TRIAL

JOURNAL OF THE AMERICAN ASSOCIATION FOR JUSTICE

MAY 2007

Medical negligence

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Battling ageism in cancer negligence cases

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Many people view the elderly as having little to live for and even less to offer society. Uncovering these assumptions is step one in achieving justice for an older client whose cancer went undiagnosed or undertreated for too long.

Trial lawyers are in the business of anticipating prejudices. As soon as a new case arrives, they consider how jurors will assess the client and the case.

When the plaintiff has suffered injury because of a doctor's failure to diagnose cancer or provide adequate treatment, the lawyer can count on jurors to hold certain biases. They have been conditioned to believe that medical negligence plaintiffs bring frivolous claims against heroic physicians who can't be blamed for their inability to save the patient from a disease's inevitable progression. Seasoned plaintiff lawyers know these biases well and welcome the chance to show the jury just how wrong these attitudes are.

Elderly cancer patients regularly face negligence, and when the plaintiff is elderly, another bias enters: ageism. Ageism is directly responsible for incomplete examinations, delayed diagnoses, and undertreatment of these patients.[1]

Many Americans regard the elderly in a less-than-charitable light. People assume that because old people typically don't work, they aren't "contributing to society," and their days of achievement are long over. Their lives are spent watching television, waiting for visitors, and perhaps slipping in and out of dementia, awaiting a fast-approaching death.

This view of the elderly makes every aspect of a medical malpractice case more difficult. It significantly reduces potential damages because a jury's assessment of damages, both noneconomic and economic, is often guided by the patient's life expectancy.

The standard of care is also affected. What is clear malpractice in the case of a younger plaintiff is often less clear when the plaintiff is elderly. Causation, too, becomes cloudier. The presence of other medical conditions, along with the weakness and fragility of old age, can complicate the case.

Defense attorneys often take advantage of ageist attitudes. Obviously, no defense lawyer would overtly disparage an elderly plaintiff because of advanced age or failing health. However, he or she might subtly seek to cultivate ageist thinking among jurors, using rhetoric and the testimony of medical experts to exploit this bias.

Nationally, plaintiff attorneys have only a 37 percent chance of winning a medical malpractice case.[2] Why, then, should a trial lawyer expend resources on a case that is almost certain to be more difficult to win than the average? There are two reasons: because the elderly need us, and because these cases can be won.

We are a nation of ageists. That our laws specifically forbid discrimination against the elderly is a testament to the prevalence of this phenomenon in American society. Indeed, a list of the books in which ageism's influence is discussed would itself fill a book.[3] Knowing this and understanding how ageist atti-

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tudes affect the care of the elderly can help your case succeed.

Cancer in the elderly

About 60 percent of new cancers are diagnosed in elderly Americans—those age 65 and older.[4] Breast cancer is the most common cancer among women; prostate cancer is the most common cancer—other than skin cancer—among men.[5]

Elderly women account for 50 percent of newly diagnosed breast cancers. By 2030, the number of cases is expected to double.[6] A 2003 study projected that about 35 percent of women who develop invasive breast cancer will be over the age of 70 when it is diagnosed.[7] Over 97,000 elderly women died from breast cancer between 2000 and 2003.[8]

Prostate cancer, too, affects a large portion of the aging population.[9] Over 75 percent of new prostate cancers occur in elderly men, and this incidence reaches 82 percent among the combined male populations of developing countries.[10] Most prostate cancer is slow-growing, and intervention may not be warranted. The more aggressive form is deadly. Only a biopsy can determine the difference. Between 2000 and 2003, more than 111,000 elderly men lost their lives to prostate cancer.[11]

These are not the only cancers afflicting old people, but if they are found early, they are often curable—even in the elderly. When an early diagnosis is missed, the patient's life may be cut short by many years.

The medical literature concerning the experience of the elderly with these diseases reveals the problem of ageism in oncologic medicine and how this prejudice leads to substandard care. It explains the central medical and bioethical terms and concepts that figure prominently in defense arguments and expert testimony presented at trial.

