefore, the DRE is almost always used in conjunction with the PSA.<sup>44</sup> The TRUSBx, in addition to being much more invasive than the PSA and DRE, can also cause a patient extreme pain and discomfort.<sup>45</sup> The additional information gleaned from the TRUSBx is also minimal in comparison to the combined PSA and DRE method.<sup>46</sup>

### C. Treatment of Prostate Cancer

Due to its slow growing nature, prostate cancer is among the most treatable of the various forms of cancer.<sup>47</sup> About ninety percent of prostate cancers are detected while they are still “local” or “regional,” meaning they have not yet spread to other areas.<sup>48</sup> In those cases, the cancer is quite treatable.<sup>49</sup> Almost one hundred percent of men treated while the cancer is in the “local” or “regional” stage can be cured within five years.<sup>50</sup> Once the cancer spreads to other areas, it is no longer curable, though still treatable.<sup>51</sup> This harsh duality between

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40. *Id.*

41. *See Id.*

42. *See* Hernández-Gräulau, *supra* note 17, at 4 (explaining that the DRE is still a component of physical examination and the TRUS is used in biopsies of the prostate gland).

43. *Id.* at 4-5 (“Multiple studies have demonstrated that TRUS, although sensitive, is not specific for the detection of prostate cancer.”); *see also* CARROLL & SHINOHARA, *supra* note 37 (“TRUS alone should not be used as a first line screening tool as it lacks acceptable specificity. . . .”); *TRUS and Prostate Cancer*, *supra* note 37; *PSA & DRE Screening*, *supra* note 29 (explaining that even with “normal” DRE results an individual can still be found to have prostate cancer).

44. *See Fact Sheet: Prostate-Specific Antigen (PSA) Test*, *supra* note 26, at 1.

45. Carroll & Shinohara, *supra* note 37.

46. *Id.* (“[The TRUS] adds little information to that already gained by the use of serum PSA and digital rectal examination.”).

47. *See What is Prostate Cancer?*, *supra* note 12.

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*; *see also* Joseph Hernandez, “Watchful Waiting” with Elevated PSA Results May Give Rise to a Medical Malpractice Claim, *THE ARTICLE DAILY*, (Feb. 25, 2009), <http://www.thearticledaily.com/watchful-waiting-with-elevated-psa->

diagnosis time and treatment speaks to the importance of early detection, which is why some recommend PSA and DRE tests for men beginning at age forty.<sup>52</sup>

There are a variety of prostate cancer treatment options available. Treatment can include, but is not limited to, prostatectomy, radiation and chemotherapies, hormone therapy, or the controversial active surveillance (watchful waiting).<sup>53</sup> Watchful waiting has been described as “not a euphemism for doing nothing, but rather . . . [as a] . . . decision to delay treatment in favor of careful monitoring for the progression of prostate cancer.”<sup>54</sup> Despite seeming counter-intuitive, watchful waiting may be a very good option for some patients. Specifically, elderly patients who might not fare well with other treatments may choose to just wait and let the cancer take its course.<sup>55</sup> In fact, the American Urological Association (AUA) recommends a cutoff age of seventy-five years for performing radical surgery.<sup>56</sup> The AUA specifically suggests watchful waiting as the correct treatment, or perhaps more appropriately “non-treatment,” option for older patients.<sup>57</sup>

#### D. End-of-Life Costs

One of the areas most frequently blamed for dramatically high health care costs is the area of end-of-life spending.<sup>58</sup> There seems to be a real debate in the United States over the practice of providing and

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results-may-give-rise-to-a-medical-malpractice-claim/ (“When prostate cancer spreads outside the capsule, it is no longer considered curable.”).

52. *Early Detection & Screening*, PROSTATE CANCER FOUND., [http://www.pcf.org/site/c.leJRIRORepH/b.5802037/k.6B8C/Early\\_Detection\\_Screening.htm](http://www.pcf.org/site/c.leJRIRORepH/b.5802037/k.6B8C/Early_Detection_Screening.htm) (last visited Oct. 30, 2010) (explaining that opinions differ on when to start screening, with some recommending age forty for those at highest risk, ages forty to forty-five for those at high risk, and between ages forty and fifty for those at average risk).

53. *Treatment Options*, PROSTATE CANCER FOUND., [http://www.pcf.org/site/c.leJRIRORepH/b.5802089/k.B8D8/Treatment\\_Options.htm](http://www.pcf.org/site/c.leJRIRORepH/b.5802089/k.B8D8/Treatment_Options.htm) (last visited Oct. 30, 2010).

54. *Watchful Waiting Description*, PROSTATE CANCER TREATMENT GUIDE, <http://www.prostate-cancer.com/watchful-waiting/treatment-description/watchful-description.html> (last visited Oct. 30, 2010).

55. *Id.* (“Patients who choose to undergo watchful waiting will be able to avoid the side effects and prolong their current activities and physical state.”).

56. Hernández-Gräulau, *supra* note 17, at 6.

57. *Id.* It is important to take specific note of this proposition; it will become even more important in the parts of this Note yet to come. See discussion *infra* Part IV.

58. See Robert Pear, *Researchers Find Huge Variations in End-of-Life Treatment*, N.Y. TIMES, Apr. 7, 2008, at A17.

paying for health treatments, typically expensive ones, to patients who end up dying despite said treatments.<sup>59</sup> This typically involves the elderly and those with chronic disease.<sup>60</sup> End-of-life costs comprise a significant proportion of America's health care spending.<sup>61</sup> Medicare expends an estimated \$88 billion, or twenty-seven percent of its \$327 billion budget, on patients who are in their last year of life.<sup>62</sup>

Recent studies have found that there are dramatic differences in the end-of-life costs in different regions of the United States.<sup>63</sup> Not surprisingly, areas that are densely populated or have traditionally older populations consume a larger proportion of Medicare spending compared with the national average.<sup>64</sup> While an exact and definite reason for this phenomenon has yet to be determined, analysts point to specific instances that suggest what is at the heart of the problem.<sup>65</sup> Hospitals in densely populated areas aggressively treat patients with chronic disease by throwing specialist after specialist and treatment after treatment at them, thus racking up costs but seemingly doing little to actually cure the patient.<sup>66</sup>

The concerned community at large suggests that medical centers should not be financially rewarded for what has been deemed "futile care."<sup>67</sup> Whether these end-of-life treatments are "futile" is debatable.<sup>68</sup> Great concerns remain over a patient's dignity during these

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59. See Appleby, *supra* note 8 (noting the debate surrounding whether increased health care costs actually result in better health care or a better quality of life). See generally Emanuel & Emanuel, *supra* note 10, at 540 ("For more than a decade, health policy analysts have noted—and some decried—the high cost of dying.").

