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## Medical Malpractice—The Medical and Legal Aspects of the Post-Prostatectomy Urinary Incontinence Suit

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plished by law enforcement officers throughout the country. The real victim of an invasion of privacy is the person whose home has been "bugged" or whose telephone has been "tapped," where the information obtained evidences no criminal activity, and offers no leads to the police in crime detection. To avoid this problem, and to protect the individual from less than diligent methods of law enforcement, the strictest standards must be established if eavesdropping is to be permitted. While a certain amount of inconvenience will result from a more restricted use of electronic methods of surveillance, the individual will be assured of the protection of his right to be "let alone."

MARY E. BISANTZ

## MEDICAL MALPRACTICE—THE MEDICAL AND LEGAL ASPECTS OF THE POST-PROSTATECTOMY URINARY INCONTINENCE SUIT

### INTRODUCTION

John Starr had worked as a carpenter and then as a carpenter foreman in Florida, Georgia and Virginia for over twelve years. In 1956 he had become afflicted with mild prostatitis, an inflammation of the prostate gland, and had been treated successfully with antibiotics by his family doctor. When the condition recurred in 1960, Starr went to see Dr. Albert Fregosi, who also treated him conservatively with antibiotics, but the symptoms soon returned. Dr. Fregosi determined that an obstruction of the urinary tract might be the cause of Starr's illness, and he decided upon surgery. In early May of 1961, when Starr was forty-six years of age, the doctor performed a transurethral resection, by which he removed part of Starr's prostate gland, the apparent cause of the obstruction. Following the operation Starr was unable to urinate. Fregosi determined that, because of tissues which had not been removed during the course of the first operation, a second surgical procedure was necessary. Subsequent to this procedure, performed in late May of 1961, Starr complained consistently of urinary incontinence, the inability to hold his water, both at home and at work. He had to wear a plastic bag, diapers and pads, and a penile clamp. However, he found that there was leakage even through the clamp when he was under stress.<sup>1</sup>

During the next year and one half, Starr continued to have intermittent prostate infection and incontinence. He saw a number of doctors and urologists about his condition. Two of the doctors treated him with drugs for about eight months, but they were unable to determine the reason for Starr's urinary incontinence. Finally Starr was sent to Dr. Tom Florence, an Atlanta, Georgia

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1. Brief for Appellant at 7-13, *Starr v. Fregosi*, 370 F.2d 15 (5th Cir. 1966).

urologist, who concluded that either the external urinary sphincter muscle<sup>2</sup> had been damaged or the elastic tissue had been disturbed, preventing the usual closure mechanism. Dr. Florence performed surgical procedures in an effort to cut the stricture of the posterior urethra at the bladder neck and to remove a false passage in the urethra. However, Starr's condition of incontinence remained unchanged. In July of 1963, he went to Dr. Ian Thompson at the University of Missouri, who determined that there had been surgical destruction of a portion of Starr's external urinary sphincter muscle, including destruction of the *veru montanum*,<sup>3</sup> causing him to become incontinent. Dr. Thompson performed radical reconstructive surgery, but it proved unsuccessful.<sup>4</sup>

Starr and his wife sued Dr. Fregosi for malpractice, alleging that he had damaged the external urinary sphincter, thereby causing urinary incontinence. The medical experts who testified all agreed that any surgeon who might have cut Starr's sphincter muscle during the course of a transurethral resection would have been guilty of incompetence. However, the United States District Court for the Northern District of Georgia found that Starr had not carried his burden of proving want of due care, and rendered judgment for the defendant. The United States Court of Appeals, Fifth Circuit, Wisdom, J., *affirmed. Held*, the judgment of the court below was not clearly erroneous, and the evidence did not show that plaintiff's total urinary incontinence was caused by defendant's two surgical procedures, or that those procedures were performed without due care, skill and diligence.<sup>5</sup>

Since neither the facts nor the result of *Starr v. Fregosi* are atypical of malpractice cases involving post-prostatectomy urinary incontinence,<sup>6</sup> the case will be used as the prototype in the discussion which is to follow. As *Starr* indicates, the medical malpractice suit founded on post-prostatic urinary incontinence is a difficult one in which to prevail. One reason is that the medical profession itself cannot explain with certainty the cause of urinary incontinence. A further explanation is that attorneys have failed to explore the medical authority thoroughly and to apply relevant findings about urinary incontinence to the legal principles involved in proving medical malpractice generally.

Because of the importance of both medical and legal principles to the successful post-prostatectomy malpractice suit, the following analysis attempts to show the interrelationship between the medical knowledge about post-prostatic urinary incontinence and the legal principles involved in malpractice generally.

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2. This and other anatomical terms concerned with the urinary mechanism and used throughout this introductory section will be defined and explained in the section of this comment entitled *Mechanisms of Normal Urination* at *infra* notes 8-18 and accompanying text.

3. This and other anatomical terms concerned with post-operative urinary incontinence and used throughout this introductory section will be defined and explained in the section of this comment entitled *Post-prostatectomy Urinary Incontinence* at *infra* notes 31-72 and accompanying text.

4. Brief for Appellant at 13-19, *Starr v. Fregosi*, 370 F.2d 15 (5th Cir. 1966).

5. *Starr v. Fregosi*, 370 F.2d 15 (5th Cir. 1966).

6. See also *Fehrman v. Smirl*, 25 Wis. 2d 645, 131 N.W.2d 314 (1964), *aff'g on remand* 20 Wis. 2d 1, 121 N.W.2d 255 (1963); *Bellis v. Herman*, 16 A.D.2d 662, 226 N.Y.S.2d 948 (2d Dep't 1962).

It should also be noted that many of these legal principles bear equally as well upon incontinence caused by injury other than that resulting from surgery, as in automobile accidents or other instances of personal injury. Thus, the discussion which follows is also relevant to the assessment of damages in any personal injury suit in which the injury produces incontinence.<sup>7</sup>

At the outset, the mechanisms of normal urination will be explained, and the types and causes of urinary incontinence will be presented. Thereafter the legal problems involved in a malpractice case founded on urinary incontinence will be analyzed: the standard of care required of a surgeon in performing prostate surgery; causation of urinary incontinence as a result of such surgery; the question of negligence, including the applicability of the doctrine of *res ipsa loquitur* in such malpractice cases; and the duty of the surgeon to warn his patient that urinary incontinence may result from the prostatectomy. In addition, the elements and measure of damages will be explored, since the unique nature of damages in urinary incontinence cases has been largely ignored by the legal profession.

## I. MEDICAL ASPECTS

### A. *Mechanisms of Normal Urination*

The urinary system of the male, the primary focus of this study, is composed of the kidneys, the ureters, the bladder, and the urinary canal, known as the urethra. The latter is divided into four sections. First, there is the prostatic urethra, about one inch in length, and surrounded by the prostate gland just below the bladder. The second portion, immediately below the prostatic urethra, is called the membranous urethra. It lies within the urogenital diaphragm, a diaphragm of muscle and ligament, and is surrounded externally by the external urinary sphincter muscle. Below the urogenital diaphragm lies the bulbous urethra. The pendulous, a fourth part of the urethra, is the longest portion, varying in length with that of the penis within which it lies.<sup>8</sup> Before urine is expelled through the urethra, it is stored in a sac called the bladder. The urine is fed into the bladder from the kidneys above it, through two tubes known as the ureters. The opening from the bladder into the prostatic urethra is known as the vesical orifice.<sup>9</sup>

These organs operate together to perform the function of voluntary urination. However, the mechanism which permits one to retain his urine until he is prepared to urinate of his own volition is still not completely understood.<sup>10</sup> Yet, the explanation of this urinary continence mechanism offered by Dr. Jack

7. For a discussion of some causes of incontinence other than prostate surgery see *infra* notes 19-30 and accompanying text.

8. Kaufman, *Bladder and Urethral Trauma*, in 3 *Trauma* No. 6 at 77, 111-12 (1962). See generally 1 M. Campbell, *Urology* ch. 1 (1963).

9. 1 M. Campbell, *supra* note 8, at 1-33.

10. Emanuel, *The Pathophysiology of the Urinary Sphincter*, 45 *Surg. Clin. of N. Am.* 1467 (1965); Krahn & Morales, *The Effect of Pudendal Nerve Anesthesia on Urinary Continence After Prostatectomy*, 94 *J. Urol.* 282 (1965).