Elderly women seeking evaluation and treatment for breast cancer face medical opinions advanced solely in response to their age.[12] Because the benefits of annual screening mammograms in women over age 70 are uncertain, "cancer-screening practice guidelines are ambiguous and inconsistent for elderly women."[13] When breast cancer is diagnosed, less aggressive treatment is recommended. After all, many physicians believe, these women don't tolerate chemotherapy well; it can be highly toxic to them. Moreover, most elderly women have other diseases or medical conditions. Finally, their life expectancies are short, the ageist doctor thinks, so why ruin their "golden years" with the discomfort and anxiety that accompany treatment?

Without disparaging a plaintiff's age, the defense might subtly seek to cultivate ageist thinking among jurors, using rhetoric and the testimony of medical experts to exploit this bias.

Evidence suggests that this kind of attitude translates into poorer care for elderly women. A 2006 study reported that "several studies, including the present one, have shown that older breast cancer patients as a group are understaged, underdiagnosed, and undertreated compared with their younger counterparts."[14]

A study done three years earlier concluded similarly that "elderly women with breast cancer have late diagnosis, incomplete diagnostic assessment, and lack a standardized therapeutic approach."[15] This pattern of substandard care was nothing new, the authors said, and it had likely led to many deaths that could have been prevented.

Several studies have sought to propose solutions to this crisis of care. Two are especially helpful. The first examined the feasibility of administering adjuvant chemotherapy to node-positive breast cancer in women over 65.[16] It found that although breast cancers often were likely to recur in older women, this group usually wasn't given the option of chemotherapy.

However, the authors found that elderly breast cancer patients in good general health could withstand the same chemotherapy regimens as their younger peers—with comparable rates of success.[17] Thus, they argued, physicians should offer their patients this option, though with full disclosure of the possible side effects.

The second study made similar recommendations. Although it emphasized the central role of life expectancy in determining treatment options, the study urged physicians not to consider age alone, but rather to make their assessments according to the patient's individual health status.[18]

These findings illustrate a commonsense idea: that people age differently, some better, some worse. Some 82-year-olds go jogging every morning, and some 65-year-olds require a wheelchair. Their bodies also have varying tolerances to medical treatment. Therefore, oncologic care should be offered according to each patient's level of health. Medical terminology expresses this difference with the concepts of biologic age and physiologic age.

These studies focus on physiologic age and the new treatment possibilities it entails, as well as another important aspect of good medical care: candid physician-patient communication. Only after the patient's treatment options were known and the side effects discussed could elderly patients safely begin their treatment regimens.

The literature on prostate cancer reveals similar ageist attitudes toward elderly male patients. These men, doctors say, usually have slow-growing cancers, and because these patients are of advanced age, some other disease will likely take their lives before the cancer does.[19] Doctors say that they want them to have the best quality of life possible in their final years and that surgery, chemotherapy, hormone therapy, and radiation aren't pleasant and can be dangerous to elderly men.

Whether it's useful to screen elderly

men for prostate cancer is one of the biggest controversies in urology. The American Cancer Society does not believe that screening men with less than 10 years of expected life left is useful because the treatment often has painful, debilitating effects.[20]

Some studies don't see any value in prostate-specific antigen (PSA) screening at all, such as one from 1996 that found performing prostate biopsies in men with abnormal PSAs who were 70 and older was not cost-effective and could adversely affect their quality of life during their final years.[21] While this study assumed that most cancers in older men would not take their lives, it did recognize that when the variables were manipulated to express a higher likelihood that these cancers were lethal, biopsies resulted in a marginally higher quality of life.

A study performed two years earlier had similar findings. It examined the clinical and economic feasibility of screening for prostate cancer in men between 50 and 70 years old. The authors concluded that screening these men was not cost-effective and that while screening 60- and 70-year-old men resulted in fewer cancer deaths, this benefit was "offset" by the decrease in quality of life due to treatment.[22]

Other literature on the elderly in this context is more inspiring. A 2006 study examined the efficacy of radical prostatectomy in 80-year-old men. The then-current urologic thinking concerning this procedure was that it, like screening, should be reserved for men with at least a statistical 10-year life expectancy. Ignoring this proscription, the study found that fit 80-year-old men, properly briefed on the side effects and possible complications of prostatectomy, had success rates comparable to those of younger patients.

Commenting on their conclusions, the authors explicitly recognized that withholding certain treatment because of a patient's old age alone "would amount to ageism, a problem now recognized as pervasive in our society."[23] Physicians, they argued, need to accommodate these men, not discriminate against them. Some physicians have begun to emphasize the need to assess and treat patients as individuals with varying degrees of health.