60. Appleby, *supra* note 8.

61. Emanuel & Emanuel, *supra* note 10, at 540.

62. See Appleby, *supra* note 8.

63. See *id.*; Pear, *supra* note 58, at A17.

64. See JOHN E. WENBERG ET AL., DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICE, TRACKING THE CARE OF PATIENTS WITH SEVERE CHRONIC ILLNESS 22 map 2.1 (2008), available at [http://www.dartmouthatlas.org/downloads/atlas/2008\\_Chronic\\_Care\\_Atlas.pdf](http://www.dartmouthatlas.org/downloads/atlas/2008_Chronic_Care_Atlas.pdf) (noting New Jersey, California, and New York's health care expenditures were more than twenty percent above the national average and Florida's numbers also fell in a range slightly higher than the national average).

65. See Pear, *supra* note 58, at A17.

66. See *id.* Hospitals also seem rather unapologetic about it. Dr. J. Thomas Rosenthal, chief medical officer at the U.C.L.A. hospital—one hospital indicated by the study to be particularly aggressive—defended his hospital's practices: "Some of the aggressive care saves lives. . . . The Dartmouth study does not ferret that out in a systematic way." *Id.*

67. Appleby, *supra* note 8.

68. See Emanuel & Emanuel, *supra* note 10, at 540.

emotionally charged, end-of-life times.<sup>69</sup> This often can lead to families throwing as many medical resources as possible to stave off the impending passing of their loved ones.<sup>70</sup> Some suggest one problem in accurately determining end-of-life care costs is that these studies of Medicare spending in the last year of life are done after the fact.<sup>71</sup> Except in instances of advanced and predictable types of cancer, predicting beforehand that a patient is going to die despite treatments is much more difficult.<sup>72</sup> The combination of these factors can skew a cost-benefit analysis and suggest that there are not as many savings to be had in the end-of-life spending area.<sup>73</sup> Regardless, there has been an outcry for an improvement in the care given to end-of-life patients, a kind of "quality over quantity" argument.<sup>74</sup>

Given the presence of high end-of-life spending and the importance of the issue to the health care debate and to academics, it is easy to see why more and more Americans are now considering the option of "non-treatment" for situations involving the chronically diseased and the elderly.<sup>75</sup> Doctors are now urging us to "come to grips with our own mortality" and to make plans for treatment or non-treatment in advance of ill-health.<sup>76</sup> One recent survey, a joint effort by USA TODAY, Kaiser, and ABC, illustrates that some might be taking their advice.<sup>77</sup> Forty percent of survey participants would seek to keep a patient alive at all costs, whereas forty-eight percent claimed they would engage in a cost-benefit analysis before making the determination.<sup>78</sup> This disparity increased with a participant's age: sixty percent of participants aged sixty-five and older indicated they would weigh

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69. *See id.*

70. Appleby, *supra* note 8; Turk, *supra* note 7.

71. Emanuel & Emanuel, *supra* note 10, at 540. The article explained that "[i]t is difficult to know in advance what costs are for care at the end of life and what costs are for saving a life. Only in retrospect, after a patient's death, can we identify the last year or month of life." *Id.* at 540.

72. *Id.* at 540 ("The time of death is usually unpredictable, however, except perhaps when the patient has advanced cancer.").

73. *Id.* at 541.

74. *See* Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 *NEW ENG. J. MED.* 2205, 2205-07 (2006) (explaining that changes must be made to aid patient safety and communication with physicians); Appleby, *supra* note 8.

75. *See* Appleby, *supra* note 8.

76. Turk, *supra* note 7.

77. *See* Appleby, *supra* note 8.

78. *Id.*

the costs and benefits, whereas only twenty-eight percent would keep the patient alive as long as possible.<sup>79</sup>

Doctors are not the only ones who have realized the existence and inefficiency of high-cost, low-utility treatments and their relation to age. Members of the academic community also have identified the situation and its underlying complications.<sup>80</sup> The status quo in health care, especially among the elderly and those at the end of life, is rife with what Yale Law Professor Peter Schuck calls “bad bets.”<sup>81</sup> Applied in a strictly economic sense, a “bad bet” is a person who is “unlikely to derive much benefit from a programmatic intervention on their behalf relative to . . . the resources that they would consume . . . .”<sup>82</sup> Conversely, there exist “better bets,” or people who would derive more benefit from the same quantity of resources compared with a “bad bet.”<sup>83</sup> The assumption is that since the elderly tend not to derive as much utility from high cost treatments, these resources may be put to better use on others.<sup>84</sup> Professor Schuck suggests that policy making and reform to the health care system should center on identifying “bad bets” and reducing the amount of investment in them as much as possible.<sup>85</sup> Some of his suggestions to effectuate this change include informing doctors about “bad bets” and influencing their decisions with more strategic choices regarding what types of procedures get subsidized.<sup>86</sup>

Schuck also suggests altering reimbursements for diagnostic tests.<sup>87</sup> He suggests that reimbursement should be denied in situa-

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79. *See id.*

80. *See generally* Peter H. Schuck, *The Golden Age of Aging, and Its Discontents*, 18 ELDER L.J. 25 (2010) (arguing that much of the spending on seniors is inefficient and occasionally ineffective).

81. *Id.* at 64.

82. *Id.* at 43–44 (quoting PETER H. SCHUCK & RICHARD J. ZECKHAUSER, TARGETING IN SOCIAL PROGRAMS: AVOIDING BAD BETS, REMOVING BAD APPLES 7–8 (2006)).

83. *Id.* at 44.

84. *See id.*

85. *Id.* at 44–45 (“Allocating scarce resources to bad bets rather than to good ones is wasteful and surely unfair, even when the bad bets are admirable people, as in the case of spending hundreds of thousands of dollars on an exemplary citizen who is near death. Those resources could accomplish much more for other medically needy citizens, promoting both fairness and cost effectiveness goals.”).

86. *See id.* at 67 (“Medicare policymakers should set general default rules about who should receive which subsidized treatments based on large-population statistics.”).

87. *Id.* at 69.

tions where diagnostic tests would lead to overly expensive treatments that would have little value, or in other words, would be a “bad bet” based on age.<sup>88</sup> Schuck considers doctors to be “notoriously poor gatekeepers” in “bad bet” investment situations due to fear of liability.<sup>89</sup> He argues that doctors have “[p]owerful incentives—including ethical obligations, loyalty to their patients, a desire to gain a reputation for saving lives, knowledge that insurance will protect most of their patients from the costs, and possible personal financial interests” and, therefore, are encouraged to make diagnosing and treatment decisions “as if those resources were essentially free and unlimited.”<sup>90</sup> For these reasons, Schuck believes that doctors alone cannot be expected to usher in a system that effectively targets “bad bets” and invests in them at an economically efficient level.<sup>91</sup>

What makes Schuck’s suggestion regarding diagnostic test reimbursement most relevant to the topic of this Note, however, is that he specifically points to instances where PSA testing has tended to generate high-cost, low-utility treatments—in other words “bad bets”—when watchful waiting would be a more prudent option.<sup>92</sup> It is clear that cost effectiveness between treatment and non-treatment is on many Americans’ minds. Academics and physicians seem to agree that non-treatment should be used when cost efficient, prudent, and acceptable.<sup>93</sup> This seemingly agreed upon proposition should pave the way for the use of treatments like watchful waiting, and we accordingly should see a decline in end-of-life costs, as well as health care costs as a whole. This, however, still does not seem to be the case. Why is watchful waiting not used more? Why do doctors keep generating “bad bets?” Perhaps the answer lies somewhere that society and the academic community seem to have missed but is all too famil-

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88. *Id.*

89. *See id.* at 47.

