

View Point Article

Medico-Legal Litigation: The clinical contractual nature of the Obstetric Anaesthetist -Patient relationship

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Once the hand-maiden of obstetrics, obstetric anaesthesia, now a fully fledged sub-speciality today provides indispensable multi-faceted services mainly but not solely to the peripartum obstetric patient. Be it in routine as well as acute obstetric work, the speciality is an integral part of the team made up of obstetrician, midwife and neonatologist. Its input ensures modern optimal care to the parturient patient and her baby.¹ The anaesthetist's unique resuscitatory skills and critical care experience makes him/her particularly valuable, especially in high-risk patients¹ as evidenced by the struggle of units lacking such a service in overcoming numerous administrative, financial and logistical problems to reach this paragon of standard of care.² By the very nature of the acutely challenging situations it deals with, this speciality is especially vulnerable to medico-legal litigation.

Conceptualising medico-legal liability

To the medical practitioner facing a court case with all its psychological, corporeal and behavioral practice changes,³ it may matter little, but a fierce and endless legalistic argumentation exists as to whether medical malpractice cases should fall under the law of Tort or that of contractual relationships. This is no airy-fairy battle fought in legal fora. Suffice it to mention one point out of many, namely the prescriptive difference of the two. However, the argument we shall sustain here, purely conceptually speaking, is to look at malpractice litigation under the Law of Contract. For the often poorly legally informed physician (here the obstetric anaesthetist) looking at malpractice as the presumed breaking of the Law of Contract may effect a clearer understanding than invoking the meanderings of the law of Tort.

Poor knowledge of the Law

The poor knowledge of the law by most medical doctors is often acknowledged widely. In a whitepaper on Legal Knowledge, Attitudes and Practice at the Queen Elizabeth Hospital in Barbados, 52% of senior medical staff and 20% of senior nursing staff knew little of the law *pertinent to their work*.⁴ We believe this to be a rather accurate universal. However one must reflect on the situation *before* one receives the court summons. We recommend that the obstetric anaesthetist assumes the habit of thinking that he/she is embarking on a legal contract with a patient. This contract demands a legal responsibility from him and if this responsibility is not fulfilled, problems may result. If such failure is found to have been responsible for resultant harm than he/she is liable at law. Far from encouraging defensive medical practice, the concept adds a valuable new perspective which we believe should be inculcated even at undergraduate level without de-humanising the 'most noble profession of all'. Invoking the law of contract is a positive legal concept telling you how to safeguard your contract while the law of Tort latter tells you *retrospectively* where you went wrong. The contractees – the physician and the patient – are bound by a legal agreement which demands "good practice" as deemed by current peer practice or quoting the Bolam⁵ test "

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If a doctor reaches the standard of a responsible body of medical opinion, he is not negligent".

The cold reality of court

To the healer, the term contractual relationship sounds alien, impersonal, legal and non-medical. It is. Medical doctors have wanted to and eventually been suitably qualified and licensed to heal, relieve suffering and distress of body and mind. However, the well documented emotional and physical stress resulting from medico-legal litigation⁶ should rapidly awaken the obstetric anaesthetist (in this case) to the legally binding conscious or unconscious contractual latitude supervening on the therapeutic nature of the doctor-patient relationship. 23% of doctors identified medico-legal litigation as their most stressful life experience.⁷ In a scenario with rapidly changing socio-legal dynamics there is general exhortation to diminish the plague of malpractice claims which has reached epidemic proportions⁸ Of all anaesthetic sub-specialities the obstetric anaesthetist is the commonest to retire from work due to medico-legal concerns.⁹ One official survey revealed that 89% of respondents had been sued during their lifetime with an average of 2.6 cases per individual⁹ Kuczowski commenting on the current medico-legal climate in Australia and New Zealand points out that 47.2% of obstetric anaesthetists were seriously concerned about the viability of their practice vis-a-vis indemnity premiums and 20.2% were planning outright to retire in the following two years because of the issue.⁹ Hence we speak of a problem with intense effects on the individual and ending in a negative multiplier effect with a demographic finality.