Lapides, the noted urologist associated with the University of Michigan, is one of the best and most widely accepted elucidations of this phenomenon: Urinary continence in the normal individual is maintained by a two-fold mechanism, nervous and muscular. First, the cortical regulatory tract, which emanates from the cerebral cortex of the brain, has an inhibitory influence on the lower motor neurons to the bladder. When the bladder is filling with urine and one does not intend to void, the lower motor neurons are maintained in a state of rest by this tract. At this point, motor neuron impulses to the muscle of the bladder and urethra are absent. Secondly, and quite independent of the control of the central nervous system, the smooth and elastic muscle tissue of the bladder and urethra exert continuous tension. The maintenance of this tension, particularly by the urinary sphincter muscles, is essential to the mechanism of continence. Thus, during the state of rest of the lower motor neurons, urine is held in the bladder by the autonomous activity of the urinary sphincter.<sup>11</sup>

The urinary sphincter is a muscular structure synonymous with the proximal three fourths of the female urethra or the prostatic and membranous portions of the male urethra. In both male and female these segments of the urethra are actually the true bladder necks.<sup>12</sup> The sphincter is a tubular structure rather than a ring and maintains continence by virtue of the resistance it creates. When pressure on the area is greatly increased by coughing, straining or other forms of exertion, urethral resistance must be increased to maintain continence.<sup>13</sup> This is done by increasing the resistance of the urinary sphincter to the flow of fluid through it.<sup>14</sup> On the other hand, the resistance of the urinary sphincter is decreased during urination because its lumen, or passageway, has been widened, its length shortened and tension of its walls against the urethral passage has been lessened by the active contraction of the smooth muscle. The striated muscle surrounding the urethra is in a relaxed state during active urination.<sup>15</sup>

While Dr. Lapides traces the phenomenon of continence to the sphincter mechanism, and to the *striated* muscle of the external urinary sphincter in particular, this explanation is not universally accepted. Other urologists maintain that either the internal or external sphincter is essential for urinary continence; either one, but not both, may be damaged without incontinence resulting.<sup>16</sup> Still others believe that continence may be maintained despite the incompetence of both the internal and external sphincters, because there is sufficient tension exerted by the *smooth* muscle and elastic tissue in the urethra to prevent the urine in the bladder from leaking out of the urethra.<sup>17</sup>

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11. Lapides, *Urinary Incontinence in the Male*, 55 So. Med. J. 965, 965-66 (1962).

12. Lapides, *Stress Incontinence*, 85 J. Urol. 291 (1961).

13. Lapides, *supra* note 11, at 966.

14. Lapides, *supra* note 12, at 291.

15. Lapides, *supra* note 11, at 967.

16. Samellas, *Urinary Control Following Radical Perineal Prostatectomy*, 95 J. Urol. 580, 581-82 (1966).

17. Krahn & Morales, *supra* note 10, at 285.

The primary role of smooth muscle, emphasized by this theory, is indicated by the fact that urine is normally held at the vesical neck, which is composed entirely of smooth muscle. Secondly, urinary continence is believed to be an essentially involuntary function; the normal person does not need to consciously contract his perineal musculature to prevent the escape of urine. Thirdly, since the urethra is immediately surrounded by smooth circular muscle fibers, rather than by striated muscle, it is reasonable to assume that it is smooth muscle that exerts the primary influence in retaining urine at this point. Further evidence is that transurethral excision of the urethra too close to the external sphincter, without damaging the sphincter itself, may produce incontinence.<sup>18</sup>

This conflict about which muscles have the most direct bearing on the maintenance of urinary continence, the striated muscles of the external sphincter or the smooth musculature of other parts of the urethral area, presents problems both medical and legal. As shall be demonstrated, it becomes difficult to determine the true etiology, or medical causation, of incontinence following prostatectomy and, consequently, it becomes extremely troublesome to prove proximate cause in a malpractice suit following such surgery.

#### B. Urinary Incontinence: Causes Other than Prostate Surgery

*Stress incontinence* results when the *internal* sphincter is damaged or destroyed. It has been found to occur only in female patients.<sup>19</sup> This is probably because of the unusually short urethra found in certain women when in the standing position.<sup>20</sup> The urethral length in these patients when lying down is frequently within normal limits, but there is a shortening of the urethra when they stand up. "It is evident that if the length of the urinary sphincter or urethra is decreased sufficiently, stress incontinence will result—particularly when it is known that stress forces urine part way down the urethra in the normal female."<sup>21</sup> It should be pointed out, however, that an unusually short urethra is not necessarily associated with stress incontinence, and a normal length urethra in the standing position is no guarantee against stress incontinence.<sup>22</sup>

Stress incontinence may be congenital, post-operative or menopausal.<sup>23</sup> It may be caused by emotional upset. However, the most common cause of stress incontinence in women is repeated childbirth,<sup>24</sup> resulting in relaxation of the supporting muscles around the bladder.<sup>25</sup> The common feature to all these forms of stress incontinence is that the internal sphincter cannot perform its normal function of withstanding unusual stresses and strains, because it has been damaged or destroyed. This leads to some leaking of urine at times of

18. H. Weyrauch, *Surgery of the Prostate* 469 (1959).

19. Hutch, *A New Theory of the Anatomy of the Internal Urinary Sphincter and the Physiology of Micturition: The Urinary Sphincter Mechanism*, 97 J. Urol. 705, 710 (1967).

20. Lapidus, *supra* note 12, at 291.

21. *Id.*

22. *Id.*

23. Emanuel, *supra* note 10, at 1474.

24. *Id.* at 1474-75.

25. Kaufman, *supra* note 8, at 108.

stress, for example, on coughing, straining, sneezing, laughing or sudden change of position.<sup>26</sup>

*Neurogenic forms of incontinence*—As stated previously, urinary continence is maintained by a two-fold mechanism, muscular and nervous.<sup>27</sup> While stress incontinence is caused by damage to one of the muscles (internal sphincter) and post-prostatic incontinence is also caused by damage to musculature (probably the external urinary sphincter), certain forms of incontinence are caused by damage to the nervous system. Involuntary contractions of the bladder, resulting in voiding of urine, can occur whenever there is a break in the cortical regulatory tract. The defect may be caused by damage to the spinal cord in an automobile or other accident, by brain tumor or simply by a failure in the normal development of the integrating centers.<sup>28</sup> Any such nervous system injury may lead to neurogenic incontinence. In addition to these traumatic causes of incontinence, such inability to retain urine may be the first symptom of a central nervous system disease, such as Parkinson's disease, multiple sclerosis or tertiary syphilis.<sup>29</sup>

*Paradoxical or overflow incontinence* is due to obstruction such as benign hyperplasia of prostate, urethral strictures, calculi (stones) or foreign bodies. It is not produced by neurological or muscular injuries, but "by a compensatory mechanism which forces the urine from an over-distended bladder out past the sphincters, which are competent but only to a certain point of resistance."<sup>30</sup>

### C. Post-prostatectomy Urinary Incontinence

The purpose of prostate surgery is often to remove a urinary obstruction which has made it difficult or impossible for the male to void. Yet, following such surgery, the patient may find that his problem has been reversed; rather than being unable to void at will, he is now unable to hold his urine at all.<sup>31</sup> Loss of urinary control can occur following any type of prostatectomy.<sup>32</sup> It may be partial or complete, temporary or permanent. In partial incontinence, there is a slight leakage of urine between normal voidings. Complete incontinence refers to the inability to retain any urine in the bladder.<sup>33</sup> In some patients who are totally incontinent, loss of urine occurs only in the sitting and erect positions, while in others wetting is present even when the patients are lying down.<sup>34</sup> It is not always possible to determine immediately whether incontinence will be

26. *Id.*

27. See *supra* note 11 and accompanying text.

28. Lapidès, *supra* note 11, at 967.

29. Berry, *Postprostatectomy Urinary Incontinence and Some Experiences with the Berry Procedure*, 45 *Surg. Clin. of N. Am.* 1481, 1481-82 (1965).

30. Berry, *Problems in Correction of Urinary Incontinence*, 63 *Rocky Mt. Med. J.* 51 (Oct. 1966).

31. H. Weyrauch, *supra* note 18, at 115-21.

32. Lapidès, *supra* note 11, at 969.

33. H. Weyrauch, *supra* note 18, at 461.

34. Lapidès, *Reconstruction of Damaged Urinary Sphincter in a Female Child*, 91 *J. Urol.* 58 (1964).

temporary or permanent. Generally, complete incontinence is more likely to be permanent than is partial incontinence.<sup>35</sup>

Some form of *temporary* incontinence frequently follows prostate surgery.<sup>36</sup> It may be due to the surgical reversal of the pressure balance in the urethral and bladder area,<sup>37</sup> or to the fact that the internal sphincter, which usually provides some resistance, is always damaged or removed in prostate surgery.<sup>38</sup> In a large percentage of patients control will gradually return. The incontinence will either disappear completely or it will be reduced to the loss of no more than a few drops of urine with exertion.<sup>39</sup> The natural forces of bodily repair can be relied on to effect a cure in most cases.<sup>40</sup> Generally, incontinence disappears when the pressure balance is restored and the bladder neck narrows as it heals.<sup>41</sup> Since the internal sphincter has been ablated in most prostate surgery, another factor in restoration of continence is the strengthening of resistance to the urinary flow along the remaining segment of the posterior urethra, the remaining sphincter muscles.<sup>42</sup>

While this explains temporary incontinence, why are some patients totally and permanently incontinent following prostate surgery? Although many theories have been advanced,<sup>43</sup> probably the best summary of the causes of permanent post-prostatectomy urinary incontinence is given by Dr. Weyrauch in his textbook on prostate surgery: Since the internal sphincter is ablated in nearly all prostate operations, the external urinary sphincter takes on added importance in preserving urinary continence. Thus, if the external urinary sphincter is also damaged or weakened, permanent post-operative urinary incontinence may result. Injury to the external sphincter may be caused by actual cutting of the muscle during surgery, by prolonged pressure of a hemostatic bag which is used to control bleeding, or from secondary infection which may intensify the effect of the initial trauma. A secondary cause of post-operative incontinence is distortion of the external sphincter and the adjacent prostatic urethra without damage to the musculature itself. Preexisting lesions must also be given consideration as causes of post-operative incontinence.<sup>44</sup>

There are four major types of prostatectomy: suprapubic, retropubic, perineal and transurethral.<sup>45</sup> There is greater probability that urinary incontinence will result from some methods of surgery than from others.