90. *Id.*

91. *See id.* (“Still, if insurers and policymakers are counting on physicians to be vigilant, cost-effective stewards of scarce health care resources, it is a vain hope . . .”).

92. *Id.* at 69 (“This more cautious approach to testing is bolstered by recent research findings on the unfortunate propensity of prostate-specific antigen (PSA) screening to generate bad bet treatments for slow-growing prostate cancer where “watchful waiting” would be more individually and socially prudent.”).

93. *See* Hernández-Gräulau, *supra* note 17, at 6 (advocating watchful waiting for “older” groups of patients per the AUA suggestion); *see also* Schuck, *supra* note 80, at 69 (advocating a more cautious approach to treatment when it is individually and socially prudent).

iar for doctors—in defensive medicine and the medical malpractice system.

### E. Medical Malpractice and Defensive Medicine

It remains controversial just how much medical malpractice payouts cost the health care system.<sup>94</sup> Doctors claim the number is high, suggesting that medical malpractice payouts comprise as much as ten percent of overall health care costs.<sup>95</sup> Others do not agree.<sup>96</sup> As one commentator put it, “After all, including legal fees, insurance costs, and payouts, the cost of the [medical malpractice] suits comes to less than one-half of [one] percent of health-care spending.”<sup>97</sup> One scholar offers plentiful evidence that patients with medical malpractice claims do not take them to court nearly as often as people think.<sup>98</sup> First of all, injured persons, as a general rule, are far less likely to sue than is generally thought.<sup>99</sup> Research indicates that only ten in every one hundred persons injured in some type of accident will make a liability claim.<sup>100</sup> Of those, only two will actually file a lawsuit.<sup>101</sup>

The general trend for injured persons not to sue can be applied to victims of medical malpractice too. This can be seen when the number of people injured by medical malpractice is compared to the number of medical malpractice lawsuits actually filed. A number of studies have shown the alarmingly large amount of medical malpractice that occurs in American hospitals.<sup>102</sup> A 1974 California study revealed that doctors and hospitals in that state injured at least 140,000 patients and killed almost 14,000.<sup>103</sup> The study suggested that around

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94. See LeBlanc, *supra* note 5.

95. *Id.*

96. See Ezra Klein, *The Medical Malpractice Myth*, SLATE (July 11, 2006, 6:20 AM), <http://www.slate.com/id/2145400/>.

97. *Id.* (alteration in original) (drawing on the work of University of Connecticut law professor Tom Baker).

98. See David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1088–92 (2006) (offering a great deal of research on the occurrence and success rates of malpractice lawsuits).

99. *Id.* at 1089 (quoting THOMAS F. BURKE, *LAWYERS, LAWSUITS, AND LEGAL RIGHTS: THE BATTLE OVER LITIGATION IN AMERICAN SOCIETY* 3 (2002)).

100. *Id.*

101. *Id.*

102. TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 24–36 (2005).

103. *Id.* at 26.

24,000 California patients were the victims of medical malpractice.<sup>104</sup> The Harvard medical practice study, another frequently cited medical malpractice study, took a random sample of 31,000 medical records and screened them for medical injury.<sup>105</sup> About one out of every four records, or 8000, suggested medical injury.<sup>106</sup> Of the 31,000 records and the 8000 injuries, 280 were found to be serious injuries caused by medical malpractice.<sup>107</sup> The results of the California study and the Harvard medical practice study were essentially the same, suggesting that medical malpractice occurs at a staggering rate.<sup>108</sup>

When these and other findings are compared with the rate of filing suit for medical malpractice, however, the ratio is surprisingly low.<sup>109</sup> Of the 280 instances of severe injury due to medical malpractice in the Harvard study, only eight patients brought claims.<sup>110</sup> That is a rate of less than three percent.<sup>111</sup> Studies from Utah and Colorado yielded rates of just under three percent as well.<sup>112</sup> This strongly suggests that people who are injured by medical malpractice, even severely, do not sue doctors as much as conventionally thought.

When patients do file suit, the outcomes favor health care provider-defendants.<sup>113</sup> The American Bar Foundation analyzed jury verdicts reported for a three-year period at the end of the 1980s and determined that plaintiffs lost in medical malpractice cases seventy percent of the time.<sup>114</sup> Other studies suggest that the number may be even higher and that doctors are winning at jury trials up to eighty-one percent of the time.<sup>115</sup> Regardless of the actual number, the fact

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104. *Id.*

105. *Id.* at 27.

106. *Id.* at 28.

107. *Id.* at 69.

108. *Id.* at 29.

109. *See id.* at 68–70. Professor Danzon reported that there was one claim for every ten instances of medical malpractice in the United States. Other localized studies reported even lower ratios. *Id.* at 69.

110. *Id.* at 69.

111. *Id.*

112. *Id.*

113. BAKER, *supra* note 102, at 70–77; Hyman & Silver, *supra* note 98, at 1107.

114. BAKER, *supra* note 102, at 74.

115. Hyman & Silver, *supra* note 98, at 1107 (“According to the Insurance Information Institute, a study of almost 11,000 medical malpractice trials between 1985 and 1999 found that provider-defendants won approximately [eighty-one] percent of the time.”) (alteration in original).

remains that doctors are successful civil defendants.<sup>116</sup> Ordinary, non-physician, civil defendants only prevail in jury trials about fifty percent of the time.<sup>117</sup> While this may be due to inaccuracies in the jurors' fact-finding regarding medical malpractice, the statistics suggest that juries do not exhibit the bias favoring plaintiffs in malpractice suits once believed to be prevalent.<sup>118</sup>

What these statistics and conclusions regarding malpractice, jury verdicts, and their relationship to health care costs do not consider, however, is that they represent only costs attributed to medical malpractice cases that proceed to a jury trial.<sup>119</sup> It is well known that, in order to get to a jury trial, the suit must survive discovery and various motions for dismissal and summary judgment before it can proceed to a jury.<sup>120</sup> Only then is there the possibility that a plaintiff might win a judgment against a doctor-defendant. The cost of medical malpractice liability extends further than just litigation. What if all of the situations that never involve an actual malpractice claim—of which, according to the above mentioned statistics, there are many—still involve physicians ordering expensive tests, treatments, and visits as a shield to liability? There still must be a cost for this practice of “defensive medicine” that is unaccounted for in the study of successful malpractice claim costs.

