

MISCELLANY

THE PREVENTION OF CLAIMS FOR MALPRACTICE

The problem of the allegation of malpractice incident to the administration of anesthesia is not new. Lyman (1) in 1881 devotes considerable space to this subject; many of his comments are very interesting in the light of today's problems. Of further interest is a recent article by Hawkins (2).

In present day practice, allegations of malpractice have increased in frequency. Likewise the monetary demands have increased and many substantial judgments have been awarded. This is reflected by the marked increase in rates for malpractice insurance during the past decade.

The causes for the increase in the number of alleged claims are many. One cause is probably related to the large number of claims for personal injury incident to automobile and other types of accidents. Another cause is undoubtedly due to the "advance" in knowledge by the general public in medical matters. A third cause is unquestionably the fact that so often, through good intentions, anesthesiologists and surgeons have led patients and their relatives to believe that because of today's "advances," the risks of anesthesia and surgery are essentially nonexistent. This is certainly not a realistic attitude. Another cause for claims for malpractice is the irresponsible remarks of one physician concerning the activities and practices of another. These remarks are frequently well meant, but are not interpreted in the intended sense, and with today's litigation-minded population, an allegation of malpractice against the discussed physician ensues. It has been estimated by many individuals interested in this problem that perhaps as high as 50 per cent of all malpractice claims result either from careless or malicious criticism of one physician by another. While this cause may not apply often to anesthesiologists, nevertheless, it is one factor in the general increase of malpractice allegations, and is directly or indirectly the cause of some malpractice claims against anesthesiologists.

A serious and not infrequent cause of the institution of action for malpractice, in my experience, has been incorrect or irresponsible diagnoses of the cause of injury or death. These diagnoses have invariably been made on the basis of either incomplete information or on a condition outside the proper knowledge of the individual making the diagnosis. I believe the words "due to" in respect to anesthetics should be very carefully employed.

The magnitude of the judgments rendered against defendants reflects a sociological trend. There is no way in which a defendant can exert influence to reduce the size of these awards. His only hope is in acquittal of the charge and, ultimately, in a reduction of the total incidence of claims as a result of improved practice and conduct. Physicians must encourage re-education of the public to the fact that medicine in general and anesthesia and surgery, in particular, are not without hazards beyond human control. If anesthesia and surgery are without hazard, as the general population has more and more been led to believe, then it is true that every surgical and anesthetic death and injury is due to malpractice and may fall within the doctrine of *res ipsa loquitur*. This, in essence, means that the facts speak for themselves and the defendant must prove that no action of his was causally related to the death or to the injury (3). Since anesthesia, with which we are particularly interested, by virtue of the state it produces and the methods required to produce it, is associated with an expected incidence of mortality and morbidity, patients and their relatives should be made aware that there is an inherent risk in every anesthetic. This does not mean that every patient and his family should be frightened by an overly conscientious surgeon or anesthesiologist, but public consciousness should be redirected to a more realistic point of view. If there is

proper public recognition of the fact that anesthesia is associated with an inherent risk, regardless of the excellence of care in administration, then the doctrine of *res ipsa loquitur* may not be applicable and the physician need only show the exercise of due care and diligence consistent with the level of practice in his community.

In the course of the past ten years, I have been asked to review and consult on many allegations of malpractice against anesthesiologists. From this experience it became apparent that certain omissions in the records have made the explanation of events difficult if not impossible. In almost all cases these omissions occurred, and since they are remedial, they deserve the attention of anesthesiologists.

Absence of Preoperative Notes.—The absence of a preanesthetic note has several possible if not actual implications. It may be inferred by a plaintiff's attorney that the anesthesiologist (using the term loosely) has so little regard for the seriousness of an anesthetic that he feels he need not see a patient to determine what type of anesthetic is most suitable for that patient, or even worse that he is too lazy to do so. In cases where the anesthesiologist claims that he has seen the patient but no note has been made, it has been my uniform experience that the complainant will either deny the visit completely or at least deny the point in challenge; that is, type of anesthetic, sensitivity to particular drugs, and the like. At the very best, the lack of a preoperative note, even when the patient has been seen, tends to denote to legalistic minds a certain lack of attention to details on the part of the anesthesiologist. It is well recognized that in group practice of anesthesiology, it is not always possible or practical for the particular anesthesiologist who is scheduled to administer an anesthetic to the patient to see that patient before the operation, but certainly it is practical and possible for some member of the anesthesia group to see the patient and record the visit. If such a note as "patient seen, record reviewed, anesthesia discussed and accepted, no preferences expressed, no sensitivities or allergies known, no recent medication, patient in good general health, blood pressure . . . , no recent colds or respiratory disease," is made or modified, as the case may be, to fit the individual, there can be no question of the basis for selection of the anesthetic. In addition, the note will support the preoperative orders that are left.

