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Medical malpractice

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MEDICAL MALPRACTICE

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FOREWORD

This thesis is long because of necessity.

To properly understand this complicated subject it is necessary to study it from numerous aspects.

Definitions, causes, prevalence, general practitioner and specialist problems, public criticism, liability for others, noxious factors, criminal implications, hospital liability, insurance, legal defenses and plans for decrease are all inter-related.

An adequate history and physicial examination needs to cover the entire body. An adequate approach to medical malpractice makes it necessary to cover the above inter-woven aspects.

To over simplify this highly technical field would be a dis-service to the physician reader.

Canada has decreased the number of malpractice suits per physician. For a detailed description see Chapter XIX and Appendices #1 and #2.

CHAPTER I

Introduction

The mission of this thesis is to prevent malpractice suits.

It is basically an analysis of why doctors are sued.

Most malpractice suits are avoidable.

Medical malpractice suits can be reduced by:

1. knowing what medical malpractice is.
2. studying its causes.
3. examining the plans for its decrease.

Structure of the thesis:

1. Summaries are presented at the end of each chapter.
2. Summaries are mostly in outline form to reduce verbiage.
3. The summary at the end of the thesis summarizes each chapter in outline form.

There has been no adequate work in this field since Regan, L.L.B.,M.D., wrote "Medical Malpractice" in 1943. and revised it slightly to "The Doctor The Patient and The Law" in 1949. Regan's death in December of 1955 precludes another revision of his work.

Actual cases have been cited wherever possible. This

thesis purports to be what the State Supreme and Federal Courts say it is and not what some non-judicial individual thinks it is.

Physicians can adopt two attitudes toward malpractice: They can either avoid the topic and hope it never comes their way or they can study the subject and avoid it through knowledge. Apparently one half of the malpractice suits involve the more reputable members of the medical profession.

Suits are attaining staggering monetary factors--though ludicious this World Herald Omaha article shows a trend of the day:

"New York--A Greenwich Village housewife filed a 500-thousand-dollar claim against the City Tuesday charging her 9-year-old son was inoculated with Salk anti-polio vaccine against her wishes.

Mrs. Nancy Benton charged her son, Peter, was given an injection last December 9 at a public school after she wrote a note to school authorities saying she did not want the boy to have the shot." (Omaha World Herald, (1).

Medical malpractice combines the most complex problems of law and medicine. Overgeneralization is a pitfall to be avoided in this field. This thesis endeavors to quote the courts exactly as their decisions held.

Effort has been made to get pertinent Nebraska cases, although the fundamental considerations remain the same in most jurisdictions. Specifically the law varies enough from state to state to trap the unwary.

CHAPTER II

The Definition of Medical Malpractice and the Legal Duties of Physicians

This chapter defines medical malpractice, gives the various types and explains eighteen duties of the physician. Violation of one of these duties may be the basis of an action at law for medical malpractice.

Definitions:

The aim of this section is to define medical malpractice as simply as possible. However, to oversimplify this complex problem could be a vital error. A number of definitions are given. In the summary at the end of the chapter the essential elements are given in a very reduced form.

It should be remembered that it is not what we don't know that causes us trouble. It is what we think we know that is actually wrong that gives us difficulties. Therefore for maximum benefit it would be wise to approach this subject with an open mind and without preconceived concepts.

Dorland's medical dictionary states that malpractice is: "Improper or injurious practice; unskilful and faulty medical or surgical treatment." Dorland,(2)

This definition is medically correct. But it is

not very helpful to one practicing medicine and thereby standing under the Damaclean sword of malpractice suits.

Black's Law Dictionary third edition states that malpractice is: "Any professional misconduct, unreasonable lack of skill or fidelity in professional or judicial duties, evil practice, or illegal or immoral conduct. As applied to physicians, in a more specific sense, it means bad, wrong, or injudicious treatment resulting in injury, unnecessary suffering, or death to the patient, and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rules or principles, neglect, or a malicious or criminal intent." Regan,(3).

This definition helps a little, but let's see how Louis J. Regan, M. D., LLB., the world's foremost authority on medical malpractice who died December 3, 1955 defines this subject. He states: "Malpractice may be defined as the failure upon the part of a physician or dentist properly to perform the duty which develops upon him in his professional relation to his patient. Thus, malpractice has two essential parts to it:first, that the physician fails to do his duty; and second, that definite injury to the patient is the result of

his failure." Regan, (3).

This concept of duty is fundamental and is elaborated upon later in this chapter under the heading of Legal Duty.

TYPES OF MEDICAL MALPRACTICE

There are three large categories into which most medical malpractice cases fall. They are civil, criminal, and ethical. They are defined as follows:

1. Civil malpractice, called a tort (Latin for wrong) in legal proceedings, is the negligent performance by a physician of the duties which are devolved and incumbent upon him on account of his contractural relations with his patient. Tucker v. Gillette (4). Civil malpractice is the commoner arena of litigation. In this form of suit, the plaintiff is seeking monetary remuneration--"money damages"--for injury sustained through the negligence of the physician. Discussion of this type of malpractice forms the bulk of this paper.

2. Criminal malpractice results when the activities of a practitioner result in prosecution by the state rather than by an individual plaintiff. A physician may become liable for performing illegal operations, for violation of narcotic laws, for falsifying records or reports on patients, and for many other illegal acts.

In addition, the treatment of an individual patient may lead to indictment for negligent homicide or involuntary manslaughter under certain conditions. This field is discussed in the chapter criminal malpractice.

3. Ethical malpractice is that kind of malpractice in which persons claiming to be medical men bring suits against physicians or against medical societies for alleged insults to their professional dignity. It also deals with discipline of physicians by medical groups. Culbertson (5).

LEGAL DUTIES OF PHYSICIANS

The liability of the physician rests upon the concept of duty. If there is no legal duty imposed then there is no recoverable case for the plaintiff patient regardless of damages to the patient.

Duty hinges on three factors. How does the physician's duty arise? How does it terminate? What is it's scope?

The physician's duty arises basicly from a contract formed when the patient comes to the physician and the physician undertakes treatment. The courts, however, have amplified this straightforward legal concept into something more because of public considerations. In the Missouri case of Parkell v. Fitzporter the Supreme Court

of Missouri in 1923 states to the effect that the duty of a physician to bring skill and care to the amelioration of the condition of his patient does not arise only from contract, but has its foundation in public considerations which are inseparable from the nature and exercise of his calling. Although the relation of physician and patient may be, and is perhaps generally, created by contract, the duty of the physician when he assumes it is fixed by rules which operate independently of its origin. He may be employed by a stranger, or take up the burden of treatment for purely humanitarian reasons, yet his duty to have the requisite knowledge and to employ it with the care made necessary by the occasion is to his patient. Parkell v. Fitzporter (6).

The relation of patient and phsycian rests upon this contract, express or implied, it is almost always implied rather than expressed. This contract raises up certain duties, a breach of one or more of which, if it leads to a bad result, is the basis of an action for malpractice. Lawyers speak of it as an action in tort sounding in contract. A tort is a civil wrong founded upon some breach of duty, this duty may arise from contract or it may be one which the law imposes. Thus, every driver of an automobile owes to every pedestrian

and to every other driver on the road the duty to use due care, that is, such care as is necessary, having regard to all the surrounding circumstances, such as the time of day, the width and character of the road, whether it is wet or dry, the state of the traffic and so on. A failure to use due care resulting in injury to another is called negligence, and gives rise to an action for damages. Negligence is one of the most important branches of the law of torts. An action for malpractice is an action in negligence. It is based upon a physician's alleged failure to comply with the duty which the law rasies up from his contract of employment. Malpractice has been defined as "negligent performance by a physician or surgeon of the duties which are devolved upon him by virtue of his contractional relations with his patient; bad or unskilfull practice by a physician or surgeon whereby the patient is injured." Malpractice may also be the result of ignorance or wilfulness or of negligence.

Briefly, there are considered four different ways by which the physician-patient relationship can be terminated and thus the "legal duty" of the patient extinguished:

1. Death of the patient.
2. Discharge of the physician by the patient.

3. Mutual agreement of patient and physician to end the relationship.

4. Appointment of a qualified sucessor or the giving of notice to the patient in advance so he will have ample time to secure a sucessor.

In general, the scope of the physician's duty involves a continuing obligation to give the patient's case proper attention. The following outline presents a more detailed delineation of this problem in terms of specific duties:

1. Most jurisdictions reecognize the responsibility of the practitioner to be duly licensed in the state wherein he practices. Brown v. Shyne (7).

2. "A physician undertaking the treatment of a patient is required to possess and exercise that degree of skill and learning ordinarily possessed and exercised by the members of his profession in good standing practicing in the same or similar localities." Persten v. Chesney (8).

This phraseology is more often quoted than any other in civil malpractice suits. It should be a part of every physicians education. It should be his guide in considering what procedures to do or not to do. For example, a certain procedure may have the qualified

approval of John Hopkins and the Mayo brothers but if it is not the accepted procedure in the locality in which a physician practices he embarks on this procedure without the sanction of the courts and if anything goes wrong his standing in court will be precarious at best.

The law very wisely requires that some standard by which to determine the propriety of treatment must be adopted; otherwise experiment would take the place of skill, and the reckless experimentalist the place of the educated experienced practitioner. Tefft v. Wilcox (9).

Before it can be said that there is any established mode of treatment, it must appear that according to the general consensus of opinion of medical men, that it is so considered, and if followed by the ordinary practitioner. Physicians are bound by what is universally settled in the profession and not by the mere fact that some writers on the treatment of a certain ailment or that a few surgeons prescribe a certain mode of treatment. Burnham v. Jackson (10).

A reckless disregard of a new discovery, and an adhesion to a once approved but exploded or abandoned practice resulting in injury to a patient, will give cause of action. But, on the other hand, no medical man can

be bound to resort to any practice or remedy that has not the test of experience to recommend it, and a physician or surgeon resorting to such new practice or remedy with injurious consequences following, would be more liable to an action than one who with like result followed the beaten track. Without experiment there would be no progress in medical or any other science. Still he who tries the experiment and thereby injures another must take the consequences. It is sufficient if the practitioner follows a known and recognized system. Williams v. Poppleton (11). It matters not then how much skill a physician or surgeon may have if he does not follow the established mode of practice in the particular case. This fact may be taken by the jury as evidence of the want of such skill. Jackson v. Burnham (12).

The general practitioner and specialist are held to different standards of conduct. The latter by definition that can reasonably be expected from the former, whose practice covers a much wider field. It follows, therefore, that a stricter test must be applied to the conduct of a specialist then to that of a general practitioner. There is no more than a further but logical extension of the maxim imperitia cuplae adnumeratur, i.

e., lack of skill is treated as culpable. The general practitioner, should be reasonably skilled in all branches of medicine; the specialist should be particularly skilled in his specialty. But the skill required will, in accordance with general principle, be that of an average specialist, not that of an exceptionally able or gifted one.

3. Reasonable care and diligence by the physician is required. Owens v. McCleary (13).

These words are often quoted and used by courts in all the states.

A physician and surgeon by taking charge of a case impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in localities similar to that where he practices, and which are ordinarily regarded by those conversant with the employment as necessary to qualify him to engage in the business of practicing medicine and surgery. Force v. Gregory; Gramm v. Boneuer; Whitsell v. Hill; Small v. Howard; Burke v. Foster (14).

4. The physician is required to use his best judgment.

In contrast to the previous elements set out, this factor of "judgment" has more of a subjective tinge--the individual physician's best judgment at the time in question and in view of all attendant circumstances in the case. The following language from the earliest Missouri malpractice case reported indicates the interrelations of these elements:

Whether errors of judgment will or will make a physician liable in a given case depends, not merely upon fact that he may be ordinarily skilful as such, but whether he has treated the case skilfully, or has exercised in its treatment such reasonable skill and diligence as is ordinarily exercised in his profession. For there may be responsibility where there is no neglect, if the error of judgment be so gross as to be inconsistent with the use of that degree of skill that is the duty of every surgeon to bring to the treatment of a case according to the standard indicated. West v. Martin (15).

A later Missouri case makes reference to the subjective nature of this factor of judgment:

"Physicians and surgeons must be allowed a wide range in the exercise of their judgment and discretion. The science of medicine is not an exact science. In many instances there can be no fixed rule by which to

determine the duty of a physician, but there must often use his own best judgment and act accordingly. By reason of the fact the law will not hold a physician guilty of negligence as long as he uses his best judgment, even though his judgment may prove erroneous in a given case, unless it be shown that the course pursued was clearly against the course recognized as correct by the profession generally. As long as there is room for an honest difference of opinion among competent physicians, a physician who uses his own best judgment cannot be convicted of negligence, even though it may afterward develop that he was mistaken. Bailey v. St. Louis-San Francisco Ry. Company (16).

5. The physician's duty of exercising reasonable care and diligence and his best judgment:

It is evident that the physician must exercise his knowledge, skill, care, diligence and judgment. It is no defense for him to merely show that he has these qualities.

He must use them in the particular case under litigation if he is to avoid liability.

6. The physician is legally required at times to testify in court. Technically speaking, it is comtempt of court for a physician to refuse to testify in a medico-

legal case. Whether he wishes it or not, he is under legal obligation to render expert opinions when called upon in the administration of justice. This fact renders it mandatory that all practitioners be grounded in legal medicine if truly scientific justice is to prevail in an age of science.

However, it should be definitely understood that being unduly critical of another's physician's work could and has accomplished untold damage to the profession as a whole. This point is elaborated in the Chapter Causes of Malpractice Suits.

7. The physician must give proper instruction to his patients.

Related to the discussion on rehabilitation is a well-recognized duty of giving proper instructions to the patients and those around him who may assist in his aftercare. A leading case on this point is Pike v. Honsinger, (17).

8. The physician may in some cases have a duty to refer patients.

Several reported cases have hinted that, in certain difficult cases, a physician's failure to refer his patient for consultation with one more qualified in the appropriate area may be an independent ground for liability. Merin v. Cory; Benson v. Dean; Sinz

v. Owens, (18).

9. The physician must keep up with the technical advance of his locality.

Not only may malpractice liability be founded upon failure to "keep abreast", but a physician's competency as a witness may be attacked on this ground. A Missouri case, arising out of a fractured ulna and radius sustained in 1930, found defendant's counsel contending before the Supreme Court that one of the plaintiff's medical witnesses was not competent to testify.

"The point arises upon the court's overruling of defendant's motion to strike which was interposed by counsel during the physician's cross-examination, after the doctor stated since 1913, when he gave up his office, he had not kept himself familiar with the methods and procedures followed by ordinarily careful, prudent, and skillful physicians and surgeons in St. Louis County in reducing fractures such as those the plaintiff had sustained.

"If this were all there was in the case, there would be more reason for insisting that the physician was not competent to testify as an expert, for certainly the propriety of the course of treatment followed by defendant was to be measured by the standing existing at some

time in the past. But the fact is that in closing his office the doctor had given up only the most of his practice, and that such practice as he had had in the interim had been general, including the care of at least one fracture. Furthermore he testified that the reduction of fractures had not changed during that period. Our conclusion is, therefore, that while the matters complained about went most pointedly to the question of the weight to be accorded the physician's testimony by the jury, yet as far as concerned the question of his competency as a witness, the court rules properly in denying the defendant's motion to strike." Gunter v. Whitener,(19).

10. The physician must get the patient's consent for procedures under normal conditions.

This duty has most often been discussed in regard to surgical procedures, but it would seem that any radical therapy contemplated should be explained to the patient and his consent obtained in order to avoid possible liability. Judge Cardozo, in a famous opinion, set forth the law in succinct language:

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation with-

out his patient's consent commits an assault, for which he is liable for damages. This is true except in cases of emergency where the patient is unconscious, and where it is necessary to operate before the consent can be obtained." Schloendorff v. Society of New York Hospital, (20).

11. The physician has a duty of non disclosure to third parties.

Most of the reported cases on this subject have arisen under provisions of the local statutes concerning privileged communications. Types of cases arising under this head include statements that patients have a venereal disease. Shoemaker v. Friedberg; Munzer v. Blaidell; Barber v. Time, Inc. , (21).

12. The physician must exercise utmost good faith with his patient.

The law recognizes that the relation of a patient to his physician is one of trust and confidence. General rules of law as concern the trust relationship are applicable. Duties of a fiduciary particularly important to the physician include:

All transactions between a doctor and his patient are carefully scrutinized by the courts, lest the physician use his superior position to effect fraud or un-

due influence.

13. The physician must employ ordinary reasonable diagnostic procedures:

Negligent diagnosis is an ever-increasing threat, especially as the public has become to believe in the infallibility of the many diagnostic tests which the modern physician may employ in his practice.

An inadequate differential diagnosis may result in liability, as illustrated by Gottschall v. Geiger. A female patient had had all but a small portion of ovarian tissue removed, and testified that the defendant told her that she would be unable to become pregnant again. After several months, however, she felt that she was "in a family way" and reported back to the defendant. A diagnosis of "tumor" was made and the patient's uterus was incised for removal thereof. Actually, a normal pregnancy was found, and two months later a healthy baby boy was born. Although there was much conflicting testimony in the case, the court condemned inadequate diagnostic methods:

"There was evidence, even from the expert witnesses offered by the defendant, that if at the time the plaintiff was operated on the second time she had perfect freedom of movement in every way and her symptoms

and conditions were no different from those of her other pregnancies, and she told the doctor she had been pregnant and had borne children twice before and thought she was pregnant again and the doctor, only two months before the birth of a fully developed full-period child, merely pressed his hand across her abdomen and decided she had a tumor, then such was not a sufficient and careful examination. There was also evidence that "ballottement" was one of the tests proper to be used, and that the beating of the fetal heart could be determined by the use of the stethoscope. The defendant says he did not use the stethoscope, and, if plaintiff's evidence is true, he did not use the (sic) ballottement. There was also expert evidence to the effect that if at seven months the uterus and its contents could be manipulated freely from side to side and there was no pain, no catching or holding on the inside and no hindrance to the freedom of movement the diagnosis would be that there were no adhesions--at least, no adhesions dense enough to interfere with pregnancy or childbirth and a woman could go through the latter all right." Gottschall v. Geiger, (22).

14. The physician must use ordinary, reasonable therapeutic procedures.

In this connection, it is necessary to point out that a physician or surgeon ordinarily does not warrant or guarantee a cure, but he may be held to have promised a salutory result in some instances. A leading Missouri case, Vanhoover v. Berghoff, expresses this distinction:

"Under the law, his contract is not one of warranty that a cure will be effected but only that he possesses, and will use, reasonable skill, judgment and diligence, such as is ordinarily possessed and employed by the members of the same profession. It is, however, competent for the surgeon to make a contract expressly binding himself to cure; and the petition in this case charges that defendant undertook to reduce and set the bone, and to attend, cure and heal the same; but it also charges that he 'promised carefully and skillfully to perform said service' and that he carelessly, negligently and unskillfully failed to set, locate and reduce the dislocation, and to bind up, dress, and secure the same. Taken altogether, we do not think the petition sets out an express promise to cure, but only such an undertaking as the law implies, which is to employ in this behalf reasonable skill and diligence." Vanhoover v. Berghoff, (23).

15. The physician must exercise ordinary reasonable

care in post-operative management,

Judicial recognition has been afforded the proposition that a surgeon owes a duty to a patient extending to subsequent care and treatment of that patient. Hopkins v. Heller, (24). It would appear, then, that liability might be incurred in any situation where a physician is negligent in regard to rehabilitation of his patients.

16. The physician must use ordinary reasonable care in regard to prognosis.

The courts have traditionally required physicians to act with the "highest degree of fairness and good faith" as regards this phase of the physician-patient relationship. "If the plaintiff (an otolaryngologist) by the exercise of that degree of care and skill which the law exacts of a physician might and ought to have reasonably discovered that the defendant's ailment was incurable, or that it was a case that would not yield to the usual treatment, or that it was probable that the defendant would not be benefited by such treatment, and yet failed to do so, or if he made such discovery and failed to so advise defendant, he was guilty of negligence." Logan v. Field, (25).

17. The physician must refrain from purely exper-

imental procedure on his patients.

Although certain early cases gave expression to an absolute prohibition against clinical experimentation, it is doubtful that a physician can incur liability solely on the ground that he has engaged in experimentation. This problem is more thoroughly explained in the March 1952 issue of the Annals of Western Medicine and Surgery, page 164.

18. The physician has a duty of disclosure to the patient.

The physician under usual circumstances must disclose the patient's true condition to either the patient or to a responsible party of the patient's family. If the physician does not he assumes a heavy burden and may expose himself to litigation. For further discussion please see the paper of Dr. Hubert Winston Smith. "Therepeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness." 19 Tennessee Law Review 349 (1946).

SUMMARY OF MALPRACTICE DEFINITIONS AND THE LEGAL DUTIES OF PHYSICIANS:

The meaning of the term malpractice should be clearer. It designates any conduct on the part of the physician that is not in line with the requirements of good medical practice. Good medical practice is the standard; it comprehends what the average careful, diligent, and skillfull physician in the community, or like communities, would or would not do in the care of similar cases. (See legal duties below) If the physician fails to meet the standard demanded of him and if, as a result, the patient suffers injury, the physician may be required to respond in money damages.

The physician's failure to meet the required standard may be due (1) to his negligence; (2) to his ignorance; (3) to his wilful departure from acceptable practice; or (4) to his breach of positive law, e.g. operating without the consent of the patient.

The three main types of malpractice are civil actions for money damages, criminal prosecution by the state, and ethical actions between medical people.

The eighteen legal duties of the physician are to be correctly licensed, exercise the ordinary reasonable care of his locality, use good judgment, testify

in court, give proper instruction to patients, refer patients, keep up with the physicians of his locality's medical advance, get patient's consent for procedure, non-disclose certain facts to third parties, keep utmost good faith with the patient, reasonable diagnostic, therapeutic and post-operative procedures, reasonable prognosis, refrain from experimentation, and to disclose certain information to his patient.

CHAPTER III

History

Medical malpractice has co-existed with the practice of medicine. A complete history would fill volumes. A short comparison of ancient and modern rulings is given.

The ancient regulations were considerably more stringent than the milder rulings today. For example the code of Hammurabi, Babylon, about 2250 B.C., imposed an insurer's liability on the physicians of that day: "If a physician make a deep incision upon a man with his bronze lancet and cause the man's death, or operate on the eye socket of a man with his bronze lancet and destroy the man's eye, they shall cut off his hand." Regan, (26).

Contrast this severe regulation with the rulings of the Nebraska Courts discussed below.

One of the earliest Nebraska cases decided May 23, 1883 by the Supreme Court of Nebraska was O'Hara v. Wells, The court laid down the rule that "the law implies on undertaking his part (that of the physician and surgeon) that he will use a reasonable degree of care and skill in the treatment of his patient and he is not liable in damages for want of success unless it

is shown to result from a want of ordinary skill and learning, and such as is ordinarily possessed of others in his profession, or for want of ordinary care and attention." The judge also instructed, "A party is not negligent if he uses all the skill and diligence which can be obtained by reasonable means." These instructions were approved. The court also instructed, "the patient must exercise ordinary care and prudence, and obey all reasonable instructions given him by the surgeon." Judgment for plaintiff patient was denied. O'Hara v. Wells (27).

The Nebraska case of Douglas v. Johnson (Re Johnson's estate) is considerably more recent, November, 24, 1944. In this case judgment was entered in the lower court in favor of the plaintiff and was reversed on appeal. In this case the court stated: "A patient is entitled to an ordinarily careful and thorough examination, such as the circumstances, the condition of the patient, and the physician's opportunities for examination will permit,, and while he does not insure the correctness of his diagnosis, a physician or surgeon is required to use reasonable skill and care in determining through diagnosis the condition of the patient and the nature of his ailment, and is liable for a failure, due

to a want of the requisite skill or care, to diagnose correctly the nature of the ailment, with resulting injury or detriment to the patient."

The court said further: "there is a fundamental difference in malpractice cases between mere errors of judgment and negligence in previously collecting data essential to a proper conclusion....thus, if he omits to inform himself, by proper examination, as to the facts and circumstances, and injury results, he is not relieved of liability for errors of judgment." Continuing, "Malpractice may consist in a lack of skill and care in making the diagnosis as well as in the treatment of the ailment."

The court further said that a surgeon called in by the patient's physician to perform an operation could rely upon the diagnosis of the attending physician and is not required to make an independent diagnosis and may proceed until he discovers facts which suggests a different conclusion, and he may then proceed upon a proper course of action based upon the newly discovered facts or conditions. But if before he performs the operation he discovers facts or conditions that seem to contradict the attending physician's diagnosis, then the surgeon must make additional and proper diagnosis before

proceeding, and if he does proceed without so doing, he would be negligent and liable in damages therefore. (In this case the doctor operated to remove a "tumor" but when he got in he discovered that her appendix needed to be removed and he did so.) (Judgment for plaintiff was reversed because of an error in the court's instructions, not pertinent here.) The court however approved this instruction: "You are instructed that even if a physician or surgeon has used his best judgment in treating a patient, he is not relieved of a charge negligence or carelessness against him when it appears that such judgment as he possessed and used was not such judgment as is possessed and used by physicians and surgeons of ordinary learning, skill and ability practicing in the same community where it is alleged that the negligence and carelessness occurred, or in similar communities."

Douglas v. Johnson, (28).

SUMMARY OF MEDICAL MALPRACTICE HISTORY:

Medical malpractice liabilities have kept pace with general enlightment.

The physicians liabilities have changed from making the physician absolutely liable for good results to the standard of "ordinary reasonable care" of the physicians of the locality in which the physician practices.

CHAPTER IV

Prevalence of Medical Malpractice Claims

In 1929 there were approximately 400 malpractice suits filed in the entire U.S.A. In 1952 there were over 4,000 cases. Lusby, (29). There are 156,000 physicians engaged in practice. This means that one physician in every 39 would be sued in one year. In less than forty years there would be an average of one suit for every physician who had practiced that period of time. This would be at the present rate, and there are many more suits each year.

In one large city in 1953, one of every 21 physicians was sued for malpractice in that one year along. Regan,, (30). At that rate it would be only 20 years until there would be an average of one suit per physician.

Between 1946 and 1954 in two counties in California there were 125 malpractice claims. This was one claim for every fourteen physicians for each year. The average claim was for $65,000. Thirty one of these claims were settled for $100. or more. Sadusk, Jr.,(31).

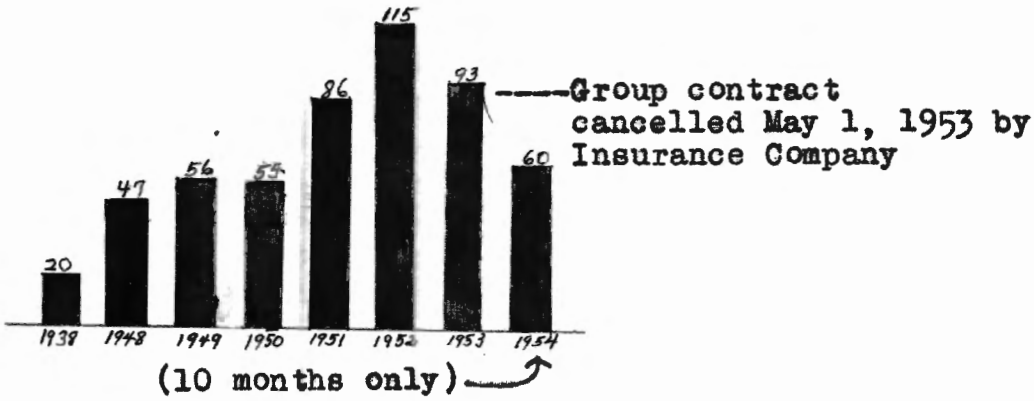
In the seven years between 1948 and 1954 there were 512 malpractice actions in the District of Columbia against the members of the District of Columbia medical

society. There was an average of <u>one suit for every three members</u> during that period. The District is exceeded only by New York and California and perhaps Missouri in the number of claims. Den, (32).

<u>GRAPH #1</u>

Increase in Malpractice Actions Against Active Members of the Medical Society of the District of Columbia

1948-1954
7 years...512 malpractice actions
Average...73 per year
One out of every 3 active members in the medical society



Den (32).

SUMMARY OF PREVALENCE OF MEDICAL MALPRACTICE CLAIMS:

The statistics indicate that in many areas that in the next twenty year period there may be an average of <u>one malpractice suit for every practicing physician</u> in the U. S. A.

CHAPTER V

Causes of Medical Malpractice Suits

I. Introduction and Frequency of certain causes:

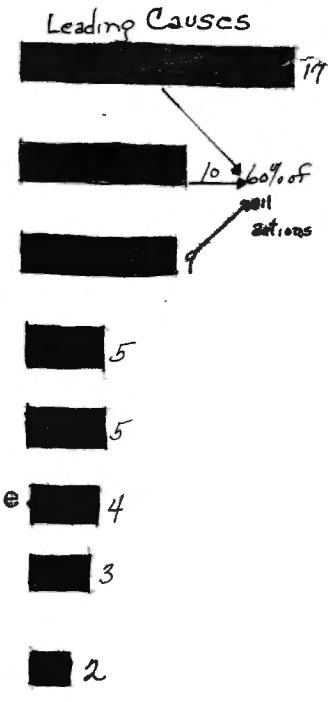
This causes chapter is as important as any chapter in the thesis. By studying the causes we are laying the foundation for their removal.

The most common allegations and causes are listed and graphed.

This chart is fairly typical of the leading causes of malpractice actions in the country as a whole:

GRAPH #2 (60 causes of suits in D.C. in 1952)

Causes ih Malpractice Actions against Active Members of the Medical Society of the District of Columbia in 1952



Discriminating, careless or injudicious remarks of physician against another.

Excessive fee, unpaid bill, suit by physician for payment, thence counter charges by patient

Failure to explain the probable results in the management of a surgical or medical case.

Failure to carry out a complete examination and/or to heed all complaints of patient.

Accident during surgery or anesthesia.

Failure to properly supervise patient in office

Physician ostensibly protecting hospital from charges of negligent care.

Failure to properly protect the post-operative patient.

Hospital negligence [redacted] 2

Failure to obtain operative permit [redacted] 1

Question of misuse of opiates [redacted] 1

Premature announcement of death [redacted] 1

Den, (32).

CHART #1

One hundred fifty-three recent consecutive cases in New York were distributed as follows: (1942)

Fractures, etc.	14
Obstetrics, etc.	13
Amputations	2
Burns, x-rays, etc.	22
Operations; abdominal, eye, tonsil, ear, etc.	38
Needles breaking	1
Infections	17
Eye infections	1
Diagnosis	12
Lunancy commitments	2
Unclassified--medical	31

New York State Medical Journal,(33).

One survey covering about ten years' experience in a large metropolitan area, made from the point of view of losses paid, may be of some interest. Only claims which cost three hundred dollars or more were included. The percentages represent the <u>percentage of the whole amount paid out in each category</u>.

CHART #2

Anesthesia	1.5%
Burns, diathermy, hot lights, etc.	7.5%
Burns, fluoroscopic	12 %
Errors in diagnosis	5 %
Fractures	29 %

Hypodermic and I.V. injections	5%
Improper medication	4%
Obstetrical injuries	6%
Surgery, general and surgical specialities	20%
Sugery, plastic	5%
Surgery, lack of consent	2%
Soft tissue traumatic injuries	3%

Regan, (34).

In several categories these percentages are not currently accurate, as reflecting present experience, in the area referred to. Notably there has been a marked decrease in the number of claims of fluoroscopic burns; and claims involving qualified and reputable plastic surgeons have been practically eliminated. On the other hand, claims in the field of anesthesia has decidedly increased. There is also some increase in claims based upon shock therapy and xray cancer therapy. A special note of warning should be heard in two fields: (1) the first, relatively new but growing deals with the charge of failure to diagnose, or delay in diagnosing cancer and (2) the second, perennially with us, is the problem of fracture, for it continues to afford more claims and greater costs than any other service rendered in the whole field of medical care. It is, however, distinctly emphasized that the latter remarks have application to the care of fractures by the general practitioner--very few claims, and almost none of the merit, are brought against the orthopedic specialist.

Reference may also be made to the classification of the defendants, as specialists or general practitioners, in the study referred to. It has been observed that there has been a steady increase in the percentage of general practitioner defendants with a corresponding decrease in the number of specialist defendants in the area under consideration. Regan, (34).

In New York, during the 1947-1948 reporting period 153 new actions were commenced. These cases are classified as follows:

CHART #3

1.	Fractures, etc.	11
2.	Obstetrics, etc.	23
3.	Amputations	1
4.	Burns, x-rays, etc.	16
5.	Operations--abdominal, eye, tonsil, ear, etc.	39
6.	Needle breaking	7
7.	Infections	13
8.	Eye infections	4
9.	Diagnosis	10
10.	Unclassified	29

There were 22 actions for deaths and 17 infants' actions. New York State Medical Journal, (35).

II. The common allegations in malpractice suits:

The most common allegations in medical malpractice suits: The internist and the general practitioner.

1. Examination without consent.

2. Injury during examination.

3. Error or delay in diagnosis.

4. Failure to use laboratory aids.

5. Failure to administer standard treatment.

6. Failure to leave instructions for protection of attendants and of other contacts.

7. Failure to leave instructions for treatment of patient.

8. Failure to hospitalize.

9. Aggravation of existing condition.

10. Abandonment.

11. Infection resulting from injection.

12. Infection, slough.

13. Burns--Xrays, diathermy, infra-red, heating pads, etc.

14. Breach of warranty to cure.

15. Error in the prescription or in dispensing.

16. Overdosage.

17. Use of harmful drugs.

18. Unnecessary medical treatment.

19. Death from injection, from vaccination, etc.

20. Improper quarantine.

21. Carrying contagin.

22. Defective equipment.

<u>The surgeon (general, industrial, orthopedic)</u>

1. Most of the allegations set forth above, and:

2. Breaking and slipping of instruments.

3. Foreign bodies left in patient's tissues.
4. Operation without consent.
5. Operation more extensive than that consented to.
6. Operation on the wrong part.
7. Unnecessary operation.
8. Delay in operating.
9. Failure to operate.
10. Unsuccessful operation.
11. Needle broken off in tissues.
12. Bad results from operations--severed nerve or tendon, injury to sphincter, etc.
13. Failure to follow-up.
14. Failure to discover severed tendon.
15. Failure to use X-ray.
16. Failure to discover fracture; second fracture overlooked.
17. Failure to diagnose dislocation.
18. Injuries from application of cast.
19. Insufficient immobilization.
20. Deformity and loss of function (fractures, dislocation).
21. Cast too tight; removed too soon; left on too long.
22. Failure to use traction.
23. Failure to employ fixation.
24. Failure to institute active and passive motion.
25. Unneccessary scarring.

26. Use of unsterile needle or instruments.

27. Experimentation.

The obstetrician:

1. Many of the allegations set forth above;
2. Failure to attend at time of delivery.
3. Wrong baby given parents.
4. Poor or no prenatal care.
5. Unnecessary caesarean section.
6. Negligent delay in performing caesarean section.
7. Unnecessary use of instruments.
8. Instrumental injury to mother, to baby.
9. Placenta not completely removed.
10. Hemmrrhage from cord.
11. Injury to baby, fracture, paralysis, etc.
12. Failure to protect perineum (and rectum).
13. Failure to repair birth canal injuries.
14. Eclampsia not properly treated.
15. Lack of sterile technique--infection of mother.
16. Diagnosis of pregnancy as tumor(operation, miscarriage).
17. Diagnosis of tumor as pregnancy(special tests not empbyed)

The gynecologist:

1. Many of the allegations set forth above, and:
2. Slander in charging patient had venereal disease.
3. Operation resulting in sterility.

4. Negligent puncturing of uterus during curettage.
5. Injury to ureter.
6. Stricture of cervix, caused by too extensive cauterization.
7. Fistulae--bladder, rectal.
8. Illegal abortion performed without consent.

<u>The Urologist:</u>

1. Many of the allegations set forth above, and:
2. Burns from fluoroscopic examinations.
3. Failure to remove kidney stones, bladder stones.
4. Too strong solutions in urethra and bladder.
5. Wrong solution in making pyelogram.
6. Puncture injury in doing cystoscopy.
7. Use of unsterile instruments.
8. Unsuccessful vasectomy, wife pregnant.

<u>The ear, eye, nose and throat specialist:</u>

1. Many of the allegations set forth above, and:
2. Failure to remove eye--sympathetic.opthalmia.
3. Failure to remove foreign body.
4. Wrong solutions.
5. Cataract improperly treated-blindness.
6. Wrong glasses.
7. Injury to tear ducts.
8. Treatment caused scarring and deformity.