A 2006 article again cites the commonsense basis for this principle: "[I]t is difficult to make categorical recommendations for such a diverse population."[24] While elderly men suffering from many medical conditions might "have little to gain from prostate cancer screening unless they have a potentially fatal high-grade tumor," those 70-year-old men who are "in good heath may continue to benefit from screening."[25]

Another 2006 article also emphasizes physiologic age coupled with the need for informed patient decision-making. Physicians, the author writes, should "help patients make informed treatment decisions based not only on survival predictions but also on health status, functional concerns, and—most importantly—personal preference."[26]

This literature also highlights another central concept in oncologic care: quality of life. Physicians may withhold treatment if the quality of any saved years will be compromised by the pain, discomfort, or disability that treatment will cause. However, because what constitutes good quality of life for one person may be different for another, mentally competent patients should make this choice.

Juries understand this simple concept. Incomprehensibly, some physicians still do not.

Ageism at trial

Changing prejudice is a long-term project, and people require motivation to change. Jurors usually need more time than a trial allows. While lawyers can eliminate overtly prejudiced jurors from the panel in voir dire, jurors who do not recognize or admit any prejudice against the elderly must be convinced that the client, although of advanced age, does not deserve to be labeled "elderly."

Point out that the client has overall good health and an active life. Some senior clients travel extensively, play bridge, dance competitively, enjoy golf or tennis, and volunteer at their church or lo-

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Court documents

Ball v. Shanahan. Expert testimony in a case alleging failure to diagnose breast cancer. (No. LR2376)

Bennett v. McGrath. The parties' depositions of the defendant's cancer surgery expert in a case alleging failure to diagnose breast cancer. (No. LR2687)

Daigle v. AMI/St. Jude Hospital. Deposition of an oncology expert in a case alleging that a radiologist misread a mammogram. (No. LR2762)

Doe v. Western Queens Community Hospital. Trial transcript excerpts containing the testimony of the plaintiffs' breast surgery expert in a case alleging misdiagnosis of breast cancer and failure to inform the patient of the option to undergo a lumpectomy with radiation instead of a mastectomy. (No. LR3403)

Gorman v. LaRoche. Deposition transcripts of the plaintiff's and the defendant's expert witnesses in a case alleging failure to timely diagnose breast cancer. (No. LR2411)

Litigation packet

Failure to Diagnose Breast Cancer. This packet includes documents, analysis, and strategies to assess and litigate cases. The included materials focus on complex questions regarding causation, standards of care, loss of chance for cure, staging, and life expectancy.

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cal homeless shelter. Friends can testify as to their mental and physical agility.

Every panel includes jurors who know someone who is aging gracefully and vibrantly. And most, if not all, jurors will say that age should not make a difference in medical treatment and that older people who are competent to make their own medical decisions should be allowed to do so under all circumstances. Ask questions during voir dire that will reinforce these beliefs with each juror before the trial begins.

At trial, the first and most obvious plan of attack for the defense attorney centers on the plaintiff's life expectancy. The defense will try to avoid physiologic age and will focus on statistics, such as the U.S. Life Tables—which list death rates by age, race, and sex—to lump the plaintiff in with all the others in his or her age group on a statistical table.[27]

To erase the plaintiff's physiologic age and its association with poor health from the minds of the jurors, realize what the defense is really doing: de-individualizing your client. The defense does not want the jury to hear that shortly before her breast cancer diagnosis, Margaret took a trip to Europe alone or that she goes dancing every weekend. Your opponent wants to reduce her to a statistic and counter your efforts to present a strong, vibrant, 86-year-old woman who prefers walking over driving.

Accordingly, you need to show your client's individuality, particularly as far as her health is concerned. For Margaret, you would argue, 86 years of age doesn't mean anything; it's just a number. Actively shape the testimony of her family, friends, and neighbors to emphasize her individual level of health.

Use your experts to show this as well. For example, your client's family doctor may describe her excellent health: normal body weight, low cholesterol, normal blood pressure, and absence of diabetes. The doctor also may minimize normal age-related maladies that do not seriously affect life expectancy, such as atrial fibrillation that is well controlled.