As it stands, defensive medicine and claims about its impact are among the most difficult to quantify.<sup>121</sup> Yet, some studies have tried to determine the costs and prevalence of defensive medicine.<sup>122</sup> A 1994 study by the now defunct Office of Technology Assessment of the United States Congress (OTA) analyzed several surveys and studies that attempted to determine the extent to which the behavior and practice of doctors was influenced by the possibility of malpractice

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116. MARK A. HALL ET AL., *MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS* 289 (2d ed. 2008).

117. *Id.*

118. *Id.* (“It appears that physicians’ concerns about juries being biased in favor of injured patients are exaggerated.”).

119. See generally BAKER, *supra* note 102, at 70–71 (explaining why medical malpractice research is commonly thought to be incomplete); HALL, *supra* note 116, at 289–90 (analyzing research that discusses jury findings); OFFICE OF TECH. ASSESSMENT, *DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE* (1994), available at <http://biotech.law.lsu.edu/policy/9405.pdf> (explaining how juries arrive at awards and deal with the standard of care).

120. MARY KAY KANE, *CIVIL PROCEDURE IN A NUTSHELL* 175 (6th ed. 2007).

121. BAKER, *supra* note 102, at 118.

122. See, e.g., OFFICE OF TECH. ASSESSMENT, *supra* note 119.

liability.<sup>123</sup> The results tell an interesting story. Of the studies analyzed by the OTA concerning positive-defensive medicine, which is the ordering of extra tests, treatments, and visits, they found that a range of twenty to eighty-one percent of doctors self-reported engaging in some kind of positive-defensive medicine practice due to potential malpractice liability.<sup>124</sup> The OTA also analyzed studies to attempt to quantify their findings in terms of cost.<sup>125</sup> An analysis of the physician studies yielded estimates suggesting that the cost of defensive medicine in 1994 was approximately \$13.7 billion.<sup>126</sup>

Despite the fact that these studies were completed in 1994, it does not appear that defensive medicine is on the decline.<sup>127</sup> Although there have not been any definitive studies done on the topic lately, doctors acknowledge that defensive medicine is still in practice.<sup>128</sup> Doctors are not secretive in their practice of defensive medicine techniques either: "It's one thing to order up a test to protect my patients . . . [i]t's something else if I order up a test to protect myself," says Dr. James Wang, an OB-GYN.<sup>129</sup> He stated that he attempts to explain to his patients why tests are not necessary but will sign off on them at a patient's insistence in order to avoid malpractice liability.<sup>130</sup>

#### F. **Tying It All Together: Defensive Medicine and Malpractice Liability in the Treatment of Prostate Cancer**

Incidents of successful malpractice cases in the area of prostate cancer and treatment provide a good example of the problems caused by excessive and unwarranted malpractice liability. Take, for example, a widely publicized case from the state of Florida.<sup>131</sup> An eighty-year-old, mentally competent man was found to have elevated PSA results, indicating that he might be at risk for prostate cancer.<sup>132</sup> The urologist followed up by performing the TRUSBx biopsy of the pros-

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123. *Id.* at 43–47.

124. *Id.* at 43.

125. *Id.* at 47–48.

126. *Id.* at 48.

127. See generally Hernández-Gräulau, *supra* note 17, at 6 (discussing the continued use of defensive medicine); LeBlanc, *supra* note 5 (explaining how doctors resort to defensive medicine to protect against lawsuits).

128. LeBlanc, *supra* note 5.

129. *Id.*

130. *Id.*

131. See Hernández-Gräulau, *supra* note 17, at 6.

132. *Id.*

tate, which came back positive for prostate cancer.<sup>133</sup> The urologist carefully explained to the patient the available treatment options, including the AUA approved, and in this case given the patient's age, *suggested*, option of non-treatment, or watchful waiting.<sup>134</sup> The patient selected the watchful waiting option.<sup>135</sup> He lived another seventeen years, to the age of ninety-seven, before finally passing away due to the prostate cancer.<sup>136</sup> The family of the deceased then sued the urologist for medical malpractice and won.<sup>137</sup> Despite the doctor following the standard treatment suggested to him by his own professional association, he was still subject to malpractice liability.<sup>138</sup>

This specific case leaves urologists between a rock and a hard place. Naturally, many urologists will continue to give patients annual PSA tests and will follow up any elevated PSA with a TRUSBx biopsy.<sup>139</sup> If the TRUSBx is positive, many urologists will now *always* recommend a proactive treatment to these patients to avoid malpractice liability.<sup>140</sup> This is the exact type of "bad bet" identified and discussed by Professor Schuck.<sup>141</sup> The above case shows that urologists' fear of malpractice liability—and not a belief that the resources are "essentially free and unlimited"—causes them to make this type of "bad bet."<sup>142</sup>

More alarmingly, on the back of this case and others like it, aggressive plaintiff's attorneys have pounced on the concept of being able to recover in these types of watchful waiting situations.<sup>143</sup> Now, not only can plaintiff's attorneys sustain claims for watchful waiting, but they also have the increased opportunity to sustain claims for other things associated with prostate cancer diagnosis and screening. Cases like the one above essentially have *required* the use of the TRUSBx biopsy. This procedure is mildly invasive and can come with its own set of complications that sometimes requires hospitalization,

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133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. See Schuck, *supra* note 80, at 44–45.

142. *But see id.* at 47 (suggesting that doctors order tests recklessly because they consider them "essentially free and unlimited").

143. See Hernandez, *supra* note 51.

not to mention give rise to their own malpractice claims.<sup>144</sup> The most common complication of a TRUSBx biopsy is blood in the patient's urine; rectal bleeding and fainting episodes are other possible immediate complications.<sup>145</sup> Delayed onset complications include pain with urination, persistent blood in the urine, rectal bleeding, vague pelvic discomfort, and blood in the patient's semen.<sup>146</sup> Some savvy plaintiff's attorneys have built entire practices around this situation.<sup>147</sup>

Having established that the current system leaves urologists with practically no choice but to engage in defensive medicine, even against the recommendations of an organization such as the AUA, attention must turn to finding a solution. The next section will feature an analysis of several of the more popular proposed solutions and how they might improve the status quo.

### III. Analysis

There are a number of proposed solutions to reform the medical malpractice regime in the United States. Each proposed solution has its own advantages and disadvantages, as well as some outspoken critics. The purpose of the analysis that follows in this section is to look at a few of the solutions that are most frequently offered to solve the growing general malpractice "crisis" and the high-cost nature of health care in an attempt to see how each solution might remedy the more specific prostate cancer malpractice situation. This section also will analyze the potential effect the proposed solution might have on elderly patients. For the purposes of this Note, the potential solutions to be analyzed will be damage caps, the implementation of the practice of preventative medicine, and redefining the standard of care for medical malpractice claims.