9. Destruction of sense of smell.

10. Removal of uvula.

11. Injury to pillars.

12. Injury to tongue.

13. Injury to speech.

14. Failure to remove all of tonsils.

The dermotologist:

1. Many of the allegations set forth above, and:

2. Failure to improve.

3. Ointments discoloring or disfiguring skin.

4. Loss of hair (improper treatment.)

5. Xray burns and shocks.

The Pediatrician:

1. Many of the allegations set forth above, and:

2. Failure to immunize (having general charge).

3. Failure to diagnose, (thymus).

4. Delay in diagnosis (imperforate anus, congenital glaucoma, etc.)

5. Harmful formula (infant feeding).

6. Multiple self-inoculation (no dressing on vaccination).

The clinical laboratory:

1. Mixing or contamination of material.

2. Wrong diagnosis (venereal disease).

3. Wrong diagnosis (biopsy).

The anesthetist:

1. No preliminary examination.
2. Too much anesthetic.
3. Death from anesthetic.
4. Injury to eyes or skin.
5. Injury from mask; from mouth gag.
6. Injury from improper position on table.
7. Injury from struggling(inproper adminisitration).
8. Pneumonia caused by fluid ether in lungs.

The radiologist:

1. Electrical shocks and burns.
2. X-ray and radium burns (pigmentation, loss of hair, etc.)
3. Errors in diagnosis.
4. Injuries to vision.
5. Sterilization.
6. Radium needle escaped from control.

III. General and Underlying Causes of Malpractice Suits:

1. The most common cause of all malpractice suits is criticism by one physician of another. Most of this criticism consists of careless comments.

The patient nearly always alleges that the doctor failed to apply properly or exercise that requisite knowledge and skill usually possessed in his area by his colleagues. This is usually inspired by some thoughtless or

careless remark by a doctor who too frequently does not know all the facts about the patient's condition or the treatment given. Many times the doctor cannot substantiate his remark when called to the witness stand. Other contributory causes of a professional nature are bad hospital public relations and specialization. Resident and intern staffs of hospitals can stand considerable improvement in their relations to practicing physicians. Too often they make unfortunate remarks about the care of the patient.

The"golden rule" should be applied here. Comment upon another's work as you would want him to comment about yours.

Use of phrases, "Why wasn't this done?" "Something else should have been done" "Why didn't you see me earlier?" "How in the world could he have missed it?"--all these plant the seed of discontent. These comments may be made without malice, but they are frequently misinterpreted by the patient. Medicine is not an exact science, and there can be a perfectly honest difference of opinion regarding the mode or method of treatment. Your opinion may or may not be correct, but if the other physician has honestly proceeded with the same degree of knowledge and skill, the mere fact that you disagree may be construed

by the patient to mean that he was mistreated and should pursue compensation for damages. Remember--"Don't build yourself up by knocking the other fellow down."

2. The second most important cause is the failure to maintain close relationship with the patient.

Many physicians fail to listen to patient's complaints about their disease, their fees, their care, the results of procedures. Patients should be urged to discuss fully and freely any real or imaginary complaints.

A sympathetic ear of the doctor may prevent a call to a lawyer who in most cases apparently has too sympathetic an ear from all the unwarranted suits which are filed and lost.

3. Malpractice lawsuits are usually instigated by patients who expect "perfect" solutions to their medical problems, states Louis J. Regan, M.D. in Look Magazine November 1, 1955. The increasing number of malpractice suits is not the result of an actual increase in the indidence of malpractice but rather is due to the belief shared by laymen and some doctors that medicine has become as exact a science as mechanical engineering. Medicine in the News, (36).

Physicians are contributing to this cause when they say "everything will be all right".

"It will be as good as new" may be famous last words.

This conversation makes the physician appear to be and insurer of good results. This is an over optimistic viewpoint as 4000 malpractice suits a year testify.

4. Publicity:

The juryman especially does not pause long because he has become aware, as people have in general, that physicians universally carry professional liability insurance and he has read and heard of extremely high judgments rendered elsewhere. In addition, he may well be one of the many under the impression that"all doctors are rich"!

5. The law:

In some localities rules of law have changed so that it is now much more difficult to defend a malpractice suit than formerly and courts-seemingly increasingly loath to dismiss these actions for a lack of substance-are allowing the issues to go to the jury. Juries today apparently deal less frequently with the question of "whether" to find for the plaintiff-patient, than they do with the question of "how much" damages to assess against the defendant-physician. In addition, one cannot dismiss the legal aspect without comment on the

National Association of Compensation Claimant's Attorney's which has been organized to assist lawyers in obtaining "more adequate and equitable judgments for compensation claimants". Since appraisals of both adequacy and equity can and do vary, the purposes of NACCA boil down to larger judgments in all cases brought to bar. To this end the NACCA Law Journal is published and in it successful claim actions, trial procedures and methods of litigation as well as publicity concerning five and six figure judgments are outlined for the benefit of the attorney membership of 1700. Finally, NACCA has a legislative program, the objective of which is to amend the laws of the various states to make even simpler the gaining of ever higher awards for claimants.

California even requires the defendant physician to testify as a witness for the plaintiff patient.

6. Guarantee of a <u>therapeutic result</u>:

Explain the probable and possible results and what may be reasonably expected from the therapy instituted. Be wary of anything that may be construed to imply a guarantee.

7. <u>Excessive fees</u>:

Your attention is invited to a sign distributed by the American Medical Association for display in your

waiting room which in substance invites a frank discussion of your services and fees.

8. Improper collection methods antagonizes patients.

9. Specialization which has led to medical fragmentation of the family unit with a loss of loyalty feelings on the part of the patient to any one family physician.

10. The admission of negligence made by physicians within the patient's hearing.

11. The patient's idea of getting something for nothing; the "soak the rich" idea associated with the opinion that all doctors are rich and drive Cadillacs.

12. The feeling on the part of the patient that the doctor has not done his best; that he has been disinterested or callous.

13. The publicity that a few notorious malpractice cases receive with unlicensed physicians involved.

14. The increased public claim consciousness.

15. Bad public relations.

16. More liberal court interpretations broadening liability in the field.

17. Some adjustors want to rush out and talk to a possible claimant as soon as the doctor reports a possible suit, even though no legal action has been started. This is an open invitation to a claimant to start a suit. A

seasoned, tactful and wise adjustor may spell the difference between a fair and honest settlement and a law suit.

18. Failure to educate the public and individual patient their share of the responsibility for their health.

Many unjustified malpractice claims could be avoided if patients were educated to follow this advice:

1. Remember that the human body is not a machine, and always keep in mind what results you can reasonably expect from medical or surgical treatment.

2. If the results are bad, carefully consider what happened and obtain expert opinion before bringing charges of malpractice. Remember that many malpractice claims turn out to be unjustified.

3. Choose your doctor in advance of actual need. Get to know him, so that you can determine whether you wish to give him your confidence. You used to admire your "good old family doctor" as a dedicated person. You cannot expect a strange doctor to show such dedication the first time he meets you.

4. Before suing go to a medical association and save the costs of a defeated suit. (Lawyer's fees court costs, time.)

19. Failure to proceed wisely after a claim has been made against a physician may cause an unhappy ending to the suit.

The physician should immediately notify his insurance company and make available to his attorney all his records. Prepare as detailed and as complete a statement of all facts of his interviews and mental and physicial examinations of his patient as possible. Enumerate the causes and facts upon which he based your diagnosis, the treatment he prescribed and the progress made by the patient. Endeavor to explain the reasons that could have influenced his patient in becoming dissatisfied with your treatment. Consult any physician who may have seen the patient, either separately or jointly with him. He should reduce to writing all of the facts of which he has any information. Obtain a statement from his nurse or secretary, especially remarks she may have overheard the patient make in the office or over the telephone,

The next thing is to request the secretary to the Medical or Chirurgical Faculty to arrange a meeting of a group of physicians who are particularly qualified to pass judgment on the particular matter about which the patient complains, and suggest the names of the physicians that he personally feels are best qualified to render assistance.

The meetings hold a two-fold purpose. First, the attorneys and the accused physician obtain the benefit and experience from the observations, suggestions and recommendations of the Committee; and as some of these doctors will be asked to testify for the defendant, they will from the start have become familiar with the facts of the case, and the medical and legal questions involved. All information possible pertaining to the patient's background and medical history should be obtained; and while this work will largely fall upon the attorney, there is much that the physician can do to assist.

The physician should be careful in making any statement which could be construed as an admission of fault on his part, even though it were not so intended. Not only should he exercise ordinary skill and due care in treating his patients, but should exercise extrordinary tact not only in handling his patients but also members of their families. Any sensing of an undercurrent of dissatifaction of discontent should automatically suggest consultation.

20. <u>Failure to refer patient is one of the chief underlying causes of malpractice suits.</u> General practitioners should get help when they <u>first</u> realize that the condition is beyond their training and capacities. They

should not delay in this referral. Many malpractice suits show the disatrous results of such failure.

21. The acts of others may cause liability. (See chapter on "The Physician's Liability for Acts of Others).

22. Grossest negligence is a cause of action both by the injured party and for criminal prosecution by the state. (See chapter on "Criminal Medical Malpractice".)

IV. Specific Causes of Medical Malpractice Suits Including Substantial Medical Practice.

The physician is required to keep abreast of medical advances and to use such modern procedures in diagnosis and treatment as are now presently accepted.

. Substandard medical practice may fall into one of the following groups:

1. Failure to use accepted methods of diagnosis. Examples of this are (a) not using Xrays in cases of musculoskeletal injuries. (b) not doing a biopsy when indicated, and (c) not using simple laboratory tests (urinalysis before operation; blood sugar determination to differentiate diabetic from insulin coma). (d) another type of negligence coming in this group is improper diagnosis; for example, removal of a pregnant uterus. With the preoperative diagnosis being uterine fibroid, no laboratory test for pregnancy had been done.

2. Insufficient attention.

3. Failure to use accepted methods of treatment. The act might be one of omission such as failure to give tetanus antitoxin in the case of crushing injury when standard practice would be to administer the antitoxin. It might also be a positive act of omission. To follow good medical practice is the criterion. An important point is that the physician cannot experiement. In his private practice he should not attempt to test the effects of new drugs, new operative procedures and the like. Even consent of the patient for this to be done may not be valid. Human research of this nature should be carried out only under adequately controlled situations--the well equipped and staffed hospital or the equivalent.

4. Misrepresentation. The physician must act in good faith and is required to let his patient know the true situation. He should not over-emphasize or de-emphasize the condition. The facts should be presented dispassionately and in their true light. If the status of the patient is such as not to warrant his being given this information, this should then be given to a relative, preferably the nearest of kin.

5. Res ipsa loquitur. By res ipsa loquitur is meant literally, "the thing speaks for itself". Res ipsa loquitur

refers to untoward events not ordinarily occurring in the absence of negligence. In such instances the defendant physician is presumed guilty, the lay person being regarded competent to recognize that a negligent act has been done. The particular point is that expert medical testimony is not needed in the claimant's behalf. The consequence is that the suing attorney often tries to apply the doctrine of res ipsa loquitur without adequate justification. Res ipsa loquitur is held applicable in the six following situations. (1) slipping instruments, for example, fracture of a patient's tooth by insertion of a mouth gag incident to tonsillectomy; (2) foreign bodies left in tissue after operation (except in Massachusetts); (3) injury following application of too-hot water bottles, etc., or by various types of electrical apparatus; (4) x-radiation injuries; (5) infection following use of unsterilized instrument and (6) any injury taking place outside of operation during anesthesia.

6. Failure to conform to the required standard of conduct.

Malpractice (mala praxis) is bad practice, either through lack of skill or neglect to apply it, if possessed. The term has been variously defined as the negligent performance by a physician or surgeon of the duties

which are devolved and incumbent upon him on account of his contractual relations with his patient; bad for unskilled practice by a physician or surgeon, whereby the patient is injured; the treatment by a physician or surgeon in a manner contrary to accepted rules and with injurious results to the patient; the bad professional treatment disease, pregnancy or bodily injury from reprehensible ignorance or carelessness, or with criminal intent. Malpractice is either wilful, negligent or ignorant.

7. Negligence on the part of a physician has been said to consist in doing something which he should not have done, or omitting to do something which he should have done; or his failure to exercise the required degree of care, skill and diligence. In the absence of a special contract to do so, a physician or surgeon is not required to exercise extraordinary skill and care, or the highest degree of skill and care possible, nor, if not a specialist, the skill and care of the specialist or expert, but is only required to possess and exercise the degree of skill and learning ordinarily possessed and exercised, under similar circumstances, by the members of his profession in good standing, and to use ordinary and reasonable care and diligence, and his best judgment, in the application of his skill to the case.

8. Failure to exert ordinary skill and care of physicians in that locality.

In the case of McQuire vs. Rix the plaintiff sought to recover $100,000. in damages resulting from alleged malpractice by the defendant physicians and surgeons, in reducing and treating a comminuted fracture of estragalus of plaintiff's right ankle and for alleged negligence of defendant hospital in caring for the plaintiff while a patient therein. The negligence pleaded by plaintiff was denied by the defendant. The burden of proof was on the plaintiff to prove that the defendant did not possess and exercise the degree of skill and care ordinarily possessed and exercised by physicians and surgeons in Omaha and vicinity. To make a case the plaintiff was required to prove actionable negligence that was the proximate cause of the injury of which he complained. The Court denied recovery and in it's opinion stated: "A cure or restoration of the injured ankle to it's normal condition was not warranted or implied by the relation of physician and patient. "The weight of expert testimony shows conclusively that this (the method employed) was the usual and ordinary method practiced in Omaha by physicians and surgeons of the school to which the defendants belonged. McQuire v. Rix, (37).

The case of Stohlman vs. Davis was an action brought

by the plaintiff against the defendants for malpractice. Judgment for the plaintiff was sustained. The case was submitted to a jury as to only one doctor, and the only questions submitted was whether the defendant was negligent in the proper diagnosis of plaintiff's disease, and whether the defendant was negligent in abandoning plaintiff at a critical period of plaintiff's illness without proper notification of his necessary absence. The high standing of the defendant as a surgeon was not questioned; his knowledge and skill were admitted. The inquiry in the case was strictly limited as to whether the defendant doctor in treating the plaintiff exercised the ordinary care, skill and diligence which, in view of his undoubted qualifications, the law requires to be exercised in behalf of his patient. The Court said, "The test is that which physicians and surgeons in the same neighborhood and in similar communities, engaged in the same or similar lines of work ordinary exercise and devote to the benefit of their patients".

The Court further said that the courts "in cases wherein these questions are involved are necessarily dependent, to a degree at least, on witnesses versed in the sciences of medicine and surgery. When a given state of facts, submitted to the jury, is such that reasonable

men may fairly differ on the question as to whether there was negligence or not, the determination of the matter is for the jury, as triers of fact".

The Supreme Court of Nebraska said further: "The undoubted rule applicable to the situation is that 'a physician who leaves a patient in a critical stage of the disease, without reason or sufficient notice to enable the party to secure another medical attendant, is guilty of a culpable dereliction of duty and is liable therefor! " Stohlman v. Davis, (38).

In the case of McDaniel vs. Wolcott/ (39) the plaintiff sued the defendant for malpractice. The court dismissed plaintiff's petition. The action was based upon the theory of the unskillful and negligent manner in which the operation in question was performed. The Supreme Court of Nebraska said, "The rule is well established in this jurisdiction that physicians and surgeons do not impliedly warrant the recovery of their patients and are not liable on account of any failure in that respect unless through default of their duties. The rule is also established that: 'Physicians and surgeons are not required to possess the highest knowledge or experience, but the test is the degree of skill and diligence which other physicians in the same general neighborhood and in the same general line

of practice ordinary have and practice.' Booth v. Ardus, (40).

The plaintiff's theory was that the bad results alone were sufficient evidence of negligence to submit that question to the jury. In this connection the court quoted with approval from the case of Tady vs. Warta, (41), as follows: "In an action against a physician for malpractice, where the acts charged as negligence require in their performance the exercise of professional skill and knowledge, and are such with respect of which a layman can have no knowledge at all, the jury may not draw the inference of negligence without the aid of expert testimony as to the quality of such acts to guide them; in such case the doctrine of res ipsa loquitur has no application."

In the case of Booth vs. Andrus, (40), the Court also said, "When they (physicians and surgeons) accept professional employment, they are only bound to exercise the reasonable care and skill which are usually exercised by physicians or surgeons in good standing in the same school of practice. And where any person claims a cause of action through neglect to exercise the required degree of care and skill, the burden is upon him to prove such neglect".

9. Failure to limit his practice to his training and capabilities is often the cause of a suit.

The physician should limit his work to a field within the scope of ordinary skill and training, to practice that particular branch of medicine and surgery in the locality in which he is working. And consultations should be requested in cases where things are not proceeding satisfactorily or where additional help is necessary. The mere question of consultation does not relieve a physician of primary responsibility, but it does create an atmosphere of good will between the doctor and the patient that probably could not be had by other means.

10. Failure to keep adequate records. This section is of vital importance.

In any consideration precautions against claims of malpractice, the keeping of good medical records must be emphasized. It is desirable that a physician from time to time ask himself what he would wish to have in the record in the case under treatment in the event that he should later be called upon to justify in court his conduct of the case. "Ideal" medical records should be kept in every case: records that are presentable when offered in court; records that clearly show what was done and when it was done; records that indicate that nothing was neglected, that the care given fully met the standard demand by law. If a patient discontinues treatment before he should or fails to

follow instructions, let the record show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course. Although there is a legal presumption that a letter that has been mailed has been received by the addressee, there is no presumption that a letter has been mailed. The record should, of course, also contain laboratory reports, consultant's reports, and certain miscellaneous forms that are necessary or desirable in particular cases, such as consent for operation, consent for autopsy, copies of reports required by law to be made, and acknowledgement of hazards of particular procedures (shock therapy, fever therapy, Xray therapy).

Records are the first thing your attorney will request if you consult him about a potential malpractice case.

Be sure any changes or corrections made are initialed and dated by the physician. Very important if examined in court.

It is a chore for a busy doctor to record what happens at each visit of the patient, but bear in mind when a claim is made against you it is very often a year or more since you last saw the patient. He or she now alleges that on a certain visit to your office, giving a certain date , you did so and so, or you said so and so, or

recommended so and so, and is most positive and emphatic about it. If your record merely contains a notation that "Mrs. X was in, to come back in ten days," you are at a great disadvantage. The jury knows that you have seen many, many patients since that important date and that you can have no actual memory as to what transpired on that day. Consequently, Mrs. X's statement is accepted, and an unnecessary defense burden is placed upon you. All treatments and prescriptions should be recorded and all statements of the patient as to how she is feeling.

If you have discussed the patient's condition with another doctor, be sure to record the fact on the chart. Two years later you might have forgotten the incident and possibly lost a helpful witness. Should you become exasperated by the failure of your patient to keep appointments or carry out your instructions concerning dieting, taking prescribed medicine or exercise at home, write her a polite letter insisting on complete cooperation and attach a copy to her history chart. Do not show your exasperation on her chart. Remember that should she sue you, <u>all your records pertaining to her case will be read to the jury</u>.

A typical case involving records is the treatment of a boy of 6 for a deep wound on the bottom of his right

foot, apparently caused by a nail. You recommend tetanus antitoxin, but the boy's mother refuses to permit an injection.

Should you (a) tell her she's risking her son's life and let it go at that? Or (b) send her a registered letter and keep the carbon to the boy's parents, noting the mother's refusal to permit the tetanus injection and urging her to reconsider? Or (c) tell the mother to go to another doctor the next time her son's in trouble?

Correct answer is (b). In this case, when complications developed, the doctor was sued. But he was unable to present in court both a carbon of the registered letter and a signed receipt for it. The case was thrown out. Lindsey, (42).

11. Failure to secure consent for medical procedures.

Operative procedures without consent is a trespass in law. It constitutes a technical assault and renders the operative surgeon liable both civally for money damages and liable to criminal prosecution by the state,

Every physician should lean over backward to get consent in writing from the legal correct party for all operative procedures.

A physician or surgeon no matter how experienced, how eminent or how skilled, except under certain conditions,

can operate or treat only if his patient acquiesces. "Every human being," said Chief Judge Cardoza of the New York Court of Appeals, in the celebrated New York Hospital case, "has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages....This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained." Schloendorff v. New York Hospital, (20).

In a Minnesota case the plaintiff gave her consent to an operation on her right ear. During the operation it was fouhd that the condition of the left ear was more serious in that there was a small perforation high up in the drum membrane with granulated edges, and that the bone of the middle ear wall was necrosed. The defendant surgeon called the attention of the family physician to this condition during the operation and they both concluded that the left ear should be operated upon instead of the right. The defendant then performed a very skilfull and sucessful ossilulectomy on the plaintiff's left ear. Later the plaintiff complained of an impaired hearing and sued the operating surgeon. The court held that there was a technical assault, and that while a surgeon during his patient's

unconsciousness is justified in operating without the patient's consent to meet an emergency, an emergency was not shown to have existed under this state of facts. An emergency, said the court, means a condition endangering the life or health of the patient, and in that case it was decided that the condition of the left ear drum did not endanger the patient's life or health, and therefore, that there was no emergency present justifying an operation without the patient's consent. Mohr v. Williams, (43).

This is a hard case, but it shows how zealously the courts will guard a human being's "right to determine what shall be done with his own body."

In Texas a hard application of the rule is likewise found. There it appeared that a minor child was visiting her elder sister in a city some distance from the child's home. She discovered that the child was having difficulty with its breathing. The physician who was consulted, found diseased tonsils and adenoids, and with the elder sister's consent performed an operation on the child. The consent of the parents was not obtained. While under the ether the child died. The parents sued the doctor, and the court held that he was guilty of a technical assault, inasmuch as no emergency existed as to justify the operation without

the consent of the parents. "The authorities," said the court,"are unanimous in holding that a surgeon is liable for operating on a patient unless he obtains the consent of that parent, if competent to give such consent, or if not, of some one who under the circumstances would be legally authorized to give the requisite consent. If a person should be injured to the extent that he is unconscious and his injuries are of such nature as to require prompt surgical attention, a physician called would be justified in applying such treatment as might be resonably necessary for the preservation of his life or limb and consent on the part of the injured person would be implied upon the ground of an existing emergency." Moss v. Rishworth, (44), The defendant contended with great force that under the circumstances and in view of the elder sister's authority he was justified in operating, but the court said: "The law wisely reposes in the parent the care and custody of the minor child and neither a physician nor those in temporary care of the child will be permitted in a case of this character to determine those matters touching its welfare."

An illustration of the rule that emergencies justifying operations without consent are those when life or health is endangered, is found in a New Jersey case.

There the plaintiff had given his consent to the removal of a hernia on the left side. Upon opening the abdomen the defendant surgeon found a hernia on the right side far more serious than that upon the left. He later testified that the condition there was dangerous both to the life and health of his patient. When sued for assault, the court exonerated him upon the ground that the emergency was such as to justify the operation even without consent of his patient. Bennan v. Parsonnet, (45).

The rule permitting a surgeon to operate without his patient's consent where the life or limb of the patient is endangered, applies even in a case of minors. Thus a fifteen year old boy, while crossing a railroad track in Michigan, was struck by a train and had his foot crushed. He was taken to a hospital. Upon his arrival he was sufficiently conscious to give his name and address, but he soon lapsed in unconsciousness. The surgeon upon inquiry found that none of the boy's relatives were present nor resided near enough to be summoned or communicated with. An amputation was imperatively needed than if the boy's life was to be spared. The surgeon therefore proceeded and amputated the injured foot. He was later sued. The court exonerated him. The emergency was such, it was said, that he was justified in doing what he did. Luka v. Lowrie, (46).

But whether a patient's life or limb is actually endangered may become a hard fought question of fact in any case, a question upon which honest experts may honestly differ. A conscientious surgeon may therefore ofttimes be confronted with a serious dilemna. He may say to himself: "If I do not operate on this newly discovered condition, the patient's life or limb will be endangered! If I do operate I may sued for assault. What shall I do? A conscientious man, any man fit to be a surgeon, will under such circumstances do what he thinks is right for the patient and will ignore his own potential danger. All too often, alas, in the medical profession great service is rewarded not with remuneration, but with abuse and an action for malpractice or assault.

A situation differing essentially from those just considered arises where a patient engages a surgeon to relieve him of the condition from which he is suffering, and when there is no definite agreement as to just what the surgeon shall do. In such a case the law implies an authority in the surgeon to take such steps as he may deem necessary to accomplish the desired result, even though in so doing he may be forced to go beyond what either he or the patient may have originally contemplated. Thus in an Oklahoma case a woman who suffered from miscarriages,

informed her doctor that she wanted to bear children. She stated that she wanted to be "fixed" so that she could do so. During the ensuing operation her doctor found both ovaries sealed and adhesions about the uterus and intestines. He removed the diseased organs and the contiguous infected tissues. The patient later sued him for assault, but the court exonerated him, declaring that the plaintiff's desire to be "fixed to have children not only authorized the doctor to diagnose her case for the purpose of discovering..the exact cause of her sterility and to make whatever exploratory incisions might be necessary for this purpose. And the mere fact that the plaintiff may have believed that her condition was caused by a laceration of the uterus did not relieve the operating surgeon of the duty of discovering for himself the cause of the physicial defect he was called upon to remedy." King v. Carney, (47).

The general rule on this branch of the subject was never more clearly stated than by the Ohio courts in these words: "When a patient describes to a surgeon the symptoms of an ailment from which she is suffering and consents to an operation for the relief of her condition she will be presumed to have authorized the surgeon to perform such operations as may be required by the conditions

which he finds. And when during the course of the operation it appears to the surgeon to be necessary to extend its scope beyond what was originally contemplated consent to such extension will be implied." Hanson v, Reed, (48).

Points to consider in securing consent:

1. Legal age of consent. It is only the adult in full possession of his faculties who can give legal consent. The age of consent by tradition is 21 years but there are a number of exceptions. For example, a married female is regarded as an "adult" if she is over 18 years. Actually, there is a good deal of legal hair-splitting concerning the age of consent which varies from state to state and from one situation to another, In civilian circumstances, the married male person even though below 21 years frequently is considered to be an adult.

2. A minor. Consent of the parents is necessary. If there are no parents the legally appointed guardian is the person qualified. It should be pointed out that authority of the parent ceases in the event a guardian of the person of a child has been appointed by law.

3. Procedure in dangerously ill, unconscious person. Any dangerously ill or injured unconscious person, adult or minor may be treated if the procedure is life-saving. In such instances the physician may go ahead with the

indicated procedure without legal consent. He would be well advised, however, to secure consultation before he gives treatment.

4. An insane person. For non-life-saving procedures, consent is needed from guardian or relatives. If an emergency life-saving measure, the administrator of the hospital probably is legally empowered to give consent to treatment.

5. Miscellaneous categories of consent:

a. Latitude of operation. The physician needs sufficient scope so that the indicated procedure can be done, For example, a surgeon may be liable if, with a preoperative diagnosis of appendicitis and a previous agreement for performance of appendectomy only, a ruptured tubal pregnancy is found. Doing the indicated salpingectomy, the physician exposes himself to malpractice even though the operation was required and life-saving. Particular attention to the matter of obtaining proper consent is needed when the contemplated operation possibly may lead to sterility, in which case it is advisable that the other spouse should be taken into the preoperative conference and signature secured.

b. Disclosure. Incident to administration of a local anesthetic the needle broke, lodging in the patient's hip tissue. To remove the needle clearly is indicated. However,

the physician must inform the patient immediately concerning precisely what happened and what should be done to correct the situation. To remove the needle without consent and without knowledge on the part of the patient is an act of poor faith and may constitute "assault and battery".

c. Deliberate sterilization. This should be done only when there is medical indication. Consent of both husband and wife should be obtained.

d. Therapeutic abortion. Therapeutic abortions should be done only on medical indication to preserve the health or life of the female. A consultation with another physician is practically mandatory. Obviously, therapeutic abortions should be done only in a recognized hospital with adequate records being kept. (See chapter on criminal medical malpractice..section on abortions.)

e. Artificial insemination. This procedure is still too new to have much of a legal background. If the impregnating material comes from the husband there should be no difficulty. If obtained from someone other than the husband, there are large areas of potential conflict. From one point of view, the resultant child may be considered illegitimate and the woman to be guilty of adultery. An enlightened bill proposed in New York State failed of

enactment. Mixing husband's and donor's sperm may be the answer.

f. Autopsy. Autopsy consent cannot be given by the patient before his death. He cannot give what he does not have to give; when he is dead the right of property to his body belongs to the nearest of kin in order; the surviving spouse, parents with the father having supercedence, children, brother or sister, others. The consent may be oral or written or it may be taken over the telephone assuming adequate identification and witnesses. Damages for wrongful autopsy may follow performance of an autopsy on the wrong body, unnecessary mutilation, doing more than was given permission for, failure to put organs back in the body after autopsy, and having witnesses without specific permission. Exceptions to all of the above occur in the case of medicolegal autopsies where examination is indicated in the interest of public welfare.

Some problems involving consent:

"Your diagnosis indicates that a tonsillectomy is advisable for an 11-year old girl. Her adult sister, who's taking care of the girl at the widowed father's request, offers to sign a consent form.

Should you (a) accept the older sister's signature? Or (b) get the father's consent before operating?

Correct answer (b). The doctor who chose (a) was sued and lost the suit because the adult sister was not the child's legal guardian. The court ruled that only the father could give the necessary consent.

You diagnosis indicates a tubal pregnancy, and the patient and her husband both give their consent to an operation. When you operate, however, you discover that the pregnancy is normal, but that the patient's appendix is acutely inflamed.

Should you (a) remove the appendix? Or (b) postpone the operation until the husband can get to the hospital to sign a new consent form?

Correct answer (a). But either way, the doctor takes a chance. In the actual case, the physician removed the appendix without consent. He was sued, but the court upheld him, declaring that in an emergency it's the surgeon's duty "to perform such operation as good emergency demands, even when it means extending the operation further than was originally contemplated."

You have the father's consent to perform an autopsy on the body of a 9-year-old boy. But you happen to know that the father is either divorced or in the process of being divorced, and that the boy has been living with his mother.

Should you (a) proceed on his go-ahead? Or (b) risk a painful scene with the mother to get her consent in writing? Or (c) call off the autopsy?

Correct answer is (b). The physician who choose (a) was held liable for a wrongful autopsy. Reason: The parents were separated and only the mother had the legal custody of the child.

You're on emergency duty at the hospital whan a man is brought in from an auto accident. Although he's been drinking, he's conscious and talks rationally. Several colleagues confirm you judgment that an immediate operation is necessary. But the patient belligerently refuses surgery.

Should you (a) go ahead with the operation without his consent? Or (b) accept his decision?

Correct answer (a). But here, too, either choice is somewhat risky. The physician in this case was upheld for operating in an emergency without the patient's consent. From a medical point of view, the operation had to be performed; but it was technically an assault, since a surgeon may ordinarily operate without consent only if the patient is unconscious or unable to understand. Lindsey, (42).

12. Violation of privileged communications.

By privileged communications is meant all information ob-

tained by a physician (including his records) incident to his professional care of a patient. Information given in the presence of a third person, not a paid assistant of the physician, is not a privileged communication. Not to treat privileged communications as confidential may constitute libel or slander. The tenet of privileged communications is cancelled: (a) When the information is needed in the interest of public welfare, the right of the individual becomes secondary. Thus, the legal duty of the physician requires his reporting cases of gunshot wound, venereal disease, etc. (b) By written consent of the patient, by his legal representative or by the nearest of kin if the patient has died. The consent must be "enlightened", so that precisely what is being done and what may be the possible result is made clear. (c) When the physician is required to do so by the court. (d) When the physician is sued by his patient for malpractice.

13. Abandonment of the patient by the physician:

By abandonment is meant failure of the physician to continue care when the physician-patient relationship has not been cancelled. Although a type of negligence it may be discussed conveniently here. Abandonment may occur as follows:

1. Gross abandonment. This needs no explanation. A typ-

ical example is the physician who leaves his patient during labor and does not return for delivery. Another example is the physician who agrees to make a call and then does not do so.

2. Vacation, Leave, etc. Physicians leaving their practice over weekends or for longer periods must see that their patients are covered by comparable medical care.

3. Failure to make frequent enough visits. The attending physician makes the decision of how often shall be his visits. If it can be shown his attendance was insufficient, and that as a result of this the patient suffered, the physician may be held liable.

4. Failure of patient to keep an office appointment. This usually is the patient's own fault. To safeguard himself the physician should write ot otherwise notify his patient that possible harm may result from his failure to keep the appointment.

5. Insufficient attention. Another area of abandonment may be shown by the following example: A patient was having a pelvic examination done. The physician left to answer the telephone. During his absence, the patient fell from the unguarded examing table sustaining injuries. The physician was held liable for leaving the patient "unattended."

When a physician is dismissed by his patient he is obligated to give up the case, and is, therefore, justified in doing so. Becker v. Janiniski,, (49) But it is the patient and not the doctor who has the power of summary dismissal. Thus, a physician cannot discharge a case and relieve himself from responsibility without first giving his patient notice sufficient to enable him to procure other medical attendance. Ballard v. Prescott, (50). "When," said Judge Pryor in a celebrated New York case, "a physician engages..to attend a patient..without limitation of time he cannot cease his visits except first, with the consent of the patient, or secondly, upon giving the patient timely notice, so that he may employ another doctor, or thirdly, where the condition of the patient is such as no longer to require medical treatment, and of that condition the physician must be the judge at his peril." Becker v. Janinski, (49).

The courts are zealous as between laymen and their professional advisers to protect the rights of laymen. Thus, there are many instances in which that which laymen may do, the professional man may not. An illustration of this is seen in the right of the patient to discharge his physician with or without cause, but the doctor cannot so easily disassociate himself from his patient. "Before

he can withdraw," the Ohio courts have said, "it is necessary for him to give reasonable notice to the patient in order that another physician may be procured, the character of the services of the physician being such, and his relation to the patient being such that he is not permitted under the law to arbitrarily to quit the service at any time without any cause and leave his patient without medical attendance, but he must give reasonable notice though his patient may discharge him at any time." Tucker v. Gillett, (51).

In a New York case the plaintiff had ffactured her arm. The defendant doctor reduced the fracture and then advised his patient he was going away for a ten day vacation, at the end of which time he would return. He did not come back until after the expiration of five weeks, when he found that the bones of the plaintiff's arm had slipped from their proper position, and had formed a union with the ends overlapping. A permanent deformity was present which could not be remedied except by rebreaking and resetting. There was a verdict for the plaintiff, and the Appellate Division in affirming the judgment said that "when a physician is employed to attend upon a sick person his employment continues while the sickness lasts, and the relation of physician and patient continues, unless it is put to an

end by the assent of the parties, or is revoked by the express dismissal of the physician." Gerken v. Plimpton, (52).

It would, said the court in a Maine case, "certainly be a dereliction of duty to leave the patient in the midst of critical sickness without care or without sufficient notice to enable the party to procure other suitable medical attendance." Barborn v. Martin, (53). No matter what the provocation, a physician who leaves his patient in the midst of the sickness, does so at his peril unless either his patient has dismissed him, or he has terminated the employment upon such notice as to enable his patient to procure another doctor.

Thus in California, a case arose where the plaintiff was being delivered of a child. It was a difficult delivery and the doctor decided the use of instruments was necessary. Each time when he attempted the insertion of an instrument the patient screamed. After several fruitless efforts he finally told her if she did not stop screaming he would leave. She did not stop and he left. Later another physician was called in. The first doctor was thereafter sued, and a verdict was recovered against him. "It is," the California courts declared,"the undoubted law that a physician may elect whether or not he will give his ser-

vices to a case, but having accepted his employment and entered upon the discharge of his duties he is found.... to abandon the case only under one of two conditions: First when the contract is terminated by the employer.... second, where it is terminated by the physician which can only be done after due notice and ample opportunity to secure the presence of other medical attendance." Lathrop v. Flood, (54).

These principles like all general rules, however, are not without their exceptions or at least their limitations. Thus, as we have previously seen a surgeon who leaves the aftercare following an operation to a competent hospital staff, is not deemed to have abandoned his patient, unless he has expressly contracted to do this work in addition to the operation.

If after one or more calls the patient tells his physician that he need not come again until he is sent for, the doctor is not liable for an intervening injury where upon the last visit the nature of the trouble could not be diagnosed even after a careful and skillfull examination. Gedney v. Kingsley, (55). When a patient discharges a physician he cannot thereafter hold him liable for an injury occasioned by the doctor's failure to perform some act before the discharge, if it appears that such act should not have been performed before the discharge took

place. Kendall v. Brown, (56). So, too, when a specialist is called in as consultant, it has been held that he is under no duty to continue with the treatment. Nelson v. Farrish, (57).