Don't let a few medical conditions discourage your advocacy. Elderly people often have hypertension, arthritis, or various other controllable health con-

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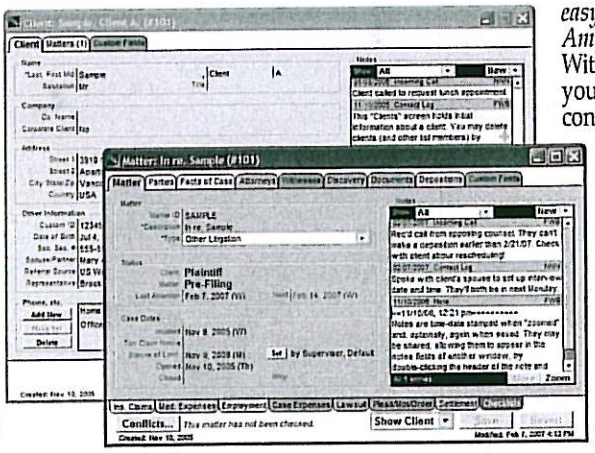

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ditions or problems. Even atherosclerosis can be effectively held in check with cardiac stent placement. Demonstrate that any medical problems have only a negligible effect on your client's overall health.

As far as the patient is concerned, focus on his or her robust health before becoming ill with cancer. For example, argue that before he began treatment for prostate cancer, Al, who was 79, worked around the house and went golfing every day. His heart was fine, and he was as mentally sharp as any juror. Do not let your opponent cast him as the average 79-year-old man, with only a few years left to live.

While this counteroffensive is under way, you must concentrate intensely on the ageist bias. Seek to undermine the main assumption behind all ageist thinking: that elderly people have no value. This is not easy, but it can be done. Again, ageism devalues the elderly with three ideas: They are sick, they don't work, and they don't do anything. Thus, the ageist thinks, they don't matter.

You have already addressed the issue of the client's supposedly poor heath; now tackle these other ideas. Consider what ethicist John Kilner identifies as the economic or "productivity-oriented" issue.[28] The elderly are devalued because they aren't employed. The United States is a robustly capitalist society, and its citizens prize the ability to work. Employment is a measure of social value.

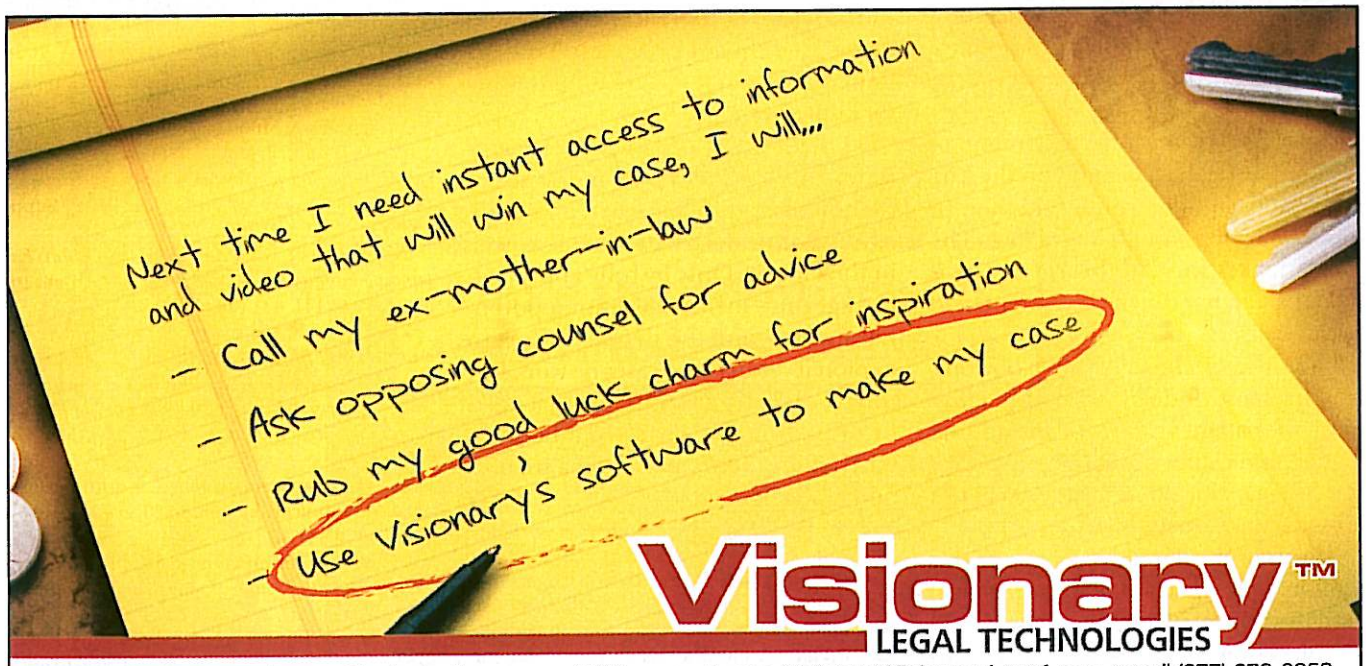
Suppose your client retired long before succumbing to cancer. Does this man or woman therefore have less social value than another? Certainly not—he or she has completed a lifetime of work. This plaintiff was paying societal dues long before many of the people in the courtroom were born. Make these points clearly to counteract economic ageism.