Awareness of malpractice action as well as instilling at least a basic working knowledge of the law are an urgent necessity and we believe should be stressed from undergraduate level. Working on the medico-legal aspect of the anaesthetist-patient relationship on a contract basis is a good beginning. The contractual relationship between doctor and patient was also stressed in the Annual International Medical Journal of 1983.¹⁰ A number of court pronouncements have indeed stressed the existence of such a contractual bond between medical practitioners and patients.¹⁰ One can appreciate this if one bears in mind that a contract is defined as 'an agreement between two or more competent parties in which an offer is made and accepted, and each party benefits. The agreement can be formal, informal, written, oral or just plain understood.'¹¹ In this case, the patient and the anaesthetist enter into a signed agreement where the latter offers his/her services to the patient who in return will effect payment with mutual advantage. In a way, even NHS patients can be considered as paying - albeit indirectly - through their NHS contributions.

Raising patient awareness of the role of the Obstetric Anaesthetist.

It is possible that the *gradual* development of the sub-speciality of obstetric anaesthesia underlies a certain cinderella-like attitude towards it by specialists and doctors outside the speciality. While the speciality's cornerstone support of modern obstetrics goes unquestioned, it tends to suffer from what we term the "Commando Syndrome". Like "action man", SEALs or Commandos, the anaesthetist tends to be *inserted* in a field of action, *perform* his mission and *withdraw* out of the targeted field- with all due apologies to the unintended puns. Few see these people at work as they effect their high risk job and by the time of the big bang they're almost out of the picture already. Another analogy comes from Alfred Tennyson's quote from his "The Charge of the Light brigade" - "Ours is not to question why, Ours is to do or die". The establishment of *regional* anaesthesia has at least contributed much to direct *patient* awareness of her anaesthetist. With *general* anaesthesia say for a C-section, the patient may hardly have ever even said "hello". But when a problem arises and people are indicted, then everybody knows who the anaesthetist had been.

Invoking the Law of Contract to conceptualise pre-empting malpractice quandaries, demands a minimal aspect of doctor-patient bonding. And bonding as a minimum demands one person acknowledging the existence of another. Bonding may allow allegedly impaired contractual obligations to be discussed, reviewed, sorted out especially if the contractees have befriended one another to any extent. Lack of fulfilment of contractual obligations by a faceless person are like nature abhorring a vacuum - they are magnets for some litigious lawyer who may fan frustration, anger or hurt whether justifiable or not. We cannot over-stress the role of the anaesthetist being introduced to the patient and his/her bonding (albeit limited) as the first step in pre-empting, eliminating, minimising or sublimating malpractice court action.

The anaesthetist's disadvantage at establishing rapport and patient bonding is a universal default mode in any acute labour ward situation. Accepting that such bonding is crucial in minimising the chance of malpractice suits,¹² the anaesthetist should visit the patient well before the administration of anaesthesia in any form if the scenario permits. We are not referring to situations like abruptio placentae or a cord prolapse but in an elective caesarean section for example, time spent examining the patient and discussing one's role on the eve of the case is time well invested indeed. Likewise a visit the day following the section may go a long way in cementing a short but hopefully not unpleasant doctor-patient relationship. On the big day itself re-explaining, reassuring, congratulating are all facets which bring out

the obstetric anaesthetist's humanity and which give the anaesthetist's role a face to be remembered. Urgent situations of life and death still allow follow up visits and explanations by the anaesthetist. In a labour ward set-up, attending the obstetrician's wards rounds may be a further help. The obstetrician himself should well remember that besides obstetricians, anaesthetists are frequently named in cases with bad neonatal outcome.¹³ Using his/her own long built bonding relationships with the patient and spouse or partner, the obstetrician should introduce the anaesthetist and raise the patient's awareness of their colleagues' service. This is also advisable in expected serious or difficult cases.

Making the acquaintance of your co-signatee.