14. Concealment of medical information from patient: Contrary to what many physicians believe most medical information important to the patient's condition must legally be diclosed to him. There are certain exceptions. One is presented in the second extract.

Extracts of cases involving concealment:

A patient was not told that an operating needle broke during surgery for rectal ulcers. The patient did not recover until he consulted another specialist and the needle part was removed. Was the surgeon liable in damages?

The New York Court of Appeals said that the doctor wrongfully concealed the accident and should have advised consultation with a rectal specialist. Forensic Mag, (58).

The plaintiff filed an action against the defendant dermatologists for damages caused by their alleged malractice in the administration of gold sodium thiosulfate injections. From an adverse judgment, the plaintiff appealed to the Supreme Court of Washington.

The plaintiff consulted the defendant dermatologists concerning skin lesions on his face and neck, which they

diagnosed as chronic discoid lupus erythematosus. A recognized treatment for this disease consists of periodic injections of heavy metal salts, the continuity of which must be maintained. After a series of bismuth injections the plaintiff was started on a course of gold sodium thiosulfate therapy. Since gold sodium thiosulfate has a possible toxic effect on some persons, the defendants, in accordance with their usual procedure, first gave the plaintiff a small injection of the gold sodium thiosulfate. When the plaintiff appeared the next week for his second and larger injection he complained of muscle soreness in his neck, joint pains, and pains in his arms and stated that he did not think he should have the injection that day. The defendants, after examining the plaintiff, and inasmuch as the plaintiff did not complain of or manifest any symptoms that disclosed an adverse reaction to the therapy, gave the plaintiff an injection of gold sodium thiosulfate. Shortly after this injection was given, the plaintiff developed hepatitis resulting in jaundice.

The plaintiff contended that the defendants caused the jaundice by negligently administering excessive amounts of heavy metal salts, over the protest of the plaintiff, after toxic symptoms had developed and that they were negligent in treating him without warning him of the dangers

incident to the treatment.

The Court said in order for a physician or surgeon to be liable for malpractice, he must have done something in the treatment of the patient that the recognized standard of medical practice in his community forbids or he must have failed to do something required by that standard. Except in those cases where the negligence is so gross as to be readily apparent to a layman, a finding of negligence on the part of a physician or surgeon must be based on medical testimony that shows that he departed from the recognized standard of practice of the community. The trial court found that treatment with heavy metal therapy and the dosages and intervals at which the injections were given represented the standard practice of dermatologists in the community; that it was not the standard practice to tell the patient all of the risks involved (whether a patient is advised of the risk depends upon the judgment of the individual doctor, exercised in the light of the mental and psychosomatic make-up of the patient); that it was standard practice, when possible symptoms of toxicity arose, to evaluate them in relation to the progress made in the therapy in making a decision whether to stop or continue the treatment. The Supreme Court said that, since these findings of fact by the trial were supported by the record,

it could not disturb them.

Accordingly the judgment in favor of the defendant' physicians was affirmed. Woods v. Pommerening, (59).

Some problems are presented dealing with concealment of medical information.

Now for some cases in which the patient's decision to sue may be prompted by what the doctor says or doesn't say:

"A woman whom you've treated with radium for fibrous tissue growths has suffered radium burns."

Should you (a) admit it was your fault? Or (b) say the nurse should have been more careful in handling the radium? Or (c) tell the patient not to worry because you carry $80,000. insurance? Or (d) tell her that you'll begin a course of treatment to minimize the effect of the burns?

Correct answer is (d). There have been many court cases in which the doctor chose one of the other three ways out; and in each case he was sued because of what he had said to the patient. Too often, a competent physician will invite a lawsuit by unnecessarily assuming blame or by mentioning his insurance coverage,

Following a hysterectomy, you discover that all sponges and instruments are accounted for, but that a curved surgical needle is missing.

Should you (a) arrange to have the patient Xrayed? Or (b) say nothing about it, on the grounds you'd only be exposing yourself to litigation?

Correct answer is (a). In the actual case, the doctor who said nothing was sued for "deliberate concealment" and he lost the case. He had turned an honest mistake into fraud. In such a situation, not even the statute of limitations applies. Lindsey, (42).

15. Failure to get Xrays where fractures or foreign bodies are suspected.

16. Telephoning prescriptions. Danger of error.

17. Testifying at coroner's inquest without legal advice about former patient.

18. Fee disputes and excessive charges.

19. Failure to write prescriptions legibly.

20. Experimentation on patients.

V. Unwarranted suits:

"Seventy-eight percent of medical malpractice suits are unwarranted." Medical Economics, (60).

Too often, the motive that initiates the suits and urges it forward is a most unworthy one, and it is scarcely to be distinguished from the wickedness of blackmail. Too often, it is stimulated and nutured by lawyers more hungry for plunder than ambitious for a good name. Too

often, it is abetted by medical men ready to share with the lawyer the chances of pecumiary gain to be secured in the event of a verdict for the plaintiff, and willing, therefore, to put the needed emphasis into this partisan testimony, Sometimes, no doubt, a case of tort is well founded; but such instances are exceptional and bear no comparison with the number of actions brought with discreditable motives. Over these suits the physician is powerless to bring any control. However good his defense may be, he cannot prevent a trial, with all its annoyances and costs, except by adopting the course of paying money to settle the claim out of court--a course which any self-respecting medical man, with a clear conscience, will not adopt, though sorely tempted to escape thereby all the wretched risks and miseries. This constant menance of unjust lawsuits, which every physician, and especially every surgeon, has constantly before him. as the law is practiced now, is one of the chief evils of which medical men are exposed.

California law aggravates the rash of malpractice suits, one trick provision compels the defendant doctor to serve as an expert witness for the plaintiff. The epidemic in Los Angeles is especially severe because Southern California is full of elderly hypochondriacs.

Says Dr. Regan: "We have so many people in the fringe group here--the lunatic fringe, that is" Examples.... One woman accusing the surgeon of having left needles in her arm, stuck 26 sewing needles into herself, another woman claiming that she had been examined without her consent, sued under the Fourth Amendment guarantee against unlawful search and seizure. Both plaintiffs lost.

CHART #4

VI. Who generates malpractice incidents.

Women patients	54%
Men patients	34%
Minor patients	12%

In liability, as in lifeboats, women and children come first. Taken together, they generate almost twice as many malpractice incidents as do the men. "These differences are interesting", Dr. Sandusk says, "but no satisfactory explanation can be offered." Medical Ecomonics, (60).

SUMMARY OF THE CAUSES OF MEDICAL MALPRACTICE

Part I is the introduction. PartII lists the common allegations. Part III explains 22 general underlying causes. Part IV explains 20 specific causes. Part V concerns unwarranted suits. Part VI cites who generates the suits.

Part I:

Quotes surveys and a graph of the statistics on the most common causes of malpractice.

Part II:

The most common allegations made by the plaintiff-patient against the defendant-physician.

The internist and general practitioner:

1. Examination without consent.
2. Injury during examination.
3. Error or delay in diagnosis.
4. Failure to use laboratory aids.
5. Failure to administer standard treatment.
6. Failure to leave instructions for treatment of patient.
7. Failure to leave instructions for protection of attendants and of other contacts.
8. Failure to hospitalize.
9. Aggravation of existing condition.
10. Abandonment.

11. Infection resulting from injection.

12. Infection, slough.

13. Burns--Xray, diathermy, infra-red, heating pads, etc.

14. Breach of warranty to cure.

15. Error in the prescription or in dispensing.

16. Overdosage.

17. Use of harmful drugs.

18. Unnecessary medical treatment.

19. Death from injection, from vaccination, etc.

20. Improper quarantine.

21. Carrying contagin.

22. Defective equipment.

<u>The Surgeon</u> (general, industrial, orthopedic)

1. Most of the allegations set forth above, and

2. Breaking and slipping of instruments.

3. Foreign bodies left in patient's tissues.

4. Operation without consent.

5. Operation more extensive than that consented to.

6. Operation on the wrong part.

7. Unnecessary operation.

8. Delay in operating.

9. Failure to operate.

10. Unsucessful operation.

11. Needle broken off in tissues.

12. Bad result from operation--severed nerve or tendon, hernia, injury to sphincter, etc.
13. Failure to follow-up.
14. Failure to discover severed tendon.
15. Failure to use Xray.
16. Failure to discover fracture; second fracture overlooked.
17. Failure to diagnose dislocation.
18. Injuries from application of cast.
19. Insufficient immobilization.
20. Deformity and loss of function (fractures, dislocations).
21. Cast too tight; removed too soon; left on too long.
22. Failure to use traction.
23. Failure to employ fixation.
24. Failure to institute active and passive motion.
25. Unnecessary scarring.
26. Use of unsterile needle or instrument.
27. Experimentation.

<u>The obstetrician</u>:

1. Many of the allegations set forth above, and
2. Failure to attend at time of delivery.
3. Wrong baby given parents.
4. Poor or no prenatal care.
5. Unnecessary caesarean section.

6. Negligent delay in performing caesarean section.
7. Unnecessary use of instruments.
8. Instrumental injury to mother, to baby.
9. Placenta not completely removed.
10. Hemorrhage from cord.
11. Injury to baby, fracture, paralysis, etc.
12. Failure to protect perineum (and rectum).
13. Failure to repair birth canal injuries.
14. Eclampsia not properly treated.
15. Lack of sterile technique--infection of mother.
16. Diagnosis of pregnancy as tumor (operation, miscarriage).
17. Diagnosis of tumor as pregnancy(special tests not employed).

<u>The Gynecologist</u>:

1. Many of the allegations set forth above, and,
2. Slander in charging patient had venereal disease.
3. Operation resulting in sterility.
4. Negligent puncturing of uterus during curettage.
5. Injury to ureter.
6. Stricture of cervix, caused by too extensive cauterization.
7. Fistulae-bladder, rectal.
8. Illegal abortion performed without consent.

<u>The Urologist:</u>

1. Many of the allegations set forth above, and

2. Burns from fluoroscopic examinations.

3. Failure to remove kidney stones, bladder stones.

4. Too strong solutions in urethra and bladder.

5. Wrong solution in making pyelogram.

6. Puncture injury in doing cystoscopy.

7. Use of unsterile instruments.

8. Unsuccessful vasectomy, wife pregnant.

The Eye, Ear, Nose and Throat Specialist:

1. Many of the allegations set forth above, and

2. Failure to remove eye--sympathetic opthalmia.

3. Failure to remove foreign body.

4. Wrong solutions.

5. Cataract improperly treated-blindness.

6. Wrong glasses.

7. Injury to tear ducts.

8. Treatment caused scarring and deformity.

9. Destruction of sense of smell.

10. Removal of uvula.

11. Injury to pillars.

12. Injury to tongue.

13. Injury to speech.

14. Failure to remove all of tonsils.

The dermatologist:

1. Many of the allegations set forth above, and
2. Failure to improve.
3. Ointments discoloring or disfiguring skin.
4. Loss of hair (improper treatment).
5. Xray burns and shocks.

The pediatrician:

1. Many of the allegations set forth above, and
2. Failure to immunize (having general charge).
3. Failure to diagnose (thymus).
4. Delay in diagnosis (imperforate anus, congenital glaucoma, etc).
5. Harmful formula (infant feeding).
6. Multiple self-inoculation (no dressing on vaccination).

The Clinical Laboratory:

1. Mixing or contamination of material.
2. Wrong diagnosis (venereal disease).
3. Wrong diagnosis (biopsy).

The anesthetist:

1. No preliminary examination.
2. Too much anesthetic.
3. Death from anesthetic.
4. Injury to skin or eyes.
5. Injury from mask; from mouth gag.
6. Injury from improper position on table.

7. Injury during struggling (improper administration).
8. Pneumonia caused by fluid ether in lungs.

The radiologist:

1. Electrical shocks and burns.
2. Xray and radium burns (pigmentation, loss of hair, etc.)
3. Error in diagnosis.
4. Injuries to vision.
5. Sterilization.
6. Radium needle escaped from control.

PART III:

The General Underlying Causes of Malpractice Suits:

1. Derogatory comments by one physician about another's treatment lay the basis for more malpractice suits than any other cause.
2. Second is the failure to maintain the old, close doctor-patient relationship.
3. Physicians assuring patients that "they will be as good as new."
4. Publicity by press of present and past malpractice suits generates more suits.
5. Law changes in certain areas. (statutory changes).
6. Guaranteeing satisfactory results.
7. Excessive fees and patients failure to understand charges.

8. Improper collection methods.
9. Specialization with loss of loyalty to physician.
10. Admission of negligence by physician.
11. "Soak the rich" attitude of some patients.
12. Notoriety of a few sordid suits involving not physicians but unlicensed people which cast a cloud on all medicine.
13. More liberal court interpretations (common law changes).
14. Public getting more claim conscious.
15. Patient's feeling that physician is indifferent to his problems.
16. Unwise adjusting by insurance companies.
17. Bad public relations.
18. Failure to educate public to their share in the responsibility for their health.
19. Failure to proceed wisely after claim is made.
20. Failure of prompt referral to specialist (very important).
21. Acts of others may sometimes cause liability on part of physician.
22. Grossest negligence may also be a cause for criminal prosecution by the state.

PART IV:

Specific Causes of Suits Including Substandard Medical Care.

1. Failure to use accepted methods of diagnosis.
2. Insufficient attention.
3. Failure to use accepted methods of treatment.
4. Misrepresentation as to the seriousness of a procedure.
5. Res ipsa loquitur. Matter speaks for itself e. g. Sponge left in abdomen.
6. Failure to maintain standard of the locality.
7. Negligence.
8. Failure to exert the ordinary, reasonable skill of the general practitioner or specialist. (whichever the defendant is).
9. Failure to limit his practice to his capabilities and training.
10. Failure to keep adequate records.
11. Failure to get consent. A complicated field of legal requirement.
12. Violation of privileged communications of patient by physician.
13. Abandonment by physician.
14. Concealment of medical information.
15. Failure to get Xrays in fractures and foreign bodies.
16. Telephoning prescription.

17. Testifying at coroner's inquest on former patient without legal counsel.
18. Fee disputes and excessive charges.
19. Failure to write prescriptions legibly.
20. Experimentation on patients.

PART V:

Unwarranted Suits:

Seventy-eight percent to ninety percent of malpractice suits are unwarranted. Some amount to legal blackmail. Physicians may be preyed upon because of their abhorrence of publicity and a public trial.

PART VI:

Who Generates Malpractice Suits:

Women and children and new patients bring the most malpractice suits.

CHAPTER VI

Medical Malpractice in Ophthamology

Introduction:

This chapter contains extracts of cases dealing with treatment of eye disease.

The Nebraska cases of malpractice were reviewed without revealing any such cases. Any cases settled out of court would not be in the legal cases reports.

A review of the Iowa case reports reveals the early Iowa case of Peck v. Hutchinson which deals with the care of eye disease.

Eye injuries present a field of malpractice where the cases reveal difficulty in distinguishing between the results of the treatment or the original injuries, especially since, due to the delicacy of the eye structure, even a slight injury may produce very serious results and surgery is seldom undertaken except in cases where the loss of vision is threatened as an effect of the diseased condition.

Accordingly, the result has been reached in most of the cases coming within the scope of the present section that causation was not established. The contrary result has, however, occasionally been reached.

Extracts of cases involving eye diseases and treatment.

Peck v. Hutchinson is an early Iowa case involving an eye injury. Action for damages arising from alleged malpractice. Trial to a jury. Verdict and judgment for plaintiff patient. Defendant physician appeals. Decision reversed for physician defandant.

" Plaintiff, as guardian of Anna Peck, the patient, a minor, avers that in 1886 the defendant, who held himself out to the public as a physician and surgeon, especially skilled in the treatment of diseases of the eye, was employed and undertook to treat a diseased eye of Anna Peck; that he negligently resorted to a surgical operation, instead of using proper medical treatment, and, in performing said operation, negligently used a large knife, instead of an instrument adapted to that purpose; that he negligently and unskillfully undertook a painful operation on the eye without first giving the proper drug to render the patient insensible to pain, and negligently and unskillfully cut a long gash in and about the sight of the eye, and left said gash without proper treatment. He says that, in consequence of all of said negligent and unskillful acts, said Anna Peck, without fault on her part, suffered great pain and lost the use of her eye; that, but for the said acts, the eye would have recovered. Damages in the sum of $5000. are prayed. In an amendment

to the petition, it is said that defendant employed by Dr. H. R. Paige, with the knowledge and consent of Charles Peck, the father of said Anna Peck; that no arrangement was made fixing defendant's compensation, and he has not been paid anything for his services. It is also averred that the pain now exists and will continue. Defendant admits treating Anna Peck for a diseased eye, and that he performed a surgical operation upon the same, and denies all other allegations in the petition. Defendant also charges, that the injury to plaintiff's ward, if any, resulted from her contributory negligence in carelessly moving her head during the operation, and in that her parents forbade the use of general anesthetics upon said Anna while she was undergoing said operation.

In December 1885, the defendant was called to examine the eye of Anna Peck. That at this time there was a perforating ulcer of the left cornea, with protrusion of the iris, a small part of the iris, about the size of a grain of wheat, being outside the cornea, protruding from the eye. The external parts of the eye were watery, irritable, and spongy. That the ulceration spoken of was the result of the infection of conjunctivis and blennorrhea. The defendant did not see the eye again until January 17, 1886. At this time there was greater protrusion in a marked de-

gree, and very little sight in the eye, Defendant then advised the parents that without an operation the eye was absolutely lost; that he could not tell with certainty the result of an operation. It was consented to, and performed the next day. The patient was placed upon a lounge, her hands held, and also her head during the latter part of the operation. Near the end of the operation, and while the final incision was being made, the patient flinched, and the knife made a cut across the cornea in a diagonal direction. It is this cut which plaintiff claims destroyed the eye. Either by reason of the diseased condition of the eye, or by reason of the operation and cut, the sight of the eye was entirely lost. The diseased condition of the eye, as it existed prior to the operation, was caused by infection of the iris, either gonorrheal or blennorrheal, transmitted from the vagina to the eye. The operation was successful so far as the excising the prolapsed portion of the iris was concerned, but the sight was not restored. There is much conflict in the testimony as to whether the defendant used an anesthetic. Plaintiff contends he did not. Defendant claims that he was preparing to use chloroform, when the mother of the child forbade its use, whereupon he consulted with his colleague, Dr. Paige, as to the propriety of proceeding

with the operation, using cocaine or local anesthetics, and they decided that they could properly proceed using cocaine, which they did. The testimony tends to show that a patient may flinch or jerk in case of such an operation, even if a general anesthetic is used. We have stated this much touching the condition of the child, the operation, and surrounding circumstances in order that a better understanding may be had of the points hereafter discussed.

Many error are assigned. Some of them are purely technical, and without merit. In other cases the error, if any, was clearly not prejudicial. We can consider at length only those assignments which seem to raise questions of controlling importance. Against the objection of the defendant, plaintiff was permitted to read to the jury from "Wells' Treatise on the Eye" what that writer says as to the operation of "iridectomy". This evidence was objected to as incompetent, immaterial, and because the work was an old edition. The book was published in 1880, and states that chloroform should always be administered. It does not recognize local anesthetic treatment; in fact, says nothing about it. The operation was performed in 1886, and it is claimed that after 1880, and prior to 1886, great changes occurred in optical surgery;

that, during that time, cocaine, a local anesthetic, was discovered, and came into use, thus superseding the use of general anesthetics in such cases. This may be conceded. The evidence, we think, preponderates largely in favor of the claim that in such cases the modern and better practice is to use local anesthetics. Now, that fact was fully shown to the jury, and from the evidence it appeared that the Wells book antedated the time when local anesthetics first began to be used in such cases in this country. As the evidence clearly showed what the modern practice was, we cannot say that the defendant was prejudiced by the introduction of the book.

Defendant asked Dr. Schooler the following question: "What is the general result of perforating ulcer of the cornea produced by gonorrheal blennorrhea?" An objection was sustained to the question, as being incompetent and immaterial. We think the question was both competent and material. If the general result of operations in such cases was not to restore the sight, it would be proper, as tending to show that the sight of Anna Peck's eye would have been lost by reason of the disease, regardless of any negligence in performing the operation. But the doctor afterwards testified that "operations performed for the disease of gonorrheal blennorrhea do not usually

result in saving the sight of the eye." There was therefore no prejudice to the defendant from the ruling.

It is said that the court erred in refusing the sixth instruction asked by the defendant. It reads: "Physicians and surgeons are required to use ordinary skill and diligence, only the average of that possessed by the profession as a body, and not by the thoroughly educated only, having regard to the improvements and advanced state of the profession at the time of the treatment." This instruction should have been given. It is a correct statement of law. The eleventh instruction given by the court is objectionable, in that it is liable to be understood by the jury as requiring a greater degree of skill and care than that stated in the instruction asked. The instruction given also fails to state to the jury, that, "indetermining what is ordinary skill and care in such a case, regard must be had to the improvements and advanced state of the profession at the time of the operation." Smothers v. Hanks, (61). Gates v. Fleischer, (62).

The following interrogatory was submitted to the jury: "Would the sight of the diseased eye of the said Anna Peck have been saved had the accident complained of not happened?" The jury answered, "Yes". Now, we think

it clearly appears that this finding is not sustained by the evidence. We need not set it out in detail. It is sufficient to say that the evidence shows that the child could see very little with this eye prior to the operation. The ulcer in the eye it appears, had almost destroyed the sight. There was a possibility, merely, of restoring sight by means of the operation; but the evidence, in any view of it, cannot be said to justify the conclusion reached by the jury, as evidenced by the answer to this interrogatory. The injury was a material one. Of necessity, it must have been in a large measure influential with the jury in determining the amount of their verdict. If the sight would not have been restored by the operation in the absence of the accident, it must be conceded that the damages allowed--$2500.--were excessive. "When a special finding is not supported by the evidence, and the fact so found is material, though not "necessarily of a determinative character", a new trial must be granted, Jeffrey v. Railroad Co.,(63). Heath v. Mining Co.,(64),Baldwin v. Railroad Co.,(65).

The judgment of the district court must be reversed in favor of the defendant physician. Peck v. Hutchinson, (66).

An expert's testimony that the glaucoma which destroyed the plaintiff's eye might have developed because of

negligence in the performance of a cataract operation by the defendant, or from various causes, was held in Ewing v. Goode, (67) not to support the plaintiff's burden of proving by more than a scantilla of evidence that the injury was so caused, the court stating that the necessary connection could not be inferred from the unsuccessful result of the treatment. The plaintiff's claim of damage from a negligent failure to properly diagnose and treat the glaucoma upon complaints of pain following the cataract operation was also held not to be supported by evidence, since it appeared from the expert testimony that where secondary glaucoma developed a cataract operation, and the treatment by eserine was unsuccessful, as in the case at bar, the chances for recovery by a furthur operation were practically nil in any event.

Proof that after an operation on the plaintiff's eye for strabimus, both of her eyes became much weaker and she suffered from sore eyes, it appearing, however, that other members of her immediate family were also afflicted with sore and defective eyes, was held in Pettigrew v. Lewis, (68), not to be sufficient to justify a verdict for the plaintiff in a malpractice action. No medical or scientific evidence was offered showing the cause of the present condition of the plaintiff's eyes, said the court, nor

that the defendant's were negligent or careless in the performance of the operation. To maintain her action, it was added, the plaintiff should have offered the evidence of skilled witnesses to show that the present condition of her eyes was the result of the operation, and it would have been easy for the plaintiff to have submitted to an examination by an experienced physician or oculist capable of determining whether the condition of the eyes was the result of such operation.

The plaintiff, her parents and others having testified that before the operation upon her eye by the defendant there was no defect in vision, or that they had never observed any, but their being expert testimony to the effect that an examination of the eyes showed conclusively that the defective vision had existed from birth, and that her sight was as good at the time of the trial as it had ever been, it was held in Feeney v. Spalding, (69), that a verdict for the plaintiff was not authorized by the evidence and would be reversed and the cause remanded for retrial. However, the court went on to say that even if there was sufficient evidence to authorize a finding for the plaintiff upon this question, the verdict would still not be warranted, since there was no evidence of want of skill or negligence and it had

been testified that it was impossible for the operation, a simple one, to have caused the result alleged.

Since the evidence suggested that the impairment of the plaintiff's vision following treatment by the defendant might have been caused wholly or partly by either the natural development of the disease with which he was originally afflicted, by contributory negligence of the plaintiff after consultation with the defendant, or by the negligence of the defendant in treating the plaintiff, the court in Dellapenna v. Irwin, (70), held that an instruction that the plaintiff had the burden of proving that the impairment was the result of the defendant's negligence alone, and of nothing else, was not proper. Although ordinarily such instruction would be incorrect since proximate cause is not necessarily sole cause, said the court, yet, since the plaintiff was entitled to recover for any of the unavoidable consequences of his original ailment, and this phase of the case was covered by correct instructions and the causal effect of the original condition dealt with fully in other parts of the charge, when the judge referred to the necessity that the negligence must be the sole cause of the injury, the jury could not have understood him to mean that there could be no recovery if the original disease still con-

tributed to the present condition, but must have understood that in using this language the judge had in mind the only remaining possible cause other than negligence of the defendant, that is, contributory negligence by the plaintiff, so that an instruction that as between negligence of the defendant and contributory negligence of the plaintiff there could be no recovery unless the defendant's negligence was the sole cause was correct.

Since the experts who testified were agreed that the condition of glaucoma with which the plaintiff was afflicted at the time he first sought treatment from the defendant was practically insurable, and would almost inevitably result in blindness, it was held in Wohlert v. Seibert, (71), that a verdict had properly been directed for the defendant, since, although his diagnosis was incorrect, it had not been shown that the treatment actually given resulted in, contributed to, or caused the loss of sight or undue and unnecessary pain and suffering, the court saying that it was not possible for the jury to separate the degree of pain which the plaintiff suffered as a result of the disease from that which might have resulted had a different course of treatment been pursued.

In Peddicord v. Leiser, (72), the action was based on the defendant's alleged negligence in failing to

promptly wash out the plaintiff's eyes with water after a refrigerator explosion had thrown sulphur dioxide gas into them. Although the question of the defendant's liability for the loss of eyesight was not before the court on appeal, it reviewed the evidence and referred to the conflict as to whether anything which the defendant could have done would have saved the eyesight, the consensus of the expert opinion being that nothing that the defendant could have done would have helped the plaintiff's eyes, and the experts also being in substantial agreement that the application of water to the injured eyes would not have helped and might have been harmful, although some of them testified that in the defendant's shoes they would have used the water.

In the absence of any evidence, expert or lay, that the injured condition of the plaintiff's eye was due to the defendant's failure to remove foreign objects which had been introduced into the face at the time of the accident, or to use the Xray to diagnose the fractured bones, it was held in Davis v. Grissom, (73), that it could not be inferred that the condition complained of had been produced by the defendant's treatment rather than as a natural result of the original injury, so that a verdict had properly been directed for the defendant.

In Jensen v. Findley, (74), the court, in affirming a directed verdict for the defendant, said that even if it were assumed that good practice required the defendant to cap plaintiff's right eye in the course of treating the other eye for gonorrheal ophthalmia, the failure to do so would furnish no ground for a reversal, since the eye, which was not capped, did not become infected and was not injured in any way, and the failure to cap it was neither a proximate nor a contributing cause of any injury suffered by the plaintiff.

Where the plaintiff became blind following an unauthorized tonsillectomy and a fall from his hospital bed, and the experts who testified were unable to agree upon any cause for the blindness, although various theories were advanced which might have caused it, there being no other symptoms to make one theory more probable than the other, it was held in Zoski v. Gaines, (75), that a finding of the trial judge that there was no causal connection between the unauthorized operation and the subsequent blindness would be sustained, the court saying that it could not consider causes based on conjecture, probability, or mere guess.

Where it was admitted by all the experts that the source of irritation or inflammation of the plaintiff's

eye was an injection which the defendant had made in order to produce just such an irritation, but none of the experts ventured an opinion attributing the prolonged persistence of the irritation to any fault or want of skill on the part of the defendants, it was held in Cassity v. McLaughlin, (76), that a verdict for the plaintiff would be reversed.

Loss of weight, severe pain from the injured eye, sores on the plaintiff's face, abscesses in his ear, and stomach trouble, were held in Slack v. Crawford, (77), not to justify a recovery against the defendant for malpractice in treating the plaintiff's injured eye, where there was no evidence, expert or otherwise, to the effect that the treatment by dilating the pupil with atropine, hot applications, an injection of French protein, and a later prescription of butyn for the relief of pain, was not in accordance with approved medical practice, and no evidence of any kind indicating that the varied physical ailments complained of were, or were likely to be, the result of the course of treatment undertaken by the doctor, the evidence on the contrary indicating that none of the ailments suffered before the eye was finally removed could or did result from the defendant's treatment.

Where there was testimony to the effect that the

eye infection of which the plaintiff complained could not have been caused by the defendant's alleged act in probing the eye with a toothpick when asked to examine it, but was due to a gonorrheal infection contracted from her husband, and the only testimony that the condition resulted or was aggravated by the defendant's failure to send her to a hospital at once was a statement by the doctor who finally treated the eye that there would have been a better chance if treatment had been received earlier but he did not know whether he would have been able to save the eye, it was said in Phebus v. Mather, (78), that a verdict for the defendant would be affirmed, the court saying that the burden was on the plaintiff to prove by expert testimony that the injuries claimed were the result of negligent treatment. To permit a jury of laymen to speculate as to the result of the alleged "better chance" which might have been produced by earlier treatment was clearly improper, said the court, especially in view of the expert physician's statement that he had no opinion on that subject.

However, where it was alleged that the pain and suffering of the plaintiff and his subsequent blindness were the result of the defendant's diagnosis of his condition as plastic iritis, and the treatment with aconitine, to-

gether with his failure to properly attend the plaintiff after such treatment in order to observe and if necessary correct its effect upon him, and there was medical testimony offered to the effect that the plaintiff was actually suffering from glaucoma, and that if the defendant had attended him when requested to do so he might have done something to alleviate his condition, it was held in Saunders v. Lischkoff, (79), that the question of negligence and causation was properly for the jury, so that the court had erred in directing a verdict for the defendant.

Evidence that the defendant's negligent failure to diagnose the disease of the plaintiff's eye as glaucoma resulted in damage to the plaintiff was held in Shives v. Chamberlain, (80), to be supplied by a showing that the eye progressively deteriorated under the defendant's treatment, and that when the proper treatment for glaucoma was finally supplied by another physician, the progress of the malady was stopped and such vision as he then had was preserved. Since it also appeared that the defendant had treated the plaintiff for both eyes, and an expert testified that primary glaucoma ordinarily affected both eyes, and there was nothing in the record tending to prove that the plaintiff's case, if one of secondary

glaucoma at all, was confined to only one eye, it was held that the evidence was also sufficient to establish that the glaucoma which the defendant had failed to diagnose had also caused the loss of the sight of the plaintiff's other eye.

And the question as to whether the defendant's negligent failure to operate immediately to remove an eye which had been seriously injured was the cause of the resulting ophthalmia and blindness of the other eye was held to be for the jury in Hunder v. Rindlaub, (81), where there was medical testimony that the failure to remove an injured eye was responsible for the development of sympathetic ophthalmia, and that if the injured eye had been removed immediately or within a week in all probability the other eye would not have become involved.

So, although it was conceded that the defendant's diagnosis of a detached retina of the plaintiff's eye as a cold did not produce the condition which resulted in her blindness, since there was evidence that when prompt and proper treatment was given to such a condition cures could be expected in from 25 to 35 per cent of the cases, and the plaintiff's chance of a cure would be even better by reason of her age and good health, and it was further testified that where the treatment was

delayed good results could be obtained in from 1 to 2 per cent of the cases only, a verdict for the plaintiff was sustained in Smith v. Mallinckrodt Chemical Works, (82), the court saying that the causal connection, like negligence, was usually a matter of inference from other facts, and that under the evidence in the case it was a question for the jury to determine.

In Wood v. Vroman, (83),where the plaintiff contended that the infection which caused the loss of the sight of his eye resulted from the defendant's action in wiping pus from a sore which he had opened on the eyelid across the eye after extracting a piece of steel therefrom, so that the pus came in contact with the open wound, and the defendant contended that the infection was caused from the dirt which was blown into the eye at the time of the original injury, or from the hands or handkerchiefs of the plaintiff and his fellow workman who had attempted to remove such dirt, it was held that the question of causation was properly submitted to the jury, the plaintiff having testified that before the action of the defendant complained of there had been no pain or smarting in the eye, and that immediately afterward the eye began to pain him and an expert testified that the effect of the introduction of pus into an open wound on the eye would be such burning

and pain, the court saying that this evidence established facts from which an inference of causation might fairly be drawn by the jury, and that infection from another cause was a matter of defense.

A defendant's contention that the inflammation and infection of the plaintiff's eye which she alleged was due to his negligence in operating was actually caused by arrested syphilis was held in Glover v. Burke, (84), to be overcome by evidence that she had married and had a baby since she was originally infected with this disease, and a Wasserman test given her has proved to be negative.

In an action alleging that the loss of the use of the plaintiff's eye was due to the negligence and lack of skill of the defendants in treating her for typhoid fever, where the plaintiff submitted evidence that the defendants had treated her for, and cured her of, typhoid fever, but that while one of the defendants was attending her she had a pain in her eye and asked him to send an oculist to her, that he said that he would do so but did not, and that when an oculist was finally secured, he stated that he could do nothing for her but that if he had been called earlier he might have helped her, the plaintiff was nonsuited on motion of the defendants. There was medical

testimony to the effect that the injury to the eye was caused by a cataract, and some testimony that typhoid fever might cause injurious effects upon the eye, but the court said that the plaintiff had employed the defendants to treat her for the fever, that there was no evidence that they did not bestow upon her all the attention and skill which the nature of the disease and her condition required, and no evidence whatever that the injury to the plaintiff's eye was a result of the fever, and defendants were under no duty to provide her with a specialist for her eye. Jones v. Vroom, (85).

April 1, 1934, a man slightly over 50, consulted the defendant physician, an ear, eye, nose and throat specialist, relative to an ailment of his left eye. The physician diagnosed the plaintiff's ailment as plastic iritis and instituted a course of treatments with atropine. On May 22, after examining the patient's right eye on request, the defendant administered "some treatment to the right eye, and from then on it never cleared, and excruciating pain and agony was felt by the plaintiff." Thereafter the physician treated both eyes, In June the patient lost his vision in both eyes, which loss apparently was permanent. Some time in October he became unable physicially to continue his visits to the defendant's

office. According to the patient, during October and November, by telephone, he repeatedly urged the defendant to call on him at his home, but the defendant refused to do so. A general practitioner, Dr. Bryans, informed the defendant that he had visited the patient after the defendant's refusal and had found him nauseated, weak and suffering from severe pain in the head. On December 1, Dr. McLane, an eye specialist, was called. He found the patient suffering from glaucoma, a condition characterized by a hardening of the eyeball. Subsequently the patient sued the defendant physician for malpractice, alleging, in effect, that the bad result was due to the unskillful negligent manner in which the defendant had attended and treated him. The trial court directed a verdict for the physician and the patient appealed to the Supreme Court of Florida, Judgment of the lower court was reversed. Re-trial ordered.

At the trial there was uncontradicted medical testimony that (1) the administration of atropine is the recognized standard treatment for plastic iritis, but that if such a drug is administered the physician must see and observe the patient every forty-eight to seventy-two hours in order to check or test the intraocular "tension" or pressure; (2) if a patient appears to be hypersensitive

to atropine, or any other drug, due care requires that a close check be kept and the drug changed so as not to cause the patient pain or agony; (3) a glaucomatous eye first appears red and later white, and the eyeball, while its shape may or may not be changed, has a tendency to appear to be pushed outward; (4) glaucoma in its early stages may be remedied by drugs or surgery; (5) plastic iritis, an involvement of the iris with adhesions, frequently develops into glaucoma, and (6) in the locality in question it is customary for a physician to visit his patient when the latter is physically unable to come to the physician's office.

The Supreme Court discussed the general rules of law relating to (1) the burden which rests on the plaintiff in a malpractice suit to show that the defendant was unskilled or negligent and that his unskillfullness or negligence resulted in harm to the plaintiff, (2) the liability of a physician for an erroneous diagnosis and (3) the duty of a physician, in the absence of an agreement to the contrary, to continue in attendance until dismissed by the patient, or until his services are no longer required, or until he has properly withdrawn from the case after giving the patient reasonable notice. Referring to the defendant's contention that during the

period of treatment the patient's ailment was iritis and that there was but little intra-ocular pressure present, the Supreme Court called attention to the trial court's refusal to permit Dr. McLane, an eye specialist, to answer the following hypothetical question propounded to him:

Doctor, from his condition of the glaucoma and with a hypothesis that in July and September a layman observed the conical shape and pressure of his eye, how long would you say that glaucoma had existed at the time you saw him?