The third ageist belief is related to the second. It holds that old people are not trying to achieve, make a name for themselves, or do anything great.

To counter this, first focus on your client's lifetime accomplishments and interests. Next, teach the jurors that what they define as an accomplishment at their age—getting a promotion, for example—will shift as they get older. The elderly, who have finished working, can concentrate on the passions they have long sought to indulge, whether painting, teaching, traveling, or competing in triathlons. Tell the story of your client's passions after retirement, and show the jury the value of an active life.

Argue that the elderly also have value because of their relationships with other people. Older plaintiffs often are the patriarchs or matriarchs of their families, with children and grandchildren. They have war buddies, lifelong friends, and vast networks of acquaintances. Emphasize their central place in these social and familial spheres to overcome this aspect of age bias.

With these general principles of anti-ageist advocacy in mind, focus on specific elements of the defendant's case. How will your opponent shape standard-of-care arguments in view of your



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client's advanced age? As noted above, for example, physicians do not screen, or recommend self-screening for, anyone they won't treat.

Thus, the defense will argue, the defendant should not be faulted for incomplete or unattempted screenings because the plaintiff was too old to be treated anyway. This is a prominent theme in cases of delayed diagnosis of prostate cancer because many urologists think that a man with less than a 10-year life expectancy should not be treated for prostate cancer.

The pattern of substandard care is not new. A study found that although breast cancers often were likely to recur in older women, this group usually wasn't given the option of chemotherapy.

To combat this argument, attack the concept directly. The idea that age alone should be a bar to the treatment of a healthy elderly patient is ridiculous. "Age is not a contraindication to life," our expert urologist once said on the stand.

This is precisely the argument to make. The client's location on the Life Tables doesn't determine whether, or how, he or she should be treated. The client makes this choice: He or she is healthy, can handle the treatment, and wants to live.

This idea of choice, though obvious, is important. Indeed, patient autonomy—the patient's right to determine the nature and extent of his or her medical care—is a major ally in an elderly client's missed-cancer-diagnosis case.

Jurors are generally receptive to this notion: Our legal and political systems, and the ethical principles that support them, center on the idea of rights—to vote, to bear arms, to freely practice religion. People don't like to give up their rights, including the right to choose whether to receive potentially lifesaving medical treatment.

In a cancer case involving a missed diagnosis or inadequate treatment, interference with this right almost always involves a physician withholding information from the patient—about either available diagnostic tests or possible treatments—because the doctor believes the patient is too old to be treated safely or to see any benefits from treatment.

Though these physicians believe they are acting in the patient's best interest, they are merely substituting their own judgment for the patient's. Bioethicists refer to this behavior as strong paternalism.[29]

Defense attorneys will attempt to clothe a doctor's diagnostic apathy in a paternalistic beneficence: The defendant didn't want to bother the patient with a diagnosis, they will argue, because he or she didn't want to subject the patient to the agonies of treatment. Doctor knows best.

This tactic, and other ageist attitudes, must be identified and exposed to show the significance of a missed diagnosis or undertreatment of cancer in the elderly. Only by fully appreciating ageism's influence among potential jurors—and the defense effort to exploit it—can these cases be won. But this is only half the battle. We first need to overcome our own prejudices toward taking these cases and realize how much we are needed. ■

Notes

1. *See* Christine Bouchardy et al., *Undertreatment Strongly Decreases Prognosis of Breast Cancer in Elderly Women*, 21 J. Clin. Oncology 3580 (2003); David A. Litvak & Rajeev Arora, *Treatment of Elderly Breast Cancer Patients in a Community Hospital Setting*, 141 Archives. Surg. 985 (2006); *see also* Richard T. Penson et al., *Too Old to Care?* 9 Oncologist 343 (2004).

