The Causes of Malpractice Action

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MOST lawyers will affirm that the incidence of malpractice suits has increased in recent years. Most physicians will affirm that during the last decade scientific progress in medicine has been the greatest in history. In this period of our greatest scientific achievement, does it not seem incongruous that we are being accused more frequently of treating our patients carelessly and negligently?

Many experts as well as quasi-experts have editorialized and philosophized concerning the increase in the number of malpractice actions currently being brought against practicing physicians. The condemnation for this increase has embraced overdiligence on the part of the "vicious" plaintiff attorney, NACCA, and large judgments, to the impressment of absolute liability upon the medical practitioner. While most of the reasons possess elements of truth and validity, the most accurate reason may perhaps be found in the court records themselves.

In the legal sense, malpractice is defined as the breach of duty of a physician to his patient. The common law states that a physician's duty of care is to exercise that degree of diligence and skill that is exercised by the reasonable and prudent physician practicing in the same or similar locality. Thus, the malpractice action rests upon two legs, it may stand upon either one or on both. The element of care is defined as active attention. The element of skill is defined as technical expertness or, a learned power of doing a thing competently. The real basis of the malpractice action therefore is lack of attentiveness and competence. Either element or both elements are sufficient as a basis of an action in malpractice.

Fortunately for the physician, there is much more to a malpractice action than the mere establishment of a breach of a duty of care and skill. Numerous other hurdles are placed in the way of would-be plaintiffs, making their task much more difficult than it would casually appear to be. Despite comments to the contrary, the image of the physician in court is still quite good. Most persons serving upon a jury respect and admire the physician. By most jurors he still is classified as a rather special person, and he is viewed in the light of the traditional family physician. The court classifies him as an expert, and permits his opinion testimony to be admitted into evidence. In a practical sense, the court is prejudiced in his favor.

When a physician is asked to appear to defend himself in an action of malpractice, the jury is instructed that the law of evidence considers the physician to have exercised reasonable care and skill in the care of the patient: that is, there is a legal presumption of nonnegligence, and unless plaintiff establishes sufficient evidence during his presentation, the court may dismiss the case against the physician. It is the burden of the plaintiff-patient to overcome this presumption by introduction of evidence. The responsibility rests upon the plaintiff, therefore, to open the case and to present testimony to convince the jury or the judge or both, that the physician has breached the duty of care. By means of this evidence, the plaintiff must establish that the physician was not reasonably attentive to his patient and/or that he was not reasonably knowledgeable and skilled in the diagnosis and treatment of the disease.

According to the rules of evidence, these elements of the negligence action must be established by expert testimony. The plaintiff must secure an expert who can and will testify to these various elements. A conspiracy of the medical profession to deny the plaintiff expert testimony can be an exceed-

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ingly hazardous means of defending a malpractice action. The "expert rule" is a requirement that protects the defendant. Converting this defensive weapon into an offensive weapon is a dangerous maneuver. The requirement of testimony of an expert is a matter of evidence and is procedural law. The judge may, at his discretion, change procedural elements. Should there be a "conspiracy of silence," the court will permit the plaintiff to go forward without expert testimony, on the basis of the doctrine of *res ipsa loquitur*. This must be avoided at all costs.

Based upon these facts it would appear, at first blush, that suits in malpractice based upon actually negligent acts should never come to trial. Physicians purchase insurance to protect themselves in just such circumstances, should they negligently or accidentally injure their patients. However, it becomes necessary in some instances to try in court certain cases in which the physician has been negligent. When the plaintiff does not agree to a reasonable settlement, the question of damages may be submitted to a jury. This is a procedure fraught with danger. Whether or not to submit the question of damages to a jury, stipulating negligence, depends wholly upon the facts of the individual case and particularly upon the judgment of counsel.