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144. See Carroll & Shinohara, *supra* note 37; Hernandez, *supra* note 51 (explaining that the TRUSBx biopsy comes with a range of potential risks, like bleeding and infection, which could form the basis for additional claims).

145. See Carroll & Shinohara, *supra* note 37.

146. *Id.*

147. See *A Resource for Prostate Cancer Malpractice Victims*, LAW OFFICE OF JOSEPH A. HERNANDEZ, <http://www.prostatecancerlaw.com> (last visited Oct. 30, 2010).

### A. Damage Caps

Perhaps the most contentious solution proposed to rectify the medical malpractice and lofty health care cost situation is the use of damage caps.<sup>148</sup> The idea behind damage caps is a simple one: place a limit on the amount of damages a plaintiff with a medical malpractice claim can recover.<sup>149</sup> These damage caps often come in one of two varieties: non-economic damage caps (which include punitive damage caps) and total damage caps.<sup>150</sup> Non-economic damage caps place a limit on the amount of money a plaintiff can recover for non-pecuniary losses, or damages that are non-compensatory in nature.<sup>151</sup> Non-economic damages traditionally include things like “pain and suffering, loss of consortium, emotional distress, and other intangible losses.”<sup>152</sup> Total damage caps place a limit on the total amount of any kind of damages recoverable by a plaintiff, including compensatory damages.<sup>153</sup>

According to the law and economics school of thought, compensatory damages are meant to do two things: compensate the injured plaintiff for his or her loss and deter defendants from partaking in potentially risky behavior.<sup>154</sup> Punitive damages, one form of non-economic damages that proponents of this solution seek to cap, are intended for instances when compensatory damages simply are not enough and the tortfeasor should be punished for behavior deemed reprehensible or malicious.<sup>155</sup> The economic theory is that the expect-

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148. See José M. Hernández-Gräulau, *Striking Down Illinois' Medical Liability Reform Law: Is the Future of Tort Reform in Jeopardy?*, PEORIA MED., Fall/Winter 2007, at 2, 2.

149. See generally *id.* (providing a cursory overview on damage caps).

150. See Joanna M. Shepherd, *Tort Reforms' Winners and Losers: The Competing Effects of Care and Activity Levels*, 55 UCLA L. REV. 905, 915-18 (2008).

151. *Id.* at 915.

152. *Id.*

153. *Id.* at 918.

154. *Id.* at 912-13 (explaining how compensatory damages can achieve the goals of both deterrence and victim compensation and that “[t]he higher the compensatory damages [a physician] expects to pay, the greater the cost of engaging in the dangerous activity, and the less likely he will engage in the activity without proper precautions.”) (alteration in original).

155. *Id.* at 913 (“[P]unitive damages are awarded not to compensate victims, but to punish defendants for intentional and malicious conduct and to deter future conduct. They provide more to the victim than is necessary for full compensation.”) (citing *BMW of N. Am., Inc., v. Gore*, 517 U.S. 559, 568 (1996) (internal quotation marks omitted)).

tation of paying these types of damages forces physicians to run a cost-benefit analysis and internalize their potential harm.<sup>156</sup>

The current debate focuses on the effectiveness of damage caps, especially non-economic damage caps.<sup>157</sup> Doctors, whose specialties often do not lie in the area of law and economics, are for the most part quite fond of the idea of capping potential damages and are among this solution's primary supporters.<sup>158</sup> Doctors, along with other critics of non-economic damages, claim that non-economic damages serve no compensatory purposes<sup>159</sup> and that "no amount of money can eliminate pain, and money cannot possibly return a victim to his position before the injury."<sup>160</sup> Critics of non-economic damages also claim that physicians will not internalize all of this cost;<sup>161</sup> rather, physicians will pass on the costs to consumers in the form of higher prices as a sort of "unwanted insurance."<sup>162</sup> The critics, therefore, conclude that non-economic damages should rightfully be capped, thereby relieving some of the burden of malpractice liability felt by physicians, as well as the burden of the overall cost of health care.<sup>163</sup>

Bolstering the pro-damage cap camp is the fact that some state legislatures have responded to their arguments.<sup>164</sup> As of 2005, forty-four states have enacted statutes either capping the amount of punitive damages that may be awarded or increasing the evidentiary requirement for awarding them.<sup>165</sup> Further strengthening these decisions are statistics gleaned from studies on caps of non-economic damages in general. One study found that non-economic damage

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156. *Id.* at 912 ("The expectation of paying compensatory damages forces a potential tortfeasor to internalize the costs of his dangerous activity. That is, because he expects to pay for the harm he imposes on others, he will consider the cost of that harm as he weighs the costs and benefits of engaging in the activity.").

157. Compare Cleckley & Hariharan, *supra* note 4, at 60 (concluding that damage cap statutes ultimately increase the probability of a patient being injured or even killed by a treating doctor), with Shepherd, *supra* note 150, at 939 (suggesting that non-economic, including punitive, damage caps lessen the occurrence of accidental death, while total damage caps do not).

158. See Hernández-Gräulau, *supra* note 148, at 2-3.

159. Shepherd, *supra* note 150, at 913.

160. *Id.* at 915.

161. See *id.*

162. *Id.* ("[A] tort system that provides noneconomic damages is, in effect, requiring everyone in society to pay for insurance to cover such losses. Sellers who become liable for noneconomic damages will pass their costs on to all consumers through higher prices, so that everyone will end up paying for them.").

163. See *id.* at 915-17.

164. *Id.* at 917.

165. *Id.*

caps in California of \$250,000 would reduce damage awards in over fifty percent of malpractice cases.<sup>166</sup> This suggests that the occurrence of non-economic damage awards is high. The same study also revealed that the non-economic damage cap reduced the average total damage award by thirty-four percent,<sup>167</sup> suggesting that non-economic damages are a significant portion of medical malpractice awards.

Critics of the damage cap solution regarding non-economic damages are quick to point out that sometimes compensatory damages alone simply are not enough to achieve the full deterrent effect needed to prevent doctors' negligence and that non-economic damages, such as punitive damages, are necessary.<sup>168</sup> The law and economics analysis boils the problem down to the idea that damage caps lower the expected cost of activities and incentivize doctors to take less care in preventing instances of malpractice, thereby leading to inefficiency and higher costs.<sup>169</sup>

Many critics of the damage cap system, whose ranks include some very big names like President Barack Obama and Secretary of State Hillary Clinton,<sup>170</sup> also indicate that damage caps do nothing to improve the quality of the health care given to patients.<sup>171</sup> Recent studies, such as the 1999 Institute of Medicine study, indicate that poor procedures and failed systems cause a majority of medical errors, not the negligence of doctors.<sup>172</sup> Critics and scholars alike suggest that damage caps would be more useful if implemented strategically.<sup>173</sup> One suggestion is to reward physicians and health care providers for the timely reporting of errors with a non-economic damage cap.<sup>174</sup> This gives physicians the damage caps they so desire, while also improving the quality of care given to patients.