2. Carmel Sileo & David Ratcliff, *Straight Talk about Torts*, TRIAL 42 (July 2006).

3. For a thorough treatment of the subject, see *Ageism: Stereotyping and Prejudice against Older Persons* (Todd D. Nelson ed., MIT Press 2004).

4. Penson et al., *supra* n. 1, at 346; *see also* R. Houston Thompson et al., *Radical Prostatectomy for Octogenarians: How Old Is Too Old?*, 68 Urology 1042 (2006).

5. Thompson et al., *supra* n. 4; Martin D. Abeloff et al., *Clinical Oncology* 2371 (3d ed., Churchill Livingstone 2004).

6. Jeanne Mandelblatt, *Treating Breast Cancer: The Age Old Dilemma of Old Age*, 24 J. Clin. Oncology 4369, 4369 (2006).

7. Chris E. Holmes & Hyman B. Muss, *Diagnosis and Treatment of Breast Cancer in the Elderly*, 53 CA Cancer J. Clinicians 227, 227 (2003).

8. L.A.G. Ries et al., *SEER Cancer Statistics Review 1975-2003* tbl. I-12 (2006), http://seer.cancer.gov/csr/1975_2003/results_merged/topic_age_dist.pdf.

9. Philip W. Kantoff et al., *Prostate Cancer: Principles & Practice* 179 (1st ed., Lippincott, Williams & Wilkins 2002).

10. Patrick C. Walsh et al., *Campbell's Urology* 3004 (8th ed., Saunders 2002).

11. L.A.G. Ries et al., *supra* n. 8.

12. Bouchardy et al., *supra* n. 1; Litvak & Arora, *supra* n. 1.

13. Truls Ostbye et al., *Screening Mammography and Pap Tests Among Older Women 1996-2000: Results from the Health and Retirement Study (HRS) and Asset and Health Dynamics Among the Oldest Old (AHEAD)*, Annals Fam. Med. 209, 210 (Nov./Dec. 2003).

14. Litvak & Arora, *supra* n. 1, at 989.

15. Bouchardy et al., *supra* n. 1, at 3584.

16. Hyman B. Muss et al., *Adjuvant Chemotherapy in Older and Younger Women with Lymph Node-Positive Breast Cancer*, 293 JAMA 1073 (2005).

17. *Id.*

18. Holmes & Muss, *supra* n. 7.

19. *See* Robert J. McKenna, *Clinical Aspects of Cancer in the Elderly: Treatment Decisions, Treatment Choices, and Follow-Up*, 74 Cancer 2107 (Supp. 1994).

20. William J. Catalona et al., *Viewpoint: Expanding Prostate Cancer Screening*, 144 Annals Internal Med. 441, 441 (2006).

21. Ronald H. Gottlieb et al., *The Prostate: Decreasing Cost-Effectiveness of Biopsy with Advancing Age*, 31 Investigative Radiology 84 (1996).

22. Murray D. Krahn et al., *Screening for Prostate Cancer: A Decision Analytic View*, 272 JAMA 773 (1994).

23. Thompson et al., *supra* n. 4, at 1044.

24. Catalona et al., *supra* n. 20, at 441.

25. *Id.* at 441-42.

26. Mark S. Litwin & David C. Miller, *Treating Older Men with Prostate Cancer: Survival (or Selection) of the Fittest?*, 296 JAMA 2733, 2734 (2006).

27. *See e.g.* Elizabeth Arias, 54 Natl. Vital Statistics Reps. 1 (Apr. 19, 2006), www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_14.pdf.

28. *See* John F. Kilner, *The Ethical Legitimacy of Excluding the Elderly when Medical Resources Are Limited*, in *On Moral Medicine: Theological Perspectives in Medical Ethics* 979 (Stephen E. Lammers & Allen Verhey eds., 2d ed., Eerdmans Publg. Co. 1998).

29. Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 181-82 (5th ed., Oxford U. Press 2001).