If the trial court had permitted Dr. McLane to answer this question a possible conflict of opinion would have developed which would have required the trial court to submit the matter to a jury. In fact, there already was a dispute as to the appearance of the diseased eye. Likewise, an inference could have been drawn that the pain and agony suffered by the plaintiff was due to the atropine as prescribed, and that if the defendant had contacted his patient at more frequent intervals this condition could have been alleviated. <u>If the evidence is conflicting or will permit of different reasonable inferences, or if there is evidence tending to prove the issues, it should be submitted to the jury for its</u>

determination as a question of fact and not taken from the jury and passed on by the court as a question of law.

Accordingly, the Supreme Court reversed the judgment of the trial court and, in effect, ordered the case retried. Saunders v. Lischkoff, (79).

A cesarean operation was performed by the defendant physician. The baby was taken from the operating room to the nursery by the obstetric supervisor of the hospital, who, about an hour later, without the direction or knowledge of the physician, instilled a solution in the baby's eyes from a bottle indicating that it contained a 2 per cent solution of silver nitrate. Severe injury to the eyes resulted, eventuating in blindness. Substantial vision, however, was later regained. The baby sued the physician and obtained a judgment.

The nurses assisting in the operating room at the time of the delivery were the agents and servants of the physician, for they were under his direct control and supervision and subject to his orders. To say, however, that such relation continued in all postnatal treatment administered by the nurses or by the hospital would cast too great a burden on the physician. The physician may not be held liable for the negligence of another

assuming to act, not under his directions,,but in pursuance of an independent judgment, in the absence of any duty imposed on the physician to perform the act.

In assuming the care of the mother and child, the physician impliedly contracted that he possessed and would use in the treatment of his patient a reasonable degree of skill and learning. He owed a duty toward each to exercise such reasonable care and skill as a reasonably prudent and careful physician and surgeon would use under like circumstances. So far as the record discloses, the physician fully and skillfully performed the duty. He was likewise responsible for the negligent acts of otheres who were his agents or employees and who were acting within the scope of their employment or agency. But under the circumstances here present it cannot be said that those responsible for the most unfortunate condition of the baby's eyes were in any sense acting for or on behalf of the physician. The judgment against the physician was therefore reversed. Harlan v. Bryant, (86).

The plaintiff patient engaged the defendant, a physician but not a specialist in diseases of the eye, to remove a cyst from the "underside of the upper eyelid". He advised her that this could be done by a slight operation

without causing pain or affecting her sight and that she would be cured in a short time. He everted the eyelid, made an incision and scraped out the cystic material with a curet. He then applied hydrogen peroxide and a 5 per cent solution of mild protein silver, placed a bandage over the eye and instructed the patient not to touch the bandage or her eye, to prevent infection. Thereafter he treated her daily for almost two weeks and then made arrangements for another physician to take over so that he might attend a physicians' meeting out of town. Up to the time he left he repeatedly assured the plaintiff that her eye was "doing nicely" and was not infected. The plaintiff patient called the physician who was to take the defendant physician's place during his absence. He found "the entire eyeball completely inflamed," refused to treat it and sent the plaintiff to an eye specialist. In spite of treatments for a few days the condition of the plaintiff's eye became worse and the eyeball had to be removed. The plaintiff patient later brought suit against the defendant physician for malpractice. From a judgment in favor of the plaintiff the physician appealed to the court of appeals of Tennessee.

The defendant contended that the judgment was not supported by the evidence and that the trial court had

erred in not directing a verdict in his favor. He further contended that the infection of the plaintiff's eyeball was the result of syphilis which she had contracted in 1931 and which had become arrested following her discontinuance of treatment before a cure had been effected. A Wasserman test for syphilis, taken during the course of the treatment of her eye, was negative. There was no evidence, said the court of appeals, that the defendant injured the plaintiff's eyeball in operating on her eyelid, and there was no evidence as to the cause of the inflammation of the eyeball. So far as the record showed, the plaintiff's eyeball may have become infected by her own fault in adjusting the bandages or in rubbing her eye, or it may have resulted from an "abscess caused by syphilis." But, continued the court, the lower court would not have been warranted in directing a verdict for the defendant on the proposition that he had exercised due care and skill in treating the plaintiff's eye after the operation on her eyelid. The defendant admitted that before he had turned the case over to the second physician he had observed a white ring "around the outer portion" of the iris which gradually became cloudy and remained cloudy. , Both the other two physicians who attended the plaintiff were of the opinion

that her eyeball had been infected for several days prior to the time of the defendant's departure from town. In the judgment of the court, the defendant evidently did not know or was negligent in not observing the infection when he assured the plaintiff that her eye was "doing nicely." It was therefore a question for the jury's determination whether or not the defendant in treating the eye subsequent to the operation had possessed and exercised the reasonable learning, skill and experience ordinarily possessed and exercised by members of the medical profession in good standing under similar circumstances. The court could find no reason to disturb the jury's finding that he had not. Accordingly, the judgment in favor of the plaintiff was affirmed. Glover v. Burke, (84).

The plaintiff patient suffered from "malignant destructive myopia", threatening practical blindness in her right eye. The defendant, a physician, performed an operation on that eye January 9, 1930, consisting, in the words of the defendant, of "what we call needling, break- the capsule which holds the lens, breaking into the capsule and breaking up the lens to some extent so that the water in the anterior chamber is absorbed into the lens, causes the lens to soften and absorb and disappear."

The vision in that eye seemed thereafter to have improved temporairly and a similar operation was performed on the left eye, May 11, 1930. The right eye, however, began to grow worse again; it appearing that after a lens has been removed the posterior capsule frequently becomes opaque, making it necessary to needle it also. Accordingly, the defendant performed a second operation on the right eye on May 9, 1931. Inflammation developed, which was made necessary still another operation, May 11, 1931. Finally, in July 1931 the right eye had to be enucleated. The patient, August 8, 1932, brought an action in trespass, to recover damages for the injuries to the eye and its ultimate loss. She did not claim that either the original or any subsequent operation was ill advised or was negligently performed. The action was for false and fraudulent representations, based on the allegation that the defendant has assured her that the operation was not a serious one and that it would correct her vision and would enable her to dispense with glasses. The trial court entered judgment for the defendant and the patient appealed to the Supreme Court of Pennsylvania. Affirmed.

The only question presented on appeal was whether or not the action was barred by the statute of limitations

which required that it be brought within two years from the time when the "injury was done". The physician contended that the "injury was done" at the time of the first operation, January 9, 1930, and that therefore the two year period had elapsed before the suit was instituted. The plaintiff, on the other hand, contended that the statute began to run when the second operation was performed May 9, 1931. The statute begins to run, said the Supreme Court, at the time the injury was done even though the damage may not then be known and may not in fact have occurred until afterward. Whatever injury was done to the plaintiff in the present case was occasioned by the first operation, from which her condition on May 9, 1931, was a direct outgrowth. The secondary or capsular cataract removed at that time would not have occurred but for the operation on the lens. The patient contended that she could not know the original operation was unsuccessful until the later measures proved unavailing and therefore the statute should not be held to run until that time. This argument, answered the Supreme Court,, rested on a misapprehension of the nature of the present action. The suit was not based on a promise or guaranty that the plaintiff would be cured; the alleged fraudulent representations were that an op-

eration of the type here involved was not serious and was practically certain to effect a cure. Obviously, the plaintiff was not obliged to wait for the outcome of her own operation in order to discover whether or not the representations were true. Even before the operation was performed at all, she by inquiry from the medical profession could have ascertained whether the operation was of the nature represented by the defendant, whether it was serious or inconsequential, and whether it was speculative or almost certain in its results. While the running of the statute is postponed where by some independent act of fraud or concealment a wrongdoer prevents discovery, there was no evidence of any such independent act on the part of the physician.

The judgment in favor of the physician was accordingly affirmed. Bernath v. Le Fever, (87).

The head of a nail struck the plaintiff in the eye on August 23, 1934. The physician-employee of the defendant, to whom the plaintiff went for treatment, examining the eye with a magnifying glass, found a lineal laceration of the cornea, with air bubbles present. He removed some particles of rust and did not examine the laceration to see how far it extended or attempt to extract anything therefrom. He washed out the eye with boric acid, instill-

ed a mild protein silver solution and covered the eye with a pad, which was repeated daily until September 3, when he discharged the patient as recovered. On October 23 the plaintiff returned, complaining of pain and diminishing sight. The physician treated him for seven days, when he sent him to an eye specialist, who removed a piece of steel from the eye. Some days later the retina collapsed and the plaintiff finally lost the entire sight of his eye. He then brought against the defendant physician.

At the trial the eye specialist was permitted to testify that when he first examined the plaintiff's eye he found a puncturing injury in the cornea, and a window or tear in the iris with scars and inflamed vitreous, and that by use of an ophthalmoscope he determined the presence of a piece of steel embedded in the vitreous, which he removed. The loss of sight, he further testified, was caused by the presence in the patient's eye of a foreign body, that the removal had nothing to do with the loss of vision, and that the length of the time the particle remained in the eye contributed considerably to the loss of vision, as a result of the inflammation resulting from its presence. Another physician testified that the customary means used by physicians to determine the presence or absence of a foreign body in the eye are

the ophthalmoscope and the Xrays. Notwithstanding this evidence, the trial court entered a judgment of non-suit and the patient appealed to the district court of appeal California. Reversed in favor of plaintiff patient.

The evidence just noted, said the district court of appeal, was sufficient to establish a prima facie case. The legitimate inference to be drawn of a foreign body in the eye, that in failing to make such examination as would make reasonably certain that there was nothing in the eye he failed to exercise that degree of care which the practice of his profession requires, and that this lack of care was the proximate cause of the loss of sight. It is difficult to understand how a physician examining the injured eye and viewing the air bubbles and the laceration present could feel that he had exercised ordinary care and skill without making any examination to see how deeply the injury extended, or doing nothing to give reasonable assurance that there was no foreign body in the eye. The attending physician even neglected to use Xray apparatus that was in his office. For these reasons the court concluded that the trial court erred and reversed the judgment of non-suit. McBride v. Saylin, (88).

The defendant physician attended the birth of the

plaintiff's baby. Four days thereafter the baby developed an infection of the eyes, which eventually resulted in total blindness of the right eye and impairment of vision of the left eye. Suit was instituted against the physician, attributing the infection and its results to his negligence in caring for the child at and after birth. In the trial court the jury disagreed but the court, on motion of the defendant, dismissed the case on the ground that the evidence was insufficient to sustain a verdict for the plaintiff physician. Thereupon the plaintiff applealed to the Supreme Court Washington. Reversed for plaintiff patient.

"Ophthalmia neonatorum, said the court, is an infection in the eyes of the new-born and although the term may be applied to any infection, it is generally accepted as indicating the presence of gonococci. As a precautionary measure, the state health regulations require that at birth a solution of silver nitrate or mild protein silver (argyrol) shall be put in the infant's eyes. When the prophylactic is used, ophthalmia neonatorum develops in only one case in a thousand; when it is not used the infection develops in 10 per cent of the cases. In the present case the prophylactic was not used. When the mother left the hospital, a nurse advised her to put one drop of 5 per

cent mild protein silver (argyrol) in the baby's eyes twice a day and wash them every three hours with a solution of boric acid. Subsequently the right eye became infected and the discharge from the eyes became streaked with blood. Finally the defendant advised the parents to take the child to an eye specialist, who caused laboratory tests to be made of the discharge from the eyes. The laboratory reports failed to show the presence of gonococci. This specialist diagnosed the condition as conjunctivitis and attributed it to closure of the nasal ducts.

There was no direct testimony that the child was suffering from a gonorrheal infection. A number of experts testified that the treatment given by the parents was proper and adequate for the condition described. This testimony, the court thought, was predicated on the assumption that the infection was not gonorrheal. While the laboratory reports on the smears taken from the eyes indicated that no gonococci were present, the fact, the court said, did not eliminate a diagnosis of gonorrheal infection if a clinical examination so indicated. The failure to administer the prophylactic constituted negligence, viewed either as a violation of the state health regulations or as a departure from accepted practice. Whether the

infection was gonorrheal and whether it was the proximate result of such negligence were for the jury to say. In the opinion of the Supreme Court, therefore, the trial court erred in dismissing the case and it remanded to the trial court for further proceedings. Jordan v. Skinner, (89).

The plaintiff consulted the defendant, a specialist in the disease of the ear, eye, nose and throat, because of a badly infected and swollen eye. A diagnosis of gonorrheal ophthalmia was made and a course of treatment instituted. After eight days of treatment, the plaintiff consulted a specialist in another city who found the eye full of pus and badly swollen. There was a perforation of the cornea and prolapsus of the iris. Since sight from the eye was destroyed and could not be restored, this specialist removed the eyeball. Subsequently, the plaintiff patient sued the defendant physician attributing the loss of an eye to his negligence. The trial court directed a verdict for the defendant and the plaintiff appealed to the district court of appeal, fourth district, California.

The degree of skill and care required of the defendant as a specialist, the court said, is stated succinctly as follows:

"One who holds himself out as a specialist in the treatment of a certain organ, injury or disease, is bound to bring to the aid of one so employing him, that degree of skill and knowledge which is ordinarily possessed by those who devote special study and attention to that particular organ, injury or disease, its treatment, in the same general locality, having regard to the state of scientific knowledge at the time.

The plaintiff based his allegations of negligent treatment on the contention that the defendant failed (1) to cap the unifected eye; (2) to hospitalize the plaintiff; (3) to take and test a smear from the infected eye; and (4) to use more energetic treatment on the eye. Even if good practice required the defendant to cap the unifected eye, the court said, that eye did not become infected and the failure to cap it was neither a proximate nor a contributing cause of any injury suffered by the plaintiff. Furthermore, there was no evidence to show that hospitalization of the plaintiff was required by the standards of good practice in and around the community. The specialist who enucleated the eyeball testified that hospitalization in such cases is desirable and that he himself did not see how a patient could properly irrigate his own eye. This fell short, in the opinion of the court,

of proving that the standard of care in the particular community required hospitalization of patients suffering from gonorrheal ophthalmia. There was testimony to the effect that good practice required the defendant to take a smear from the infected eye to determine the nature of the infection and the type of treatment required, the nature of the treatment being dependent on the nature of the infection and its virulence. The defendant, however, recognized immediately the nature of the infection on his first examination. The only merit to this particular contention would depend, therefore, the court said, on the propriety and efficacy of the treatment administered by the defendant.

According to the record, the defendant, after diagnosing the condition as gonorrheal ophthalmia, irrigated and cleaned the eye, painted the lids with a 1 per cent solution of silver nitrate, and placed two drops of atropine solution in the eye. He administered this treatment daily during the eight days that the plaintiff was under his care. He also advised the plaintiff to apply ice compresses continuously, to keep the eye clean with frequent irrigations of a salt or boric acid solution, and prescribed a one-half of 1 per cent solution of zinc sulphate with directions to place two to three drops in

the eye every two hours. Subsequently, the zinc sulphate solution was discontinued and a 15 to 20 per cent solution of neosilvol was substituted. The specialist who operated on the eye, testifying for the plaintiff patient said: "If I were treating such a case, I would want to have more energetic treatment. In this serious disease the outcome might be grave in any event." He admitted, however, that "there is a great difference in the opinion about the use of drugs" and that each step in the treatment administered by the defendant was proper. This, in the opinion of the court, did not prove that the defendant did not bring to the case the required degree of skill and knowledge. The evidence only tended to prove that in the opinion of the witness a method of treatment other than that employed by the defendant might have produced a better result. Such evidence was not sufficient to make out a case for the plaintiff.

The judgment of the trial court for the defendant physician was therefore affirmed. Jensen v. Findley, (74).

SUMMARY OF CASES ON MEDICAL MALPRACTICE IN OPHTHAMOLOGY

1. The test of malpractice in ophthamology is whether the defendant ophthamologist has acted with the ordinary reasonable care of the ophthamologists in the area in which the treatment was given.

2. The general practitioner treating eye is under the test of the ordinary, reasonably prudent care of the general practitioners in his area. But he is under the duty to refer his patient to an ophthamologist if such is indicated and practicable without undue delay.

3. The actual cause of the patient's injury is often very difficult to establish. It is not easy to determine if the damage complained of is from the original injury or from the subsequent treatment.

4. The plaintiff defendant must prove beyond reasonable doubt the cause of the damage was the defendant physicians negligent action. This is difficult to do.

5. Medical testimony by another physician is required to establish a physician's liability.

6. The courts have presumed the doctors to be using the necessary care and skill unless proved otherwise.

7. There are few actual cases where the physician has been held liable.

8. The ophthamologist will be confronted with the

problem of testifying against a general practitioner or other ophthamologists who have handled an eye case. Most ophthamologists in most areas today, only testify where it is necessary to defend their own acts.

9. Causes of actions are often based on the defendant's physicians failure to properly explore the extent of the damage. e.g., removal of steel splinters from the eye.

10. The plaintiff-defendant must prove that the damage to the eye was the legal "proximate" cause of the physician's defendant's negligent act.

11. The physician is not responsible for the acts of others not under his control. e.g. hospital nurse in the post-operative care.

12. Physicians are sued for promising too much. e.g., "your eye will be as good as new"; "the operation will not be serious". The patient plaintiff can then sue for fraudulent representations, and this is much easier to recover on than the usual malpractice case.

13. Failure to follow a serious eye case carefully has been used by patient's in suits.

The most frequent allegations in the treatment of the eye disease are:

1. Failure to remove eye--sympathetic ophthalmia.

2. Failure to remove foreign body.
3. Wrong solutions.
4. Cataract improperly treated--blindness.
5. Wrong glasses.
6. Injury to tear ducts.
7. Treatment caused scarring and deformity.
8. Examination without consent.
9. Injury during examination.
10. Error or delay in diagnosis.
11. Failure to use laboratory aids.
12. Failure to administer standard treatment.
13. Failure to leave instructions for treatment of patient.
14. Failure to leave instructions for protection of attendants and of other contacts.
15. Failure to hospitalize.
16. Aggravation of existing condition.
17. Abandonment.
18. Infection, slough.
19. Breach of warranty to cure.
20. Error in the prescription or in dispensing.
21. Overdosage.
22. Use of harmful drugs.
23. Unnecessary medical treatment.
24. Defective equipment.

CHAPTER VII

Medical Malpractice Cases Involving Anesthesia

This chapter presents certain representative cases involving anesthesia malpractice litigation. It is by no means complete. It's purpose is to illustrate the problems involved in this field. Each case involves a State Supreme Court decision.

Regan stated in 1949 that his survey indicated that the most common allegation in anesthesia suits were the following:

1. No preliminary examination.
2. Too much anesthetic.
3. Death from anesthetic.
4. Injury to eyes or skin.
5. Injury from mask; from mouth gag.
6. Injury during struggling (improper administration).
7. Pneumonia caused by fluid ether in lungs.

Regan, (90).

Nebraska anesthesia cases are few in number.

1. One Nebraska case was:

The plaintiff sued to recover damages against the doctors and the hospital. The astragalus of her right foot was split in two and a large portion, perhaps half, was forced out of the ankle joint or socket. The dis-

located fragment lodged under and distended the outer skin of the foot. One of the defendant doctors was called and he administered an anesthetic and attempted to reduce the fracture by manipulation. Being unable to do so, he loaded the patient into his automobile and drove to the hospital and called Rix, an expert in surgery. They took x-ray pictures and decided to operate. The court said: "The law did not require defendants to restore plaintiff to consciousness for the purpose of securing consent to surgery--the only alternative in the line of professional duty for which they were called (reduction of the fracture). the use of anesthesia in modern surgery has modified to some extent the ancient rule of the common law requiring consent. Of course the general rule requires consent of the patient, but consent may be applied from circumstances and an operation may be demanded by an emergency without consent." In that case there was a directed verdict for defendants. McGuire vs Rix, (37).

2. In the Minnesota case of Moehlenbrock vs. Parke Davis & Co. et al judgment was entered against the defendants and they appealed. Plaintiff's intestate, a young man in good general health, was operated upon, under the influence of ether, for the removal of his ton-

sils. The operation was performed and the ether administered by the defendant doctors, and the ether was supplied by the defendant company. The deceased never recovered from the administration of the ether. There was a showing that the ether was unfit for use and dangerous to life and the defendant company was held liable for that reason. The court also found that there was evidence to sustain the contentions of the plaintiff that the doctors early discovered the pernicious effect of the ether, but negligently persisted in its use, and that they neglected to give the patient proper care after the operation. The court said: "From the testimony of the defendant surgeons and from common knowledge of physicial facts and laws, the jury might infer that if the defendants had desisted from the use of the ether at the first sign of danger, decedent's life might have been spared, and that reasonable prudence required them to do so." The judgment was affirmed. Moehlenbrock vs Parke Davis & Co. et al (91).

3. Another case where an anesthetic was fatal was the Michigan case of Bishop vs Shurly. The plaintiff's intestate went to the defendant to have his tonsils removed under a general anesthetic. Deceased was under 19 years of age. His father was dead. His mother made the

arrangement for the general anesthesia. However as the deceased was entering the operating room a lady was passing out, and the deceased asked the doctor what was her operation and what anesthetic and was told tonsils and a local, and he then asked if he might not also have a local, and this was explained to him and he asked for local anesthetic. The assistant gave an injection of procaine in the back of the throat. Before a second injection could be given, the deceased collapsed and died soon after. Death was accounted for by the presence in the person of the deceased of the thymus gland.

The court instructed the jury that before the plaintiff could recover she must prove, (1) that a contract had been entered into between the mother and the doctor that a general and not a local anesthetic be used, and that particularly cocaine was not to be used; (2) that cocaine was actually used; (3) that the use of cocaine was the real cause of death and (4) her damages. The instruction was approved by the appellate court. There was verdict and judgment for the defendant and this was affirmed. There was evidence on the part of the defendant that thymic death might also have been caused if ether had been used. Bishop vs Shurly, (92).

4. This Massachusetts case deals with the cause of

and effect of ether administration and a resultant bronchitis. The decision was actually based on the physician's negligence in giving ether to a patient with a cold.

"Anna Butler claimed that she acquired bronchitis because the defendant administered ether to her when she had a severe cold, and sued for damages. The defendant asked the trial court to direct a verdict in his favor. When the court refused to do so, he appealed to the supjudicial court of Massachusetts. The court found that the refusal of the court below was proper and overruled the exceptions filed by the defendant.

The ether was administered to the plaintiff in the course of a tonsillectomy performed by the defendant, June 22, 1925. There was evidence to show that at the time the plaintiff had a severe cold and that she informed the defendant of that fact before the operation. The plaintiff left the hospital a day after the operation. About two weeks later she started coughing and sneezing, as soon as the condition of her throat permitted her to cough, and she had a feeling of congestion in her chest which she had not noticed before. In asking for a directed verdict in his favor, the defendant did not contend that there was not sufficient evidence to take the

case to the jury on the question whether he had or had not failed to exercise reasonable professional skill in administering the ether. He contended, however, that he was entitled to have the court direct a verdict on the ground that even assuming that he had failed to exercise reasonable skill, there was no evidence that his failure was the cause of the attack of acute bronchitis of which the plaintiff complained. The plaintiff's family physician, testifying on her behalf, said that the administration of ether to a person having a head cold would carry the inflammation downward and would increase the secretion and the amount of infection, "reducing the amount of air coming in and out," which would cause bronchitis. The usual case of bad effects of ether, this witness testified, invaribaly develops in two or three days. On direct examination he was asked:

Assume....that two weeks after the operation, during which period she (the plaintiff) was at home, she began to cough and sneeze and felt some congestion of the bronchial passages. What relation in your opinion did the etherizing have to that condition?

To this he answered: "It caused that condition." He testified further that the etherizing, June 22, 1955, was the cause of the plaintiff's condition at the time

of the trial and that the cold from which the plaintiff had suffered did not cause the bronchitis. The defendant testified that it would be improper to administer ether to a person having a bad head cold or a bad cold involving the head and the chest and would subject the patient possibly to serious consequences. He offered evidence to show, however, that the ill effects of administering ether would develop, if at all, within three or four days in case of bronchitis.

On the evidence, said the supreme judicial court, the jury could have found that about two weeks after the operation the plaintiff was suffering from acute bronchitis as a result of the administration of ether, Although it might be assumed that the bronchitis resulted from causes other than the administration of ether, it could not be said as a matter of law that the jury was not warranted in finding that the ether administered by the defendant caused it. On such a finding, the jury could find further that the defendant failed to exercise reasonable skill and diligence in treating the plaintiff. In view of all of the testimony it could not be rightly said that there was no evidence of a casual connection between the administration of the ether and the bronchitis which thereafter developed. The cause of the plain-

tiff's illness, therefore, could not be said to rest on mere conjecture and speculation, and the trial court could not properly have directed a verdict for the defendant." Butler v. Layton, (93).

This case also illustrates the effect of one physician testifying against another. If you'll read the testimony carefully you will see that the family physician was extremely positive about cause and effect.

5. Negligent pre-operative examination was the basis of a Kentucky case. "Two of the defendants, one the county health director and the other a specialist in diseases of the ear, eye, nose and throat, undertook to remove the tonsils of the plaintiff's 9 year old boy at a clinic conducted by them. During the administration of the anesthesia by the third defendant, a lay employee of the specialist, the patient developed what the court referred to as "alarming symptoms" and, despite effort to revive him, died shortly thereafter. The plaintiff, as administrator of the estate of his deceased son, sued the three defendants. The trial court directed a verdict for the defendants, and the plaintiff appealed to the Court of Appeals of Kentucky.

The evidence tended to show that the plaintiff informed the defendant that his son had only recently re-

covered from influenza, and that he had "rheumatic fever" and "a rheumatic heart". Although the defendant physicians were in possession of this information, it was contended, they proceeded with the operation without subjecting the boy to a thorough examination to determine his fitness to undergo it. The defendant physicians contended, on the other hand, that what they did was in accordance with the duties imposed by law on them and that the methods employed to ascertain the patient's condition were sufficient for the purpose. A duty devolved on the defendant physicians, said the court, to ascertain whether or not the patient's physicial condition was such to enable him to undergo or withstand any required action as a necessary part of the treatment proposed to be administered. A physician, continued the court, who administers or procures the administration of an anesthesis preparatory to a surgical operation is required to possess the same degree of skill and has imposed on him the same obligations as were set forth in Stevenson v. Yates/ (94) as follows:

The law is well settled.....that a physician or surgeon is answerable for an injury to his patient resulting from want of the requisite knowledge and skill, or from the ommission to use reasonable care and diligence to discover the patient's malady. (Citations ommitted)

Concerning the standard of knowledge and skill and the required care which the physician should possess and exercise under this rule, it is quite generally agreed that he is bound to bestow such reasonable and ordinary care, skill and diligence as physicians and surgeons in similar neighborhoods and surroundings engaged in the general line of practice ordinarily have and exercise in like cases. In the present case, said the court, more than one witness testified to facts which, if true, tended to show that the defendant physicians either did not possess the requisite skill to discharge the task they assumed to perform or that they negligently and carelessly exercised their skill. The sufficiency of the evidence to support a verdict either way on a general submission of the case to the jury was not before the court for determination. The sole question was whether the trial court correctly directed the verdict for the defendants. Before a court is authorized to direct a verdict, it should be prepared to say that, admitting as true all testimony on behalf of the party against whom the verdict is directed, and every fair and reasonable inference that might be deducible from it, he has failed to make out his case. Applying that rule to the evidence in the present case, the Court of Appeals felt impelled to conclude that the trial court erred in directing the jury to return a ver-

dict for the defendant lay anesthetist, since there was no proof that she was competent to perform the task she undertook, or that she administered an excessive amount of anesthesia. The judgment was affirmed as to the anesthetist but reversed with respect to the defendant physicians." VanSant's Adm'r v. Overstreet, (95).

6. Skill of the anesthetist is involved in this Massachusetts case. "The plaintiff underwent an operation for the removal of a thyroid cyst. The defendant, a physician, was engaged to administer the anesthetic. He was assisted by a nurse provided by the hospital. Alleging that the defendant negligently administered the ether, resulting in serious injury to her eyes, the plaintiff sued the defendant. At the close of the evidence, a motion by the defendant for a directed verdict was denied." A verdict was rendered for the plaintiff, and the defendant appealed to the Supreme Judicial Court of Massachusetts.

"There is no evidence," said the Supreme Judicial Court, "that the defendant did not possess the standard of skill which the law requires him to possess, nor is there any testimony in the record that the defendant departed from the usual technic in handling the anesthetic. The fact warranted by the evidence, that the plaintiff's eyes were injured by the administration of ether by the defend-

ant does not alone warrant the inference of fault on the part of the defendant. In the absence of expert affirmative evidence of fault in the administration of ether, the basic question is whether the defendant in administering the ether did use the care and skill which the law requires. There is nothing in the record to exclude the reasonable inference, the court said,, that the nurse in pouring the liquid ether spilled it on the outside of the cone and that it found its way to the plaintiff's eyes to their harm. If such was the fact, the defendant was not responsible. The nurse was furnished by the hospital and there is no evidence that the defendant directed or failed to direct her other than to say that the liquid ether she poured into the cone was "enough". In the opinion of the court, the trial court should have directed a verdict for the defendant." The Supreme Court, therefore, entered judgment for the defendant. Klucken v. Levi, (96).

7. Death was attributed in this case to the negligent administration of anesthetic. The defendant, a physician, administered the anesthetic during an operation performed on the plaintiff patient. The patient died on the operating table and the husband and daughter of the deceased sued the defendant, claiming that the patient died from asphyxiation as a result of his negligent ad-

ministration of the anesthetic. The superior court, Los Angeles County, gave judgment for the plaintiff's and the defendant appealed to the district court of appeal, second district, division 1, where judgment of the trial court was reversed. The case then came before the Supreme Court of California on appeal.

According to the evidence, said Supreme Court, after the operation was performed and the operating surgeon was closing the incision, he requested a deeper anesthesia. The anesthetic used was ethylene gas, carbon doxide gas, ether and oxygen. The defendant anesthetist, at time of the request for deeper anesthesia, noticed that the oxygen in the tank had depleted. He ordered a fresh supply. It took about five minutes to connect up the new tank, and when this had been completed, the patient was dead. The nurse who assisted in the operation testified that the defendant continued to administer the anesthetic while the oxygen supply was being replenished and that the anesthetic mask was held on the patient's face by the defendant during that time. An osteopath, testifying for the plaintiff, stated in answer to a hypothetical question that the deceased died of asphyxiation resulting from the administration of ethylene gas without oxygen. The medical testimony was in agreement that the breathing of ethylene

gas without oxygen for a few minutes would probably be fatal. The defendant contended that the patient died from heart failure and that he did not hold the mask tightly over the patient's face during the period of the change of oxygen tanks, but kept his finger under the mask, raising it slightly so that the patient could breathe. Medical experts testified for the defendant that the patient's symptoms, particularly a drop in the blood pressure prior to cessation of respiration, indicated death from heart failure and that the symptoms of asphyxiation were not present.

Although the weight of expert medical opinion for the defendant, said the Supreme Court, was greater than that for the plaintiffs, there was sufficient direct evidence supporting the plaintiffs' theory of the cause of death to justify a submission of the case to the jury. In the absence of prejudicial error committed by the trial court, the jury's verdict is binding. The opinion of an expert witness, continued the court,, does not become valueless by reason of the omission from a hypothetical question of some disputed facts. "The question may be framed upon any theory of the questioning party which can be deduced from the evidence, upon which the opinion of the expert is desired. It may omit any facts not deemed by the questioner material to the inquiry."

(Treadwell v. Mickel, (97).

The court finding no prejudicial error in the record, affirmed the judgment of the superior court for the plaintiffs. Forbis v. Holzman, (98)

8. Suspicion of negligence is not enough. Proof of negligence is required. The defendant physicians performed a herniotomy on the plaintiff in a hospital owned and operated by the defendant county. The operation was performed under a local anesthetic. Alleging that the defendants negligently used alcohol instead of novacaine as an anesthetic, with resultant injury, the plaintiff sued the defendants. At the close of the plaintiff's evidence, the trial court sustained a motion filed by the defendants for a judgment of nonsuit, and the plaintiff appealed to the Supreme Court of Idaho.

The complaint charged that the defendants, instead of using a solution of novacain as a local anesthetic, "carelessly, negligently and recklessly furnished, supplied and injected into and under plaintiff's skin and the underlying tissues of right inguinal area a solution of alcohol, which said alcohol destroyed the tissues of said area to infection and caused to be broken down or infected plaintiff's skin, subcutaneous tissues, muscles and nerves in said area and the plaintiff's right thigh."

But, said the Supreme Court, the plaintiff utterly failed to prove that alcohol was used instead of novacain as an anesthetic. The nurses who assisted in the operation all testified that novacain was used to produce the local anesthesia and that alcohol was used only to cleanse the surface prior to anesthetizing it. No one ever testified that alcohol was injected. The trial court properly sustained an objection to a hypothetic question presented to an expert witness which was intended to elicit from the witness the effect that the injection of a solution of alcohol instead of novacain would have on the area wherein the injection was made. There was at no time any proof that a solution of alcohol had been injected instead of novacain and, furthermore, the question assumed proof of many facts that had not been suggested or covered by any evidence whatever.

The burden of proof was on the plaintiff, and it was not sufficient merely to show a possibility or raise a suspicion that the defendants may have been negligent. Some evidence is necessary, the court pointed out, either direct or circumstantial, to take a case to the jury, and there was none in this case. The judgment of the trial court was therefore affirmed. Evans v. Bannock County (99).

9. This case emphasizes the necessity of expert testimony (medical) to establish negligence. The plaintiff sued the defendant physicians, alleging that an infection in his arm was due to the negligence of the physicians' employees in administering morphine hypodermically. At the conclusion of the plaintiff's evidence, the trial court instructed a verdict for the physicians on ground that the plaintiff offered no expert medical testimony that the infection in his arm was caused by anything done or omitted to be done by the physicians or their employees, and on the ground that there was no evidence showing a causal connection between the wrong complained of and the injury resulting. The plaintiff then appealed to the court of civil appeals of Texas, Austin.

In the case of Floyd v. Michie said the court in the present, it was held:

The law entertains in favor of a physician the presumption that he has discharged his full duty, and to defeat his presumption the law exacts affirmative proof of breach of duty coupled with affirmative proof that such breach of duty resulted in injury. Negligence is never imputed from results, nor is any inference thereof indulged in against a physician...To warrant the finding

of civil malpractice there must be expert medical testimony to establish it and to establish the additional fact that death resulted from such malpractice. There being no expert medical testimony establishing such issues, the court properly instructed a verdict for the defendants. Floyd v. Michie, (100).

In the present case, there was no testimony by a medical expert that the infection in the plaintiff's arm was caused by the hypodermic needle or that it resulted from negligent acts of the defendants.

What is an infection and whence it comes are matters determinable only by medical experts. As applied in the present case, infection, the court said, means internal inflammation where pus is formed by the presence of pus germs. Without medical testimony as to the probable cause of an infection or its source, the court and jury are not qualified to pass on the question. The mere fact that infection set up in the plaintiff's arm three or four days after a hypodermic needle had been injected will not suffice as proof of negligence in failing to sterilize the needle or skin of the plaintiff's arm before the injection. Infection comes from many sources, and there must be affirmative proof of such negligence or lack of care, and that the injuries complained of resulted therefrom. Such

proof can be established only by the testimony of experts skilled in the medical and surgical profession.

The judgment of the trial court was affirmed. Kaster v. Woodson et al,(101).

10. This case deals with unhappy results of medical treatment. But negligence was not shown. Preparatory to performing a circumcision on the plaintiff, the defendant physician made several injections of a solution which he believed to be novacain, a local anesthetic. At the point of the first injection the plaintiff experienced a burning and stinging sensation, and a blister formed which bursted. The tissue in that area became necrotic, turned black and had to be excised. Later the plaintiff consulted another physician, who treated him for several weeks, but he was left "in such condition that he now at times suffers therefrom." He then brought suit for malpractice against the defendant physician. At the conclusion of the plaintiff's evidence, which consisted of testimony by himself and his wife, the trial court, on motion of the defendant physician, entered a judgment of nonsuit. From that judgment the plaintiff appealed to the Supreme Court of North Carolina.