Damage caps on non-economic damages also hurt those segments of the population that do not incur high amounts of economic

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166. *Id.* at 933.

167. *Id.*

168. *Id.* at 913-14.

169. *See generally* Cleckley & Hariharan, *supra* note 4 at 60-66 (concluding that damage caps leads to inefficient physician behavior).

170. *See* Clinton & Obama, *supra* note 74, at 2205.

171. *Id.*; Hyman & Silver, *supra* note 98, at 1131.

172. Clinton & Obama, *supra* note 74, at 2205.

173. Hyman & Silver, *supra* note 98, at 1131-32.

174. *Id.* at 1131.

damages.<sup>175</sup> As opposed to non-economic damages, economic damages are defined as “*special damages* that encompass objectively verifiable monetary losses including medical expenses, loss of earnings, burial costs, loss of use of property, costs of repair or replacement, costs of obtaining substitute domestic services, loss of employment and loss of business or employment opportunities.”<sup>176</sup> Therefore, those who suffer injuries, and yet do not incur lost wages or lost earning potential, do not incur large economic damages.<sup>177</sup> This category of people includes children, who have not developed any skills and therefore do not have a quantifiable earning potential, and the elderly, who no longer work.<sup>178</sup> Generally, the elderly do not have special damages like loss of income and usually no past, present, or future economic damages.<sup>179</sup> This means that the damage done to the elderly who are injured are generally non-economic damages like pain and suffering and mental anguish.<sup>180</sup> Therefore, caps on these types of damages severely limit the ability for the elderly to be compensated fairly for the injuries they suffer.

Regardless of their efficiency, damage caps also face the obstacle of judicial scrutiny. In states where they have been enacted, non-economic damage cap statutes have become the subject of cases challenging their constitutionality and are being struck down.<sup>181</sup> In February 2010, the Illinois Supreme Court considered the constitutionality of a 2005 statute capping non-economic damages.<sup>182</sup> The damage-limiting provision of the Illinois Code of Civil Procedure was struck

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175. See Glenn W. Cunningham, *New Malpractice Caps Will Hurt Children*, *Elderly*, SAN ANTONIO EXPRESS-NEWS, Dec. 11, 2003, at 7B.

176. Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 *ELDER L.J.* 331, 363 (2006) (emphasis in original) (quoting *Scalice v. Performance Cleaning Sys.*, 57 Col. Rptr. 2d 711, 729 (Ct. App. 1996)).

177. Cunningham, *supra* note 175, at 78.

178. *Id.*

179. See Rustad, *supra* note 176, at 364.

180. *Id.* Rustad’s list of non-economic damages suffered by nursing home victims (and generally applicable to the elderly) include “pain, suffering, mental anguish, inconvenience, physical impairment, disfigurement, loss of capacity to enjoy life, and loss of consortium . . . .” *Id.*

181. Hernández-Gräulau, *supra* note 148, at 2-3; David A. Hyman, *What Lessons Should We Learn from the First Malpractice Crisis of the Twenty-First Century?*, 1 *DREXEL L. REV.* 261, 263, 272 n.6 (2009) (indicating that Illinois’s damage cap had been declared unconstitutional and the decision was in the process of being appealed).

182. See *Lebron v. Gottlieb Mem’l Hosp.*, 930 N.E.2d 895 (Ill. 2010).

down by Illinois's highest court on the grounds that the statute interfered with the judiciary's authority regarding verdicts and was, therefore, a violation of the separation of powers provision of the state constitution.<sup>183</sup>

The strengths and weaknesses of damage caps, especially non-economic damage caps, are the same in the context of prostate cancer. Doctors may feel more comfortable with damage caps in place, but there is some empirical evidence that indicates that non-economic damage caps do not curtail the overall level of litigation.<sup>184</sup> Damage caps most often are discussed in the context of lowering health care costs, not in the context of lowering the number of malpractice claims that are brought.<sup>185</sup> Since urologists may face liability for prescribing watchful waiting, there is still an incentive to go ahead with costly treatment, even in the presence of damage caps. This does little to help elderly patients. Under a damage cap regime, it appears that they would still be subject to a urologist's practice of "defensive medicine" and would have to incur the hardships involved with a more rigorous or invasive treatment. Therefore, another option must be considered.

## B. Preventative Medicine

The next proposed solution is the practice of preventative medicine.<sup>186</sup> This solution is aimed more at driving down the cost of end-of-life care than addressing malpractice issues. Proponents of preventative medicine suggest that people should be more proactive about preventing chronic disease while they are healthy and should receive support from the medical community.<sup>187</sup> This suggestion is made with the goal of decreasing the amount of health care spending attri-

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183. *Id.* at 914 ("[T]he limitation on noneconomic damages in medical malpractice actions set forth in section 2-1706.5 of the Code violates the separation of powers clause of the Illinois Constitution.").

184. WILLIAM G. HAMM ET AL., CALIFORNIA'S MICRA REFORMS: INCREASING THE CAP ON NON-ECONOMIC DAMAGES WOULD INCREASE THE COST OF, AND REDUCE ACCESS TO, HEALTHCARE 10 (2005), available at [http://www.micra.org/patient-access/docs/micra\\_study\\_ca\\_micra\\_reforms.pdf](http://www.micra.org/patient-access/docs/micra_study_ca_micra_reforms.pdf).

185. See, e.g., Cleckley & Hariharan, *supra* note 4, at 15-17.

186. See Russell Turk, *Reform Health Care Now: We Need to Practice Preventative Medicine*, DAILY FIN. (June 20, 2009, 2:00 PM), <http://www.dailyfinance.com/story/reform-health-care-now-we-need-to-practice-preventative-medicine/19072150/>.

187. See *id.*

buted to people with chronic disease, which is estimated to be around seventy-five percent.<sup>188</sup>

This idea seems good in theory: reduce the amount of chronically sick people by preventing their chronic disease and there will be fewer sick people to spend money on. This seems relatively straightforward and could have a huge effect. An overall reduction in the amount of people that currently consume seventy-five percent of health care spending will undoubtedly reduce costs across the board.

This regime potentially could have a profound effect on malpractice too. If the standard of care were to remain defined generally as requiring a doctor to "exercise that degree of care which would be exercised by a physician in good standing in the same medical specialty in a similar community in like circumstances,"<sup>189</sup> the occurrence and success rates of malpractice claims might drop as a result of plaintiffs not following preventative measures suggested by their treating physicians.<sup>190</sup> Since the practice of preventative medicine is not the common practice nor the standard of care to which we hold doctors, it is difficult to say if this effect could ever be achieved.