*Suprapubic prostatectomy* is a procedure for enucleating the prostate

35. H. Weyrauch, *supra* note 18, at 461.

36. Thompson, *Incontinence Following Prostatectomy*, 86 J. Urol. 130 (1961).

37. Rowan, *Post-Prostatectomy Physiology*, 94 Med. Times 987 (1966).

38. H. Weyrauch, *supra* note 18, at 462; Krahn & Morales, *supra* note 10, at 282; Samellas, *supra* note 16, at 583.

39. Graham, *Complications of Genitourinary Surgery*, in *Traumatic Medicine and Surgery For the Attorney—Service Volume 47*, 58 (P. Cantor ed. 1964).

40. H. Weyrauch, *supra* note 18, at 466.

41. Rowan, *supra* note 37, at 988.

42. Samellas, *supra* note 16, at 583.

43. For a summary of these various theories see Berry, *supra* note 29, at 1485-86.

44. H. Weyrauch, *supra* note 18, at 462-64.

45. *Id.* at chs. 10-13.



gland, wherein an abdominal incision is made and the prostate is approached through the bladder.<sup>46</sup> The outstanding objection to this approach is the great difficulty in controlling bleeding.<sup>47</sup> The advantage to this type of operation, on the other hand, is that it assures good function in both sexual capacity and urinary control in most cases. Permanent incontinence will result from suprapubic prostatectomy in only about one to two per cent of such operations. However, temporary incontinence, lasting for only a few weeks, is a normal result of such surgery.<sup>48</sup> The temporary incontinence which does occur may be due to the fact that the obstruction of the urinary function caused by the prostate, which necessitated the surgery in the first place, stretched the sphincter muscle.<sup>49</sup> The external urinary sphincter, however, is not usually damaged in suprapubic prostatectomy.<sup>50</sup>

*Retropubic prostatectomy* is a procedure for enucleating the prostate gland, wherein an abdominal incision is made and the approach is made directly to the prostate.<sup>51</sup> The chief advantage of the retropubic approach is that it provides ideal exposure of the prostate, permitting complete removal of the obstructive tissue and good control of bleeding. In addition, this operation is generally not followed by loss of urinary control or sexual potency.<sup>52</sup> However, even in retropubic prostatic surgery, the nearby sphincter may be torn during the operation, causing incontinence in a small percentage of cases.<sup>53</sup>

*Perineal prostatectomy*—Conservative perineal prostatectomy is a procedure for enucleating the prostate gland, wherein an incision is made in the anal area and the prostate is approached through the thigh.<sup>54</sup> This type of surgery has never gained wide acceptance because of such complications as urinary incontinence and sexual impotence. Today, however, the problem of permanent incontinence in conservative perineal prostate surgery has been largely eliminated,<sup>55</sup> and the incidence of such incontinence is no greater than in the suprapubic operation.<sup>56</sup>

Another form of perineal prostate surgery is radical or total prostatectomy. The purpose of this operation is to cure the patient of prostatic malignancy, by removing the entire prostate gland.<sup>57</sup> There is a ten to twelve per cent incidence of permanent urinary incontinence following this type of prostate surgery.<sup>58</sup> The frequency of incontinence following radical prostatectomy can

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46. Graham, *supra* note 39, at 58.

47. H. Weyrauch, *supra* note 18, at 231-57.

48. *Id.*

49. Interview with a Board-certified urologist, who requested that he not be referred to by name in this article, January 17, 1968.

50. *Id.*

51. Graham, *supra* note 39, at 58.

52. H. Weyrauch, *supra* note 18, at 266-89.

53. Graham, *supra* note 39, at 58.

54. *Id.*; H. Weyrauch, *supra* note 18, at 182.

55. H. Weyrauch, *supra* note 18, at 172.

56. Hock, *Prevention of Urinary Incontinence Following Radical Prostatectomy: A Preliminary Report*, 66 J. Urol. 753 (1951).

57. Graham, *supra* note 39, at 58.

58. Hock, *supra* note 56, at 753.

be ascribed to injury to the external urinary sphincter, which is even more vulnerable in this procedure than in other operations.<sup>59</sup> However, incontinence may result even when the external sphincter is not damaged, but where there is simply substantial loss of urethral resistance.<sup>60</sup> In either event, it is quite possible that permanent urinary incontinence will result from radical perineal prostatectomy. Yet, the only alternative is to let the cancer grow within the patient and eventually cause his death.

*Transurethral prostatectomy* is a procedure for enucleating the prostate gland, wherein no incision is made; rather the prostate is approached through the penis.<sup>61</sup> It is performed by passing a resectoscope, a cutting and viewing instrument, into the penis and through the canal of the bulbous and membranous urethra to the prostate. The resectoscope, which is operated by an electrical current, removes the desired tissue by cutting, as the instrument is brought back from the area of the prostate and the prostatic urethra toward the membranous urethra.<sup>62</sup>

Permanent incontinence in transurethral prostatic resection can be attributed to inadvertent cutting of a portion of the external urinary sphincter by the cutting instrument<sup>63</sup> while attempting to separate the prostatic urethra from the more distal portion of the urethra.<sup>64</sup> If too much tissue is removed, urinary incontinence may result.<sup>65</sup> While it still cannot be proved that the sphincter alone is responsible for continence, if incontinence does result from this type of surgery and the external sphincter has been cut, most urologists see a causal connection.<sup>66</sup> "If you cut the external sphincter, you can cause incontinence—if you cut too far down. . . . This is one of the complications that can occur, and does in one to two percent of the operations."<sup>67</sup>

One reason that the external urinary sphincter may be cut during transurethral prostatectomy is that it is difficult for the surgeon to identify, through his resectoscope, that tissue which should be cut and that which should be left intact.<sup>68</sup> However, although the external urinary sphincter itself may not be identifiable, the *veru montanum* is a discernible fold of flesh which forms a ridge at the bottom of the prostate at its juncture with the membranous urethra.<sup>69</sup> This landmark is the distal or peripheral point beyond which the cutting in a prostate resection should generally not be carried. Since the external

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59. Graham, *supra* note 39, at 58; Hock, *supra* note 56, at 753.

60. Hock, *supra* note 56, at 755-57.

61. This was the type of prostatectomy performed on the plaintiff in *Starr v. Fregosi*, 370 F.2d 15 (5th Cir. 1966).

62. H. Weyrauch, *supra* note 18, at 311-93.

63. Graham, *supra* note 39, at 58.

64. Lapidès, *supra* note 11, at 970.

65. H. Weyrauch, *supra* note 18, at 354.

66. *Id.* at 331.

67. Interview, *supra* note 49.

68. H. Weyrauch, *supra* note 18, at 345.

69. *Id.* at 16-17.

urinary sphincter is beyond the veru montanum, it cannot possibly be cut if the identifiable veru montanum is left intact.<sup>70</sup>

While there are devices available to give the incontinent temporary relief and save him the embarrassment of leaking urine in public, the probability of permanent rehabilitation is minimal. Operations to correct permanent incontinence caused by disabled sphincters are generally unsuccessful, since there is no satisfactory technique either to construct or to reconstruct a urinary sphincter.<sup>71</sup> Even the most promising modern development, the Berry procedure to correct urinary incontinence, has only proved about fifty-five per cent successful.<sup>72</sup>

## II. LEGAL ASPECTS

### A. *In General*

There are many reasons why the post-prostatectomy malpractice case, where the surgeon is sued for resulting urinary incontinence, rarely succeeds:<sup>73</sup> First, if incontinence results but the external sphincter is intact, there are a number of possible explanations for the incontinent state,<sup>74</sup> none of which can be attributed to negligence on the part of the surgeon. Secondly, even if it can be shown that the external urinary sphincter has been cut, it may still be demonstrated that since the medical profession has not universally accepted the doctrine that the sphincter is the central mechanism in the maintenance of continence, something other than the damaged sphincter caused the incontinence. Finally, it might be demonstrated that sphincteric damage, while not a normal result of prostate surgery, is an unexplainable and expected result in a small percentage of cases, and can in no way be attributed to negligence on the part of the surgeon.