The plaintiff did not allege that the defendant phy-

sician did not possess the requisite degree of learning, skill and ability necessary for the practice of his profession or that he failed to exert his best judgment in the treatment of the plaintiff's condition. Instead, he relied on the doctrine of res ipsa loquitur. He contended that the burning and stinging sensation which he experienced immediately after the first injection of the liquid and the destruction of tissue that followed was sufficient evidence to be submitted to the jury as tending to show (1) that the liquid injected was either novacain containing foreign caustic and deleterious chemicals or some liquid other than novacain that was caustic and deleterious, (2) that the liquid injected produced the condition complained of, and (3) that the defendant physician failed to diagnose properly the trouble and neglected to use proper treatment. But, said the Supreme Court, the doctrine of res ipsa loquitur is not applicable to this case. The plaintiff's testimony that the area to be operated on became "completely dead" following the injections only indicated that some type of anesthetic had been used. Was the burning and stinging sensation which followed the first injection due to some caustic chemical in the liquid or to some unusual and unexpected reaction of plaintiff's system to the medicine?

Was the condition that allowed the injection due to a caustic chemical in the liquid or to an infection? What was the defendant's diagnosis and what treatment should he have used? Did the second physician's diagnosis or treatment differ from that of the defendant? If the defendant incorrectly diagnosed the plaintiff's condition and failed to apply the proper remedy, was this due to an error in judgment or to negligence? The answers to these questions, said the court, were not to be found in the plaintiff's evidence but were left to mere conjecture.

Practical application of medical science, continued the court, is necessarily experimental to a large degree. Owing to the varying conditions of human systems the result of the use of any medicine cannot be predicted with any degree of certainty. What is beneficial to many sometimes proves highly injurious to others. Even the expert cannot completely fathom or understand the reactions of the human system. To say then that an unexpected, unanticipated and unfavorable result of a treatment by a physician invokes the application of the doctrine of res ipsa loquitur would be to stretch that doctrine far beyond its real purpose. The court concluded, therefore, that the plaintiff had failed to offer any evidence tend-

ing to show that he had suffered any physicial injury as a proximate result of any negligence on the part of the defendant.

Accordingly, the Supreme Court affirmed the trial court's judgment of nonsuit. Lippard v. Johnson, (102).

11. In this English case actual negligence, not imputed negligence, must be shown to allow defendant patient to maintain his suit. "Mr. Justice McNair, in the Queen's Bench Division on November 12, gave judgment for the defendants in an action in which two former labourers alleged that they became paralyzed from the waist downwards following the administration of spinal anesthetics when they were operated upon at Chesterfield Royal Hospital On October 13, 1947.

The men, Mr. C.H. Roe, aged 51,and Mr. A. Wholley, aged 62, claimed damages from the Ministry of Health, as successors to the former trustees of the hospital, and Dr. J. Malcolm Graham, the visiting anesthetist, Plaintiffs alleged the anesthetic was negligently administered and contended that their paralysis was caused by the phenol solution in which the ampoules were immersed before their operations.

The allegations were denied.

Ciba Laboratories Ltd., manufacturers of "nupercaine",

the anesthetic, who appeared as third defendants, were dismissed from the action earlier as having no liability.

Expert Evidence:

Professor R. R. Macintosh, consultant anesthetist, giving evidence for the plaintiffs, said the best method of sterilizing ampoules was by autoclaving. He had used nupercaine for spinal anesthetics and did not think the anesthetic caused the paralysis. He thought the paralysis was caused by phenol.

Professor Brodie Hughes, professor of neurosurgery in the University of Birmingham, said that if [illegible] sufficiently concentrated, phenol would kill the nerve cells. He said it was a practice in 1947 to store ampoules in phenol. He knew before 1950 that it was possible for spirit to seep into ampoules through cracks not visible to the naked eye. In cross-examination he agreed that it was an accepted practice in Britian in 1947 to store ampoules in antiseptic solutions.

Dr. J. Carson, consulting neurologist, giving evidence for the plaintiffs, said he examined them in 1947; he thought the spinal injection caused the paralysis, and the most probable cause was a chemical irritant.

Sir. Francis Walshe, consultant neurologist, giving evidence for the Ministry, said the plaintiffs' injuries were consistent with the use of spinal anesthetics. He

said their case histories were inconsistent with a corrosive poison such as phenol. If phenol had been responsible, he would have expected it to be dramatic at the onset and immediate in its effects.

Dr. McDonald Critchley, consulting neurologist, said he thought the plaintiff's condition was a most intense form of complication due to spinal anesthetics. Their condition was typical of what was known to follow the administration, at times, of spinal anesthetics.

Sir Hugh Griffiths, consulting surgeon, called for the Ministry, said he thought the plaintiffs' was caused by the anesthetic injection.

Administration Perfectly Normal:

Dr. Graham said he had given about 500 spinal anesthetics before October, 1947. Mr. Roe's operation was performed in the morning and Mr. Wholley's in the afternoon. The first indication he had of anything abnormal was when Mr. Roe complained of a headache during the operation. It was not until three days later that he knew something was seriously wrong. He said that in the case of Mr. Wholley the administration of the anesthetic was perfectly normal. He had no idea what had happened to the plaintiffs until Dr. Carson had visited the hospital. In 1947 he did not appreciate the danger of phenol pene-

trating an ampoule through an invisible crack. Some weeks before the operation he had found a cracked ampoule in the phenol solution, and rejected it. He spotted it at once. He denied that he casually examined the ampoules.

Dr. R. W. Cope, consulting anesthetist, said that ampoules could be contaminated through visible cracks. He did not think an ordinary competent anesthetist would appreciate that in 1947.

Judgment:

Mr. Justice McNair, giving judgment, said the operations on Mr. Roe and Mr. Wholley are comparitively minor, but in each case the result was disastrous; both unfortunate men were now permanently paralysed from the waist downward. The method of anesthesia was in 1947 a well-known method, and no charge of negligence had been made in regard to the adoption of that method in these two cases.

The hospital's obligation was to provide a competent anesthetist, which obligation it had undoubtedly fulfilled. In his lordship's view a specialist anesthetist was in the same class as a visiting surgeon, and the hospital did not assume responsibility in law for his acts. Although Dr. Graham was responsible for the choice of anesthetic

and the activities of the theatre staff, he could not be regarded as being responsible for any acts of negligence by the theatre staff on the basis of master and servant.

The judge said he found that the plaintiffs' injuries were in fact caused by contamination of the nupercaine by phenol. The percentage of such injuries following such anesthesias seemed to be about 1 in 10,000. An explanation that in those rare cases the injuries were due to some personal idiosyncrasy of the patient was difficult to accept in these particular cases because the injuries to Mr. Roe and Mr. Wholley resulted from the same anesthesia injected by the same anesthetist on the same day. That seemed to point conclusively to some common factor in the two cases. Phenol was present in the theatre, because the glass ampoules containing the nupercaine were stored in a phenol solution of 1 in 40, after a temporary immersion in a solution of 1 in 20. Glass ampoules could crack, and if they did there might be a replacement which might not be capable of being noticed. In his lordship's opinion, therefore, phenol was the most likely common factor.

It was now clear that phenol could find its way into the ampoules through invisible cracks, but in 1947 the

ordinary general run of anaesthestist would not appreciate that risk. The judge continued: "I accordingly find that by the standard of knowledge of competent anesthetists in 1947 Dr. Graham was not negligent in failing to appreciate this risk." He also found that the theatre staff were not negligent.

His lordship added that, having seen Dr. Graham and heard him give his evidence in a forthright manner, he found it extremely difficult to believe he could have missed two visibly cracked ampoules. Plaintiffs' claim against the Ministry and Dr. Graham failed, and there would be judgment for both defendants." Queen's Bench Reports, (103).

12. This English case typifies the rule that negligence must be proved not imputed from results. "After a hearing lasting eleven days, allegations of negligence in the administration of spinal anesthetics were dismissed. Two labours were admitted to the Chesterfield and Deryshire Royal Hospital for minor operations six years ago. In both cases 'Nupercaine' was injected intrathecally on the same day. As a result, each of the men had the same symptoms; their conditions pursued much the same course; and both became permanently paralysed. They sued the Ministry of Health (as trustees of the hospital) and

the visiting anesthetist, alleging negligence or unskillfulness in the administering of the anesthetic; they also sued the company which manufactured the nupercaine, alleging that it had negligently permitted a harmful substance or irritant to be present in the anesthetic or in the ampoule. At the close of the plaintiffs' case the manufacturers were dismissed from the action, it being agreed that the company was not legally liable. An eminent witness for the plaintiffs had accepted in cross examination a suggestion that nupercaine was "as good a spinal anesthetic as you can get."

The court had to decide, if it could between some conflicting medical evidence on the cause of the plaintiffs' parplegia. It had to determine legal responsibility of the Ministry, the anesthetist, and the hospital staff in relation to one another; and it had to deal with the plaintiffs' contention that the facts spoke for themselves (in the forensic phrase res ipsa loquitur) in such a way as to impose upon the defendants the burden of proving that they had been negligent, thus displacing the normal duty of plaintiffs to establish their allegations. It must have been an important element in the case that standards of anesthesia applied in 1947 could not be expected to take account of later theory

or research. Mr. Justice McNair was satisfied that the method of injecting nupercaine by lumbar puncture was widely practiced in 1947 before the development of other relaxant drugs. No charge of negligence, he said, was based on the adoption of this method for the two operations in question.

The learned judge found himself bound by the rulings in Gold v. Essex County Council (1942) and Cassidy v. Ministry of Health (1951), and thus he held that, so far as the anesthetist was concerned, the hospital's obligation towards the plaintiffs as patients was no higher than the duty (which it had performed) to appoint a competent anesthestist. The hospital was not liable in law for his acts of negligence (if any). As for members of the theatre staff, the hospital must assume the various liability of a master for his servants. The anesthetist was a visiting specialist, comparable to a visiting surgeon or physician for whose acts the hospital would not assume liability. The legal maxim res ipsa loquitur could not apply where the criticized thing or operation was under the control of two parties not in law responsible to each other; if what had happened spoke of negligence, it did not speak against either part individually. The evidence had shown, moreover, that, although the anesthetist was responsible for

choosing the anesthetic, for directing its preparation, and for generally supervising the activities of members of the theatre staff, he must not be deemed responsible for their casual acts of negligence. In consequence, in the judge's view, the normal onus rested on the plaintiffs of proving negligence on the part of the hospital or the anesthetist,

What, then, caused the plaintiffs' unfortunate disabilities? The court remarked that it had been conceded that the injection of nupercaine was not negligent; the medical evidence "clearly established" that the injuries were not caused by an infective organism or by damage to the spinal column produced by the needle. The glass ampoules containing the nupercaine had been stored in a 1 in 40 phenol solution, after temporary immersion in a 1 in 20 solution. Phenol was the only source of contamination which had been suggested. The fact that the same substance was injected by the same anesthetist on the same day into two patients who suffered the same injuries was something which "seemed to point conclusively to some common factor." The proportion of such injuries after such injections seemed to be 1 in 10,000. The court found it difficult to ascribe to some personal idiosyncrasy on the part of the patient an injury so

rare when the common factor was present in the case of these two plaintiffs. Glass ampoules could crack; if they did, nupercaine might be replaced by phenol without being noticed. In the judge's view, phenol was the most likely common factor; "after the most anxious consideration of the medical evidence" he came to the conclusion that the injuries were caused by the injection of phenol with the nupercaine. The phenol could find its way into an ampoule stored in a solution through cracks which the eye could not detect or through molecular flaws in the glass. The attention of the profession had been drawn to this risk by Professor Macintosh's book on Lumbar Puncture and Spinal Anesthesia. This book had been published here in 1951; in 1947 the general run of competent anesthetists would not have appreciated the risk. His lordship held accordingly that the defendant anesthetist was not negligent in failing to appreciate it. A fortiori the theatre staff were not negligent. No confident medical opinion could be expressed as to the quantity of phenol necessary to produce the results in question. The judge found it difficult to believe that this anesthetist would have failed to notice a visible crack in an ampoule. It had not been shown that the hospital staff had been negligent in handling the amp-

oules so as to cause invisible cracks. As a result of these conclusions the claim must be dismissed both against the hospital and against the anesthetist.

To cite isolated passages from the evidence given by distinguished medical witnesses in a long case is less than satisfactory. It may perhaps be mentioned, however, that Professor R. R. Macintosh, consulting anesthetist to the United Oxford Hospitals, called by the plaintiffs, stated in cross-examination that he thought their injuries were due to the introduction of phenol into the spinal canal; and, asked if there was not a widespread body of opinion that spinal anesthetists caused these injuries, quite apart from any foreign influence, he replied that he did not hold that view. Professor E. B. C. Hughes, professor of neurosurgery in the University of Birmingham, stated that in 1947 an anesthestist should have known that a normal dose of spinal anesthetic was dangerous and involved the risk of permanent injury. Sir Francis Walshe, F. R. S., consulting physician to University College Hospital, called by the defence, thought that the plaintiffs' paraplegia could not be explained by the introduction of phenol; phenol could not produce such conditions. Dr. Macdonald Critchley, senior neurologist to King's College Hospital,

did not think the injuries were due to phenol; he attributed them directly to the spinal anesthetist. He considered it was high time that the whole problem of the complications of spinal anesthesia was re-examined by the medical profession." Lancet, (104)

13. Secretary Fisher, of Canada's Medical Association,gives extracts from a case which shows anesthesiolgy has come of age. "In the latter part of December, 1950 a nine year old girl was anesthetized in an anesthetic room and an endotracheal tube was inserted. During the move to the operating room, where tonsillectomy was to be done, the stage of anesthesia lightened so that the patient was coughing. Quickly the anesthestists attached to the endotracheal tube the rubber tubing which he believed to be attached to the air nozzle leading from an ether blow-bottle. The air tap of the anesthetic bottle was turned on and immediately a spurt of ether came out of a "Y" connectot which formed the junction between the rubber tubing and the endotracheal tube. Just as quickly the air was turned off and the endotracheal tube removed.

Nevertheless a considerable volume of ether had reached the patient's lungs; respiration ceased immediately and, very shortly after, heart beat stopped. Art-

ifical respiration was begun and almost immediately the chest was opened and cardiac massage started. Heart beat was restored. Various other applicable measures were instituted but pulmonary edema developed and continued in spite of treatment even though spontaneous respiration had begun. Over the twenty-four hours there was some improvements in physicial condition in spite of partial collapse of the left lung. Consciousness did not return and two days later the patient died.

An inquest was held and its verdict the coroner's jury decided that the death resulted from an overwhelming dose of liquid ether and did not specifically blame the anesthetist or the hosptial.

The case did not come to court so it was not established who had connected the ether blow-bottle, nor was there a decision about the relative responsibility of the hospital for connecting the apparatus and the anesthetist for using it when it must have been wrongly connected.

Finally, it was possible to arrive at a settlement of $1,700. with the parents of the deceased child.

It will be noted that, in this as in some previous anesthetic cases, the surgeon was not implicated. It is worth emphasis that anesthesia as a specialty has come

of age and that many things related to anesthetics for which surgeons previously were held responsible are now the sole responsibility of the anesthetist. Anesthetists, therefore, must be prepared to accept full responsibility for everything connected with anesthetics given by them! Fisher, (105).

14. This case rules that proper medical treatment is a question for medical experts to determine. This action was brought by the plaintiff to recover damages for the death of her husband, alleged to have occurred during an operation through the negligent administration of an anesthetic. The judgment of the district court was against the plaintiff and she appealed to the Supreme Court of Kansas.

The plaintiff's husband was seriously injured in his arm and was taken to the defendant's office. The surgeon who attended the patient found that the flexor and extensor muscles had been severed, that the ulnar vein had been cut, and that a clot had been organized between the outer edges of the severed muscles and the vein. The patient was removed to a hospital for operation and an anesthetist called to assist. Prior to the administration of the nitrous oxide gas, both the anesthetist and the surgeon examined the patient's

heart by placing their ears to his chest. The anesthetist also examined the pulse. During the operation, the patient's pulse rate was never lower than 84 or higher than 95. The respiration was between 20 and 24and there was no unusual cyanosis of the patient. At the conclusion of the operation the patient was breathing normally, when the anesthetist noticed a sudden failure of respiration. He could not find the pulse in front of the ear or in the neck. No heart sounds could be heard by the surgeon. All the efforts to revive the patient failed. Mucus bubbled from the mouth of the patient and continued to do so for several minutes. The plaintiff contended that a proper preoperative examination of the patient was not made, but the supreme court held that there was no evidence of any unusual condition of the patient nor that preexamination would have disclosed any contraindication of nitrous oxide at or before the time of the giving of the anesthetic or that any test other than was given would have disclosed anything to have made the giving of the anesthetic improper. Several specialists in anesthesia testified that, from the facts in the case, the death was due to an embolism, not from the anesthetic, basing their testimony on the sudden cessation of the respir-

ation and the cardiac action, the simultaneous arrest of both functions, and the frothy material that emerged from the mouth of the patient. Mucus in the mouth is not characteristic, they testified, of nitrous oxide asphyxiation. The supreme court held that the evidence showed that the patient undoubtedly died from an embolism.

Objection was made by the plaintiff to a hypothetical question propounded by the defendants to several expert witnesses during the trial, on the ground that it invaded the province of the jury. The supreme court said that the question propounded the query of whether or not certain specified treatments of the patient by the physicians would constitute skillful and proper practice in that or similar communities. The question was a proper one, the court held, and quoted from James v. Grigsby. James v. Grigsby, (106)

What is the proper treatment to be used in a particular case is a medical question to be testified to by physicians as expert witnesses; laymen, even jurors and courts, are not permitted to say what is the proper treatment for a disease or how a specific surgical operation should be handled.

The judgment of the lower court was affirmed. Updegraff v. Gage-Hall Clinic, (107).

15. An anesthetist is responsible for his own negligence in selecting an improper anesthesia or negligently administering it, or for any other failure to use due care in the performance of the work assigned him. But if the operating surgeon is negligent, may the anesthetist be held equally responsible? The question was thus succintly answered by the Iowa courts: "it is well settled that generally speaking a physician who merely administers an anesthetic to a patient who is operated upon by another is not liable for the negligence of the operating surgeon." Nelson v. Sandell, (108)Robinson v. Crotwell, (109),Jett v. Linoille, (110).

16. Thus, in a Kentucky case the plaintiff's excessive uterine bleeding necessitated the performance of a laparotomy. During the operation gauze was placed in the uterus but was not removed. The defendant was acting as the anesthetist. He took no other part in the operation. "It is a well established rule in surgical operations," said the court in holding the anesthetist not liable, "that the anesthetist is directly chargeable with the physicial condition of the patient in the operating room and his attention must always be directed solely to administer the proper amount of the anesthetic and continuing to supply it in just such proportions as

will insure the patient's remaining in a comatose condition while the knife is being used. Jett v. Linoille, (110).

17. Even where a physician has advised against an operation, but thereafter consents to act as the anesthetist during its performance, he is not responsible for the operating surgeon's acts. This was decided in Vermont where the Court said: "The physician had already advised against any operation at the time and place where it was performed, but his advice had been disregarded and the operation was being performed contrary thereto and was not subject to his control. Therefore he was not called upon to object or to protest against it and hence no inference of approval of it could be drawn against him from his silence in that respect." Lawson v. Crane, (111).

18. It is seldom if ever that an anesthetist has "control" of the operation. We have seen how the courts recognize that his attention "must always be directed solely to administer the proper amount of anesthetic", and yet he is not a mere dummy at the operation and may have some responsibility therefor if he observes something wrong and fails to object. Thus, in a Federal case and the United States Circuit Court of Appeals declar-

ed: "Two physicians independently engaged by a patient and serving by mutual consent necessarily have the right in the absence of instructions to the contrary to make such division of service as in their honest judgment circumstances may require....Each in serving with the other is rightly held answerable for his own conduct, and as well for all the wrongful acts or ommissions of the other which he observes and lets go on without objection or which in the exercise of reasonable diligence under the circumstances he should have observed. Beyond this his liability does not extend." Keller v. Lewis, (112).

19. This case involved an anesthetist and a surgeon. The plaintiff there who was delivered of a child, sued the doctors charging them with causing or permitting vaginal and uterine tears and lacerations, with having failed to remove a part of the placenta, and with such a failure properly to sterilize the instruments as resulted in infection. Now it appeared that the doctor who later acted as the anesthetist had had charge of the case before the operation and up to the time when the plaintiff's husband called in the surgeon. When the later arrived and made his examination, he concluded that a successful delivery could not be made without instrument-

ation. It was arranged between the two physicians that the surgeon should handle the instruments and that the doctor who had been in charge before the surgeon came, should administer the anesthesia. Whatever the condition of the instruments may have been there was no evidence that the anesthetist knew or had reason to suspect that they had not been properly sterilized. His contention therefor, that he was not liable for any negligence of the surgeon, as the latter was an independant contractor, was upheld by the United States Circuit Court of Appeals. Referring to the anesthetist's alleged responsibility for the improper sterilization of the instruments, that court said: "By the exercise of reasonable diligence under the circumstances should he have known? Not unless while attentively engaged in his own part of the service be ought....to have entertained a suspicion that an apparantly learned and skillful surgeon was about to commit a gross medical offense, and to have followed up the suspicion by inquiring whether his brother had forgotten to sterilize his hands and his instruments. No unreasonable burden is imposed by the law." Brown v. Bennett, (113).

20. As to the anesthetist's alleged responsibility for the retained placenta, the court said: "When the

after-birth was delivered, Rice (the surgeon) examined it, and found it to be entire and at once had it disposed of. Morey (the anesthetist) from across the bed looked at it and to him it appeared to intact. Nothing in the record warrants a finding that Morey knew that Rice had not removed all of the afterbirth. And here too Morey was not bound to assume in the absence of observable indicia that Rice was incompetent." Hitchcock vs. Burgett, (114).

21. Where, however, a physician merely attends an operation to observe it, --as a spectator-- but has no connection or responsibility for it any way, he cannot be held responsible for the acts of the operating surgeon. Gould v. Kirlin, (115).

22. "The anesthetist is charged with a particular responsibility, namely, the administration of a potentially dangerous substance to the patient. In the absence of grave emergency, when it is impossible to obtain the services of another practitioner, it is extremely undesirable for the operator himself to undertake the additional task. It is not, of course, incumbent upon the anesthetist to show the skill and knowledge of a specialist, unless he holds himself out as one, but he must show at least a reasonable degree of skill and knowledge in the

handling and administration of anesthetics. In teaching hospitals it is a common practice to allow senior students to administer anesthetics under proper supervision. In such circumstances, of course, the responsibility for all acts of the student rests upon the supervising practitioner." Gordon, Turner, Price, (116).

23. "The plaintiff patient was employed by the Manchester Corporation as a stoker in their cleansing department. On 11th January 1950 he was emptying a sack of paper through a hole in the floor where there came a backdraught which caused flames to shoot up through the hole. Jones was burned about the face, and he was taken to the Ancoats Hospital where his death occurred the same day. In due course an action was commenced against the Manchester Corporation by his widow,in which she claimed damages on her own behalf and on behalf of her children, alleging negligence against the Corporation. Subsequently, Dr. Olive Cynthia Wilkes and the Manchester Regional Hospital Board were added as defendants, it having become clear that the death of Jones did not occur through burns. Dr. Wilkes was a house-surgeon at the Ancoats Hospital, which is administered by the hospital board. It was claimed that she was negligent in regard to the administration of an anesthetic, that the death of Jones

was caused thereby, and that she and the hospital board were responsible in damages therefor....Both Dr. Wilkes and the hospital board denied negligence throughout. It is desirable that I should say something as to the facts. When Jones arrived at the hosptial he was seen by two young doctors. On that day one of the young doctors was acting as anesthetist. She had passed her examinations as surgeon and doctor, but she had no special qualifications as an anesthetist and not much experience. As the learned Judge pointed out, for many years anesthetists have been regarded as a special branch of the profession. It is a fact that to anesthetise the human being, to deprive him of consciousness, is to take a considerable step. If the matter is handled by experienced people very little danger exists, but to allow inexperienced people to practise that without supervision is a serious thing. The two young doctors decided to clean up the face, on which the burns were, under an anesthetic. Jones got on to the operating table. He was in perfectly good health. He was suffering pain from his burns, but he was not in a serious condition otherwise. He got on the operating table himself at about a quarter past five. When he was on the table Dr. Wilkes first applied nitrous oxide gas with oxygen by

means of a mask over his face. It is, perhaps, strange, and it shows inexperience of those concerned, that they that course when the operation involved attending to his face, for it meant that the face would be covered with a mask. When it was realized that the mask would be in the way for that which Dr. Sejrup had to do , it was decided to change and to give an injection of pentothal is one of the barbituric group. It is dangerous--there is no question about that--and though as time has gone on it has become much more used than it was some time ago, it is still a drug which ought to be administered with great care. Dr. Wilkes sent the nurse for pentothal. She brought it. By that time Jones had been under gas for some minutes. He was not conscious and he could not be asked to count. One of the recognized practices when pentothal is injected into a patient is to ask the patient to count, so that it is possible to tell when the stage of complete anesthesia is reached. The dose of pentothal which was administered by Dr. Wilkes was an ordinary dose which is given to a person who has not had any other anesthetic--10 c.c. At the time that the injection was given the patient was not conscious. He may have been semi-conscious; he had been according to the Judge's finding, under gas for three to five minutes.

Ten cubic centimeters of pentothal was taken into the syringe, and the whole of 10 c.c. was injected by Dr. Wilkes in two lots--first, approximately half the amount then there was a pause the length of which is all-important, and then the other half of the 10 c.c. was injected. By the time that was completed the patient was dead... Dr. Wilkes had been qualified about five months. She was appointed after an interview. There is nothing to show what the board knew of her, except that she had obtained her medical degrees. I suppose it may be said that they were entitled to expect that she had the knowledge and skill of a newly qualified doctor, and that she would exercise that degree of skill. I think, too, that in such circumstances there must be implied an undertaking by the board that they would provide some reasonably competent person to work with her, or to guide her in case of difficulty. A newly qualified doctor cannot know much of drugs such as pentothal or of the dangers arising therefrom, and it is not reasonable, or safe, that he or she would be left without guidance or help on such matters.. That was the view which Oliver, J. took. He said:

"I think to put a weapon like a barbituate within reach of a girl (Dr. Wilkes) who has only been qualified for five months and expect her to handle it accurately

with sufficient knowledge and experience--to watch the way a patient has to be watched--is simply asking for trouble. I cannot help it if it is common practice."

It is the duty of the anesthetist to satisfy himself that the patient has been examined in order to ascertain whether an anesthetic is necessary, the fitness of the patient to undergo anesthesia, and the most suitable anesthetic to use. This examination is often made by the practitioner in charge of the case, but it should always be followed by an examination by the anesthetist himself. If the patient suffers ill effects from the anesthetic, and inquiry shows that the possibility of such effects could reasonably have been foreseen if the patient had been properly examined, the anesthetist will be held liable, and so will the operator, if in the circumstances he should also have been aware of danger. Thus in the American case of Van Sant v. Overstreet the defendants were held liable for the death of a boy by heart failure under anesthetic during tonsillectomy, in circumstances in which they were aware, or should have been aware, that he has a "rheumatic heart."

It should not be forgotten, however, that surgical techniques have advanced to such an extent in modern times that operations are now continually attempted in cases

where the patient would otherwise undoubtedly die, although the operation itself may be a forlorn hope and the patient may be a very bad risk in the eyes of the anesthetist. In fact it is only in such ways that really important advances in surgery can be made. In such cases it is for the surgeon to decide finally, after consultation with the anesthetist, whether it is worth risking the operation. If he decides to operate, the anesthetist must accept his decision and give him every professional assistance. Any other course of conduct would be a serious infringement of the etiquette and finest traditions of the profession. But it must follow that if in spite of the best endeavors of the anesthetist the patient then dies under the anesthetic, the anesthetist cannot in any way be held to be blameworthy.

Whoever is responsible for the preparation of the patient must see that, if possible, the patient's stomach is emptied, and that the patient in general comes to the table ready to be anesthetized with the minimum of danger. In an emergency it may not be possible to do all that should be done and the anesthetist must then do the best he can in a difficult situation. In hospitals and similar institutions this duty of preparing the patient will fall upon the nursing staff. It has been suggested that

in such circumstances the anesthetist cannot reasonably be expected to intervene, and that if he refused to proceed when the patient had been brought into the theatre until he had questioned the members of the hospital staff in detail on their preparation of the patient, there would be "danger of mutiny". But this seems nothing less than putting susceptibilities of the hospital staff above the safety of the patient. The premedication and general preparation of a patient for the administration of an anesthetic may be a matter of life and death for him. It is clearly the duty of the anesthetist to make a last minute check on the condition of the patient before he actually proceeds to administer the anesthetic. In a hospital or nursing home this is easily done by carefully checking the patient's record card. In the absence of such a record the anesthetist must make careful and searching inquiries and assure himself that the patient is as far as possible in a fit condition to be anesthetised.

Every precaution should be taken by the anesthetist to see that his apparatus is properly connected up and working. Cases have been known where patients have been given carbon-dioxide or nitrous oxide instead of oxygen because the gas bottles have been wrongly connected up,

or where liquid anesthetic has been injected into the trachea because of the failure of the vaporiser. It seems clear that the anesthetist cannot delegate his responsibility to any other person. He must test his apparatus for himself, or take the responsibility if it is done for him. The utmost care must also be taken not to confuse one substance with another. In the American case of Hallinan v. Prindle, formaldehyde was injected instead of procaine hydrochloride; and in the English case of Collins v. Herts. C.C. a solution of 1 per cent cocaine with 1/2000 adrenaline was injected instead of one of 1 per cent procaine with 1/20000 adrenaline.

During the administration of the anesthetic a careful watch should be kept on the patient, and resuscitation apparatus should at all times be at hand.

Of course, it is well known that no precautions can guarantee the absence of ill-effects from anesthesia. Furthermore the great majority of alleged anesthetic deaths arise from some unforseeable condition or idiosyncrasy of the patient. The same may be said of spinal anesthesia, in which paralysis may ensue without any warning. Hagan gives several examples of cases arising in which no negligence could possibly be attributed to

the practitioner.

After the operation or other medical treatment is over it remains the clear duty of the anesthetist to ensure that the patient is properly attended to and safeguarded from ill-effects as a result of the anesthetic. In a hospital or nursing home the anesthetist may discharge this duty by delivering the patient into the charge of a properly trained and qualified member of the staff of the institution. It is obvious that a probationer nurse is not such a person; in fact, it may well be that the anesthetist cannot justifiably discharge himself of his patient until he has been actually handed over to a ward sister or practitioner of similar standing and responsibility, or the patient's own physician. There ia an undoubted tendency for some anesthetists to wash their hands of their still unconscious patients as soon as they can get them out of the theatre. Such laxity cannot be excused. In one case, the patient was placed on a trolley and then left in the hands of a probationer nurse to be wheeled away ot the ward. On the way the patient's tongue fell back and choked him. There can be no doubt that thus leaving his unconscious patient, he is clearly to blame for such an unfortunate result. The onus is on him to justify his conduct, and he will not

find it easy to justify. Jones v. Manchester Corporation. (117).

24. Explosion may occur through the ignition by an electric spark of the inflammable vapour caused by a mixture of anesthetic gas and air and oxygen. The most dangerous mixtures are ether-oxygen and cyclopropane-with air. The necessary ignition may come from diathermy apparatus, x-ray apparatus, surgical lamps, cauteries, and even the ordinary electrical fittings in the theatre, or static electricity sparking from a rubber-tyred trolley. It is not easy to see how an anesthetist could be held liable for such an accident, provided that his apparatus is functioning properly, and he takes reasonable precautions against the formation of pockets of explosive gas. This may be done by the observance of such precautions as the firm stoppering of bottles, the use wherever possible of efficient suction pumps, and, if necessary, the closed circuit method of administration. Electrical apparatus should always be carefully tested before use. Although sparks occur without warning, a practitioner who uses apparatus which he knew or ought to have known might emit sparks may be found liable if an explosion or fire occurs.

25. This case rules that nurses may give anesthesia.

Two practicing physicians, on behalf of themselves and all other physicians, filed a petition for an injunction to restrain the defendant nurse, employed by the defendant hospital, from administering general anesthetics in connection with operations. Such practice, it was contended, constituted a violation of the medical practice act of California. The trial court gave for the defendants, and the plaintiffs appealed to the Supreme Court of California. The findings, said the Supreme Court, show conclusively that everything that was done by the nurse in the present case, and by nurses generally, with respect to the administration of anesthetics, was and is done under the immediate direction and supervision of the operating surgeon and his assistants. Such method, said the court, seems to be the uniform practice in operating rooms. The court continued: "There was much testimony as to the recognized practice of permitting nurses to administer anesthetics and hypodermics. One of the plaintiff's witnesses testified to what seems to be established and uniformily accepted practice and procedure followed by surgeons and nurses, and that is what it is not diagnosing nor prescribing by the nurses within the meaning of the Medical Practice Act. We are led further to accept this practice and procedure as established

when we consider the evidence of the many surgeons who supported the contention of the defendant nurse, and whose qualifications to testify concerning the practice of medicine in this community and elsewhere were established beyond dispute. That such practice is in accord with the generally accepted rule is borne out by the decided cases." Furthermore, said the court, aside from the proposition that nurses in the surgery during the preparation for and progress of an operation are not diagnosing or prescribing within the meaning of the medical practice act, it is the legally established rule that they are carrying out the orders of the physicians to whose authority they are subject. The surgeon has the power and therefore the duty, to direct a nurse in her actions during the operation.

The judgment of the trial court for the defendants was therefore affirmed. Chalmers-Francis et al v. Nelson, (118).

26. The plaintiff contends: "First that she is the widow of Felix J. McFall. Second, that the 15th of June 1935, the said Felix J. McFall sustained a minor accident to his leg which necessitated an operation, which was commenced on the 17th of June, 1935 at the Royal Victoria Hospital, one of the defendant's, under

the direction and the orders of Doctor Turner, the other defendant, acting more for himself than in his quality as representative (prepose) of the defendant Royal Victoria Hospital. Third, that on the 17th of June, 1935, while the said Felix J. McFall was still on the operating table and while he was being given an anesthetic, he suddenly died. Fourth, that the death of the said Felix J. McFall, related above is entirely due to the fault and to the gross and culpable negligence of the defendants, or of their representative. Fifth, that the death of Felix J. McFall is due chiefly to the facts that: (a) The anesthetic was not administered according to the rules of the art and common usage, and this with the knowledge of, and with the authorization of the defendants or their representatives. (b) The anesthetic was not given with all the precautions required by the rules of the art before and during the course of the operation, and this to the knowledge and with the permission of the defendants or their representatives. (c) The person to whom the administration of the anesthetic was entrusted, proceeded negligently and without precautions, (d) The nurse, representative of the defendants, and by their orders, practiced and administered anesthesia contrary to the law.

Before the operation, the husband of the plaintiff had not undergone a sufficient examination of his heart, blood pressure, lungs, the bronchi, of the kidney function, and of all the functions in general of his organs, and the administrator of the anesthetic should never have administered the said anesthetic without these absolutely necessary precautions.

To details of the declaration the plaintiff adds: During the operation the administrator of the anesthetic did not have the required competence, and was not qualified to administer gas and oxygen, according to the condition of the patient during this operation.

Considering that an anesthetic agent is a remedy,a drug, which shows its action by certain signs and produces definite effects; by these symptoms and these signs one knows what is happening to the patient; and to understand these signs and to judge what may arise, it is necessary to know medicine.

Considering that whatever may have been the skill of this young lady while acting otherwise in her professional capacity as a nurse, the choice of Nurse Butler was an anesthetist, in the case of McFall, was regrettable and constituted afault on the part of the defendants because, by this choice the defendants were not

offering to McFall the maximum of protection which such a situation demands, and to which every patient who trusts his life to a hospital and a surgeon has a right,

Considering that the administration of a general anesthetic, without which certain operations would be impossible, being a dangerous act (an expert of very great experience said 'very dangerous'), it therefore results that the very fact of proposing for this duty a young nurse, necessarily inexperienced and who had very little of the medical education of a physician constiutes a fault in itself; the aptitude of the operator must be in direct relation to the danger of the operation of the patient.

Considering that a nurse has not the required medical preparation to be able to cope with an accident during anesthesia; the reflexes, the pulse, the breathing, the color of the patient, these are signs which would speak in a certain way to a specialist in anesthesia, and which by keeping him constantly informed of the condition of the patient, permit him not only to protect tha patient by intervening at a critical moment, but also to foresee and prevent such a critical moment; that which constitutes the value of a medical anesthetist having a knowledge of physiology, is his ability to per-

ceive quickly a sudden complication which may arise, to act quickly, to do what should be done and nothing else.