There are instances in which the physician is forced into court by circumstance. Insurance carriers sometimes insist upon a trial—especially when the ultimate right of disposition of the case rests solely in the carrier. Since the plaintiff presents his case first, he has time to re-evaluate its worth. Perhaps the parties may reach a reasonable if not amicable settlement. Great caution must be exercised however, where the case for the physician is not meritorious, and the testimony given by the plaintiff's witnesses excites compassion and sympathy in the court—the plaintiff's unreasonable offer at once becomes quite desirable. But, at this point, the plaintiff, too, realizes his position and reconsiders his offer. Now, it is quite difficult. The trial is going forward and time is of the essence. Usually there is no authority from the insurance carrier to settle for a still higher amount. The result: a verdict against the physician—the creation of bad case law. Once created, it affects all subsequent cases tried in that jurisdiction. The typical examples are *res ipsa loquitur* in California, and *informed consent* in Kansas.

In reviewing the cases involving anesthesia, the causes of malpractice action against anesthesiologists can be based upon four broad headings. The first and perhaps the most important (but not the most common) is the malpractice action that has been based upon the negligent act of the physician. As stated before, in most instances this action should not have come to trial but should have been settled out of court.

It is difficult to understand why a physician will refuse to admit the negligent act. To that physician, such an admission is tantamount to a confession of professional incompetence. Yet this same physician, when involved in an automobile accident, has no hesitancy whatsoever in entering into a financial settlement for damages. In fact, when his car is damaged, he becomes incensed if the other driver has no insurance, or attempts to disclaim liability. It is difficult to defend the position of this physician. When such a case is tried before the jury, the likelihood of a verdict against him is excellent, and the possibility of the creation of bad case law is not remote. Malpractice panels of the appropriate county medical society should review such a case and determine whether or not to litigate it. The panel should not attempt to evaluate the facts as a jury, but to determine whether or not, in the mind of a physician, the defendant exercised due care and skill—a kind of medical pretrial hearing.

Perhaps the greatest incidence of malpractice actions can be placed under the broad heading of the casual approach to practice, or legally speaking, the breach of the duty of care. For the most part these relate to patients who have had poor results in their operative or anesthetic procedures, and/or lack of rapport between the anesthesiologist and his patient. Usually, the records are scanty. In most instances there have been no postoperative consultations with the patient. It is common to find that the anesthesiologist is "overextended." Perhaps he has too many residents or nurse anesthetists under his direction or supervision. Perhaps he is covering too many hospitals. Perhaps he has too many patients. Perhaps he has too little time. Many

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of these items have been brought out in evidence and have weighed heavily against the anesthesiologist.

Another cause of malpractice actions is based upon facts wherein the physician is "over his head," and he is attempting to cope with situations in which his professional competency is inadequate. Speaking in legal terms, he did not exercise reasonable skill. Particularly does this apply when the physician lacks current knowledge in medical matters.

Lack of reasonable skill is lack of professional competence. While the law does not permit experimentation upon patients, nonetheless it does require the physician to keep abreast in his art and science. Although open-drop ether has been accepted in former years, it may not satisfy our duty today in certain circumstances. The defense of lack of opportunity or time to become skilled in current methods of therapy may be legally insufficient. Most courts interpret reasonable skill as that degree of expertise currently practiced by specialists. In many such discussions, restrictions to "the same or similar locality" are deleted. The anesthesiologist is held to the standard of care of other anesthesiologists.

The resident in anesthesiology presents an entirely different problem. As has been the practice in recent years, physicians schooled in foreign countries become resident physicians in anesthesiology in American hospitals. These foreign physicians must learn to administer anesthetic agents. Unfortunately, in many cases the standard of instruction of the foreign medical schools is not comparable to those of the United States. This difference in training, coupled with a language barrier, frequently leads to situations upon which malpractice actions may be based. In the State of Ohio, within the last several years, at least two cases involving foreign residents in anesthesiology have reached the Supreme Court of Ohio. Instead of being settled before trial, these cases were litigated and lost. Incidentally, in none of these cases was the position of the anesthesiologist meritorious. The resident had been alone and unsupervised.