In addition to these problems of proving causation, there is the practical problem of proving that the surgeon failed to exercise that degree of care and skill that is required of him, proof that usually must turn on the expert testimony of another doctor. So notorious has the practice become of doctors refusing to testify against their colleagues that the situation has been termed the "conspiracy of silence" on the part of the medical profession.<sup>75</sup> In sum, the attorney who champions the cause of the post-prostatic urinary incontinent has an extremely difficult task.

The law applicable to post-prostatic urinary incontinence malpractice cases is no different from the well-settled rules of malpractice generally. Prostatic

70. *Id.* at 339.

71. *Id.* at 468.

72. Berry, *supra* note 30, at 53.

73. The author could find only three reported cases: Starr v. Fregosi, 370 F.2d 15 (5th Cir. 1966); Fehrman v. Smirl, 25 Wis. 2d 645, 131 N.W.2d 314 (1964), *aff'g on remand*, 20 Wis. 2d 1, 121 N.W.2d 255 (1963); Bellis v. Herman, 16 A.D.2d 662, 226 N.Y.S.2d 948 (2d Dep't 1962).

74. See *supra* notes 36-44 and accompanying text.

75. See generally Kramer, *A Plaintiff's Lawyer Replies*, in *Medical Malpractice—the ATL Seminar 37*, 43-44 (1966); W. Curran, *Law and Medicine: Text and Source Materials on Medico-Legal Problems* 742 n.9 (1960), *citing* 22 NACCA L.J. (1958).

surgery resulting in incontinence constitutes only one kind of practice upon which malpractice may be based.<sup>76</sup> Thus, the plaintiff must plead and prove: (1) facts showing a physician-patient relationship, or a duty owed by the defendant to the plaintiff; (2) the circumstances of the injury; (3) defendant's negligence in diagnosis, treatment or post-operative care, as the case may be; (4) that such negligence was the proximate cause of the injury; (5) facts showing when the malpractice was discovered, if this is relevant to the running of the statute of limitations; (6) plaintiff's freedom from contributory negligence; and (7) the injuries sustained and damages.<sup>77</sup> The malpractice case founded on post-prostatectomy urinary incontinence is distinctive only from a factual and not from a legal viewpoint.<sup>78</sup> Therefore, the facts and holdings of the three relevant cases in this area are summarized now.

In *Starr v. Fregosi*,<sup>79</sup> whose facts were outlined at the outset,<sup>80</sup> the court held that the plaintiff did not meet his burden of proof and did not introduce evidence sufficient to show that his total incontinence was caused by defendant's two surgical procedures or that these procedures were performed without due care, skill and diligence.<sup>81</sup> The New York Supreme Court, Appellate Division, Second Department, reached a similar result in *Bellis v. Herman*.<sup>82</sup> Unfortunately, the facts are not set out in the opinion. However, the court reversed a jury verdict for plaintiff and held that the weight of the evidence did not sustain the implied finding that, in the course of prostate surgery, the surgeon was guilty of malpractice by reason of damage to the external urinary sphincter, as a result of which urinary incontinence occurred.<sup>83</sup>

*Fehrman v. Smirl*<sup>84</sup> was a malpractice action by a husband and wife against a surgeon who had performed a suprapubic prostatectomy on the husband. Plaintiff's case was based on the testimony of a urologist who stated that in his opinion the surgeon had injured the patient's external urinary sphincter while removing his prostate gland, as a consequence of which the patient claimed permanent urinary incontinence and sexual impotence, and that the damage to the sphincter could not have resulted from anything but the surgery. Despite this expert testimony, the trial court refused to instruct the jury on *res ipsa loquitur*. On appeal, the Supreme Court of Wisconsin held that if the patient's external sphincter was injured during prostatectomy, and if the injury was of a kind that would not ordinarily occur if the surgeon had exercised proper care and skill, the jury could infer from the fact of injury to the sphincter that the surgeon had

76. Annot., 88 A.L.R.2d 311 (1963).

77. 5A Personal Injury Actions, Defenses, and Damages *Physicians and Surgeons* § 2.01 (L. Frumer, R. Benoit, M. Friedman & L. Pilgrim eds. 1965).

78. Annot., *supra* note 76.

79. 370 F.2d 15 (5th Cir. 1966).

80. See *supra* notes 1-5 and accompanying text.

81. *Starr v. Fregosi*, 370 F.2d 15 (5th Cir. 1966).

82. 16 A.D.2d 662, 226 N.Y.S.2d 948 (2d Dep't 1962).

83. *Id.* at 949.

84. 25 Wis. 2d 645, 131 N.W.2d 314 (1964), *aff'g on remand*, 20 Wis. 2d 1, 121 N.W.2d 255 (1963).

failed to exercise that degree of care and skill which surgeons who practiced in the area usually exercised. The court ordered a new trial in the interest of justice on all issues except damages.<sup>85</sup> On retrial the circuit court rendered judgment for plaintiffs, and appeal was taken. The Supreme Court affirmed, and *held* that the giving of a *res ipsa loquitur* instruction was not an abuse of discretion where there was direct medical proof of negligence but the testimony did not particularize the nature of the negligence.<sup>86</sup>

### B. Standard of Care

Negligence is the basis of a malpractice action founded on post-prostatectomy urinary incontinence, as it is the basis for most malpractice actions. It is tortious in nature and predicated on a failure to exercise requisite skill and care.<sup>87</sup> The physician is bound to possess and to exercise that degree of ordinary care, skill and diligence as physicians in good standing in the same locality or community, in the same general line of practice, ordinarily have and exercise in similar cases.<sup>88</sup> The classic statement of this standard was enunciated by the New York Court of Appeals in *Pike v. Honsinger*:<sup>89</sup>

A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places on him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practices. . . . Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgment in exercising his skill and applying his knowledge. *The law holds him liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care, or the failure to use his best judgment.* The rule in relation to learning and skill does not require the surgeon to possess that extraordinary learning and skill which belong to only a few men of rare endowments, but such as is possessed by the average member of the medical profession in good standing. . . . The rule of reasonable care and diligence does not require the exercise of the highest possible degree of care . . . there must be a want of ordinary and reasonable care, leading to a bad result. . . . The rule requiring him to use his best judgment does not hold him liable for a mere error of judgment, provided he does what he thinks is best after careful examination. His implied engagement with his patient does not guaranty a good result, but he promises by implication to use the skill

85. *Fehrman v. Smirl*, 20 Wis. 2d 1, 121 N.W.2d 255 (1963).

86. *Fehrman v. Smirl*, 25 Wis. 2d 645, 131 N.W.2d 314 (1964).

87. 45 N.Y. Jur. *Physicians and Surgeons* § 181 (1966).

88. D. Louisell & H. Williams, *Trial of Medical Malpractice Cases* ¶ 8.04 (1966); *Favalora v. Aetna Cas. & Sur. Co.*, 144 So. 2d 544 (La. App. 1962); *Zoterell v. Repp*, 187 Mich. 319, 153 N.W. 692 (1915); *DuBois v. Decker*, 130 N.Y. 325, 29 N.E. 313, 4 N.Y.S. 768 (1891). See generally 5A *Personal Injury Actions, Defenses, and Damages*, *supra* note 77, at § 1.01[1][a]-[b]; 70 C.J.S. *Physicians and Surgeons* § 41 (1951); 45 N.Y. Jur., *supra* note 87, at § 182.

89. 155 N.Y. 201, 49 N.E. 760 (1898).

and learning of the average physician, to exercise reasonable care, and to exert his best judgment in the effort to bring about a good result. . . .<sup>90</sup>

Thus, a surgeon will be held liable in a malpractice case if his patient is injured because of the surgeon's failure to meet any one of his three obligations: if he lacks the requisite knowledge and skill, or if he fails to exercise reasonable care, or if he fails to use his best judgment. However, if the physician possesses the required skill and exercises the requisite degree of care, he is not liable for an honest error of judgment,<sup>91</sup> or merely because of an unexpected, unfortunate or even disastrous result.<sup>92</sup> Nor is the physician or surgeon a warrantor of results or an insurer of the patient's safety.<sup>93</sup> Where the physician or surgeon is a specialist, he is bound to bring to his duties not merely the average degree of skill possessed by the general practitioner. Rather, he is required to exercise that special degree of skill and knowledge possessed by the average specialist who devotes particular study and attention to the treatment of the particular organ, disease or injury.<sup>94</sup>

In the case of post-prostatic urinary incontinence, as in other malpractice cases, the surgeon will be held liable if he does not possess the knowledge and skill required of the physician ordinarily performing prostate surgery, if he fails to exercise reasonable care, or if he fails to use his best judgment. If the external urinary sphincter remains intact and incontinence results nevertheless, it is nearly impossible to prove any of these three failures. On the other hand, if there is proof that the external sphincter was cut and incontinence resulted, it may be possible to show that the surgeon failed to exercise the required standard of care.