Considering that it was established by proof that in the present state of medicine and surgery, when a patient has just died suddenly during the course of a surgical operation accompanied by general anesthesia, it is often, even generally perhaps, impossible to determine what was the true cause of death; the learned doctors heard were all in accord in saying that many physiological phenomenas could, in such circumstances, cause death, but not one of them was able to say positively what was the cause of death in the case of McFall; it follows then that the exact cause of death remains unknown, and, as it is obligatory in order to establish a fault, to know to begin with the cause of the death, seeing that it might result from causes completely foreign to all notion of fault, it follows, therefore that it is impossible to know if the death of McFall was the consequence of a fault, even though in another way, it is established that a fault has been committed.

Considering that this is not the place to judge the question of whether if, in administering the anesthetic to McFall, Nurse Butler practiced medicine, that question being absolutely foreign to the issue; the action

cannot rest on a statutory fault, but, only on a delictual one.

Considering that the plaintiff did not succeed in proving that the loss she had sustained was the consequence of the fault committed by the defendants, whence it follows that the action, badly founded in law cannot be maintained.

Considering that, with regard to costs they should not be accorded in favor of the defendants for the following reasons: (a) on account of the fault committed by them; (b) because, as a matter of fact, it is only because of the benefit of doubt to which they have the right, and the insurmountable difficulty for the plaintiff, to make a technical proof practically impossible to obtain, that the action is dismisses.

For these reasons the tribunal maintains the defense and dismisses the plaintiff of her action without costs." McFall v. Royal Victoria Hospital, (119).

After the judgment the Registar of the College of Physicians and Surgeons of the Province of Quebec sent a circular letter to all the hospitals in the province pointing out to them that the Law of the Province prescribed that anesthetics should be given only by duly qualified physicians, that certain hospitals had not

submitted to that law and had continued to let nurses give the anesthetics. He commented on the judgment which had just been rendered, and pointed out that the judge had blamed the hospital for having permitted the nurse to give the anesthetic. He enclosed also a copy of a letter from the Deputy Minister of Health for the Province of Quebec, stating that the Minister of Health entirely agrees with the opinion of the College on this question namely, that the administration of anesthesia is a medical act which should be undertaken only by a physician. Following the receipt of this letter, the few hospitals of the Province of Quebec which were still employing nurses decided to conform to the law without further opposition, and the nurses are now being replaced by physician anesthetists.

27. "Because of the seeming reality of dreams occasioned by narcotics and their tendency to remain permanently fixed in the memory, with all the vividness of actual events, as well as for the protection of the patient, statutes have been passed in several States declaring it to be a crime to "use upon another an anesthetic unless at administration, and during the whole time the person is wholly or partly under the direct influence of it, there is present a third person com-

petent to be a witness." Culbertson, (120).

28. In dealing with anesthestics, the practitioner must know that he is using instrumentalities which are dangerous and deadly, and his care in diagnosis, selection of drug and administration, must be in proportion to the risk involved to his patient. His responsibility begins with the examination preceding the administration of the drug, and carelessness or ignorance in diagnosis, resulting in the determination to use the particular drug, or to resort to anesthesia, when clearly it should not have been given, will make him liable in malpractice for resulting injuries, and possibly for manslaughter, where the consequences are death. He cannot trifle with the health or life of his patient and not shoulder the responsibility. State v. Baldwin, (121).

SUMMARY OF THE ANESTHESIA MALPRACTICE CHAPTER

Regan's list of the seven most common allegations of anesthesia are:

1. No preliminary examination.
2. Too much anesthetic.
3. Death from anesthesia.
4. Injury to eyes or skin.
5. Injury from mask; from mouth gag.
6. Injury during struggling (improper administration).
7. Pneumonia caused by fluid ether in lungs.

This chapter then gives extracts from cases in the anesthesia malpractice field. However, the rules of law apply to any phase of medical malpractice. The rules of law laid down by the State Supreme Courts of various state jurisdictions is as follows:

1. Nebraska: Consent for an operation may be implied while a patient is under anesthesia and conditions require the procedure for the patient's benefit.
2. Minnesota: Ether anesthesia continued after surgeon's knowledge that the effect was known to be pernicious was held to be actionable negligence.
3. Michigan: A 19 year old was held old enough to contract for his choice of anesthesia.
4. Massachusettes: One physician testified that the de-

fendant physicians giving ether to a patient with a cold caused her bronchitis and the verdict was against the defendant physician.

5. Kentucky: Inadequate pre-operative examination was held actionable.
6. Massachusetts: Proving injury only is not sufficient for sucessful suit.
7. California: An osteopath's testimony against an M. D. stating the cause of death was ethylene administration without oxygen was sufficient to get a verdict against defendant physician.
8. Idaho: The burden of proof is on the plaintiff patient in a malpractice suit. It is not sufficient to merely raise the suspicion of negligence.
9. Texas: Negligence is never imputed from results only. It must be proved.
10. North Carolina: Negligence is not imputed from results. Negligence must be shown in the defendant physicians acts or failure to act.
11. Great Britain: Actual negligence, not imputed negligence, must be shown to allow defendant plaintiff's recovery.
12. Great Britain: Paraplegia after spinal anesthesia was insufficient to substantiate an allegation of

negligence.

13. Canada: Anesthesiology has come of age. Anesthesiologists are now held responsible for everything connected with anesthetic administration.
14. Kansas: What is proper medical treatment is a question for expert medical testimony to determine--not the lay public.
15. Iowa: An anesthetist-physician is not liable for the acts of the surgeon.
16. Kentucky: The anesthetist is liable for his own acts only.
17. Vermont: The anesthetist is only liable for the anesthesia not the surgery.
18. Arkansas: Supra.
19. Michigan: Supra:
20. Michigan: Supra.
21. Illinois: A physician spectator has no responsibility for the surgery witnessed.
22. South Africa: When a student gives the anesthesia the supervising practitioner is responsible.
23. Great Britain: The anesthetist is responsible for pre-operative evaluation and to safeguard the patient post-operatively against any ill effects of the anesthesia.

24. U.S.: An anesthetist is responsible for using equipment he knows to be dangerous.
25. California: Nurse-anesthetists are permitted to give anesthesia in California.
26. Canada: Physicians only administer anesthesia in Canada. Anesthesia administration is held to be a medical act requiring physicians only.
27. State statuates: Some states require third party witnesses when anesthesia is being administered.
28. Kansas: Negligently giving unnecessary anesthesia may cause the anesthestist to become guilty of manslaughter and responsible for injuries thereby sustained.

Conclusions from Anesthesia Malpractice Chapter:

1. Statements by physicians can cause malpractice suits against other physicians.
2. An anesthetist is liable for his own actions only-not those of the surgeon.
3. The anesthetist is responsible for pre-operative evaluation and post-operative care against the ill effects of the anesthesia.
4. Negligence must be proved by the plaintiff patient-not imputed by unfortunate results.
5. What is proper medical treatment is for expert medical

testimony to decide, not opinions od the lay public.

6. The supervising practitioner is responsible for his students' acts.
7. Unnecessary giving of anesthesia through negligence is actionable.

CHAPTER VIII

Malpractice in Radiology

This chapter includes some of frequent causes of action against radiologists. Certain representative cases are extracted which involve radiology in medical malpractice cases at law.

Frequent allegations in radiology malpractice suits:

1. Xray burns.
2. Xray tissue slough.
3. Loss of life.
4. Excess radiation.
5. Loss of hair.

1."One of the best known decisions on this subject was made by the Second Department of the New York Appellate Division. In that case the plaintiff was suffering from pruritus vulvae et ani, for which Xray treatment is recognized and accepted, The defendant doctor gave the first treatment on May 17, 1919, he gave another on May 24th. The correctness of factors of dosage and manner of treatment as testified to by the defendant were not disputed. But all the experts, including the defendant admitted that if on May 24th (the date of the second treatment) redness of the external parts had appeared and hair had fallen out that there was an indication that further treatment should

not then be given. The case therefore turned upon a lay question: Was there redness and loss of hair on May 24th or not? The plaintiff testified that there was; the defendant swore with even greater positiveness that there was not. Had there been nothing else in the case, the Appellate Court declared that there was an issue for the jury to decide. But this was not all. It appeared in the evidence that there "are a few people, probably not more than one out of every 200 or 300, who are supersensitive to Xray treatment, and apparently that disposition of the patient cannot be known in advance of the test of actual treatment and its results." "Such cases," said the Appellate Division, "are so rare that evidently physicians and patients have to take that risk—the one is administering and the other in receiving the treatment" Despite this the trial judge charged the jury that the result might be considered by them "as some evidence of negligence," and was sufficient to cast upon the defendant the duty of burden of explanation.

Deciding that this was not the law, the Appellate Division in reversing said: "It having been proven that specific results might come from proper treatment without negligence on the part of the physician, that is, the case of a hypersensitive person, the mere fact that the

result did follow the treatment in this case was in itself no evidence of negligence. The case thus presented was merely one where, according to the proof, the stated result might have followed from one cause, viz. plaintiff's hypersensitiveness; and therefore, the naked facts of the result was in itself no evidence of the existence of the one cause in preference to that of the other," Antowill v. Friedmann, (122).

2."In a Pennsylvania case it appeared that the plaintiff was burned as a result of the taking of a number of Xray pictures. In effect the trial court charged the jury that they could infer negligence from the fact that the plaintiff had been burned. The Appellate tribunal reversed the lower court declaring that the charge left "out of account and idiosyncrasy of certain persons to Xray". That there is such idiosyncrasy and that it cannot be known until after the Xray has been used, was shown at the trial.

But there were other errors committed by the trial judge, among which was the manner in which he emphasized the danger of Xray. "The court duly stressed the fact", the Appellate Judge said,"that Xray is a dangerous instrumentality. So is a surgeon's knife, If human ills are to be cured such instrumentalities must be used. To put

upon the medical profession, which must use them, such a burden as financial responsibility for damages if injury or death results, without proof of specific negligence would drive from the medical profession many of the very men who should remain in it, because unwilling to assume the financial risks. Stemmons v. Turner, (123).

3. Holding that the res ipsa loquitur doctrine, (the thing speaks for itself-in other words established negligence without further proof) has no application to Xray burn cases, the Pennsylvania Appellate Judges quoted from the Supreme Court of Arkansas: "The doctrine of res ipsa loquitur does not apply in such cases, because the res ipsa loquitur does not apply in such cases, because the testimony shows that on account of the idiosyncrasies....one person of a certain type and temperament would be susceptible to a burn while another person of a different type under the same circumstances would not be burned. Moreover it is shown that burns do occasionally occur in the ordinary course of exposure in spite of the highest diligence and skill to prevent them. Ewing v. Goode, (67) Hamilton v. Harris (124),

4. A resident of the District of Columbia received an Xray burn. She sued the doctor claiming that the burn was in and of itself evidence of negligence, and

that no further proof was needed. But this doctrine was rejected both by the trial court and on appeal. "Generally speaking," said the Court of Appeals, "no inference of negligence can be drawn from the result of the treatment of a physician or surgeon. In the absence of special contract they are not insurers and there must be evidence of negligence by witnesses qualified to testify.

At the trial of that case the defendant doctor called several experts who testified that the type of apparatus used as proper and that the duration of exposure and the manner in which the apparatus was used in accordance with the practice of careful and prudent Xray operators. The plaintiff offered no evidence to the contrary. "Here", said the Appellate Court, "there was no testimony that the instrument used by the defendant was out of repair, that the exposures were of too frequent periods or of too great duration. Neither is there any evidence of lack and skill." Whereas the defendant introduced six physicians skilled in that particular branch of practice whose testimony without exception negatived the charge of negligence." Sweeney v. Ewing, (125).

SUMMARY OF RADIOLOGY IN MALPRACTICE

The most common allegations in radiology litigation are:

1. Xray burns.
2. Xray tissue slough.
3. Loss of life.
4. Excess radiation.
5. Loss of hair.

The typical radiology malpractice case states that merely showing poor results or actual Xray damage is not sufficient to win the case. The courts almost universally state that the radiologist is <u>not an insurer as to good results,</u> (unless he specifically contracts to be one). <u>Actual negligence,</u> in addition to damages to the patient, on the part of the radiologist must be shown to recover money damages in a suit at law.

CHAPTER IX

Malpractice in Surgery

This chapter lists the most common causes of action by the plaintiff patients against surgeons. It also includes extracts of two typical suits for money damages against them.

Allegations (Causes of suits):

the most frequent allegations are as follows:

1. Breaking and slipping of instruments.
2. Foreign bodies left in patient's tissues.
3. Operation without consent.
4. Operation more extensive than that consented to.
5. Operation on the wrong part.
6. Unnecessary operation.
7. Delay in operating.
8. Failure to operate.
9. Unsuccessful operation.
10. Needle broken off in tissues.
11. Bad result from operation--severed nerve or tendon, hernia, injury to sphincter, etc.
12. Failure to follow-up.
13. Failure to discover severed tendon.
14. Failure to use Xray.
15. Failure to discover fracture; second fracture overlooked.

16. Failure to diagnose dislocation.
17. Injuries from application of cast.
18. Insufficient immobilization.
19. Deformity and loss of function (fractures, dislocations.)
20. Cast too tight; removed to soon; left on too long.
21. Failure to use traction.
22. Failure to employ fixation.
23. Failure to institute active and passive motion.
24. Unnecessary scarring.
25. Use of unsterile needle or instruments.
26. Experimentation.
27. Examination without consent.
28. Injury during examination.
29. Error or delay in diagnosis.
30. Failure to use laboratory aids.
31. Failure to administer standard treatment.
32. Failure to leave instructions for treatment of patient.
33. Failure to leave instructions for protection of attendants and of other contacts.
34. Failure to hospitalize.
35. Aggravation of existing condition.
36. Abandonment.
37. Infection resulting from injection.

38. Infection, slough.

39. Burns--Xray, diathermy, infra-red, heating pads, etc.

40. Breach of warranty to cure.

41. Error in the prescription or in dispensing.

42. Overdosage.

43. Use of harmful drugs.

44. Unnecessary medical treatment.

45. Death from injection, from vaccination, etc.

46. Improper quarantine.

47. Carrying contagion.

48. Defective equipment.

Extracts of cases against surgeons:

1. "On July 14, 1955, the Court of Appeal, gave judgment dismissing the appeal of Immanuel Bierer, gynecological surgeon, of London from a judgment of Justice Pearson. Justice Pearson had awarded a total of 4,416 pounds damages for negligence against Immanuel Bierer and the Harley Street Nursing Home Limited, of Weymouth Street, London, in equal shares as a result of a swab or pack left in the body of Mrs. Ellen Urry after an operation for the delivery of a child by caesarean section on January 7, 1953. The issue before the Court of Appeal was whether the surgeon or the theatre sister was ultimately responsible for the removal of the swabs.

In his judgment Lord Justice Singleton said when a

judge was called upon to try an issue involving negligence his duty was the same whether the claim was brought against a surgeon or any other professional man or anyone else. He had to make up his mind on the evidence called before him, deciding what part of it he accepted and whether the case put forward was proved. It was no part of his duty to tell surgeons how to perform their duties.

In this case the surgical packs, each about 10 in. (25 cm.) square, were provided by the home, furnished with tapes as a help towards finding and removal, and counted by the theatre sister before and after use. The sister and the nursing-home had admitted that the count was wrong. Bierer had not used the tapes. The question was, had Bierer failed in his duty?

Although the evidence of other surgeons had been not to make use of the tapes was not by itself negligent, a surgeon who disregarded them placed an additional burden on himself. As Lord Goddard had said in Mahon v. Osborne, (126) nothing could be more disastrous to the community than to leave it to a jury or a judge to lay down what it is proper to do in any particular case without the guidance of witnesses who are qualified to speak on the subject. But if it was the task of the surgeon to put swabs

in. It was his task to take them out, and if the evidence was that he had not used a reasonable standard of care he could not absolve himself by saying, " I relied on the nurse."

In this case Bierer said he looked, and would have expected to feel a pack in the position in which the pack was left, and was satisfied no pack was there or he would not have stitched up. By not availing himself of the tapes he deprived himself of an additional precaution. He was uncertain if he had placed two or three packs on or alongside the uterus. The patient was entitled to expect the surgeon to do what was reasonable to ensure that the packs were removed before asking sister if the count was correct. The count was an additional check, and its occasional failure emphasized the need for diligence on the surgeon's part.

Lord Justice Hodson said that Brierer had fallen far short of the standard of care required him, and was equally responsible with the sister, He had insisted that he was entitled to rely on the sister's count, and his technique did not include any particular effort to remember or have himself reminded of the location of particular packs although he was not using tapes.

Lord Justice Morris gave a concurring judgment and

the appeal was accordingly dismissed. Responsibility of the accident was thus left where it had been placed by Justice Pearson, on the surgeon and the nursing-home through its servant, the theatre sister, in equal shares."

2. The Court of Appeal have upheld the finding of Justice Gorman that the late Dr. C.A. Joll was fit to perform an operation although suffering from cancer at the time. The action had been brought by Mrs. Winifred M. Nickolls against the Ministry of Health, as successors under the National Health Service Act to the liabilities of the Royal Free Hospital, for negligent performance of an operation for the removal of a goiter, performed on her in December, 1944.

The plaintiff alleged that Dr. Joll was then suffering from carcinoma of the lung, and that he and the defendants knew or should have known that he was unfit to perform the operation. As a result of it, the plaintiff was now suffering from permanent bilateral recurrent laryngeal paralysis.

Lord Justice Denning's judgment is of importance to the whole profession. His Lordship said that he could not help feeling that owing to Dr. Joll's state of health something or other went wrong in the operation. But that

could not be said to be negligence unless one was to say that every time a surgeon was taken ill in an operating-theatre that would be negligence. It was not want of skill, or that Dr. Joll was not paying attention, or anything of that kind. The real point was whether Dr. Joll should have undertaken the operation at all. It was a very arduous and important task to operate on other people, and surgeons ought not to do it unless they were fit to do it. But Justice Gorman came to a very firm conclusion that Dr. Joll was quite fit to perform this particular operation, even though he was suffering from cancer, and the Court could not overrule the judge on that point. The other Lord Justices concurred.

Negligence must always turn largely on the facts in each particular case. Hence, the judgments in the present case do not lay down hard-and-fast rules, but they do indicate general principles. It now seems that it is not necessarily negligence to operate when unwell, but that a surgeon should ask himself "Am I fit to perform this particular operation?"

SUMMARY OF MALPRACTICE IN SURGERY

The most common causes of suits against surgeons are enumerated at the very first of the chapter and are typified by operating without consent and leaving foreign bodies in patients.

Two typical cases are extracted:

1. Swabs left in abdomen were held to be equally the responsibility of surgeon and nurse.
2. A surgeon is his own judge of whether he's well enough to operate or not.

Most surveys show surgeons to have more malpractice suits filed against them than any other group.

CHAPTER X

Medical Malpractice in Obstetrics and Gynecology

Introduction:

This chapter lists the most frequent allegations in suits against obstetricians and gynecologists and includes extracts from a representative case of obstetrical malpractice.

Abortion is covered under the chapter on criminal medical malpractice.

Allegations:

Against obstetricians:

1. Failure to attend at time of delivery.
2. Wrong baby given parents.
3. Poor or no prenatal care.
4. Unnecessary caesarean section.
5. Negligent delay in performing caesarean section.
6. Unnecessary use of instruments.
7. Instrumental injury to mother, to baby.
8. Placenta not completely removed.
9. Hemmorrhage from cord.
10. Injury to baby, fracture, paralysis, etc.
11. Failure to protect perineum (and rectum).
12. Failure to repair birth canal injuries.
13. Eclampsia not properly treated.

14. Lack of sterile technique--infection of mother.
15. Diagnosis of pregnancy as tumor (operation, miscarriage).
16. Diagnosis of tumor as pregnancy (special tests not employed).
17. Examination without consent.
18. Injury during examination.
19. Error or delay in diagnosis.
20. Failure to use laboratory aids.
21. Failure to administer standard treatment.
22. Failure to leave instructions for treatment of patient.
23. Failure to instructions for protection of attendants and of other contacts.
24. Failure to hospitalize.
25. Aggravation of existing condition.
26. Abandonment.
27. Infection resulting from injection.
28. Infection, slough.
29. Error in dispensing and in prescription.
30. Overdosage.
31. Unnecessary medical treatment.
32. Defective equipment.
33. Use of harmful drugs.

Against gynecologists:

1. Slander in charging patient had venereal disease.

2. Operation resulting in sterility.
3. Negligent puncturing of uterus during curettage.
4. Injury to ureter.
5. Stricture of cervix, caused by too extensive cauterization.
6. Fistulae-bladder, rectal.
7. Illegal abortion performed without consent.
8. Many of the allegations set forth for the obstetrician.
9. Examination without consent.
10. Injury during examination.
11. Error or delay in diagnosis.
12. Failure to use laboratory aids.
13. Failure to administer standard treatment.
14. Failure to leave instructions for treatment of patient.
15. Failure to leave instructions for protection of attendants of other contacts.
16. Failure to hospitalize.
17. Aggravation of existing condition.
18. Abandonment.
19. Infection resulting from injection.
20. Infection, slough.
21. Breach of warranty to cure.
22. Error in the prescription or in dispensing.
23. Overdosage.

24. Use of harmful drugs.

25. Unnecessary medical treatment.

26. Death from injection.

27. Defective equipment.

"This was a suit for damages against the defendant physician for alleged negligent treatment and care during an obstetric case. From a judgment in favor of the plaintiff patient, the defendant physician appealed to the Supreme Judicial Court of Massachusetts."

The defendant physician was an obstetrician of wide experience, whom the plaintiff first consulted on August 29, 1946, when she was about four months pregnant with her first baby. Her sixth and last visit was on January 6, 1947, within three or four weeks of her expected date of confinement. The defendant testified that on that occasion everything was normal, including the position of the fetus, which he did nothing to change as the head was engaged in the pelvis. On the other hand, the testimony of the plaintiff was that on that occasion the defendant caused her to lie on the examining table, listened to the fetal heart, and "turned the child"; that he placed his hands on each side of her abdomen, and with a "quick sharp motion he pushed his hands down so that what was in her stomach turned around"; that she felt a sharp

pain and screamed, "What are you doing?"; that the defendant replied, "I pushed the child's head downward"; that she experienced " a terrible sharp gripping pain. ...all over her stomach"; and that he told her to expect the baby at any time, to call him at the first sign, and that he would come as soon as she called.

The plaintiff further testified that about 11 o' clock that same evening, while in bed, she felt a sudden gush of blood, which "hit down on her ankles" with great force. It was "coming down all the time", and she suffered great pain. The plaintiff's husband testified that about 11:30 p.m. he telephoned the defendant and told that she was ready to go to the hosiptal, was gushing blood and suffering severe abdominal pain, and that the defendant should come immediately; that the defendant told him to observe the plaintiff for an hour and to call him back; that he observed the plaintiff's condition; that there was "more blood all over the blanket", "a lot of blood"; that he called the defendant again in a half an hour, he could not wait a full hour; that he told the defendant that she was continuing to bleed and was suffering great pain and asked what he should do; that the defendant said that it sounded like a separation of the placenta, and that the defendant would meet him at the

hospital immediately; and that he then drove the plaintiff to the hospital, arriving at 12:30 a. m. What happened the remainder of the night, said the court is disputed. The defendant testified that he received a phone call from the hospital at 1 a. m. and went there immediately arriving at 1:30; that he examined the plaintiff and observed that she was in mild labor; that he was not certain that true labor had started; that her membranes had ruptured; that he observed no blood; that he concluded that the fetal heartbeats were normal; that after 15 minutes he went to another patient to another hospital; that, when he left, the baby was alive and "things were proceeding along"; that around 5 a. m. he recived a telephone call from the night supervisor to the effect that the patient had become nauseated, vomited and passed two blood clots, after which the nurse listened to the fetal beat, which had not been present for a half hour; that his diagnosis at that time was separation of the placenta, and he felt able to make that diagnosis from the telephone conversation; that after receiving "a call of that nature, passage of the blood, abdominal pain," his first duty was to go to the hospital immediately; that he always did that; that this was the accepted practice in the community, that he saw the plaintiff a little after

5 a. m.; that he could not hear the fetal heart beat, the obvious explanation being that the baby was probably dead and had died during his absence.

On the other hand, there was the testimony from another patient that she was in the "labor room" with the plaintiff from about the time of her arrival; that she did not see the defendant there at any time between 1 a. m. and 3 a. m.; that she saw two doctors between 7:30 a. m. and 8:30 a. m.; and that they were the first men she saw in the room. The plaintiff testified that she saw no doctor before 3 a. m.; and that the first time she saw the defendant was in the morning daylight. The plaintiff's husband testified that he stayed at the hospital until 3:45 a. m.; that he did not see the defendant; that he received a telephone call from the defendant between 7 a. m. and 7:30 a. m.; that the defendant said, "I just arrived. Come down immediately. It is important, but don't be alarmed"; that he went to the hospital; and that then the defendant informed him that the plaintiff must have an operation. A cesarean operation was performed at 11 a. m. The baby was born dead. The defendant's diagnosis was confirmed. The placenta was completely detached. The plaintiff had the ultimate in complication of abrupto placentae."

There was considerable expert testimony from the defendant physician. There are four types of separated placentas. In the type that the plaintiff developed, there is bleeding into the muscle fiber of the uterus. This is a very serious complication, and, when diagnosed properly, a cesarean operation should be performed and the uterus emptied as quickly as possible. It is unusual for the placenta to separate before the baby leaves the womb. There was a number of causes for such an occurrence; trauma, version, properly or improperly done; and any disturbance to any magnitude to the fetus or to the mother. A version is a procedure whereby the baby's position is changed externally. It means that if the buttocks were downward, the baby is turned around so that the head would be downward. The defendant testified that there was no version operation on the plaintiff because the head was always down; that he never told her that he performed a version operation; that version was one procedure he had been set against his whole life; that he had always thought and preached against it, but that he did not do it, because he thought the procedure was highly dangerous.

"On the evidence", said the court,"it could have been found that the defendant made a diagnosis of a sep-

arated placenta as early as 12 p.m. on January 6; that he did not see the plaintiff until dawn or 7 a. m. on January 7, and that, in the type of separated placenta that the plaintiff had, when diagnosed properly, a cesarean operation should have been performed and the uterus emptied as quickly as possible. The could have found that the information that the husband testified he gave the defendant before midnight of the day before was similar to that the defendant testified he received from the night supervisor, and that in accordance with his own testimony as to the practice in the community, he should have gone to the hospital the night before or, in any event, before dawn. Moreover, if the jury believed that a version was performed on the plaintiff, they could find that the defendant had within 24 hours performed an act that he believed to be dangerous and that, however well done, could be a cause of a separated placenta. In these circumstances, the court concluded, without reference to the extracts from the medical treatises introduced in evidence, the jury could find that defendant did not exercise the care and skill required of him as an obstetrician. The plaintiff sustained harm. We cannot accept the defendant's argument that evidence of causal negligence was lacking. In view of the fact that

there was substantial evidence to sustain the finding of the jury, the judgment of the trial court was affirmed and the defendant's exception overruled. Thomas v. Ellis, (127).

SUMMARY OF CHAPTER ON MEDICAL MALPRACTICE IN OBSTETRICS AND GYNECOLOGY

Most frequent allegations :

Against obstetricians:

1. Failure to attend at time of delivery.
2. Wrong baby given parents.
3. Poor or no prenatal care.
4. Unnecessary caesarean section.
5. Negligent delay in performing caesarean section.
6. Unnecessary use of instruments.
7. Instrumental injury to mother, to baby.
8. Placenta not completely removed.
9. Hemmorrhage from cord.
10. Injury to baby, fracture, paralysis, etc.
11. Failure to protect perineum (and rectum).
12. Failure to repair birth canal injuries.
13. Eclampsia not properly treated.
14. Lack of sterile technique--infection of mother.
15. Diagnosis of pregnancy as tumor (operation, miscarriage).
16. Diagnosis of tumor as pregnancy (special tests not employed).
17. Examination without consent.
18. Injury during examination.
19. Error or delay in diagnosis.
20. Failure to use laboratory aids.

21. Failure to administer standard treatment.

22. Failure to leave instructions for treatment of patient.

23. Failure to leave instructions for protection of attendants and of other contacts.

24. Failure to hospitalize.

25. Aggravation of existing condition.

26. Abandonment.

27. Infection resulting from injection.

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5. Stricture of cervix, caused by too extensive cauterization.

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23. Overdosage.
24. Use of harmful drugs.
25. Unnecessary medical treatment.
26. Death from injection.
27. Defective equipment.

The obstetrical case held the defendant physician liable in money damages for negligence in not handling a case of premature separation with the ordinary reasonably prudent care expected of an obstetrician.

For abortion see chapter on Criminal Medical Malpractice.

CHAPTER XI

The Physician's Liabilities for Acts of Others

This chapter contains extracts of cases dealing with the extent of the physician's liabilities for the acts of other persons.

1. The plaintiff patient was suffering from a small dermoid cyst in the pelvic region and entered the hospital to have it removed by a physician. The physician requested a nurse in charge of the operating room to prepare for a minor operation, informing her that he would use a local æsthetic a 1 per cent solution of procaine. Through mistake, the nurse prepared a solution of formaldehyde which the physician, believing it to be procaine, started to inject into the plaintiff in the immediate vicinity of the cyst. The patient immediately gave evidence of suffering great pain and the physician, discovering the mistake,, injected procaine and completed the operation by removing the cyst after exercising the area affected by the formaldehyde. Thereafter the plaintiff sued the physician, the hospital and the nurse. The trial court gave judgment against the hospital and the nurse for the sum of $12,500. and exonerated the physician from liability. The hospital, the nurse and the plaintiff appealed to the district

court of appeal, first district, division 1, California.

The court could find nothing in the evidence to support the plaintiff's contention that the nurse, in preparing the tray for the operation, was the servant or employee or even the agent of the physician. While, said the court, if the physician performing such an operation at the home of the patient, or in his office, without assistance, these preparations would necessarily devolve him, there is nothing in their nature which renders it improper or even undesirable that they be undertaken by another person, qualified by training and experience, acting in cooperation with the physician. The nurse in performing her duties in the operating room is acting for her employer, the hospital, and not for the operating surgeon, and the latter cannot be held responsible for her negligent acts unless performed under condition in which, in the exercise of ordinary care, he could have or should have been able to prevent their injurious effects and did not. The general rule is thus laid down in 48 Corpus Juris, Sec. 144, page 1137: "A physician is not liable for the negligence of hospital or other nurses, attendants or internes who are not his employees if he has no knowledge thereof, or has no con-

nection therewith, or if it is not discoverable by him in the exercise of ordinary care, or unless he is negligent in permitting them to attend the patient." It was plain from the evidence, that the acts of preparation performed by the nurse were not done under the special supervision and control of the phsyician. On the contrary, they were performed by her in his absence. That they were done at his request or direction has no significance, since she was merely attending to duties devolving her as an employee of the hospital.

The trial court committed no error in admitting evidence of the custom of physicians and surgeons of good standing to accept instruments, medicines and drugs from a graduate trained nurse without making an examination thereof themselves. The jury was called on to decide whether the physician was chargeable with negligence in injecting into the body of the patient the liquid placed by the nurse in the medicine glass. The test of such negligence is whether or not an ordinarily prudent person would have acted as the physician did. Although jurors are presumed to know what an ordinarily prudent person would do under any and all circumstances, it is of assistance to them to be informed what the practice is of persons habitually called on to perform a given

act, for it isobvious that such a practice is most likely to be that which is suggested by ordinary prudence. While a negligent act, clearly shown to be such, cannot be justified on the ground of custom or usage, the evidence of such custom or usage is not generally admissable for that purpose, evidence that a person charged with negligence followed the custom of other persons in the same lines of business will be received on the question as to whether he acted as a reasonably prudent man would have acted under the circumstances. The trial court committed no error in exonerating the physician.

With respect to the hospital, the court said, the evidence was clear that it was a nonprofit organization devoted to the care of the sick either without payment or at a charge which was less than the cost of such care. The hospital, being a charitable institution, was not liable for the negligence of the nurse, no lack of care having been shown in her selection and retention. The trial court erred, in the opinion of the district court of appeal, in allowing the verdict against the hospital to stand. With respect to the nurse, the court said, it could hardly be contended that she was not guilty of negligence. On the former appeal in this case, the Supreme

Court held that the evidence conclusively established such negligence. The nurse accounted for her mistake by frankly admitting that she took no pains to read the label on the formaldehyde bottle before pouring part of its contents into the medicine glass. The court thought, however, that the amount of the judgment against the nurse was excessive by $5000.

For the reason stated, the judgment in favor of the physician was affirmed, the judgment against the hospital was reversed and the judgment against the nurse was affirmed, subject to a reduction to $5000. if agreed to by the plaintiff--. Hallinan v. Prindle, (128)

2. The leading decision on the topic of physicians responsibility for nurses was rendered by the courts of Maryland. The defendant had operated on the plaintiff for the removal of the lower third of the right kidney and drainage of an abscess around the kidney lying between the kidney and the bowel. A cigarette drain was then inserted within the kidney pelvis. It was the usual drain made of gauze rolled in the shape of a gigarette and so covered with sterilized silk as to assist the blood or other foreign substances to drain from the cavity where it was placed to the outside. The end of the drain and of two gauze strips protruded several inches

from the wound. A stitch was taken in each corner of the incision, the intervening space was left open. After the operation the after-care of the patient was entrusted to the hospital internes who were not employees of the surgeon. The location and character of the drain were such as to be plainly visible to those who did the dressings.

Before the patient's discharge from this hospital, the drain should have been removed, but it was not, and thus it was five weeks later that the family physician, when the patient returned home, found in this wound a piece of gauze and some rubberized silk. Because of the retention of this foreign body the wound failed to close. The patient sued the operating surgeon, but the courts sustained the latter in his contention that he had neither knowledge of nor was privy to the negligence of the nurses or internes who did the dressings, and that in a hosptial of repute <u>when a wound is left open the operating surgeon is not liable for the negligence of those entrusted with the aftercare.</u> "At this day", said the Court of Appeals of Maryland, "where it is well known that there are physicians and surgeons of special skill in particular branches of their profession. Hunner v. Stevenson, (129)

It might be detrimental to the public if such a

surgeon was required to attend to the after treatment, as it would be impossible for him to do so and perform as many operations as some of them do. Hunner v. Stevenson,(129) Reynolds v. Smith, (130).

The United States Circuit Court of Appeals stated, "It is customary for operating surgeons to rely on internes and nurses in good hospitals. Reliance thereon by an independent operating surgeon and by patients therein for the usual care and after treatment incidental to an operation are matters of common knowledge and entitled to notice accordingly. Harris v. Fall, (131).

In Arkansas a Dr. Keller was treating a patient for a dislocated arm. Before he concluded with the treatment he advised the patient's parents that he was leaving town and during his absence a Dr. Minor would attend the case. The parents did not demur. Subsequently they sued Dr. Keller for Minor's alleged malpractice. There was no business relation between the two physicians and the court therefore decided that Keller was not responsible for Minor's treatment. Keller v. Lewis, (112).

3. "If one physician, " said the Supreme Court of Montana in a similar case, "upon leaving temporairly the community in which he is engaged in practice recommends to his patient the employment in case of need of some

other surgeon who is not in any sense in his employment nor associated with him as a carpenter, he is not liable for injuries resulting from negligence or want of skill in the latter, in case he is employed. In such case the employment of the latter is under an independent contract and he is solely responsible for the result" Stokes v. Long, (132).

4. The Georgia courts declared that "the patient will be presumed to have reposed confidence in the professional capacity of the substitute, not as an agent but as the principal, and will be taken to have relied upon him as a physician to exercise his own knowledge, skill and discretion." Mullins v. Duvall, (133).

5. T he plaintiff went to a hospital to have her tonsils removed by Xray. Dr. Jennings was the head of the Xray department, receiving a salary from the hospital for his services. The plaintiff, however, was not treated by Dr. Jennings, but by one Maechen, an Xray technician. In performing his work Maechen omitted the use of a filter, as a result of which ommission the plaintiff was burned. She sued Dr. Jennings contending that he was the head of the Xray department and was responsible for the technician's negligence. But the court said: "Maechen was not employed by the defendant; he was not the defend-

ant's agent or servant. They were fellow employees of the hospital. The defendant was not responsible for the neglect of Maechen in administering the treatment which entirely in his control. He did not participate in the operation and was not liable for her injury." Withington v. Jennings, (134).