The most onerous malpractice action to defend is that based upon a breach of trust. The courts have stated many times that the patient-physician relationship is a contractual relationship firmly based upon an element of trust. The patient is ill and knows little about the complicated study of medicine. Because of the patient's physical illness, he must seek the help of the physician. Some call it "blind faith," others, "trust and confidence" in the physician. The law requires of the physician, the highest level of trust and sincerity. For this reason, in malpractice actions and in dealings with patients, the courts are prone to impress upon the proceedings the law of trust. While it is difficult to substantiate this statement with specific examples, nevertheless there are innumerable instances in which the court's reasoning can be explained only upon this basis.

"The relation of physician and patient is founded on the theory that the physician is learned, skilled, and experienced in those subjects about which the patient ordinarily knows little or nothing, but which are most important to him. The health, or even the life of himself or his family may depend upon them; therefore, the patient must necessarily place great reliance, faith, and confidence in the professional word, advice, and acts of the physician." (Tved v Haugen 70 ND 338, 294 NW 183, 132 ALR 379.)

Since the doctrine of full disclosure is, in fact, the obligation of a physician, it may be stated axiomatically that withholding information from patients possibly may be the basis of an action in malpractice. There are many cases to support the proposition that in the event that an accident has occurred to a patient that the patient should have had full disclosure of the facts at hand. Particularly is this true when the patient has been rendered unconscious by the anesthesiologist. In this circumstance, the patient does not know what has happened to him while under anesthesia. The burden of care for this period is placed strictly upon the anesthesiologist. We all realize that accidents can occur at any time. However, where the patient has been placed in a position of peril in which he is unconscious, any untoward occurrence, irrespective of whether it is the fault of the anesthesiologist or someone else, the circumstances of the case must be disclosed to the patient when conscious, or to another in his stead. Intentional concealment of this information, to protect either the anesthesiologist or another person, can prejudice a jury to such a degree that they

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will not only render a verdict against the physician but indeed will grant what might seem to be an unreasonable judgment.

Summary

A malpractice action is a difficult case for a plaintiff to win. The courts are prejudiced in favor of the physician, and many counter-checks are placed in the path of the would-be plaintiff-patient. For the physician to lose a meritorious case is most difficult.

Most bad case law has been made in instances in which the physician attempted to defend unmeritorious situations. Perhaps we should be reminded of one of the first rules of equity: "Come into court with clean hands."

BLEEDING Plasmin level was found to be high during anesthesia and surgery, and also in the preoperative period, presumably due to emotional stress. It rose as surgery progressed. Bleeding was successfully controlled during prostatectomy under halothane-gas anesthesia by the intravenous administration of 100 ml. of 5 per cent epsilon amino caproic acid. This reduced the blood loss from an average of 800 ml. to less than 200 ml. (*Fujita, T., and Miyatani, K.: Anesthesia and Fibrinolysis: Control of Oozing During Prostatectomy (Japanese), Jap. J. Anesth. 13: 598, 1964.*)

ANOCI-ASSOCIATION Major operations upon organs of the thoracic and abdominal cavities cause injury to the nerve-endings of vascular zones in various vital organs. This gives rise to nerve impulses which are conveyed to the central nervous system and produce a reflex action on the heart, vascular tonus, respiration and metabolic processes. In 50 of a series of 100 obstetric and gynecological operations performed under general anesthesia 15 to 20 ml. of a 25 per cent procaine solution was injected into the uterine round, infundibulopelvic and sacro-uterine ligaments. In major operations, such as hysterectomy, the amount of injected procaine was increased to 60 ml. This method of procaine blocking depressed or considerably reduced the visceral reflexes and promoted a normal blood circulation during the operation; it also ensured a favorable postoperative course. (*Persianinov, L. S., and Skripchuk, L. S.: Procaine Blocking of Reflexogenic Zones as Part of General Anesthesia for Obstetric and Gynecological Operations (Russian), Eksp. Khir. 4: 74, 1964.*)

METHOXYFLURANE Methoxyflurane in a trichlorethylene-inhaler was used for anesthesia in labor. Anesthetic effect was observed in all cases without diminishing labor. The average Apgar score was 9.1 and average first respiration time was 23.3 seconds. (*Fujimori, M., and Kato, M.: Methoxyflurane (Penthrane) in Obstetric Anesthesia (Japanese), Advances Obstet. Gynec. (Osaka) 15: 247, 1963.*)

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