*C. Negligence: If the External Urinary Sphincter Has Been Cut, was the Surgeon Negligent?*

It has been said that post-prostatectomy urinary incontinence may follow any type of prostate surgery regardless of the skill of the operator.<sup>95</sup> "This com-

90. *Id.* at 209-10, 40 N.E. 760, 762 (Emphasis added.).

91. 5A Personal Injury Actions, Defenses, and Damages, *supra* note 77, at § 1.01[1][a]; *Blackwell v. Southern Florida Sanitarium & Hosp. Corp.*, 174 So. 2d 45 (Fla. 1965); *Fisher v. Wilkinson*, 382 S.W.2d 627 (Mo. 1964); *Schueler v. Strelinger*, 43 N.J. 330, 204 A.2d 577 (1964).

92. 45 N.Y. Jur., *supra* note 87, at § 180; *Starr v. Fregosi*, 370 F.2d 15 (5th Cir 1966); *Quick v. Thurston*, 290 F.2d 360 (D.C. Cir. 1961); *Piper v. Halford*, 247 Ala. 530, 25 So. 2d 264 (1946); *Hayes v. Brown*, 108 Ga. App. 360, 133 S.E.2d 102 (1963); *Hill v. Hays*, 193 Kan. 453, 395 P.2d 298 (1964).

93. 5A Personal Injury Actions, Defenses, and Damages, *supra* note 77, at § 1.01[1][a]; *Gore v. United States*, 229 F. Supp. 547 (E.D. Mich. 1964); *Pearce v. United States*, 236 F. Supp. 431 (W.D. Okla. 1964); *Marvin v. Talbott*, 216 Cal. App. 2d 383, 30 Cal Rptr. 893 (1963); *Gault v. Sideman*, 42 Ill. App. 2d 96, 191 N.E.2d 436 (1963).

94. *Harris v. Campbell*, 2 Ariz. App. 351, 409 P.2d 67 (1965); *Sansom v. Ross-Loos Medical Group*, 57 Cal. App. 2d 549, 134 P.2d 927 (1943); *Rule v. Cheeseman*, 181 Kan. 957, 317 P.2d 472 (1957); *Clark v. Wichman*, 72 N.J. Super. 486, 179 A.2d 38 (1962); *Beach v. Chollett*, 31 Ohio App. 8, 166 N.E. 145 (1928). See generally *Harolds, Overcoming Problems of Proof in Malpractice Cases*, in *Medical Malpractice—the ATL Seminar* 69, 78 (1966); 41 *Am. Jur. Physicians and Surgeons* § 90 (1942); 45 N.Y. Jur., *supra* note 87, at § 185.

95. *Berry, supra* note 30, at 52.

plication occurs frequently enough even in well trained hands to make it an accepted risk of this type of urological treatment."<sup>96</sup> While it is true that incontinence may result even when the surgeon possesses sufficient skill, these statements go to only one of the three elements of the surgeon's standard of care outlined in *Pike v. Honsinger*<sup>97</sup>—possession of requisite knowledge and skill on the part of the surgeon. But there are two other failures in the *Pike* malpractice standard, either of which may be grounds for a malpractice action—failure to *exercise* reasonable care and failure of the surgeon to use his best judgment.

A strong argument can be made for the proposition that if the sphincter has been cut, the surgeon did not exercise ordinary and reasonable care and skill. Dr. Weyrauch states: "*Special care* must be devoted to preserving the external sphincter. . . . In transurethral prostatectomy there is danger that the external sphincter may be ruptured by *inexpert* introduction of the resectoscope or divided during resection of tissue."<sup>98</sup> And elsewhere he states that in transurethral prostatectomy, "Urinary incontinence and sexual impotence do not follow unless *gross technical errors* are made."<sup>99</sup> Another urologist admits that cutting the external sphincter in prostate surgery may be due to the "fault" of the surgeon.<sup>100</sup> Louisell and Williams note that "lack of gentleness is *inexcusable* in urologic procedures, yet it appears all too often."<sup>101</sup>

It may be difficult to prove that the surgeon failed to use the required skill and care in performing the prostatectomy. However, there is one method of proof which seems to be tied very closely to another element of the *Pike v. Honsinger*<sup>102</sup> malpractice standard—the surgeon's failure to use his best judgment. Most urologists agree that, although it may be difficult to discern the external urinary sphincter during the course of transurethral prostatectomy, it is possible to identify the *veru montanum*, the landmark beyond which the cutting in a prostate resection should not be carried.<sup>103</sup> If the surgeon cuts beyond that landmark, in the area of the external urinary sphincter, a strong argument can be made that he has not exercised his best judgment. One urologist comments,

If the *veru montanum* is gone [after surgery], if he [the surgeon] cuts that far down, he was not doing the right thing. You have to assume he cut down too far. We are not supposed to cut that far. You are supposed to have the *veru montanum* left after the operation.<sup>104</sup>

Others, though not specifically mentioning the *veru montanum*, indicate that an error in judgment has been made if too much tissue is excised. Uhle and Blakey, from the Departments of Urology, Lan Kenav Hospital and U.S. Naval

96. Kaufman, *supra* note 8, at 98.

97. See *supra* notes 87-94 and accompanying text.

98. H. Weyrauch, *supra* note 18, at 166 (Emphasis added.).

99. *Id.* at 303 (Emphasis added.).

100. Interview, *supra* note 49.

101. D. Louisell & H. Williams, *supra* note 88, at ¶ 3.22 (Emphasis added.).

102. 155 N.Y. 201, 49 N.E. 760 (1898).

103. See *supra* notes 68-70 and accompanying text.

104. Interview, *supra* note 49.

Hospital, Philadelphia, Pennsylvania, comment that, "In our formative surgical years, we all can remember having removed too much apical tissue at the time of enucleation or not having paid enough respect to the membranous urethra at the time of perineal section."<sup>105</sup> And Dr. John Graham, of Northwestern University Medical School, states:

Incontinence in transurethral prostatic resection can be attributed to excision of a portion of the external urinary sphincter by the endoscopic cutting instrument. This sphincter lies immediately next to the prostate gland. When bleeding is excessive and vision impaired, such an *erroneous step* is readily possible. No cutting should therefore be done unless the location of the sphincter is clearly seen.<sup>106</sup>

In sum, if the external urinary sphincter has been cut and permanent urinary incontinence has resulted, it is possible to show that the surgeon has failed to exercise the requisite standard of care, and that, by cutting beyond the *veru montanum*, he has failed to exercise his best judgment. Yet, the problem of proving causation still remains a formidable one.

*D. Causation: Is Injury to the External Urinary Sphincter the Proximate Cause of Total Post-Prostatic Urinary Incontinence?*

The problems inherent in the very use of the term "causation" are legion, for its meaning to the doctor is very different from its connotation to the lawyer.<sup>107</sup> To avoid the complexities of this problem the discussion here is limited to the case where the external urinary sphincter has been cut and urinary incontinence has resulted. Post-prostatectomy urinary incontinence, with the sphincter intact, will not be discussed, for, as has already been mentioned, causation both from the medical and legal viewpoints would appear to be impossible of proof in such a case.

An essential element of the plaintiff's cause of action in malpractice is that there be some reasonable connection between the act of the defendant and the damage suffered by the plaintiff. Although the physician may be negligent in the performance of some duty owed to the patient and the patient suffers injury, there is no liability unless the physician's negligence is the proximate cause of the injury.<sup>108</sup> The proximate cause standard applicable to the urinary incontinence malpractice case is the same standard as that used in negligence actions generally. First, it must be established that there was a causal connection in fact. In order to establish causal connection and a foundation for legal or proximate cause, the negligent act or omission must have been such that without it the injury would

105. Uhle & Blakey, *Post-Prostatectomy Urinary Incontinence: Experience with a Group of Diverse Surgical Techniques*, 83 J. Urol. 454, 455 (1960).