6. The plaintiff was suffering from certain internal disorders requiring operative intervention. Dr. Bennett, her family physician was authorized to select the surgeon and arrange for him to perform the operation. Dr. Smith was the surgeon selected for this purpose. With the full sanction of the plaintiff it was arranged that Dr. Smith was to operate and that Dr. Bennett and others were to assist. Together with another assistant Dr. Bennett helped to sponge out the blood. That was all he did. During the operation a packoff was left in the plaintiff's body. She later sued Dr. Bennett claiming that he was responsible for Dr. Smith's neglect. "It is not the uncommon case," said the Supreme Court of Michigan, "of a practicing physician advising a patient to submit to a surgical operation to be performed not by himself, but by some surgeon of reputation, skill and experience, for which operation with the consent of his patient, he makes the necessary arrangements, in perform-

ing which he assists the operating surgeon as directed or advised.....Neither was employed by the others Each was required to exercise ordinary skill and care. But discretion and control of the operation were with one man. Whether responsibility for what occurred is rested upon contract or upon negligent performance of duty, there is no rule of law which under the undisputed facts, imputes want of skill or care on the part of Dr. Smith to Dr. Bennett." Brown v. Bennett, (135).

7. "Where the physician in charge calls a surgeon into the case, and assists in the operation by doing what he is directed by the surgeon to do it has been held that he is not liable for negligence in the operation in the absence of negligence in recommending the surgeon, or on his own part in assisting him." Nelson v. Sandell, (136)

8. The plaintiff who had injured her leg, called in a doctor to determine whether there was a fracture. Not being certain, he called in a second physician. The leg was preceptably shortened and the foot everted, yet both physicians diagnosed the condition as a contusion and advised that an Xray was unnecessary. Both than continued to treat the leg, but after a time were discharged. Xrays were taken then and a fracture was revealed. It

was properly decided that both doctors were guilty of malpractice, and that acting in conjunction as they were, each was liable for the other's negligent acts. Boller v. Kinton, (137).

9. "If one physician observes and lets go on without objection wrongful acts and omissions by the other or if the circumstances are such that he ought to have observed such wrongful acts or omission he is liable..... If one is guilty of want of ordinary professional care and skill in choosing the mode of treatment adopted, and the other expressly or impliedly gives his approval, there is no apparant reason why the latter should not be held guilty also, for by his acquiescence he fails to give the care and attention which his employment requires." Stokes v. Long, (132). Morey v. Thybro, (138).

10. "The plaintiff had been a mental patient in the State Hospital since 1943, suffering from maniac depressive psychosis. This illness is characterized by fluctuations from periods of depression, to periods of overactivity, lack of restraint and excitability. Part of the time the patient may seem entirely normal and his emergence from one mood to another may occur suddenly. During the overactive period the patient, in common language, is a raving maniac. In May, 1946, the plain-

tiff escaped, and when he was returned by the police on the following day he was in this violent maniac state. One of the defendants ordered a wet pack to be administered and the order was followed. Later a nurse reported that the plaintiff was physically fit but still violent, so a second wet pack was ordered. After that, the supervising nurse was told to continue with the wet pack treatments as long as the patient remained violent but physically fit. Altogether, three wet packs were given."

The administration of the wet packs is strictly a nursing procedure. "The wet pack treatment is administered to patients whose mental condition renders them violent. This treatment is a means of both calming them emotionally through the therapeutic effects of warm water and restraining them from violence. Such treatment is administered in the following manner. Sheets, usually six, are immersed in water. They are then wrung dry; the arms are separately wrapped and the sheets then wrapped around the body and the arms and legs, so that the patient is completely swathed in sheets from his head to the tips of his toes. Two sheets are used as ties, one placed about the body and arms in the region of the elbows and tied, and the other is tied above and below the knees. The patient is able to move his limbs but he cannot free

himself. He is then immersed in a tub of water, the temperature of which is controlled by a themostat at about 94 to 96 degrees. He is kept in the water for a period of approximately six hours. When he is taken out, the sheets are removed, and his body is bathed and rubbed with oil or grease. Fresh sheets are then applied, and he is again immersed in the water. Generally the patient receives a series of these treatments, the number and duration of which depends upon his mental and physicial condition.

After the treatments the patient's hands swelled and blistered, became infected and deformed, and lost 60% of their normal function. The plaintiff contended that such injuries were the result of the defendant's negligence in failing to properly supervise the administration of the packs and in opening some of the blisters with a knife, which one of the defendant's carried in his pocket.

The duty imposed by law on the defendant physicians is the employment of such reasonable skill and diligence as is ordinarily exercised in their profession, giving due regard to the advanced state of the profession at the time of treatment. It has been uniformly held that expert testimony is necessary to establish negligent

practice in any profession.

In the instant case the plaintiff failed to show by any expert testimony just what defendant physician should have done or refrained from doing. From the circumstances that a verdict was recovered, the inference is that the defendant physician should have been present and that he should have examined the plaintiff between each pack and during the course of them. The testimony of all the experts called on either side of the case was that this requirement was not a part of the standard and accepted practice. It is also the general rule that a physician is not liable for injury to a patient, where such occurs as a result of nursing procedures, said the Supreme Court. Judgment was entered for the defendant physicians. Powell v. Risser, (139).

11. Medical partnerships have the same legal aspects as other partnerships. These include problems arising out of the law of torts; malpractice or negligence of partners or employees. Hall, (140).

SUMMARY OF THE PHYSICIANS LIABILITY FOR THE ACTS OF OTHERS:

1. The physician is not usually liable for the negligent acts of nurses employed by the hospital.

2. The surgeon is ordinarily not liable for the post-operative care by the nurses and internes of the hospital.

3. A physician is not liable for the acts of another physician to whom he has referred a patient unless he was negligent in selecting the substituting physician.

4. The physician head of a hospital Xray department was held not liable for the negligent acts of one of his technicians.

5. Where two physicians are treating a patient one may be liable for permitting the other to perform negligent acts under his direct observation.

6. A physician was held not liable for ordering the nursing procedure of wet packs for a mental patient which caused damage to the patient's hands.

7. A physician may be liable in money damages for the malpractice of his partner.

CHAPTER XII

Attitude on Malpractice by Critical Public

This chapter consists of extracts from an article in American Mercury magazine. The article was by an unknown author.

In reply to a letter requesting information of the author's background, Mrs. Chapin wrote the following letter.

1442 Sherbrooke W
Montreal, 25
February 23, 1956

Mr. George Prichard
Omaha, Nebraska

Dear Mr. Prichard:

The American Mercury forwarded me your letter. I am still at the same address. I don't really know how much help I can give you, for the instances I gave in that article were of my personal knowledge or experience, except for those for which I gave legal citations. I know other horrors, some too bad to print, and I had several letters after the article was published, from people recounting their woes, but I don't know whether I could find them now.

As for myself, I have been correspondent here for the Christian Science Monitor for eight years,

though I am not myself a Christian Scientist. I have just published two books, QUEBEC NOW, last May and ATLANTIC CANADA, out March 3rd, and am working on a long book about Canada. The article in the Mercury is the only thing I've done of that kind, and rose simply out of my indignation at the way I and my friends had been pushed around. My education? University of Vermont, many years ago, marriage, four children, now grown up, three grandchildren. If you will let me know what you are working at, perhaps I can tell you more.

Sincerely yours

Mrs. Miriam Chapin

The article indicates some of the criticisms made of doctors. That the article is unfair is obvious. But physicians should realize that there are complaints no matter how poorly founded to strive to avoid causes of legal actions. It is a question of <u>time</u>, <u>reputation</u> and <u>dollar and cents</u>: <u>All suits, no matter how unfounded, are costly</u>.

Extracts from "Who Protects the Patient". Chapin, (141).

"A woman of 40 went to a well-known and expensive surgeon for a cervix operation. After it was over, she

was ill for months with an agonizing urinary ailment, and continued to suffer for years while going to the same doctor for treatment. Only when she visited another doctor and another hospital did she learn that the surgeon had accidentally sliced through her urethra (the canal which carries off urine from the bladder), and by that time there was nothing to be done about it. Her original doctor didn't even say "oops, sorry!". He merely said there were risks in every operation, and that he owed her no return for the thousands of dollars she had paid him and the hospitals, or the misery she had endured. He accepted no responsibility whatever."

"Lawyers and friendly doctors assured the injured patient in this instance that there was not the slightest chance of her getting damages if she took the matter to court, that it would be an exhausting procedure, that it take far more resources than she had to fight the case, that she would only be throwing good money after bad, and she had better try to forget about it. "They all gang up together-it's no use. And the insurance will have good lawyers."

"Nor will a nurse be willing to witness against a doctor, however bitterly, she may talk about his mistakes in private. She is afraid and with good reason that she

might never be called on a case again. A girl of nineteen expecting her first baby, engaged a famous obstetrician. When she reached the hospital, frightened and in pain, the head nurse scolded her for making such a fuss and left her alone to scream. When a student nurse happened to walk in, she rushed out yelling, "The head! The head!" and the girl was hastily trundled to the delivery room, where her baby was born as they pressed an ether cone over her face. When she came to her obstetrician was standing beside her, saying benevolently, "It's a fine boy". The girl vaguely noticed that he was wearing a business suit, not a white jacket. Next day a young interne came to her room and asked pleasantly how she was feeling. Never having seen her before, she asked her nurse who he was, "Oh," said the nurse, "He's the one who delivered your baby." Then a horrified look came over her face and she began to whimper, "Don't tell them--if they knew I told you I'd be fired." So the young mother paid her doctor his $500. fee and said no more."

"A boy of eight had his tonsils out. A nurse, coming to look at him a few moments after the operation noticed that he was no longer breathing. Nothing she could do revived him; he had died without regaining consciousness. Then it was discovered that a gauze sponge had been left

in the throat. Six reputable physicians were witnesses in the suit for damages--nothing so crude as manslaughter was charged. Every single one swore that he believed that all reasonable care had been exercised. But the judge decided to disregard their evidence and rely on common sense. The sponge, he said, was there, the boy was dead. He awarded a few thousand dollars to the parents for their son's life. The doctors had stood together; they assigned no responsibility and the surgeon accepted none."

"A California woman whose breast was removed after the pathological laboratory of the hospital a gland in her armpit was cancerous. Just as she came out of the operating room, the lab reported it had made a mistake, and the trouble was something else. She and her husband sued the hospital and lost. Then they sued the surgeon who performed the operation, the chief surgeon who ordered it having died in the meantime. They lost again; the judge ruled that even if the operation was done "in negligent haste", the surgeon was not to blame. She was mutilated, and paid out a lot of money---but nobody was responsible."Valdex vs Hankins, California, 1949.

A soldier in the last war got a bit of shrapnel under his kneecap. German surgeons took it out in a field hospital, and he went to a prison camp. With time on his

hands, he spent a lot of time rubbing his knee, stretching his leg and exercising it, until he could walk fairly well and bend the knee a little. Back home in a fine military hospital, he went before a military examining board. The surgeons decided to improve his leg still further. They cut open his knee, lifted a large hunk of muscle out of his thigh and draped it on an unfamiliar spot, and kept the man in bed four months with weights on his foot. When he finished with that ordeal, his knee was stiffer than the crutch he had to use, and has been ever since. They asked rather sheepishly if he wanted them to try again, and he understandably refused."

"In still another case, a young woman carrying her first child was told by her entirely reputable obtetrician that she could never have another, that after the birth she would need to have her uterus removed. Horrified, she went through a miserable pregnancy, and then sensibly consulted another specialist about the operation, telling him, "I suppose I must go through with it."

"I can't see any earthly reason why you should", said the doctor, "Youre as healthy a woman as I ever saw in my life."

"Last summer a young man came into his home city from a camp in the north woods to see his family doctor, he

complained of a sore throat an and uncomfortable feverish feeling--he turned out to have a slight temperature. The doctor said it was just a cold, and he went back to complete his vacation. Four days later his frantic wife got him out by canoe and ambulance, unable to move hand or foot. Six months after he was learning to walk again, with all the apparatus of the polio victim. One of the saddest stories of this sort is that of the little boy who for days was denied all but a drop of water on doctor's orders, until his pleading so racked the family that they carried him to a hospital, where they learned too late that one thing he needed most of all was quantities of water to drink, to flush out a badly infected kidney."

"Only a couple of years ago New York came very close to an epidemic, because no doctor who came near a sick man in a hotel bedroom, and later in a hospital, realized that he was dying of black smallpox. How should they know, never having seen a case in all their lives? They called it skin complications, when any old sawbones a hundred years ago would have sniffed the air an said, "To the pesthouse, and burn everything in this room."

"Stories about sponges and bits of scalpel left in incisions are a dime a dozen. Some of them are true,

and no joke to the patient. Doctors have favorite anecdotes about how so-and-so took out a man's good kidney or limb and left the diseased one in. They seem to think they are funny. They tell with great gust the yarn about the general from the States over in London, who was about to be operated on for cancer of the stomach by a Harley Street surgeon, when some indignificant bounder gazed at the Xray picture and remarked that the black smudge in the man's lower regions was the thumb print of the "bloody fool" who developed the Xray film. So they told the general to quit hitting the bottle so hard, and his indigestion got well."

"General practitioners who venture into special fields are sometimes absurdly stupid about pretty obvious maladies. The other day we came across a six-year-old girl who had two throat operations because she didn't talk. How could she talk when she couldn't hear, a nurse finally discovered? A famous child psychiatrist recently sent a small son of wealthy and heartbroken parents to an institution for the mentally defective. There it was found out that he had less than 50% hearing, and now he is home with a hearing aid, the happiest livliest child in the world."

"The patient is getting impatient about all those legal shelters and about the medical profession as a whole.

Every day we hear grumbling about costs. People wonder about the British Health Service, which doctors oppose because it would destroy all competition, all incentive. They complain about the scarcity of rural physicians--"Those guys have it soft in town, won't stir out nights or Sundays"--and it is indeed very hard to get a doctor at such times. The profession would be surprised at the resentment building up. "Heartless moneygrabbers" is one of the mildest epithets we've heard during this inquiry among personal acquaintances. The aura of beneficiance and selfless deviation that once hovered around the doctor's head had silently vanished, to reappear in less glamourous hues over the pate of the research man, who is now expected to produce the miracles suffering humanity desires. He may be able to keep his aura for quite a while, since his errors are more recondite."

"Well," the lawyers say, "any doctor is allowed a few mistakes. It's not an exact science." But it is not the mistakes which arouse resentment, it is the refusal to take responsibility for them. Any motorist is allowed a few mistakes too, before his license is taken from him. But if he runs a man down or smashes a car, he'll have to pay damages even if it is his first accident. So he takes out several kinds of automobile insurance, and sheds the burden on the insurance company. Fundamentally, auto-

mobile insurance liability is paid quickly because the company knows it would lose a suit if one were brought. All the car drivers don't get together to swear that he couldn't possibly be at fault."

"In the case of medical insurance, the company acts to protect the doctor to the last ditch, if the patient sues, even when it would be cheaper perhaps to settle the case than to fight it. If the patient doesn't sue, he gets nothing. Most of the protective associations advise their physician clients, when a patient comes to them with complaints or threats, to make clear statment, saying they have done their best and then to refuse to discuss matters, and under no conditions to make any payment. That simply take for granted that the complainant is trying to work a swindle. Thus, a conscientious doctor, who might be willing to make some adjustment or forego a fee when he knows he has made a blunder, is blocked off from such action for fear of compromising his own or his colleagues future.

"Doctors can hardly be blamed for setting up protection for themselves, since before they had it they were targets for outrageous malpractice suits. But the pendulum has swung too far. The patient should also be protected--from ignorance and carelessness and bungling--

without having to go through a costly court procedure."

"The weeding out process might come into play here too; if doctors had to pay higher premiums because incompetent men drew heavily on insurance funds, professional ethics would soon go by the board when they stood in the way of getting rid of such colleagues."

"If a patient believes a doctor is at fault and has done him some serious damage, he should have the opportunity to present his case to a hopital or government board, and it should be heard as a plea for justice, not as a peevish grumbling. If it is justified, then the doctor or his insurance company should be obliged to make amends. The responsibility lies on the door of the medical profession. If they fail to assume it, they build up a dam against anger which some day sweep away much that is of value, along with the cherished safeguards behind which they cower." Chapin, (141).

SUMMARY OF CRITICAL PUBLIC ATTITUDE

Criticisms made of doctors:

1. They won't testify against each other.
2. They make mistakes and won't admit them.
3. They frighten nurses into not testifying against them.
4. They assume a flippant joking attitude toward serious errors in diagnosis.
5. Doctor's don't go in sufficient numbers to rural areas.
6. Doctor's won't take night calls.
7. Too concerned only to make money.
8. No hospital or government board to handle grievances.

Conclusion:

The last complaint has received attention from some medical groups. They have suggested a grievance committee of the local medical societies to investigate and listen to all malpractice complaints. Then to give a decision. If litigation arises they would make their findings and recommendations known to the court on an <u>impartial</u> basis.

In other words to police their own and keep it in order.

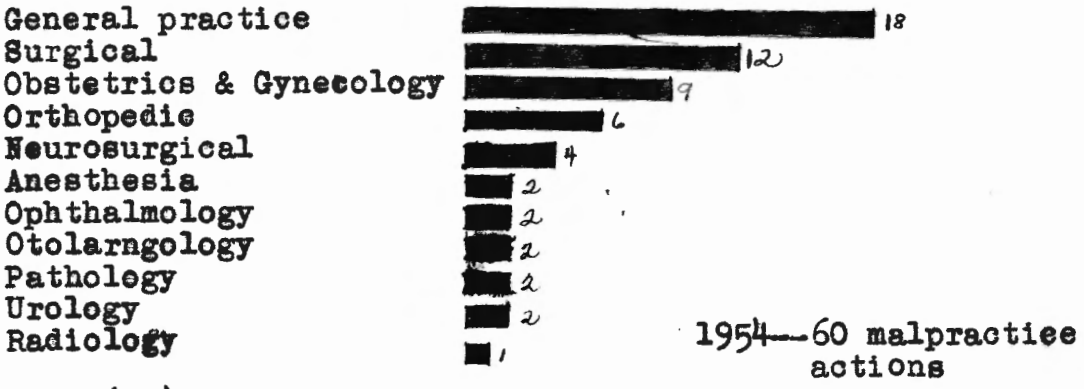
CHAPTER XIII

Who Gets Sued:

The statistics in this field are at variance as the following indicate:

GRAPH #3

Physician Specialities Involved in 60 Malpractice Actions Against Active Members of the Medical Society of D.C.--1954.



Den, (32).

CHART #5

What types of work produce most malpractice incidents?

Obstetrics/Gynecology	20%
Orthopedics	14%
General Surgery	14%
Internal Medicine	10%
Neuropsychiatry	6%

The remaining 36% of malpractice incidents arise from just about every type of work. "The large percentage of obstetrical and gyncological problems is quite surprising." says Dr. Sadusky. "It is quite possible that articles in lay magazines on this subject have contributed significantly to obsetretrics and gynecological emergence...as a

leader in professional liability. Medical Economics,(142).

CHART #6

Who Gets Involved In Malpractice Incidents?

General practitioners	54%
Certified specialists	31%
Noncertified specialists	15%

These figures follow the percentage distribution of doctors in the area rather closely. A further breakdown of General Practitioners-American Academy of General Practice members as against nonmembers-shows "no statistically valid difference." In other words, all types of doctors draw their share of malpractice incidents. Medical Economics, (143).

CHART #7

Who Gets Involved More Than Once?

Doctors with 2 incidents	0.7%
Doctors with 3 incidents	0.2%
Doctors with 4 incidents	0.1%

These "claims-prone" physicians comprise only 1 per cent of the medical society membership in the area studied. Yet in nine years they've run up 24 per cent of the group's total malpractice costs; and suits asking $780,000 in damages are still pending against them. Medical Economics, (144).

"The evidence is plain that just a few doctors are costing their colleagues plenty.

We're talking about the price of malpractice insurance, which has climbed painfully high in a good many areas. On such area in Alameda and Contra Costa counties, California. And something significant has been recently discovered there:

Over the last nine years, nearly 25 per cent of all claim costs incurred by the local group malpractice plan have been run up by a mere 1 per cent of the membership. This handful consists of doctors who have become involved in more than one malpractice incident."

So, nearly 1,400 doctors are paying heavily for the mistakes of just fourteen repeaters. And they haven't finished paying yet. Why not? Because suits asking $780,000. in damages are still pending against those with multiple incidents.

These facts are amplified in last months issue. Among the most interesting amplifications was the hint that claims-prone physicians tend to congregate in certain hospitals. For example, two of the seventeen hospitals studied have been the scene of far more than their share of malpractice trouble." Medical Economics, (145).

CHART #8

Where Do Malpractice Suits Occur?

Inside Hospitals	70%
Outside Hospitals	30%

Medical Economics, (146).

SUMMARY OF WHO GETS SUED

Statistics vary as to who gets sued the most the surgeon or the obstetrician.

The small field hardest hit is the fracture cases--but not the orthopod. (the General Practitioner).

General practitioners are getting sued more of late says Reagan. The doctor-patient relationship is not as solid as formerly.

One percent of the physicians cause twenty-five per cent of the claims cost. They are costing the other ninety-nine percent pretty heavily in malpractice insurance.

CHAPTER XIV

The Noxious Aspects of Medical Malpractice Suits

This chapter purports to indicate some of the by products of malpractice suits which may be more ulcerogenic than paying actual money damages.

Excellent reputation is no protection. Regan, M.D., L.L. B., estimates one half of all malpractice suits are against the more highly respected (and well-to-do) physicians.

1. Trial by Newspaper:

Publicity is brutal in many incidences. The allegations of the plaintiff-patient are splashed in a prominent place the press. These allegations may have no foundation in fact. They are only what the plaintiff hopes to establish, but they are in black and white. Some gullible people take the written wonderings of sensation seeking reporters as "Holy Writ". "Trial by newspaper has begun and many a defendant finds himself practically defeated before the facts are ever presented. Usually the facts are too dull for reporters to care to include them in the story.

The physician here finds himself in the characteristic dilemna often found in dealing with newspapers. He either gives reporters facts which they distort and

twist to their own purpose or if he refuses to give information the inference is made that silence means guilt. Fortunately these reporters are probably in the minority.

After the physician gets a judgment in his favor, the news is printed in some obscure place probably with his name mispelled.

2. Unwarranted claims:

Unwarranted claims which may even amount to a polite legal blackmail are astoundingly high. Some unfounded claims are apparently brought with the thought that the physician will settle out of court in order to avoid publicity, notoriety and "trial by newspaper"! There is no end, however, if a physician gets the tag of settling every possible malpractice suit out of court. One survey in Alameda County, California reported in Medical Economics, (147) the following:

CHART #9

What Percentage of Claims are Found Unwarranted:

Warranted	8%
Unwarranted	78%
Still pending	14%

This table covers all malpractice claims in the area studied--a total of 609. Classified as warranted are thrity-one claims on which the defense committee recommended cash indemnities straightaway; eighteen claims

settled later, " since they were considered meritorious"; and two claims that were upheld by jury verdict.

Classified as unwarranted are 436 claims dismissed by the defense committee as "totally without merit"; fifteen claims dismissed by a judge; and twenty claims denied by jury verdict.

Only 8% were found warranted and 78% unwarranted. Of this completed survey 90% of the malpractice cases were found unwarranted.

The part of unethical attorneys in this field is difficult to evaluate.

3. Delay in bringing suits:

Delay in bringing suit is of great importance to the physician. Medical Economics, (148) points out:

CHART #10

When Are Malpractice Suits Filed?

First year after incident	77%
Second year after suit	16%
Third year or thereafter	7%

As this table shows, it's possible for a physician to be sued because of an incident that took place years ago. Will he still have the insurance policy that covered him that year? Will he still have his records? If not, the time lag will have deprived him of his best defenses.

Nearly 25% of the suits are not filed within one year of the alleged malpractice.

4. Delay in Disposition:

Delay in disposition of the suit is even worse.

Medical Economics, (149) reports:

CHART #11

When Are Malpractice Suits Finally Disposed Of?

First year after suit	25%
Second year after suit	56%
Third year or thereafter	19%

Seventy-five per cent of suits are not disposed of until at least one year after they were brought.

This is a long time to have a damage suit of $65,000. hanging over the physician's head with frequent reference to it in the papers.

5. Expense:

Costs of suits may be expensive although the suit is unfounded.

The following incident reported by Dr. Fisher of Ottawa Canada is an illustration.

A surgeon was called in the middle of the night to see a patient was gravely ill with a condition that suggested a perforated viscus as its cause. At operation a ruptured gangrenous appendix was found and there was extensive peritonitis. Recovery was stormy and prolonged. About a month after operation there were signs of pus in the abdominal wall and a second operation resulted in the evacuation of much pus. Although the first operative

wound healed, the second one had not healed two months later when a nurse who was doing the dressings identified and removed a small gauze square, not an abdominal pack but one of the small sponges used for wiping the surface of wounds.

"When she first recognized the sponge the nurse, before touching it, attempted to reach the surgeon but he could not be found so she removed it and saved it to show him when next he visited the patient. He saw the patient the following morning and later on it was stated by the patient, by the graduate nurse who had been doing the dressings and by a third person who was present when the doctor arrived, that he became mad, blamed the operating room nurses and said they were supposed to count the sponges, that the patient must have had a strong constitution and that but for the gauze he would have had a shorter stay in hospital. There was, as far as testimony was given, no straightforward reasonable attempt on the part of the doctor to provide the patient with a fair explanation of how the sponge might have been left in the wound."

"The complaint progressed through the usual stages, threats, demands, lawyer's letter and finally a writ, issued and served on the surgeon and his assistant, The

case came to trial and as trial progressed two things became evident, that it would be difficult to establish responsibility for the presence of the sponge and that the damage to the plaintiff had been slight. The presiding judge asked if the two defendants, the surgeon and his assistant, would be willing to accept dismissal of the action without costs and whether the surgeon would be willing to forego his fee. The arrangement was satisfactory to them. The plaintiff was willing to drop the action and it was dismissed against both defendants without cost."

Lest it be thought such a course of action is cheap and easy it should be said that the surgeon lost his fee of about $200; out-of-pocket expenses of two expert witnesses who had to be present were about $200. and legal expenses were $1,192.50, a total of nearly $1600. No --or almost no--<u>legal defense is cheap</u>! Fischer, (150).

This indirect cost is still born by the physician through <u>increased insurance rates.</u>

6. <u>Trial Procedure Disadvantage</u>:

Trial ,procedure is all to the physicians disadvantage. The physician and the attorney in sharp contrast. To the attorney, the courtroom procedure is a situation for which he has trained specifically and for which he

has spent years perfecting techniques. His task is to persuade a jury to believe his arguments in preference to those of his adversary; to say absolutely, "We find as a fact...." The physician, on the other hand, is entirely out of his element in the courtroom. Except on an academic or scientific level, controversy is unfamiliar to him. He deals in judgments as to probability, not with absolute fact; even a proved scientific fact has meaning only in relation to subjective impressions. To the physician, the courtroom means wasting valuable time to give a carefully restricted opinion, necessarily based on inadequate observation, for persons who cannot understand the details of the problem and who probably will not believe him anyway. His character, qualifications, veracity, or credibility may be attacked, and he may be subjected to indignities by a clever trial attorney. The physician is always at a distinct disadvantage in court, and he must neglect his patients during this time.

Because ethical and conscientious physicians are likely to be most resistant to appearance in court, the lawyer may be forced to accept any so-called expert who is willing to testify. "Professional witnesses," who will testify as experts on any medical speciality, are

readily available in every jurisdiction. By implication, they cast unfavorable light on both the legal and the medical profession. When the unscrupulous "professional witness is pitted against an honest physician, too often the latter emerges second best. Since an active practicing physician has little opportunity to gain courtroom experience, he is not as "courtroom wise" as the "professional witness". It is unlikely that the conscientious physician will be willing to appear in court a second time. The legal profession consequently accuses the medical profession of protecting its members unreasonably by boycotting the courts." Shindell, (151).

7. Attachment of property:

The attorney may secure through the court an attachment which will tie up enough of the physician'defendant's property to satisfy a judgment until the matter is adjudicated. This may take several years. During which time the physician is denied the conveyance of his property.

8. Inadequate insurance:

Beginning physicians are often unable to obtain more than $25,000. to $35,000. malpractice insurance. One survey in Medical Economics September 1955 states that the average malpractice suit alleges money damages of approximately $65,000. A judgment for $50,000. could

an embryonic physician pretty deeply in hock.

SUMMARY OF NOXIOUS ASPECTS OF MALPRACTICE SUITS

Ulcerogenic phases of malpractice suits:

1. "Trial by newspaper" Condemnation without a hearing. The sensation-seeking press plus vicious gossip in the wake of the suit.
2. Unwarranted claims are estimated to be 90% of all claims. Many may be "legal blackmail" preying on the physicians dislike for such notoriety.
3. Delays in filing suit. 25% are not filed till well over a year after the alleged cause.
4. Delays in disposition of cases. 75% are not disposed of until one year after they are first filed. Many cases hang over the physician's head for years.
5. Expense in time, insurance, attorneys may be considerable even if the judgment is denied.
6. The physicians disadvantage in the courtroom. would be comparable to a lawyer in the operating room.
7. Attachment of physician's property to protect a potential judgment may prevent desired conveyance or improvement in a physician's property.
8. Insufficient insurance due to limitation of amount on beginners may result in an embryonic physician being forced to pay part of a large judgment.

CHAPTER XV

Criminal Medical Malpractice

Introduction:

Criminal medical malpractice actions are where the state prosecutes the defendant physician for gross breach of duty where death or injury ensues. If death is the result, it is called manslaughter. The trial may be by jury at the defendant's election. If the verdict is guilty, the defendant physician may have a heavy fine and/or stiff jury sentence. State statutes usually set out certain acts which they specifically designate as crimes, e. g. criminal abortion.

Fortunately, criminal medical malpractice suits are uncommon.

Courts have dealt very leniently with physicians accused of criminal malpractice.

Definition of criminal medical malpractice:

The definition given by standard legal texts is: "Every act of gross carelessness, even in the performance of what is lawful, and every negligent omission of legal duty, whereby death ensues, is indictable either as murder or manslaughter. If a man takes upon himself an office or duty requiring skill and care--if, by his ignorance, carelessness, or negligence, he causes the

death of another, he will be guilty of manslaughter... If a person, whether a medical man or not, professes to deal with the life of another, he is bound to use competent skill and sufficient attention; and if he causes the death of another through a gross want of either, he will be guilty of manslaughter."

It is, then, that degree of malpractice which the law characterizes as "gross" which renders the practitioner liable to punishment under a criminal charge. As in the law of civil malpractice, here, too, definitions hardly define: for the term "gross" conveys a relative and not an absolute meaning; and in many cases in which a man's liberty, or perhaps his life, depended on the decision, a real difficulty might arise. When we remember that such a decision, is to come from twelve jurymen of the ordinary type, we may well contemplate with gratitude the immunity of medical men, and may rejoice that all deaths are not made the subject of judicial investigation.

The leading cases demonstrate that in practice medical defendants under a charge of criminal malpractice have been dealt with leniently.

Criminal malpractice cases:

In an early English case a defendant physician was indicted for the murder of his patient whom he had de-

livered and who died in consequence of his attempts to drag away a prolapsed uterus with great force, mistaking it for a part of the placenta which he supposed to be retained in the vagina. The womb was lacerated and the mesenteric artery was torn.asunder. The physician defendant, in his defense, said that he acted according to the best of his judgment, and he called fourteen women to testify to his skill and kindness when he attended them in labor.

The Chief Justice said to the jury: "There has not been a particle of evidence adduced that goes to convict the defendant of the crime of murder; but still it is for you to consider whether the evidence goes so far as to make out a case of manslaughter. To substantiate that charge, the defendant must have been guilty of criminal misconduct arising from either the grossest ignorance or the most criminal inattention. One or the other of these is necessary to make him guilty of that criminal negligence and misconduct which is essential to make out a case of manslaughter. It does not appear that, in this case, there was any want of attention on his part; and from the evidence of the witnesses on his behalf, it appears that he has delivered many women, at different times and from this he must have had some

degree of skill. It would seem that, having placed himself in a dangerous situation, he becomes shocked and confounded. I think that he could not possibly have committed such mistakes in the exercise of his unclouded faculties; and I own that it appears to me that, if you find the prisioner guilty of manslaughter, it will tend to encompass a most important and anxious profession with such dangers as would deter reflecting men from entering into it.

The defendant physician was acquitted.

Gross negligence or lack of skill:

A mere mistake of judgment by a physician in the selection and application of remedies or appliances causing death does not render him criminally liable. State v. Hardister, (152).

The inadvertent infliction of a wound by a physician on a patient , resulting in death, does not render him guilty either of murder or manslaughter, where he used the instrument (surgeon's sound) commonly employed for like purposes, without evil intent or negligence. State v. Reynolds, (153).

An actual good intent and the expectation of good results by a physician in his treatment of a patient are not an absolute justification of his acts, however

foolhardy they may have been judged by an external standard; and if his act was the result of foolhardy presumption or gross negligencehe is as responsible for the result as though he had done unlawful acts for independent reasons. The condition of the individual's mind with regard to the consequences must be taken into consideration, as distinguished from mere knowledge of present or past circumstances from which others might be led to anticipate or apprehend a particular result for acts done. Commonwealth v, Pierce, (154).

A physician may be charged with manslaughter by causing the death of a sick child by advising a diet which results in it's starvation, under a statute which treats all persons concerned in the commission of an offence as principals, although it was the mother of the child who actually withheld the food from it in the absence of the accused. State v. McFadden, (155).

Where poison is knowingly administerd with intent to accomplish some unlawful purpose and death ensues, it is murder, though the death was not intended; but manslaughter only, if it was heedlessly administered with no unlawful purpose. State v. Wagner, (156).

It is the duty of a physician, neglect of which may render him criminally responsible for fatal results, to

direct as to sanitary conditions surrounding the patient, and means and manner of taking the medicines, and whatever other applications and operations are necessary to restoration of health. State v. Power, (157).

The consent of a patient is not a defense in a prosecution against a surgeon causing his death, unless the operation performed by the surgeon was done with care skill; consent is no excuse for recklessness or want of skill. A surgeon cannot be convicted of the crime of manslaughter for performing an operation upon the deceased without his consent if the operation did not result in his death. State v. Gile, (158).

The criminal liability of a physician for the death of his patient, brought about by his gross negligence, carelessness, or ignorance, may be established under an indictment or information predicated upon general statutes defining manslaughter. Hampton v. State, (159).

A statutory provision that if a physician under certain conditions shall, without design to effect death, administer any poison, drug or medicine or do any other act to another person which shall produce the latter's death, he shall be deemed guilty of manslaughter, furnishes rule of action in the enumerated cases only, and does not prevent holding a physician criminally liable for the

unintended death of his patient, brought about by his gross negligence of ignorance, in cases other than the enumerated ones. Hampton v. State, (159).

Abortions:

Introduction:

There are estimated to be approximately 330,000 criminal abortions in the United States each year. There are estimated to be from these illegal operations 5000 deaths per year. Most deaths are caused by others than doctors.

Statutory penalties for performing abortions range up to twenty years in the state penetentiary in some states. In practice criminal abortors appear to escape punishment more than most other criminals.

Definition of abortion:

"Abortion is the act of miscarrying or producing young before term and before the fetus is perfectly formed; and to cause or procure an abortion is to cause or procure this premature bringing forth of the fetus. Abrahms v. Forshee, (160).

Abortion as a crime: is to be found only in modern treatises and in modern statutes. No trace of it is to be found in the ancient common law writers. Sullivan v, State, (161).

In many of the states the procurement of an abortion with the consent of the mother before the child became quick was not at common law considered a criminal act. In other States it has been held that it is not murder of the living child which constitutes the offence of procuring an abortion, but the destruction of gestation by wicked means and against nature. The moment the womb is instinct with embryo life, and gestation has begun, the crime may be perpetrated. If this were not so it would be practically impossible to convict an abortionist for any abortion, or attempted abortion, during the first five months of pregnancy; for if gestation has not proceeded to the period of quickening there would be no disputing the testimony of the abortionist that what he removed was in fact a dead fetus. Munk v. Frink, (162).

As stated by the Supreme Court of Pennsylvania: "It is a flagrant crime at common law to attempt to procure the miscarriage or abortion of the woman, because it interferes with and violates the mysteries of nature in that process by which the human race is propagated and continued. It is a crime against nature, which obstructs the fountain of life, and therefore it is punished." Mills v. Commonwealth, (163).

This question is now regulated by statutes in the

several States which specify what acts shall constitute the crime. In the majority of the States these statutes fail to draw any distinction between the commission of the offence or attempt at commission before and after the quickening of the child. Some jurisdictions, however, still make a distinction by providing a more severe punishment when the act or attempt is committed after quickening.

Inmost states an abortion is legal when it is necessary to preserve a woman's life. In Colorado, Maryland, New Mexico and the District of Columbia, it is also legal in order to safeguard her health. The statutes-and enforcement authorities-leave the matter up to the doctor to interpret.