It is crucial to stress that the anaesthetist should *not* make the patient's acquaintance in the operating theatre where the patient's attention may be easily dulled by the tension, fear and distractions of an impending operation. Severe stress has a negative effect on both the brain's ability to encode information as well its later recall.¹⁴ Park *et al.* have shown that information garnered just before shock induced stress by rats resulted in its amnesia.¹⁵ The "contract" should be preferably signed and discussed in at least a ward environment rather than an operating theatre environment.

The contractual terms of reference – the consent form.

Under the general principles of the law of Contract and its obligations there is a voluntary exchange of an offer of a service and its voluntary acceptance. The service must be made clear along with its limitations, dangers, advantages and disadvantages, admittedly not always easy. We maintain that truly imparting *all* the necessary information and risks is not possible in a practical and functional way especially to a non-medical patient. *In fact we believe that it is not possible to obtain a hundred per cent legally viable consent form.* This is not due to conscious withholding of any information but rather through the sheer unworkable complexity of truly explaining all potential risks and advantages. Such an explanation would entail a lecture or ten on biology, chemistry, physics, anatomy, physiology, medicine, surgery, anaesthesia etc. The consent form requires disclosure of risks and alternatives that a reasonable patient (as opposed to a reasonable physician) would consider material. Yet physicians who fail to provide the required information risk liability, even if the physician was not negligent in performing the procedure. Having said all this, we also believe that the art of Medicine finds one of its finest expositions in the way the obstetric anaesthetist delivers his information which must be correct, truthful and as complete in a functional and practical manner as

possible. However we genuinely maintain that what is universally called a "consent form" should in practice be referred to as a "functional consent form". In a world witnessing the massive rise of the medico-legal epidemic¹⁶ one must beware of the full implications of the written medical contractual agreement as presently understood in the term "consent form" which must be an "an informed consent form". "Functional" here refers to language, cognizance and practicality. Cancelling a simple transvaginal sling urethropexy for severe stress incontinence after the patient was spoken to by a houseman legally bent on avoiding 'Inadequate preoperative planning'¹⁷ is precisely one of the wrongs to be avoided, (personal case of the medical author).

The obstetric anaesthetist must also be careful of withholding knowledge which may draw him/her in a disadvantageous light e.g. his/her inability to perform regional analgesia as an alternative to general anaesthesia for a C-section or avoiding mentioning that epidural anaesthesia for a C-section may be safer than a spinal in avoiding unwarranted episodes of hypotension.¹⁸ All is well when all goes well. When it does not, universally adopted and practiced bad habits are poor defence in court.

Holistic practice as alternative to defensive practice

In 1984, defensive medicine added \$2 billion annually to medical costs in New York state¹⁹ and all over the USA the cost is \$15 billion or \$1.19 per week for every American.²⁰ Borrowing a working definition from Simon, albeit originally quoted in terms of psychiatry, "defensive medicine refers to any act or omission performed not for the benefit of the patient but solely to avoid malpractice liability or to provide a good legal defense against a malpractice claim."²¹ We know that medical liability does not improve the quality and safety of health care, for example when applied in nursing homes – it decreases it slightly.²² With regard to the individual e.g. the obstetric anaesthetist, it may "paralyze flexible and patient-centered decision making to the point where it may actually be harmful to the patient."²² Taking one example initiated by obstetricians with anaesthetists being party to, is the defensive performance of performing c-sections through over-diagnosing electronic fetal monitoring artefacts as fetal distress.²³

We believe that merely 'focusing one's attention on reducing the potential for major injuries may have little effect on solving the medico-legal dilemma in obstetrics'.²⁴ We also believe one answer lies in effecting 'good practice' combined with "therapeutic alliance"²⁰ with the patient. The latter implies sharing of information with the patient to increase *her* empathy with the doctor or using reverse empathy, empathy being defined as a positive cognitive attribute leading to

‘feeling with’ the patient and understanding her perspectives as a separate individual.²⁵ In “therapeutic alliance”, the patient is encouraged to step into the doctor’s shoes. We lightly suggest that one can imagine that is trying to talk a houseman through the obstetric anaesthetist’s day without scaring him away into another profession. At the end of the day this is yet another way of communicating with the patient and any form of communication is another positive step towards bonding. The effort to bond might come easy to some and virtually impossible to others. In the present medico-legal scenario it is indispensable but even without this a patient always appreciates her carer’s humanity.