106. Graham, *supra* note 39, at 58 (Emphasis added.).

107. For a discussion of this problem see W. Curran, *supra* note 75, at 27-118.

108. Quick v. Thurston, 290 F.2d 360 (D.C. Cir. 1961); Champion v. Bennetts, 37 Cal. 2d 815, 236 P.2d 155 (1961). See generally 5A Personal Injury Actions, Defenses, and Damages, *supra* note 77, at § 1.01[1]; D. Louisell & H. Williams, *supra* note 88, at ¶ 8.07; Annot., 13 A.L.R.2d 11 (1950).



not have occurred.<sup>109</sup> Once this is established, it can then be determined whether the cause in fact also constituted the legal or proximate cause. A cause becomes a legal cause of an injury only when the necessary degree of proximity is present. Generally, it is sufficient to constitute proximate cause where the negligence was the

efficient cause which set in motion the chain of circumstances leading up to the injury, and which in natural, continuous sequence, unbroken by any new and independent cause, produced the injury.<sup>110</sup>

A number of authorities have adopted the corollary that negligent conduct is a legal or proximate cause of harm if it is a "substantial factor" in bringing about the harm.<sup>111</sup>

As has been demonstrated, there is no universal agreement among physicians about the etiology or medical causation of urinary incontinence. There is a conflict about which muscles have the most direct bearing on the urinary continence mechanism, the striated muscles of the urinary sphincter or the smooth musculature of other parts of the urethral area.<sup>112</sup> Experts have admitted that they are not certain "in the great majority of cases" about the etiology of incontinence following prostate surgery.<sup>113</sup> Indeed, cases have been reported in which perfect urinary control persisted after surgery, despite complete destruction of the external sphincter.<sup>114</sup>

Yet, where incontinence does result from prostate surgery, and proof is offered that the external urinary sphincter has been cut or damaged, many urologists are prepared to state that the cutting of the sphincter *caused* the incontinence.<sup>115</sup> Since the internal sphincter is always ablated in prostate surgery, cutting the external sphincter removes the remaining muscular resistance to the pressure from the urine, and incontinence may result. Causation is most easily shown in transurethral prostatectomy, for in transurethral resection the resulting incontinence can be directly attributed to excision of a portion of the external sphincter by the endoscopic cutting instrument.<sup>116</sup> One urologist stated,

If you cut the external sphincter [in transurethral resection], you can cause incontinence—if you cut too far down. . . . Incontinence is probably caused by damage to the external sphincter. . . . The external sphincter is the one muscle responsible for continence. If damaged, incontinence may result.<sup>117</sup>

Thus, given the optimum set of facts—transurethral resection in which the external urinary sphincter has clearly been cut, followed by total urinary incon-

109. 70 C.J.S., *supra* note 88, at § 106.

110. *Id.* at § 107(a).

111. *Id.* at §107(b). For a more complete discussion about the intricacies of proximate cause see W. Prosser, Torts chs. 7, 9 (3d ed. 1964).

112. See *supra* notes 12-18 and accompanying text.

113. Berry, *supra* note 30, at 52.

114. Hock, *supra* note 56, at 754.

115. See *supra* notes 43-44 and accompanying text.

116. Graham, *supra* note 39, at 58.

117. Interview, *supra* note 49.

tinence—causation, an essential element of the malpractice case, may be proved. *Starr v. Fregosi*<sup>118</sup> falls within that pattern, except for the subsequent surgery by a doctor other than the defendant who performed the initial operation. The court therefore found that the evidence did not show that plaintiff's total incontinence was caused by defendant's two surgical procedures. There was as much likelihood that it was caused by the non-party surgeon eighteen months later. However, given the facts of the *Starr* case, one urologist was willing to state that, assuming plaintiff was continent prior to surgery, "if the second surgeon had not intervened, the cause of incontinence would probably have been because the external sphincter was cut in the first operation."<sup>119</sup>

It should again be emphasized, however, that incontinence may occur despite maintenance of the external sphincter, that the external sphincter may be cut without resulting in incontinence, and that one of the other possible causes of incontinence may have been the most substantial factor in the case at hand, e.g., distortion of the external sphincter and the adjacent prostatic urethra without damage to the muscle itself, prolonged pressure of a hemostatic bag, or post-operative emotional or psychological upset. Thus, while both causation and negligence are sometimes provable, it is only where the facts are ideal that liability will be found. *Starr v. Fregosi*<sup>120</sup> exemplifies this problem: In addition to the fact that subsequent surgery had been performed by a non-party surgeon, there was also medical testimony that the *veru montanum* was intact after the first operation, sufficient to cast doubt on the proposition that the external urinary sphincter had been cut during that operation and was responsible for the resulting incontinence.<sup>121</sup> Thus, the evidence was insufficient to prove both negligence and proximate cause, the two essential elements of any malpractice action.

### E. *Res Ipsa Loquitur*

The doctrine of *res ipsa loquitur* is often invoked in negligence cases when the event is of a kind which ordinarily does not occur in the absence of someone's negligence, when the damage is caused by an agency or instrumentality in the exclusive control of the defendant, and when it is not due to any involuntary action or contribution on the part of the plaintiff.<sup>122</sup> Although some courts hold that in a proper case *res ipsa loquitur* can be applied,<sup>123</sup> it is generally held that

118. 370 F.2d 15 (5th Cir. 1966).

119. Interview, *supra* note 49.

120. 370 F.2d 15 (5th Cir. 1966).

121. *Id.*

122. D. Louisell & H. Williams, *supra* note 88, at ¶ 14.04. See also *Bruce v. United States*, 167 F. Supp. 579 (D.C. Cal. 1958); *Toy v. Rickert*, 53 N.J. Super. 27, 146 A.2d 510 (1958). For full annotated discussions of the doctrine of *res ipsa loquitur* in relation to medical malpractice cases see generally Annot., 82 A.L.R.2d 1262 (1962); Louisell & Williams, *supra* note 88, at chs. 14, 15; 5A *Personal Injury Actions, Defenses, and Damages*, *supra* note 77, at § 1.01[5]; Comment, *Res Ipsa Loquitur—Application to Medical Malpractice Actions 1951-1961*, 60 Mich. L. Rev. 1153 (1962).

123. See, e.g., *Valentine v. Kaiser Foundation Hosp.*, 194 Cal. App. 2d 282, 15 Cal. Rptr. 26 (1961); *Becker v. Eisenstadt*, 60 N.J. Super. 240, 158 A.2d 706 (1960); *Benson v. Dean*, 232 N.Y. 52, 133 N.E. 125 (1921).

the doctrine is inapplicable to medical malpractice cases.<sup>124</sup> The theory behind this notion is that since "the thing must speak for itself," *res ipsa loquitur* can only be applied where there is no need for expert testimony. Since expert testimony is frequently necessary in medical malpractice cases, the general rule is that

. . . the doctrine of *res ipsa loquitur* may be invoked in medical malpractice actions only where a layman is able to say as a matter of common knowledge that the consequences of the professional treatment were not such as ordinarily would have followed if due care would have been exercised, and that the doctrine is not applicable where expert evidence is required to show negligence on the part of the practitioner or proximate cause.<sup>125</sup>

However, most courts which seemingly refuse to permit *res ipsa loquitur* in a medical malpractice suit have actually ruled only that application of the doctrine cannot be based on expert testimony. Since these same courts refuse to permit medical malpractice suits at all unless founded on expert testimony, they have effectively barred the use of *res ipsa loquitur* in such cases.<sup>126</sup>

It should be clear from the preceding sections of this comment that the cutting of the external urinary sphincter is not one of those surgical errors on which the layman is competent to pass judgment and conclude from common experience that such things do not happen if there has been proper skill and care. Nor is the layman competent to determine that the cutting of the sphincter is the proximate cause of permanent urinary incontinence. Thus, under the general rule that *res ipsa loquitur* cannot be invoked in a malpractice suit if it must be based on expert evidence, the doctrine is not available in malpractice cases founded on post-prostatectomy urinary incontinence.

However, in the one unique contribution that a post-prostatectomy urinary incontinence case has made to the medical malpractice field, the Wisconsin Supreme Court in *Fehrman v. Smir*<sup>127</sup> held that the doctrine of *res ipsa loquitur* is applicable in some medical malpractice actions and that expert testimony can be used to establish the foundation for the *res ipsa loquitur* inference. Recognizing that it "does not lie within the field of common knowledge of layman that injury to the sphincter ordinarily does not occur if due care is exercised by the surgeon performing the suprapubic prostatectomy,"<sup>128</sup> the court nevertheless concluded that the instant case was a proper one in which to give a *res ipsa loquitur* instruction even though it must be founded on expert testimony.<sup>129</sup> It held that where there is no basis in common knowledge for the inference that someone has

124. See, e.g., *Hine v. Fox*, 89 So. 2d 13 (Fla. 1956); *Lagerpusch v. Lindley*, 253 Iowa 1033, 115 N.W.2d 207 (1962); *Facer v. Lewis*, 326 Mich. 702, 40 N.W.2d 457 (1950); *Hoffman v. Naslund*, 144 N.W.2d 580 (Minn. 1966).

125. Annot., *supra* note 122, at 1274.

126. Note, *Torts—Res Ipsa Loquitur in Medical Malpractice Actions—Use of Expert Testimony*, 1964 Wis. L. Rev. 133.

127. 20 Wis. 2d 1, 121 N.W.2d 255 (1963).

