EDITORIAL

ANESTHESIOLOGISTS, SURGEONS AND MALPRACTICE SUITS

Every surgeon, consciously or subconsciously, develops a preference for one anesthetic or combination of anesthetics for a particular operation. The operating conditions produced, the clinical impressions of the presence or absence of anesthetic and postanesthetic complications, and patient acceptance enter into the development of such bias. The abilities of anesthesiologists to use individual techniques may also be a contributing factor. I have used, or requested the use of, spinal anesthesia in a large proportion of my patients operated upon for intra-abdominal surgical lesions in the past 30 years. During the first 10 years, because of the lack of anesthesiological assistance, I administered the anesthetic myself, and in that period developed an appreciation for the benefits of spinal anesthesia that I have not forgotten. I still prefer its use, although willingly acceding to my anesthesiological colleagues if they think it unwise in individual patients. I am convinced that spinal anesthesia provides the best operative conditions and is the safest anesthetic for intra-abdominal operations.

The fact that spinal anesthesia is used so little in certain areas of this country is a constant source of amazement to me. I believe that this is due to two factors: Inadequate training in its proper use; and fear of malpractice suits. The problem of inadequate training can be overcome, but so long as the fear of malpractice suits persists, the technique will neither be widely taught nor used. This, in spite of the fact that Dripps and Vandam have published a study of as many as 10,000 patients to whom spinal anesthesia was given and in whom not a single major neurologic sequela was found. Beecher and Todd have published data indicating that the death rate associated with spinal anesthesia is lower than with other major anesthetic agents. Other supporting reports are available. It would appear, therefore, that the poor name given spinal anesthesia by malpractice suits is not justifiable in the light of the published data.

It is high time that the surgeon and anesthetist got together in this important area in order to set standards for their interrelated disciplines. Failure to do this may ultimately permit lawyers interested in malpractice suits to dictate control of our practices. They might direct what agents the anesthesiologist must give or what technique he must use. They might direct what treatment the surgeon must give, or what operation he must perform. We must resist these attempts. It is up to us to define our own acceptable standards. We must vigorously defend what we know to be good practice, yet we must not remain silent nor protect those involved in malpractice suits when we know they are wrong.

In an attempt to come to an understanding about these matters with the legal profession, the Board of Regents of the American College of Surgeons has arranged meetings with representatives of the American Bar Association. We believe these talks will be fruitful. Perhaps the American Society of Anesthesiologists would care to have a member or members of its organization participate in these discussions. If so, I would be happy to consider a request for such representation and to obtain the approval of the American College of Surgeons for such participation.

I believe it important to recognize that anesthesiology and surgery have common problems. These are not solved by pulling in opposite directions, nor even in parallel directions. Solution is most likely to be achieved with simultaneous and combined efforts. The legal problem mentioned is but one problem which needs our combined action. There are others. Working together brings harmony. If we can achieve a state of mutual satisfaction and appreciation of each other, we will have achieved a great deal.

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