One advantage of a preventative medicine regime is that it might curtail instances of defensive medicine in some situations. If a patient does not follow his treating physician's orders to prevent a chronic illness, the doctor would more than likely be shielded from liability later on.<sup>191</sup> Knowing they will not be held liable, doctors will not have the incentive they once did to over-treat patients or face malpractice liability. They might simply wash their hands of the disobedient patient knowing they cannot be held liable if he or she was to die. This might be good for doctors but horrible for the patient who now has a chronic disease *and* no legal recourse. It seems that there would be an overwhelming under-precautionary effect, so much that it renders this solution dangerous and an enormous violation of a doctor's Hippo-

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188. *Id.*

189. Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 655 (2001).

190. *See id.* at 667 (explaining that the use of clinical practice guidelines can have "some impact" on the medical malpractice cases that are brought and their outcomes).

191. *See Cox v. Lesko*, 953 P.2d 1033, 1035 (Kan. 1998).

cratic Oath.<sup>192</sup> This situation would be the exact opposite of defensive medicine.<sup>193</sup>

Another weakness of a move to preventative medicine is that some chronic diseases simply are not very preventable.<sup>194</sup> The definition of chronic disease usually includes cancer.<sup>195</sup> In the case of prostate cancer, like most cancers, the prospect of prevention is grim.<sup>196</sup> Preventative steps are limited to diet and lifestyle changes that can decrease the prevalence of underlying risk factors for prostate cancer, yet *actual* prevention has yet to be achieved.<sup>197</sup> Furthermore, recall that prostate cancer is slow growing, runs in families, and mostly affects the elderly.<sup>198</sup> A urologist operating under a regime of preventative medicine still has no shield against malpractice liability. There is practically nothing a urologist can tell a younger patient to do to actually prevent prostate cancer. When that patient ages and finally develops the disease, a physician is still left with nothing but the option to treat under the pain of liability. He cannot defend himself by claiming the patient failed to prevent the disease on his own; the patient could not have. The doctor, therefore, is left in the same position as the status quo: treat the patient and rack up the cost or be sued.

### C. Change the Standard of Care

As briefly touched upon in the above section, the general standard of care to which the law holds doctors is a twist on the normal “reasonable and ordinary care” standard found in most non-medical negligence cases.<sup>199</sup> The standard has evolved to state that “a physi-

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192. *The Hippocratic Oath: Modern Version*, PBS, [http://www.pbs.org/wgbh/nova/doctors/oath\\_modern.html](http://www.pbs.org/wgbh/nova/doctors/oath_modern.html) (last visited Aug. 30, 2010). The general idea of a physician’s Hippocratic Oath is that doctors have “special obligations to all [their] fellow human beings” to “apply, for the benefit of the sick, all measures [that] are required.” *Id.* (alteration in the original).

193. Might I suggest calling it “So-long-sucker medicine?”

194. Brent Savoie, *Thailand’s Test: Compulsory Licensing in an Era of Epidemiologic Transition*, 48 VA. J. INT’L L. 211, 220 (2007).

195. *About the Crisis*, PARTNERSHIP TO FIGHT CHRONIC DISEASE, <http://www.fightchronicdisease.org/issues/about.cfm> (last visited Oct. 30, 2010).

196. See *Prevention*, PROSTATE CANCER FOUND., <http://www.pcf.org/site/c.leJRIRORepH/b.5802029/K.31EA/Prevention.htm> (last visited Oct. 30, 2010) (indicating that the evidence is not strong enough to clearly point to methods of prevention).

197. *Id.*

198. See *supra* Part II.A.

199. Mello, *supra* note 189, at 655.

cian must exercise that degree of care which would be exercised by a physician in good standing in the same medical specialty in a similar community in like circumstances."<sup>200</sup> This standard has been imposed primarily because it is thought that juries and judges are not medical experts so they should consequently defer to the customs of other physicians.<sup>201</sup> This standard, however, represents a prevailing retreat from what was the traditional standard of care in medical malpractice, which was deference to medical custom.<sup>202</sup>

Until recently, courts gave the power to set the standard of care to physicians themselves by deferring to physicians' customs.<sup>203</sup> This represented one of the only instances in the negligence field where the customs of a group wholly defined the standard of care.<sup>204</sup> Quietly, yet forcefully, courts across the country have started abandoning the deference to medical custom in favor of the above mentioned "reasonable physicians" test.<sup>205</sup> The reason for the shift remains unclear.<sup>206</sup> Proffered rationales range from efforts to give more power back to juries in malpractice actions<sup>207</sup> to the accusation that courts have "lost their faith that physicians are sufficiently different from engineers, truck drivers, product manufacturers, and other tort defendants to justify the legal privileges previously accorded to them."<sup>208</sup> Whatever the justification, there is no escaping that the "reasonable physicians" standard set out above is now the prevailing standard in the medical malpractice landscape, and it is not without its own issues.

Demonstrating to a jury what constitutes a "degree of care which would be exercised by a physician in good standing in the same medical specialty in a similar community in like circumstances"<sup>209</sup> often requires the use of an expert witness, who is most commonly another

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200. *Id.*

201. Sam A. McConkey, IV, Note, *Simplifying the Law in Medical Malpractice: The Use of Practice Guidelines as the Standard of Care in Medical Malpractice Litigation*, 97 W. VA. L. REV. 491, 499 (1995).

202. See Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 912 (2002).

203. *Id.* at 912-13.

204. *Id.* at 913.

205. See *id.* at 913-16.

206. *Id.* at 917 ("The courts have not, however, explained why the once-persuasive arguments made in favor of a custom-based standard are no longer convincing.").

207. See *id.* at 911 (explaining that the jury would set the standard of care).

208. *Id.* at 918.

209. Mello, *supra* note 189, at 655.

physician.<sup>210</sup> This status quo standard pits physician against physician in the court room. More often than not, physician-defendants are held to the standard of care as defined by a plaintiff's expert, a standard that might simply be the habit of the testifying expert.<sup>211</sup> The status quo lends itself to a market for expert witnesses.<sup>212</sup> This expert witness market likely includes physicians who are willing to testify to practice methods that hold a defendant to a particular standard of care that will result in a favorable outcome for their employer, the plaintiff.<sup>213</sup>

It appears that neither deference to medical custom nor the "reasonable physician" test are effective measures of the standard of care. What if instead of deferring to the standard of care as defined by another physician or medical custom, judges and juries deferred, when possible, to something else? Perhaps a set of agreed upon treatment guidelines could point courts in the right direction. The concept of treatment guidelines is not foreign, and in fact, many treatment guidelines exist.<sup>214</sup> The problem is that so many different treatment guidelines exist from around the world that it is too difficult to agree on which should become the standard of care to use in medical malpractice situations.<sup>215</sup> This is where this Note's focus on prostate cancer again comes into play. For highly specialized practice areas such as Urology, perhaps the guidelines and recommended treatments handed down from an organization with a unique and highly specific focus in that area, like the American Urological Association, would be the best standard of care. This solution is where the answer to the prostate cancer medical malpractice problem might be found. The reasons why this may be the answer are the subject of this Note's next section.