128. *Id.* at 23, 121 N.W.2d at 267.

129. *Id.* at 25, 121 N.W.2d at 268.

been negligent, expert testimony may be offered as a foundation for that inference.<sup>130</sup> Other courts have now begun to hold that knowledge among either layman or physicians can be relied upon to show that the cause of plaintiff's injuries was something which ordinarily does not occur unless someone was negligent.<sup>131</sup>

The rule of *Fehrman v. Smir*<sup>132</sup> represents a wise policy choice, for without the aid of *res ipsa loquitur*, it is often extremely difficult for one to prevail in a malpractice suit, no matter how blatant the negligence. The occurrence usually takes place while the patient is under anesthetic; upon awakening it is unlikely that he will be informed if anything went wrong. In addition, the possibility of obtaining medical witnesses to testify against the surgeon is minimal, because of the "conspiracy of silence" on the part of the medical profession.<sup>133</sup> Some modern cases realistically discuss this so-called "conspiracy" as contributing to the development of the application of *res ipsa loquitur* to the medical malpractice field.<sup>134</sup> Probably the best statement of the problem is in *Salgo v. Leland Stanford Jr. University Board of Trustees*.<sup>135</sup>

But gradually the courts awoke to the so-called "conspiracy of silence." No matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him in litigation based on his alleged negligence. . . . This fact, plus the fact that usually the patient is by reason of anesthesia or lack of medical knowledge in no position to know what occurred that resulted in harm to him, forced the courts to attempt to equalize the situation by in some cases placing the burden on the doctor of explaining what occurred in order to overcome an inference of negligence. . . . The great difficulty in the application of the doctrine is to determine where to draw the line.<sup>136</sup>

Thus, the "conspiracy of silence" which made it difficult for plaintiffs to obtain expert medical witnesses, led the courts to allow invocation of the doctrine of *res ipsa loquitur* in medical malpractice cases. However, by the rule of *Fehrman*, and in post-prostatectomy urinary incontinence cases generally, some expert testimony is necessary even under the doctrine of *res ipsa loquitur*, since the continence mechanism and the external sphincter muscle functions are not

130. *Id.* at 26, 121 N.W.2d at 268.

131. *Miles v. VanGelder*, 1 Mich. App. 522, 137 N.W.2d 292 (1965); *Horner v. Northern Pac. Beneficial Ass'n Hosp., Inc.*, 62 Wash. 2d 351, 382 P.2d 518 (1963). See generally *D. Louisell & H. Williams, supra* note 88, at ¶ 14.06.

132. 20 Wis. 2d 1, 121 N.W.2d 255 (1963).

133. See *supra* note 75 and accompanying text. See also *D. Louisell & H. Williams, supra* note 88, at ¶ 14.02.

134. *Cho v. Kempler*, 177 Cal. App. 2d 342, 2 Cal. Rptr. 167 (1960). See also *Butts v. Watts*, 290 S.W.2d 777, 779 (Ky. 1956) (Res ipsa loquitur was utilized against a dentist who left a broken tooth in patient's mouth, with the court noting: "But the notorious unwillingness of members of the medical profession to testify against one another may impose an impossible handicap upon a plaintiff who cannot obtain professional proof."). See also *Charlton v. Montefiore Hosp.*, 45 Misc. 2d 153, 256 N.Y.S.2d 219 (Sup. Ct. 1965) (Res ipsa loquitur held inapplicable to the facts, notwithstanding the "conspiracy of silence.").

135. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

136. *Id.* at 568-69, 317 P.2d at 175. See also *Ybarra v. Spangard*, 25 Cal. 2d 486, 490, 154 P.2d 687, 689 (1944).

within the common knowledge of the layman. Therefore, despite the progressive view of *Fehrman*, the "conspiracy of silence" still militates against success in the post-prostatectomy urinary incontinence malpractice action.

#### F. Damages

Once the post-prostatic urinary incontinent has proved both causation and want of due care, to what amount of damages should he be entitled? The measure and elements of damages in malpractice actions founded on negligence are generally based on the the same rules and principles which govern damages in personal injury actions.<sup>137</sup> Indeed, the considerations brought out in the following discussion are applicable equally to urinary incontinence resulting from negligently caused personal injury and to post-operative incontinence. Thus, the fundamental rule prevails that the damages recoverable are only those which are the natural and probable consequences of the alleged wrongful act. A physician or surgeon is liable only for such damages as are the proximate result of his negligence.<sup>138</sup> Damages are usually recoverable for pecuniary losses, physical and mental disability, and pain and suffering.<sup>139</sup> In addition, there will be allowed compensatory special damages for medical or other special expenses.<sup>140</sup>

The items of pecuniary damages usually found in malpractice actions are loss of time and impairment of future earning capacity,<sup>141</sup> and past and future medical or other special expenses.<sup>142</sup> In general, a plaintiff may also recover for illness of or injury to the body and accompanying disturbance of mind caused by defendant's negligence.<sup>143</sup> Most courts hold that negligently caused mental disturbance is compensable only where it accompanies physical injury directly caused by the defendant.<sup>144</sup> They are reluctant to allow recovery for negligently caused mental disturbance when it is the sole element of injury.<sup>145</sup> Anxiety or worry about a possible future disease or condition may constitute a proper element of damages, at least if such disease or condition might reasonably be expected to result from the injury for which the defendant is assumed to be liable.<sup>146</sup>

137. See generally *Damages*, in 3 *Personal Injury Actions, Defenses, and Damages* (L. Frumer, R. Benoit, M. Friedman & L. Pilgrim eds. 1965).

138. 45 N.Y. Jur., *supra* note 87, at § 227.

139. D. Louisell & H. Williams, *supra* note 88, at ¶¶ 18.02-18.04.

140. *Id.* at ¶ 18.05.

141. See, e.g., *McElroy v. Employer's Liab. Assurance Corp.*, 163 F. Supp. 193 (W.D. Ark. 1958). See generally 3 *Personal Injury Actions, Defenses, and Damages*, *supra* note 137, at § 3.04.

142. *McElroy v. Employer's Liab. Assurance Corp.*, 163 F. Supp. 193 (W.D. Ark. 1958); *Shehee v. Aetna Cas. & Sur. Co.*, 122 F. Supp. 1 (W.D. La. 1954); *Kessler v. Kelly*, 39 Ala. 543, 104 So. 2d 767 (1958).

143. See, e.g., *McCrain v. City of New York*, 12 A.D.2d 482, 207 N.Y.S.2d 685 (1960).

144. See, e.g., *Ferrara v. Galluchio*, 5 N.Y.2d 16, 152 N.E.2d 249, 176 N.Y.S.2d 996 (1958). See generally Note, *Torts—Recovery for Mental Disturbance—Necessity of Impact*, 4 Vill. L. Rev. 292 (1958); 3 *Personal Injury Actions, Defenses, and Damages*, *supra* note 137, at § 3.04[2].

145. *Kaufman v. Israel Zion Hosp.*, 183 Misc. 714, 51 N.Y.S.2d 412 (Sup. Ct. 1944); *Dobbins v. Gardner*, 377 S.W.2d 665 (Tex. Civ. App. 1964) (Gauze pack left in plaintiff's vagina. *Held*, humiliation and embarrassment are genuine elements of damage.).

146. 45 N.Y. Jur., *supra* note 87, at § 229; *Ferrara v. Galluchio*, 5 N.Y.2d 16, 152 N.E.2d 249, 176 N.Y.S.2d 996 (1958).

Probably the largest element of damages in the malpractice suit is the physical pain and suffering undergone by the plaintiff as a result of defendant's conduct.<sup>147</sup>

Clearly no exact or mathematical formula can be applied in determining the measure of damages for pain and suffering or for mental anguish.<sup>148</sup> The amount of damages is primarily for the jury to determine. Its decision will generally not be overturned unless clearly excessive.<sup>149</sup>

In the one case where malpractice was found and recovery was granted to the post-prostatectomy urinary incontinent, *Fehrman v. Smirl*,<sup>150</sup> the jury granted damages as follows: (a) Pain and suffering, past and future, \$5,000; (b) loss of wages, past and future, \$35,700 (plaintiff was a fifty-three year old plasterer); (c) permanent disability, \$30,000; (d) future medical expenses, \$5,000. In addition, damages were granted to the patient's wife for loss of society and companionship in the amount of \$3,000 (plaintiff had been rendered both incontinent and sexually impotent as a result of the prostate surgery).<sup>151</sup>

No concrete formula is proposed for measuring the damages which should be granted to one suffering from urinary incontinence as the result of prostate surgery or personal injury. Yet, in addition to the damages awarded in *Fehrman v. Smirl*,<sup>152</sup> it is strongly suggested that damages for the emotional harm caused the patient would be a legitimate element of damages. The permanent humiliation and embarrassment which he will suffer must be emphasized.