Even today, many surgeons have standing orders that are left for every surgical patient, and in many instances these are reasonable enough not to require modification by the anesthesiologist. It is indeed a sorry situation to review a case in which there are no preoperative orders left by the anesthesiologist to support his contention of having seen the patient where a little note such as "Dr. So and So's orders noted and agreed with" would make a great deal of difference in defending the case. It is my belief and teaching that there is absolutely no excuse for the absence of some preoperative note either by the anesthesiologist or a member of his group with respect to the preanesthetic status of a patient. Even in the greatest of emergencies or when the patient is admitted on the morning of operation, at least an explanatory note can be made on the anesthetic record to indicate the circumstances.

Anesthetic Record.—There are many well designed anesthetic records enabling the notation of a variety of phenomena and procedures with a minimum of writing. These were so designed because it is recognized that it is difficult if not impossible to keep a record requiring extensive writing and give an anesthetic at the same time. However, it has been my experience that the anesthetic records that I have been asked to review almost always are grossly incomplete. An anesthetic record should describe the procedure by appropriate markings and notations so that it stands by itself and may be interpreted by someone familiar with anesthesia without the necessity of, after the fact, verbal completion or explanation. It seems that there is a reticence to note that a procedure has been difficult or that complications of a technical nature have occurred. I do not know whether this is because of fear of criticism and the hope that no subsequent action will be taken in respect to complications or to an unwillingness to admit to complications. The immediate notation of difficulties and complications is the best evidence of carefully considered management rather than the converse. There is nothing so disheartening as to review a record of a cardiac arrest, for example, where

pulse, blood pressure and respiration are all noted as being normal and steady for half an hour or so and then suddenly have "cardiac arrest" noted. Any experienced anesthesiologist and plaintiff's attorney know that this is just not so. Equally discouraging is a record with all kinds of fluctuations—blood pressure, pulse and respiration recorded quite neatly but no notation as to the possible cause or of any remedial action taken. An anesthetic record is a complement to the description of the operation made by the surgeon, and, as the operative report describes the operation, the anesthetic record should describe the anesthetic procedure.

Postoperative Note.—It is my belief and teaching that at the very least, every patient who has an operation of a magnitude to require several days postsurgical hospitalization justifies a postanesthetic note. If a patient is only in the hospital for twenty-four hours or so, this may be impractical and impossible in certain circumstances. The visit and the note have several very distinct values. If the anesthesiologist is in group practice, the visit establishes a doctor-patient relationship and is evidence of genuine personal interest in the patient and circumstances of his recovery. If in individual practice, it cements the interest and confidence established by the preoperative visit. In general, it allows the patient to express certain minor grievances, if any, and the physician to observe any minor complications, which on the whole, will remain minor if the physician shows interest and concern. An opportunity of explanation to the patient personally and the possibility of making appropriate notations on the clinical record are afforded.

I have never had the opportunity in ten years of reviewing records of cases of alleged malpractice, which after all is negligence, in seeing one record in which these three elements noted above were present, and few if any in which even the anesthetic record was actually satisfactory.

Of the many cases I have reviewed, it was my opinion, based in part on knowledge gained which was not on the patients clinical and anesthetic record, that there was no malpractice involved and that other factors were at play, but it was almost always impossible on the basis of the record alone to formulate any opinion.

Conclusion.—If anesthesiologists will make an effort to have anesthesia reappraised as a medical procedure involving a certain real risk inherent in itself, and if they will take the trouble to document this belief with sound, complete and accurate records, the present trend in malpractice as it pertains to anesthesia may be halted and perhaps reversed.

JOHN B. DILLON, M.D.

*Department of Surgery, Division of Anesthesia
University of California Medical Center
Los Angeles, California*

REFERENCES

1. Lyman, Henry M., *Artificial Anesthesia and Anesthetics*. New York, William Wood & Company, 1881.
2. Hawkins, W. G., *Medicolegal Hazards of Anesthesia*, *J. A. M. A.* **163**: 746 (March 2) 1957.
3. Morris, R. C.: "Res Ipsa Loquitur"—Liability Without Fault, *J. A. M. A.*, **163**: 1055 (March 23) 1957.