Ward showdown or court battle

Pre-emptively invoking the law of contract should never challenge the anaesthetist’s humanity. This is a sine qua non requirement of medicine and may automatically avoid negative feelings. The Closed Case Database (which reflects the consumer’s viewpoint) massive content of minor problems is instructive. Among the commonest complaints are of patients feeling ignored and mistreated.²⁴ In our opinion this lends much weight to Meyers’ theory that malpractice litigation may serve the dual purpose of reparation of injury for substandard care but also one of *emotional vindication*.²⁴ To which we add a corollary namely that emotional catharsis expressed post operatively *per voce* a day or two after surgery may eliminate emotional vindication. In a highly emotive situation it is easy for patients and/or husbands to accumulate stress and imagine misgivings and if allowed to, vocally vent frustrations, hurt, anger and tears it may suffice to end the matter. Out of all the patient who seek court remedial action for some aspect of negligent care only 2%²⁴ have their claims upheld. Furthermore anaesthetists are frequently named in bad fetal outcome claims which are deemed *not* justifiable and hence do not lead to payments.²⁶ A common mistake is to confuse giving an excellent medical service with the patient’s *perception* of what constitutes satisfactory medical service. A bruised ego suffered at the most stressful time of labour²⁶ may be assuaged by a vitriolic discussion, an explanation and maybe an honest apology. And here one must differentiate the Law of Contract as applied to medicine and not, say the selling of an apartment. Where human life and health are concerned the arena has many multi-faceted and multiplier phenomena where over-all satisfaction is often beyond legal definition. We believe that this phenomenon underlies the fact that legal claims in the highly emotive field of obstetrics and obstetric anaesthetic claims, far surpass the non-obstetric ones in the “minor injury” nature of the cases.²⁶

Clear contractual conditions, accurate file documentation

Having given all pertinent information to the patient and both duly signed the consent form, we believe that it is important for the obstetric anaesthetist *to have witnesses to this fact as well as to fully document all, including witnesses’ names in the patient’s records*. Accepting the contractual nature of the doctor-patient relationship implies abiding by contractual norms. Language must be simple, clear and accurate. Telling a 150 kg woman that “you are a bit overweight and there are a few more risks because of this” is *not* honest fulfilment of contractual obligations. This is where one bold anaesthetist’s approach may differ from a more shy one. The correct form of this address would be “Madame you are very overweight and this does make your operation substantially riskier” *and this must be said to both patient and husband/partner, be witnessed by a third person and all annotated with date and time registered in a clear legible manner in the patient’s clinical file*. Such are the medico-legal vagaries of modern life in Medicine that such doings must become habitual even if they are currently not. As in the good book, it is the one sheep that strays that counts not the ninety nine lying quietly in their pen.

Where multiple anaesthetists are involved, if a court case ensues, all anaesthetists may be sued for a given claim.²⁷ Hence we advise that all anaesthetists sign the functional consent form(s) and make their individual observations in the patient’s file, although the same witness may suffice for all. Delegating part or all of his/her work to another does not legally exonerate the original doctor and legal responsibility will be assumed of both in a court of law.²⁸ In the presence of multiple anaesthetists there seems to be a psychologically reassuring factor for ‘herd protection’ which evaporates in the courtroom.

Conclusion

We have here suggested a working pre-emptive hypothesis conceptualising the obstetric anaesthetist’s medico-legal responsibility under the Law of Contracts rather than the Law of Tort. The concept applies across the board of medical specialities and all physicians need to know the relevant sections of the law. The modern medical practice must be safe and peer reviewed, practiced with sense and honed to be delivered humanely. A holistic attitude to patients rather than defensive medicine is promulgated. We also exhort obstetric/anaesthetic units to hold regular fora to ensure the practice not only of good anaesthetists but also of a medio-legally sound one. The suggestions here imparted advocate the crowning of good practice with communication and bonding which also enhance the humanity of medical practice at times of maximal stress.

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