There is an old adage that it is "better to be dead than incontinent."<sup>153</sup> Though this may be a melodramatic overstatement, it is true that "there is no unhappier man than the constant dribbler."<sup>154</sup> He finds himself having to wear a penile clamp, a collecting bag or a catheter in order to remain dry. He is plagued by the constant odor of urine.<sup>155</sup> Before surgery, he had only symptoms of prostaticism or at worst complete obstruction. But now he "is not only sopping wet but has a foul odor. His crotch and genitals are usually excoriated. He is a social outcast, and in some cases a man without a family—an urological cripple."<sup>156</sup> In sum, urinary incontinence following prostate surgery or personal injury is "a socially disastrous situation" for the man so afflicted.<sup>157</sup> His plight must be brought home to the jury, so that a large measure of damages for emotional pain and suffering or mental anxiety may be secured. While it may not actually be better to be dead than incontinent, it is certainly fair and just to be compensated with a healthy measure of damages for being plagued by this terrible state.

147. *Hammer v. Rosen*, 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960); *Robins v. Finestone*, 308 N.Y. 543, 127 N.E.2d 330 (1955).

148. See generally D. Louisell & H. Williams, *supra* note 88, at ¶ 18.08.

149. See, e.g., *Affolder v. New York, C. & St. L.R.R.*, 79 F. Supp. 365 (E.D. Mo.), *aff'd* 339 U.S. 96 (1948). See generally D. Louisell & H. Williams, *supra* note 88, at ¶ 18.11.

150. 20 Wis. 2d 1, 121 N.W.2d 255 (1963).

151. *Id.*

152. *Id.*

153. H. Weyrauch, *supra* note 18, at 460.

154. Uhle & Blakey, *supra* note 105, at 454.

155. Graham, *supra* note 39, at 58-59.

156. Berry, *supra* note 30, at 52.

157. Thompson, *supra* note 36, at 130.

G. *Duty of the Surgeon to Warn His Patient*

Is the surgeon who finds it necessary to perform a prostatectomy under an obligation to warn his patient that permanent urinary incontinence may result?<sup>158</sup> In general, a physician has the duty to disclose to his patient serious or statistically frequent risks of the proposed treatment.<sup>159</sup> However, the physician has considerable discretion in this matter. The decision of what and how much to tell the patient involves a balancing of factors, and has been limited to those disclosures which a reasonable physician or surgeon would make under the same or similar circumstances.<sup>160</sup> Ordinary common sense may dictate that not all risks be explained in detail, for there is no reason needlessly to arouse the patient's fears. On the other hand, the risk factors should not be totally concealed or misrepresented to the patient.<sup>161</sup> This is particularly true when he inquires about the risks involved.

In the particular case of prostate surgery, it is clear that the patient with cancer who is a candidate for total removal of the prostate should be warned that urinary incontinence may ensue.<sup>162</sup> Since the incidence of permanent incontinence is as high as ten to twelve per cent following radical prostatectomy, most urological surgeons feel an obligation to give such a warning to their patients.<sup>163</sup> Once warned, however, the patient has little choice; he can either live with cancer until it causes his death, or submit to surgery where there is a ten to twelve per cent chance of incontinence resulting.<sup>164</sup>

In conservative prostatectomy, where there is no malignancy and the inci-

158. As indicated in the other sections of this comment, the medical malpractice suit is normally founded on negligence. However, when a physician or surgeon has a duty to warn his patient and fails to perform this duty, the cause of action lies, at least technically, in battery. The theory behind this distinction is that when the physician has failed in his duty to warn, the patient has not given "informed consent" to proceed with the operation. See generally Annot., 56 A.L.R.2d 695 (1957).

159. *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *rehearing denied*, 187 Kan. 186, 354 P.2d 670 (1960) (Physician must inform the patient in plain language (1) the nature of the ailment, (2) the nature of the proposed treatment, (3) the probability of success of alternatives, (4) perhaps the risk of unfortunate results and unforeseen conditions within the body. Failure to so inform the patient constituted negligence regardless of the skillfulness of the procedure.). See also *George v. Travelers Ins. Co.*, 215 F. Supp. 340 (E.D. La. 1963), *aff'd* 328 F.2d 430 (5th Cir. 1964); *Russell v. Harwick*, 166 So. 2d 904 (Fla. 1964); *Roberts v. Young*, 369 Mich. 133, 119 N.W.2d 627 (1963); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962); *Block v. McVay*, 80 S.D. 469, 126 N.W.2d 808 (1964). See generally D. Louisell & H. Williams, *supra* note 88, at ¶ 8.05; 5A *Personal Injury Actions, Defenses, and Damages*, *supra* note 77, at § 1.01[1][k].

160. *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961) (*Held*, There was no duty to disclose the risk of inability to speak above a hoarse whisper following thyroidectomy, because undisputed expert testimony established that it was not the practice of Wilmington surgeons to warn that damage of this type could result from such surgery.). For a discussion of this case see Note, 77 Harv. L. Rev. 1445 (1962). See also *Patrick v. Sedwick*, 391 P.2d 453 (Alas. 1964); *Ditlow v. Kaplan*, 181 So. 2d 226 (Fla. 1965); *Collins v. Meeker*, 424 P.2d 488 (Kan. 1967); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *rehearing denied*, 187 Kan. 186, 354 P.2d 670 (1960).

161. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962).

162. *Graham*, *supra* note 39, at 59.

163. Interview, *supra* note 49.

164. *Id.*

dence of post-operative urinary incontinence is less than two per cent, there is a split of authority within the medical profession about whether the surgeon has a duty to inform his patient that permanent urinary incontinence may result. Some urologists suggest that the patient should be warned that incontinence may result, though the possibility is slight.<sup>165</sup> Dr. Don Harper Mills writes:

Although the author is opposed to the legal necessity of informing patients of potential risks (the so-called "informed consent" trend), prostatectomy is one situation in which a prior discussion may have real medical value. Proper psychological preparation could go far to allay the postoperative distress, anxiety, and inconvenience associated with these complications [impotence and incontinence].<sup>166</sup>

Other urologists would not warn their patients that incontinence may result, since it occurs in only a very small number of cases. They believe that to warn the patient of all possible complications that might result from surgery would unduly alarm him, and perhaps even harm his emotional state as he prepares for surgery, or dissuade him entirely from undergoing the surgical procedure. Of course, if the patient specifically inquires about the possibility of post-operative incontinence, they would warn him that there is a one to two per cent chance that this will occur.<sup>167</sup>

This latter approach seems preferable. The surgeon must weigh all the risks and possible complications against the necessity for surgery. If, in his sound medical judgment, the risks are minimal, he should proceed without warning the patient of the possible complications. If, on the other hand, the chance that incontinence might develop seems great, as in radical prostatectomy, he should warn the patient. The surgeon's "most fundamental duty is to do what is best for his patient's welfare. Any conflict between this duty and that of disclosure should be resolved in favor of the primary duty,"<sup>168</sup> *i.e.*, the physician's duty to exercise his sound medical judgment to safeguard the patient's total welfare. This view was explicitly endorsed by the California courts in a malpractice suit where recovery was denied the plaintiff:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a

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165. Graham, *supra* note 39, at 59; Mills, *Medical Lessons from Malpractice Cases*, 183 J.A.M.A. 1073 (1963).

166. Mills, *supra* note 165, at 1076.

167. Interview, *supra* note 49.

168. Note, *Malpractice—Physician Has a Duty to Inform Patient of Risk Inherent in Proposed Treatment*, 109 U. Pa. L. Rev. 768, 773 (1961).



patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the psychological results of the apprehension itself. . . . in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.<sup>169</sup>

#### CONCLUSION

Inherent in the medical malpractice case grounded on post-prostatectomy urinary incontinence are the normal problems which arise in malpractice generally, such as the rule limiting use of the doctrine of *res ipsa loquitur*, the practical problem of proof in light of the so-called "conspiracy of silence," and the admittedly wise view that the surgeon is not bound to warn the patient of complications which only arise in a small number of cases. However, there is an additional problem in the post-prostatic urinary incontinence case which makes proof of legal causation and negligence, two essentials of any malpractice suit, especially troublesome: The medical etiology of post-prostatectomy urinary incontinence is not clear. There is a split of authority within the medical profession about what actually causes such a result.

This analysis has attempted to explain the many medical explanations for incontinence generally, and for post-prostatic urinary incontinence in particular. In the process, it has pointed up the ways in which this troublesome problem of etiology has made it virtually impossible to prove causation and negligence in the majority of malpractice suits based on urinary incontinence following prostate surgery. At the same time, however, it has demonstrated, through both medical and legal evidence, how such suits can succeed if the optimum set of facts, including clear proof that the external urinary sphincter has been cut, are present.

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169. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).