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210. McConkey, *supra* note 201, at 499.

211. *Id.* at 500.

212. Just run an internet search for "expert witness" and experience the avalanche of market oversaturation.

213. See Adam Liptak, *In U.S. Expert Witnesses Are Partisan*, N.Y. TIMES, Aug. 12, 2008, at A1, available at <http://www.nytimes.com/2008/08/12/us/12experts.html>.

214. To see the sheer multitude of treatment guidelines available, visit the website of the National Guideline Clearinghouse, a public resource for evidence-based clinical practice guidelines. NAT'L GUIDELINE CLEARINGHOUSE, <http://www.guideline.gov/> (last visited Oct. 30, 2010).

215. See *id.*

#### IV. Recommendation

Changing the standard of care in prostate cancer malpractice cases appears to be the best solution for solving the inadequacies of the status quo. Recall the previously mentioned case from Florida.<sup>216</sup> The physician followed the recommendation of the AUA in ruling out radical surgery and suggested watchful waiting.<sup>217</sup> The patient then made an informed decision to follow the doctor's advice. In doing so, the patient also simultaneously agreed with the recommendation of the AUA. The entirety of the AUA was undermined by the legal system. If the medical malpractice system instead deferred to the AUA's recommendation and treatment guidelines, the claim would not have succeeded. Many urologists believe it should not have, because to them, individually and collectively as the AUA, the physician on trial did nothing wrong.

This solution seems quite rational. After all, would it not be better to defer to a large group of medical experts all practicing in the same field across the country than to a handful of biased expert witnesses? Adherence to the AUA standard would eliminate a cause of action in a situation like this. Therefore, unlike damage caps, this solution has a direct effect on the amount of litigation that is brought concerning this issue. Urologists would be assured that they would no longer be subject to malpractice liability for prescribing watchful waiting if they prescribed it under the circumstances set forth by the AUA. Urologists would be free to utilize this treatment option when it is available to them, knowing that it is the right choice. This enhances predictability and eliminates the defensive medicine aspect that is so prevalent in this area.

While this solution looks like a relapse to deferring to medical custom, closer inspection reveals that this is not the case. The AUA might look to custom when establishing its recommendations and treatment guidelines, but it preserves the freedom of the AUA to add any additional courses of treatment the urologists feel are pertinent or effective but have yet to be put to the test of custom. In other words, their recommendations would be in no way *limited* by custom. This alleviates the fear that some have expressed that medical experimentation and advances in medical treatments are chilled, because such

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216. See Hernández-Gräulau, *supra* note 17, at 6.

217. *Id.*

treatments would almost always involve a breach of the standard of care since they were not customarily used by members of the profession.<sup>218</sup>

If the AUA knew that its guidelines would be given the power to set the standard of care in malpractice cases, it seems likely that it would be even more diligent in the creation and maintenance of the guidelines. Part of this recommendation, therefore, is to have the AUA work with outside organizations in order to properly address prevailing concerns. The AUA could work more closely with the government, which would more than likely be looked upon favorably in this political climate where there has been a noticeable call for more government involvement in health care.<sup>219</sup> Doing so may help establish guidelines that create treatments that are both economically efficient and of a higher quality than what the status quo offers.

Lastly, the concerns of the academic community, like those identified by Professor Schuck, are adequately dealt with by this solution. Recall that PSA testing led to many of Professor Schuck's "bad bets."<sup>220</sup> This phenomenon is mainly attributable to urologists following up any elevated PSA tests with further high-cost, low-utility testing and treatments like the TRUSBx biopsy because of a fear of malpractice liability.<sup>221</sup> Professor Schuck would rather see watchful waiting used in these situations and so would the AUA.<sup>222</sup> If doctors were free from the threat of liability because they were following the AUA's recommendation when prescribing watchful waiting, the occurrence of watchful waiting would increase, thereby also increasing the efficiency of resource allocation and allaying Professor Schuck's fears in over-investing in "bad bets."

Like all other solutions, this one is not without its shortcomings. Critics might argue that, knowing they would be immune, doctors would *always* choose watchful waiting and would never choose to treat where the circumstances dictate that they would not face malpractice liability. It cannot be ignored, however, that an AUA-recommended treatment is a culmination of numerous experts in the

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218. *Id.* at 69.

219. See Schuck, *supra* note 80, at 41 (describing the call, from both sides of the political aisle, for government involvement and government programs like Medicare).

220. *Id.* at 69.

221. Hernández-Gräulau, *supra* note 17, at 6.

222. *Id.*; Schuck, *supra* note 80, at 69.

field.<sup>223</sup> It can be assumed that these experts have devoted significant time to researching and thinking about the various issues associated with different treatments. The treatment path that they choose represents the most informed, effective, and efficient treatment available. Accordingly, forcing doctors to stick to AUA recommendations might not be such a bad thing. Critics of damage cap solutions also have suggested that physicians who adhere to these types of consensus standards should be immune from suit.<sup>224</sup>

## V. Conclusion

The road to finding a solution to high health care costs in the United States is one that will take quite some time to traverse. It involves medical malpractice, defensive medicine, and discussing potentially difficult and emotion-provoking topics like a cost-benefit analysis of a loved one's end-of-life care. Before tackling these big issues, it is important to look more narrowly in hopes of finding a starting place. Prostate cancer is the crossroad. Prostate cancer quite poignantly demonstrates an area of medicine that involves people at the end of life, the chronically ill, and the choices they and their doctors face when deciding to treat or not to treat, decisions that are all made in the presence of the lingering specters of malpractice liability and high-cost health care. While there are many proposed solutions for reform and change, only one seems to help in the prostate cancer situation: adhering to the suggestions of a consensus of experts, represented by the AUA, in establishing a new standard of care. Doing so will relieve much of the heavy burden of liability and cost imposed on urologists. Perhaps by starting here, with small steps, the pathway to reform will present itself.

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223. See *Vision & Mission*, AM. UROLOGICAL ASS'N, <http://www.auanet.org/content/about-us/vision-and-mission.cfm> (last visited Aug. 30, 2010). The AUA boasts a board of directors with impeccable credentials, and the organization's official mission statement is "to promote the highest standards of urological clinical care through education, research and in the formulation of health care policy." *Id.*

224. Hyman & Silver, *supra* note 98, at 1133 ("Although there are obvious difficulties associated with the development of consensus standards, physicians who adhere to those standards should be immune from suit.").