The medical profession has, as a rule, paid but little attention to what was written in the statute books.

Rape is not generally considered ground for legal abortion in the United States, and few hospitals would permit abortion for this cause.

Poverty is never a legal excuse.

The women involved are not, as you might suspect, young unmarried girls. Nine of every ten are married women, mostly between the ages of 25 and 35, with three or more children.

There is one circumstance in which many hospitals do allow a therapeutic abortion--although its legality is certainly questionable. This is when there is reason to believe that the pregnancy may result in an abnormal or deformed child. This is prohibited in other states.

The proportion of legal abortions for psychiatric reasons is going up. In California an estimated two of every five therapeutic abortions are for reasons of mental health. In other states the patient must have demonstrated a convincing intent of suicide.

A class of patients who do not get a fair hearing when they seek legal abortions is unmarried women whose lives or health may be endangered by pregnancy.

In some states the law requires only one doctor's approval for a legal abortion, but careful doctors insist on at least two.

Many hospitals are setting up rules and committees to pass on abortion applications. Some hospitals even put limits on the number of legal abortions.

Extracts of cases:

In a majority of States it is not necessary that the thing administered should actually produce the effect desired, or that it should have qualities efficient to produce that result, State v. Owens, (164), though some courts have held otherwise. Fretwell v. State, (165).

The testimony of a physician is sufficient to show that the means are capable of producing an abortion. Cave v. State, (166).

The actual miscarriage of a woman in some States is an essential element of the crime, Scott v. People, (167), but in the majority of the States it is not essential to the consumpation of the statutory offence, the consequence not being held material. Dougherty v. People, (168).

Any person who in any manner aids, abets, or assists the woman or any other person to procure an abortion is an acessory or accomplice. All parties concerned in the offence are responsible, whatever may be the part they take.

It is not a defense to such prosecution that the defendant did the act charged with the consent or at the request of the woman. State v. Carey, (169).

The statutes of the several States expressly except those cases in which the abortion may be necessary to preserve the life of the mother, or shall have been advised by a specified number of physicians to be necessary for such statutory provision the fact that the mother's life requires that a miscarriage be performed upon her is always a justification for producing abortion, whether

the statute expressly so provides or not. If a physician seeks to justify his act of procuring an abortion on the ground that it was necessary to save life, without obtaining the advice of the number of physicians required by the statute, he must prove that the necessity did in fact exist.

A physician operated with a knife upon the womb of a healthy woman, aged nineteen years, and a few days afterward she was delivered of a partly matured child, and was immediately attacked with peritonitis, of which she died, raised an inference that it was unnecessary to destroy the child in order to preserve the life of the mother; and the fact that the woman had threatened to commit suicide unless relieved from her child does not show such a necessity. State v. Lee, (170).

It has been held to be no defence to an indictment under a statute requiring the advise of two physicians as to the necessity of performing the act to save life, that one of the defendants, who was a physician, thought the operation to be necessary to save the life of the mother, if the evidence shows that it was in fact unnecessary. Hatchard v. State, (171).

Consent of the woman to the procurement of an abortion is no defense. Smith v. State, (172).

A woman who carries a fetus in her womb is held in law to be pregnant whether the fetus is living or dead, and the fact that the fetus was dead at the time of the unlawful act is no defense. This does not apply, however, to cases where a physician performs an operation to remove a dead fetus. Honnard v. State, (173).

SUMMARY OF CRIMINAL MEDICAL MALPRACTICE

Criminal medical malpractice is gross breach of a physician's duty. This is usually determined by jury. It is punishable by fine and/or imprisonment in the state penitentiary. It is uncommon.

Cases show courts are lenient in judging physicians. They request proof of grossest dereliction of duty. Mistake of judgment is not sufficient. Proof of "foolhardy presumption" causing injury may bring a guilty verdict, as will proof of neglect of giving proper medical directions in administration of medicines.

Consent is no excuse for recklessness or want of skill.

Abortion is defined legally as the act of producing young before term. (There is an implication that this is by artificial means.)

Abortion is legal in most states where it is necessary to save the mother's life. This is a matter for the doctor's interpretations. Some states require one, some two signatures on the patient's chart. Mental health is increasing as reason for therapeutic abortion though most jurisdictions require definite threat of suicide.

Abortion when there is a diagnosed deformity of the fetus is legally questionable.

Rape and poverty do not constitute grounds for therapeutic abortion.

Hospitals often limit the type and number of therapeutic abortions.

Criminal prosecution for abortion indicate that the act need not actually produce abortion (Texas, Colorado) ; but the actual "miscarriage" is necessary in others (Illinois). All parties to the offense are responsible. Consent of the abortee is not a defense. A physician not getting sufficient statutory consultation is under the burden of proof to show that the danger to life existed.

The statutory number of physicians signatures is not a defense if the evidence shows the operation was in fact unnecessary to save life.

That the fetus was delivered dead is no defense.

CHAPTER XVI

Hospitals in Medical Malpractice

Extracts of typical cases at law in suits for money damages against hospitals are presented here in brief.

1. The American Medical Association took the position in 1943 that "the practice of pathology was the practice of medicine." Journal American Medical Association, (174).

But the Supreme Court of New York recently, November 1955, ruled that Rh typing, a test utilized by pathologists was not in itself the practice of medicine.

In this case the plaintiff patient entered the hospital and received a transfusion of Rh positive blood, based on laboratory reports. She developed a reaction. She was Rh negative.

One month later patient became pregnant. Her baby was Rh positive. The baby was born dead. The court held the transfusion responsible for the death.

The court held here that the laboratory typing was not a medical act, and found the defendant hospital liable for this "administrative" act. Journal American Medical Association, (174).

2. "A hospital was held liable for a reaction from transfusion of incompatible blood." National Hemeopathic Hospital v. Phillips, (175).

3. "An employer was held liable for injuries to a job applicant by a physician in its medical department in getting a blood sample." Mrachek v. Sunshine Biscuit Incorporated, (176).

4. Plaintiff here was involved in an accident injuring her left leg. She was taken to a city hospital in New York City where Xrays were taken. The attending physician looked at the wet Xray plates as soon as they were developed and then told the plaintiff that the Xray plates showed no fracture. The plaintiff was then sent home. The next day a roentgenologist, looking at the "dry" Xray plates, detected a rather serious fracture of the left femur (impacted transverse cervical fracture). However, the hospital did not notify the plaintiff of this new diagnosis for two weeks even though the roentgenologist noted the revised or new diagnosis on the plaintiff's hospital record. When this new diagnosis came to the attention of plaintiff's family doctor two weeks later it was necessary to "reset" plaintiff's fracture with a pin, after keeping plaintiff in traction for a while. Plaintiff paid the city hospital for all services. Plaintiff then sued the city of New York for negligence of its servants. The issue before the courts was-was the failure to notify the plaintiff of the new diagnosis (fractured

leg) an administrative act as distinguished from a medical act, thereby holding the hospital liable for damages--despite the fact that the hospital was operating as a "charitable" one?

Verdict for plaintiff upheld on appeal, on the basis that although a charitable hospital is not liable for the negligence of its staff (doctors, nurses, technicians) it is none the less liable for negligence of its administrative agents. The negligence here (failure to notify the plaintiff of the new diagnosis) was an administrative error rather than a medical error, On this basis the city of New York was liable." Aberson vs City of New York, (177).

5. Plaintiff here was delivered of a baby at defendant's hospital. After the delivery plaintiff received the wrong baby by reason of negligence on the part of the hospital. She took this baby home and soon discovered the error. Eventually she received the right baby from the hospital. The plaintiff then sued the hospital alleging--"profound shock to the nervous system; that (she) sustained great physical and mental suffering and was made sick, sore and lame." There was no medical testimony. In fact, the plaintiff did not even see a doctor for her "profound shock to the nervous system".

The only testimony supporting her allegation was the plaintiff's claim that she suffered insomnia, back and stomach trouble, and ached all over. There was a verdict for the defendant which was upheld on appeal. The appeal court said that mere mental suffering alone would not support an action such as this. One must show actual physical injuries as a proximate cause of the defendant's negligence. Nervous disturbances and nervous shock would have constituted physicial injuries proximately due to defendant's negligence in this case. However, there was no proof of "nervous shock" or "nervous disturbance" only testimony by the plaintiff that she endured "mental suffering." Espinola et al v. Beverly Hospital, (178).

6. Plaintiff sued the defendant hospital for negligently causing the death of her husband.

The hospital holds itself out as equipped to care for mental patients. The plaintiff's husband was admitted to the hospital suffering from emphysema, a stomach ulcer and insane delusions. The patient's personal physician told those in charge of the hospital about the patient's condition and that he would have to be placed on the ground floor andwatched or otherwise he might harm himself. The admitting doctor was not at the hospital when the patient entered, but he had left the following

instructions for the care of the patient; "Low bed, sideboards, and restrain if necessary, soft diet. In general the nurses aids on that floor were unable to control his actions. The patient had not been placed in a low bed with sideboards, and no restraints were used to keep him in bed, About 6:30 p. m. the patient fell or jumped out of the window of his second floor room. The fall caused his death. At the trial the medical director testified that he saw the patient during the afternoon and at the time considered either moving the patient to another section of the hospital or tying him in bed, but that he decided to do neither. Also the evidences showed a conflict as to whether or not the hospital officals told plaintiff that she could get a special nurse to attend her husband. In any event she did not do that."

The court of appeals pointed out that: "A private hospital owes a duty to give its patient such reasonable care and attention for his safety as his condition may require; and it must use reasonable care to safeguard him against any known or reasonably apprehended danger to himself due to his mental derangement." In light of the patient's behavior in the afternoon, the jury was justified in finding that the doctors and nurses did not act reasonably in not restraining the patient for his own safety.

Judgment against the hospital. Rural Education Association v. Anderson, (179).

7. A legal differentiation is made between governmental hospitals operated as nonprofit organizations in contra distinction to those hospitals operated for profit. In the case of the former, the hospital generally is not regarded to be liable for the acts of its employees, assuming that "due care" has been used in their selection (possession of licenses of house officers and nurses, for example). The distinction is that "profit-hospital" is responsible for all acts of its employees. In both cases, it should be emphasized the individual physician (and nurses) is still liable for his own acts.

SUMMARY OF HOSPITALS IN MEDICAL MALPRACTICE

1. New York and Pennsylvania Supreme Courts have ruled that blood typing and other hematological laboratory acts in a hospital were not medical acts but administration acts and held the hospital liable for damages caused by their incorrect results.

2. Hospital was held liable for failure to notify physician of a change of diagnosis by the hospital roentgenologist of a fracture. Court held this negligence in an "administrative" act.

3. Hospital not held liable for giving wrong baby because of failure to secure pychiatric testimony that patient suffered a "nervous shock" from the error. No actual damage to plaintiff was shown; therefore no recovery.

4. Plaintiff recovered from hospital for not properly restraining a mental patient and his subsequent jumping out a window to his death.

5. "Profit" hospitals are liable for the acts of their employees. Non-profit governmental hospitals are not. In each instance the individuals are liable for their own acts.

CHAPTER XVII

Medical Malpractice Insurance

This chapter points out several important facts:

1. Insurance premiums are climbing rapidly.
2. Some companies due to heavy loss now no longer insure in certain areas.
3. Insurance clauses are construed liberally in favor of the insuree physician.
4. The <u>better</u> insurance companies keep staffs of attorneys to conduct most of the doctor's defense in malpractice suits. The selection of an adequate company is of primary concern.

Malpractice insurance rates increase:

Insurance claims have jumped tremendously in past years. e.g., one state in one year had their premiums go up 850%. Lusby, (29) They have kept pace with claims.

Malpractice claims in 1929 were 400 in the United States; in 1952 they were 4000-one for every 39 physicians.

Insurance increase:

"As a result of the large numbers of claims being filed in many metropolitan areas most physicians' professional liability insurance premiums have been raised two to five times the rate prevailing only a few years ago."

"In Maryland for example, policy rates have increased

as much as 261 per cent for Radiologists in the year of 1954. Macht in a survey of all radiologists in Maryland found threats of legal suits in only three instances in the experience of 57 readiologists who had examined 3,870,260 cases for diagnosis and who had treated 181,751 cases during the ten year period of 1943-1953. Two of these threats were obvious fraudulent claims which never came to court and in which no financial settlement was made. The third case was a suit for an alleged Xray burn during therapy; a suit which has not yet come to court."

"In one state, premiums increased 850 per cent in 1952. Experts conclude the problem is a serious national one for all physicians. It is predicted that soon malpractice coverage will not be available from any company. It has been suggested that Medical Societies enter the insurance business and issue protective policies for the members of the medical profession." Lusby, (29).

Present premiums:

Insurance rates vary of course with the amounts of protection and for the types of physician. Insurance is more if there is a partnership involved. As one partner is civilly liable for his partner's malpractice.

For a general practitioner the cheapest insurance

in Iowa and Nebraska is about $45.00 a year for $5000.

Since most claims average $65,000. this hardly seems adequate. $100,000. protection is approximately eighty-five dollars for a General Practitioner in Iowa or Nebraska who does no surgery.

CHART #12

Rates as of March 1, 1954 by Lloyds of London quoted as follows:

For Florida, New York, Illinois $25,000-$75,000.
Physicians.....$230.00
Surgeons.....$360.00
Radiologists
(doing any surgery).....$690.00

For California 33 1/3 per cent must be added to these figures; for all other states 25 per cent may be deducted. States with lower rates than Maryland are: Alabama, Connecticut, Delaware, Louisana, Massachusetts, Michigan, Mississippi, Nebraska, New Hamsphire, part of New Jersey, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Carolina, Texas, West Virginia.

"Recently, as a result of Macht's survey, Lloyds of London has offered the Maryland Radiological Survey members a $50,000/$150,000. policy for a premium of $150.00 a year.

The following table is taken from figures supplied by the State Insurance Department of Maryland:

GRAPH #4 See previous page

YEAR	NO. DRS.	LOSSES	COSTS PER POLICY
1948	748	$1,668.	$2.23
1950-1951	1,750	$50,000.	$29.00 (company got $13.52

Causes of high rates:

"The losses stated above include all expenses; court costs, adjustor's fees, lawyers' fees, amounts paid to claimants in settlement, etc. No further breakdown of these figures could be obtained. The figures presented must be reconsidered when the following facts are made known:

1. Some companies total their experience with dentists, chiropractors, osteopaths, veterinarians, hospitals, etc. all in one figure with their experience with medical doctors. It is, therefore, impossible to obtain any accurate figures from such companies so far as their experience with medical doctors alone is concerned.
2. There is one very big item to consider. All State Department of Insurance Agencies encourage a lumping of actual losses and reserves posted against future possible losses under the title "Incurred losses". A loss might therefore be apparent when actually a profit has been

made by the company during a year when the company had threats of cases. For example, the threat of a $75,000. suit is listed as a loss. The case may be settled for less at a later date. Under non-group selling a large part is consumed by actual selling and home office costs. This figure added to "incurred losses" can easily be made to show a loss.

3. The most potent factor is the very spiraling inflation and dollar devaluation.

4. Nuisance claims are very troublesome and costly. They run a long time, require frequent follow-up, require investigation and funds which have to be set up for a possible loss.

5. Claims of admitted negligence can often be settled quickly, but these are few." Lusby, (29).

Malpractice Insurance coverage:

"In Ohio there was a legal action to determine the obligation of the plaintiff insurance company to one of its policy holders.

The plaintiff patient commenced an action against a chiropodist defendant to recover damages for personal injuries attributed to his negligence. She alleged that she was a patient of the chiropodist and went to his office to receive treatment for a foot ailment. She

attempted to seat herself in the metal hydraulic chair designed for the occupancy of patients; The chair suddenly rotated causing her to fall to the floor, whereby she was injured. Negligence of the chiropodist was charged.

Defendant held a policy for liability insurance which provided that the company would defend each claim and suit "arising out of the practice of the insured's profession as specified herein, and to pay the expense incurred in the defense of such claim or suit in addition to the applicable limit of liability of the policy." It also provided that the insurance company would pay on behalf of the insured all sums that the insured becomes obligated to pay because of injuries resulting from professional services rendered or that should have been rendered. The insurance company contended that, under the policy, its liability either "to defend" or "to pay" was strictly limited to those injuries that might arise out of actual rendition of professional services by the insured and that the allegations of the petition did not disclose an incident within the protection of the policy. Defendant on the other hand, contended that the language of the policy is in broad and comprehensive terms, and that, in conformity with the well-established and univers-

sally recognized rule, any doubt or ambiguity with respect to the meaning of the phraseology employed in the policy must be resolved in favor of the insured and against the insurer, which prepared and issued the policy and collected a premium therefor.

Said the Supreme Court, the insurance company is liable under its policy. The policy is entitled "Professional Liability Policy" and nowhere in the language relied on is the liability of the insurer restricted to "malpractice" or, by the wording of the policy, is liability thereunder confined to a failure on the part of the insured to exercise the standard of professional skill in the treatment of patients prescribed by law. Maintaining the treatment chair in a proper and safe condition for the accomodation of patients was a service or duty directly connected with the practice by the defendant of his profession as a chiropodist. The insurer, concluded the Supreme Court, is therefor obligated to defend the action in the event of a verdict and final judgment against him, the insurer is liable to pay, on the doctor's behalf, such sum as may be within the limits of the policy. The judgment of the court of appeals against the plaintiff insurance company was therfor affirmed. American Policyholders Insurance v. Michota, (180).

IMPORTANT FACTS AND SUMMARY OF MALPRACTICE INSURANCE

1. Some companies, hard hit by heavy malpractice insurance losses have already withdrawn from malpractice insurance in certain areas. e.g. United State Fidelity and Guaranty will not insure Nebraska physicians,

2. Starting physicians, who need insurance the most, are often unable to get more than $35,000. coverage. The average suit is for $65,000.

3. Insurance rates are from two to five times higher than they were a few years ago.

4. Malpractice insurance usually covers accidents connected with treatment as well as for the treatment itself.

5. An insurance company should be selected with care, because in case of legal suit, the better companies have staffs of attorneys who conduct the bulk of the defense of the doctor. This should be looked into before buying insurance.

CHAPTER XVIII

Legal Defenses of Defendant Physicians in Malpractice Suits

Introduction:

The "burden of proof" is on the plaintiff patient to prove an actionable case. He must show beyond reasonable doubt:

1. the doctor-patient relationship existed.
2. the doctor was culpably derelict in his duty to the patient.
3. that the patient suffered damage.
4. the doctor's failure of duty was the legal "proximate" cause of the actual damage to the patient.

Legal defenses:

1. General denial of plaintiff-patient allegations.
2. Affirmative defenses
   1. res adjudicata.
   2. contributing negligence.
   3. statute of limitations.
   4. assumption of rick by plaintiff-patient.

Practical defenses:

1. Expert testimony by another physician is necessary to prove medical breach of duty. This is not always obtainable.

2. The better insurance companies provide a staff of attorneys to aid the insuree physician in his case.

1. Doctor-patient relationship:

The relationship of physician and patient must exist. A doctor, like any other citizen, is a free agent. He may accept or reject such employment as he chooses. He is not an inn keeper or a common carrier. A physician's duty to his patient arises out of his contract of employment, it is measured and defined by that contract. What is a contract of employment? It is an agreement whereby a physician, at the instance and request of a patient, agrees to diagnose, treat, operate or prescribe for that patient. The agreement need not be formal in its terms, it practically never is. No form of words or writing is required. Any conduct by the parties indicating an accord that one shall become the patient of the other is sufficient. The largeness or smallness of the fee agreed upon (if one is agreed upon) , is immaterial, nor does it matter if anything is said about the fee at all. Usually nothing is said about it, and the physician is relegated (if the is not voluntarily paid) to his legal right to recover what may be reasonable under the circumstances. But if it is understood that no fee is to be paid at all, the doctor's obligation is no less great. It is one of the

great glories of the medical profession that its members devote a large proportion of their time in rendering their services to charity patients free of charge. In doing so, however, the doctor assumes no less risk and no smaller obligation than as though the services were performed for a captain of industry. Thus, in a New York case the judge charged the jury that the mere fact that the plaintiff was a charity patient in no wise qualified the liability of the defendant doctor. Becker v. Janbski, (49). In still another a surgeon operating in a dispensary inflicted an injury on the plaintiff's hand by cutting through a bandage to the hand itself. The doctor admitted that before cutting he made no examination to ascertain where the hand was or what was concealed under the point where he applied the shears. In affirming the judgment of negligence against him, the court said: "The hurried work in a public dispensary does not excuse the lack of ordinary care. The defendant could not assume that the hand was in a safe condition and rely on it when he readily could have ascertained the condition before applying the shears. Volhell v. Wolf, (181).

2. Breach of Duty:

That the doctor departed from some duty which he owed his patient. We have seen that the actual contract between the patient and physician is usually most informal.

What is not said, however, the law supplies. A physician usually makes no actual representation as to his ability or skill, yet "by taking charge of a case he impliedly represents that he possesses and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed" by physicians of his locality. Pike v. Honsinger, (17). Not only must he possess the skill, but "upon consenting to treat a patient it becomes his duty to use it." Pike v. Honsinger, (17). He must not depart from "approved methods in general use." Pike v. Honsinger, (17). He must "keep abreast of the times," or as the Pennsylvania courts have said, he "is bound to be up to the improvements of the day." McCandless v. McWha, (182). Not to have or use the required skill and learning, not to use his best judgment, not to keep abreast of times, to depart "from approved methods in general use" is a breach of duty. This breach of duty is the second element in an action for malpractice which, in order to recover, a plaintiff must establish by a fair preponderance of evidence.

It should be noted, however, that a plaintiff cannot succeed merely by establishing that the doctor was guilty of an error of judgment. "The rule requiring him to use his best judgment," said the New York Court of Appeals,

"does not hold him liable for a mere error of judgment, provided he does what he thinks is best after careful examination." Pike v. Honsinger, (17). Thus, it may transpire that in a given case there are several different approved methods of treating a fracture or other injury or condition. Perhaps one method may be preferable to another. The doctor must decide, that is, he must use his best judgment as to which method he will follow. If he errs in this he is not liable, provided he has done what he thinks is best after careful examination. A doctor is not a guarantor or warranter of cures. A doctor may not, however, adopt a procedure which has been universally condemned or one which has not yet received the sanction of scientific men, and then claim that doing what he did involved a mere "error of judgment". There is, of course, a domain beyond which he may not use his judgment. No doctor, for example, would be heard to say that his failure to use modern asceptic precautions, where it was possible to use them, was a mere error of judgment.

3. <u>To plaintiff defendant:</u>

If a person has a cancerous member amputated and it is discovered that there had not been proper consent given for such amputation, an interesting situation, legally, is presented. Ordinarily a surgeon removing tissue without

consent would be held liable. But in this instance, it might well be found that there had been no actual loss. Cases in which this legal maneuver has been employed successfully involved amputation of the breast and of the penis. Testimony was introduced that but for the operation, the plaintiff would in all probability have not lived until the time of the trial. Obviously, the loss of a breast or of a penis under ordinary circumstances is of such significance that huge damages could well be imposed against one wrongfully removing these organs. But where life, itself, is preserved at the expense of losing such tissue, the enormous benefit rendered by this surgery tends to cancel out whatever loss is claimed by the plaintiff.

Once the plaintiff has established this "prima-facie case", he is entitled to have a jury weigh the evidence submitted and render a verdict for him if the proof amounts to "a preponderance of the evidence." If the plaintiff is unable to establish such a prima-facie case, the defendant is entitled to a directed verdict upon motion at the close of plaintiff's case.

4. Proximate Cause of Damage to plaintiff-patient:

The law of negligence is predicated upon both duty and responsibility. To hold another liable in damages, it must

be shown that the other is responsible, that is, that he has caused the injury for which damages are being sought as compensation. There must be a causal connection between the injury and some act or omission of the person sued. Brown v. Goffe, (183). A mere breach of duty alone is not sufficient. There must be a distinct and clear chain of causation between the breach and the injury for which damages are being asked. Thus, there might be a breach of duty and there might be an injury, yet this could not prove a case--there must be a causal connection between the two. The breach of duty must produce the injury; the injury must proceed from the breach of duty. "Mere lack of skill or negligence, not causing injury," declared Judge Taft in a celebrated case, "gives no right of action and no right to recover even nominal damages. Ewing v. Goode, (67).

This rule has been nowhere better expressed than in the New York case of Smith vs. Dumont, (184), where the General Term said: "<u>In order to entitle plaintiff to recover for the permanent injury which it was proved he has sustained, it was necessary to prove that this permanent injury would not have been present had not the defendant been guilty of negligence or want of skill.</u>" There must be a <u>direct</u> not a remote, an actual not a speculative

causal connection between the breach of duty and the bad result. The case last cited was one brought against a physician for his alleged negligent treatment of a Pott's fracture.

The court declared that " a recovery will not be allowed unless the evidence shows that the injuries are a natural and probable consequence of the wrongful act or omission of the defendant. Where they are remote and speculative, the law will not enter upon an inquiry for the reason that such a degree of certainty cannot be arrived at in respect thereto as will constitute a safeguard for judicial action." Smith v. Dumont,(184).

Thus, in the Pike case it was said that a departure from "approved methods in general use if it injures the patient will render him (the physician) liable however good his intentions may have been." And still further that "to render a physician and surgeon liable, it is not enough that there has been a less degree of care than some other medical man might have shown, or less than even he himself might have bestowed, but there must be a want of ordinary and reasonable care leading to a bad result. Pike v. Honsinger, (17).

The basis of medical malpractice actions are usually based on:

1. the doctor's duty to "use reasonable care and diligence" in his professional work.

2. his duty not to depart "from approved methods in general use." or, as it is usually stated in the trial courts, not to depart from the "proper and approved practice."

As every doctor admitted to practice medicine is presumed to possess the knowledge and skill of the average physician. London v. Scott, (185), a plaintiff who sets out to prove the contrary will be confronted at the outset with this presumption, which would have to be rebutted by affirmative evidence.

Apparently no cases show a duly licensed physician does not possess the requisite skill.

1. General denial:

The most effective legal defense is the general denial. This translated legally means that the doctor-defendant denies all the plaintiff patient's allegation and makes it necessary for the patient to prove his entire case with nothing admitted on the part of the plaintiff. By this defense the doctor contends that his entire conduct has been proper.

2. Affirmative defenses:

1. res adjudicata: Where a doctor sues and recovers for his professional services, the judgment in his favor in

that action is a bar to any later suit by the patient for any alleged malpractice committed in connection with the services for which recovery has been had. Thus, in the Blair case, the doctor recovered for his services, later the patient instituted a separate action against him for malpractice. Referring to the doctor's services, the Court of Appeals declared: "But if of value, they could not have been useless; and if of use, they could not have been harmful; and if not harmful, there could not have been mala praxis until the performance of them. Hence, it is res adjudicata between these parited that there was not the malpractice, on the allegations of which, in this action, the plaintiff here seeks to recover. The same question, now raised in this action.....has once been judically decided between them, and the judgment remains unreversed...That question is settled forever between them by that judgment. It cannot be opened and litigated again, by either of them, in another action." Blair v. Bartlett, (186).

The fact that the doctor's recovery for services in the first action had been secured by default was deemed by the court of no importance. But in all jurisdictions, except New York the fact that the doctor's judgment for services was recovered by default""is not to bar an action

by the patient against the physician for damages caused by malpractice in the performance of such services."

2. Contributory negligence of the plaintiff defendant: Where the negligence of the patient or that of those who were acting for him caused or contributed to the injury complained of, no recovery can be had. If, however, both the patient and the physician have been negligent and the injuries due to the respective negligence of each are capable of separation, then the doctor is liable for the injuries occasioned by his own want of care or skill. No other negligence on the part of a patient will bar action against recovery. His negligence must be "contributory negligence", that is, it must have contributed proximately to the injury caused by the malpractice of the physician. In New York it is necessary to allege contributory negligence in order to establish it as a defense, except where the action is to recover damages for causing death, in which case the defense must be both "pleaded and proven by the defendant."

3. Statutes of limitations:

The theory underlying all statutes of limitation is that valid claims are usually asserted with promptness and that an undue lapse of time in the assertion of a

claim creates a presumption that the right did not originally exist. Statutes of limitation are "statutes of repose" the object of which is to suppress fraudulent and stale claims from springing up a great instances of times and surprising parties or their representaitves when all the proper vouchers and evidence are lost or the facts have become obscure from the lapse of time or the defective memory or death, or removal of witnesses. The underlying purpose of statutes of limitations, said the Appellate Court of Illinois, "is to prevent the unexpected enforcement of stale claims, concerning which persons interested have been thrown off their guard by want of prosecution." Miller v. Calumet Lumber Co., (187).

The fundamental characteristic of a statute of limitation "is that it accords and limits a reasonable time within which a suit may be brought upon causes of action which it affects. Statutes of limitation do not confer any right, otherwise unlimited, might be asserted." The legislatures of the several states, varying as they do in their conceptions of public policy, have prescribed different periods within which an action for malpractice may be begun, and have likewise varied in their laws as to when a physician must sue for his services or be forever barred from claiming compensation for them. But all

the states have set some time limits for the commencement of such suits. The term of these statutes, as well as their interpretation and effect may offtimes become a matter of extreme importance to the doctors, for doctors, like men in other walks of life, may be thrown off their guard by reason of the prosecution against them of stale claims. Doctors, like other men, lose or destory their vouchers, books and records, move their offices, get sick or otherwise have their papers in confusion, or find that a lapse of time has obscured their memory of the facts.

In New York the law provides that an action for malpractice "must be commenced within two years after the cause of the action has accrued." A doctor's action for his professional services must be commenced within six years after the rendition of the last service. Two years is the legal limitation for the commencement of a malpractice action in many of the states, among which are Massachusetts, Minnesota, New Jersey and Pennsylvania. In California, Connecticut and Ohio there is a one year limitation for the commencement of malpractice actions. And in Maryland the limitations is for three years. For states other than those here mentioned, the laws of each state should be separately consulted.

These statutes seem plain enough upon their face, but with them as with other laws difficulty arises in their interpretation. One of the questions most frequently occurring under these statutes is: When does the period of limitation begin to run? This becomes expecially important in that class of cases where foreign bodies have been permitted to remain. In such cases does the period start at the time the malpractice was committed or does it begin when it was discovered? Sometimes a negligent act does not result in injury until some time after it was committed. In such cases does the statute begin to run at the time of the commission of the negligence or at the time of the commencement of the consequent injury?

These questions have been asked many times and have been clearly answered by the courts. One of the most important decisions on this subject arose in New York, where a dentist in extracting a tooth permitted it to drop down the plaintiff's trachea and lodge in her lung. It was more than three years after this that she discovered the fact. In New York, as will be recalled, the statute is two years, applicable alike to doctor's and to dentist's. The dentist in the case under discussion moved to dismiss the complaint upon the ground that it set forth a cause of action based on an act of malpractice, i. e. the dropping of the

tooth into the trachea which act had occurred more than two years before the commencement of the action. The plaintiff contended that the dentist had known of his negligent act when it occurred and had concealed it from her in the meantime, and that she had not begin her suit within the two year period because she did not know the facts until more than two years had elapsed. Nevertheless, the court held that the action was barred. "There is nothing alleged," the court declared, "from which we may infer that the defendant knew or ought to have known that the tooth had lodged in the lung....There is nothing alleged from which we may infer any intentional fraudulent misrepresentation of fact as to the presence of the tooth in the lung resulting from letting it fall down her throat. At most there was a breach of professional duty in the operation alleged to have been negligently performed and in the concealment of his negligent act. That was malpractice and the statute had run against such a cause of action." Tulloch v. Hasselo, (188).

In a still more recent New York case, the defendant physician operated upon the plaintiff for appendicitis. The operation occurred May 27, 1925. In a subsequent operation on July 13, 1927, it was discovered that a pair of forceps had been left in the plaintiff's peritoneal

cavity. Plaintiff did not begin her action against the defendant doctor until four years after the original operation for appendicitis. The Appellate Division squarely decided that the plaintiff's action was barred by the two years' statute of limitations. The plaintiff there argued that the statute "should begin to run from the time of the discovery of the malpractice." The court overruled this contention saying: "The decisions setting forth the purpose and effect of such statute are to the contrary." Conklin v. Draper, (189).

On the appeal the Court of Appeals sustained the lower court. Conklin v. Draper, (190).

In Massachusetts a surgeon was charged with leaving a piece of gauze in the patient's abdomen after the performance of an abdominal operation. More than two years after the operation the plaintiff sued for malpractice. The surgeon contended that the action was barred by the two years' statute of limitations, in as much as the action was not begun until more than two years after the operation was performed, and that the statute begun to run from the date of the alleged malpractice and not from its discovery. The Supreme Court of Massachusetts in sustaining him in this contention said: "the damage sustained by the wrong is not the cause of action; and the

statute is to bar to the original cause of action although the damages may be nominal and to all the consequential damages resulting from it though such damages may be sustained and not forseen." Cappuci v. Barone, (191).

"The statute of limitations on an act of malpractice ordinarily runs in favor of the physician or surgeon from the time of the negligent act rather than from the time of the consequential injury."

An exception to the foregoing rules should, however, here be noted, namely, that arising from the suspension of the statute during infancy or other disability. The New York law is that when the cause of action accrues against a person who is insane or imprisoned on a criminal charge, or in execution upon conviction of a criminal offense, for a term less than for life, that the term of such disability is not a part of the time limited for commencing the action, except that the time so limited cannot be extended more than five years by any such disability, or, in any case, more than one year after the disability cases. An infant may bring an action either within the two year period, or, if that has expired before he attains his majority, then within one year thereafter.

4. Assumption of risk by plaintiff patient:

Even though plaintiff's prima-facie case be established, the defendant doctor can escape liability "on the law"

by pleading and proving a defense. Two common "affirmative defenses" invoked to defeat liability are assumption of risk and contributory negligence.

Assumption of risk is a defense made out in a situation where the patient, with full knowledge of the risks involved, voluntarily submits to a procedure in which he "is taking his chances". Since the patient consciously and deliberately chooses a dangerous course, often against the physician's advice,, the law relieves the defendant physician from any duty to protect his patient. Actual reported cases of this nature are extremely rare. This obtains since the patient has a right to rely on the superior knowledge of his physician and thus is not "assuming the risk" in most instances where recommended therapy is being carried out. Furthermore, it is very uncommon for medical practitioners to undertake procedures which they, themselves, advise against.

Expert testimony required in a malpractice suit. In every case in which the point at issue involves a question requiring for its correct solution scientific or medical knowledge, expert testimony must be adduced before a jury can be permitted to consider it. Any question involving in any way the propriety of the treatment, however obvious the question may appear to the layman,

requires expert testimony for its solution.

This expert medical testimony is not always available. Physicians are often reluctant to testify on matters which they can only make assumptions concerning.

Insurance defense attorneys:

Where the physician defendant is insured by one of the better insurance companies, there is a staff of attorneys ready to assist and advise him from the onset of the suit. They will defend him to the very best of their ability because a judgment against the doctor' is a heavy financial blow to the company,

SUMMARY OF THE PHYSICIAN-DEFENDANT'S DEFENSES

In general the physician's best defense is the fact the plaintiff patient must prove his entire case or fail to recover. The "burden of proof" is on him. If any part of the plaintiff's case fails, the entire case fails.

The plaintiff patient must show all these factors:

1. The existence of the doctor-patient relationship.
2. Culpable dereliction of duty of physician-defendant.
3. There was damage to the patient.
4. The breach of duty was the legal cause of patient's damage.

Physician defendants legal defenses are:

1. General denial.
2. Affirmative defenses.
   (1). res adjudicata.
   (2). contributory negligence of plaintiff patient.
   (3). Statutes limitations.
   (4). Assumption of risk by plaintiff patient.

Practical defenses:

1. Expert testimony by physicians is necessary to prove medical breach of duty. This is not always obtainable.
2. The better insurance companies provide staffs of attorneys to aid their insuree physician in his defense.

CHAPTER XIX

Plans By Organizations To Reduce Malpractice Suits

The Canadian Medical Protective Association has apparently been quite successful in handling Canada's malpractice problems.

This association is composed of the physicians of Canada and is operated by them. They charge approximately $20.00 per year and provide defense for the physicians by their staff of attorneys.

When a physician is first presented with a claim he is advised to state nothing to the claimant about the case. He is immediately to notify the association. The association conducts the defense from there.

Apparently the association handles much of its own discipline. A member may be expelled for cause.

The physician's of Canada apparently like the system very much. They get swift protection, and the cost is only a fraction of the malpractice insurance cost in this country. (See Appendices #1, #2).

Suggestion:

Dr. Lusby of Maryland has suggested that Medical societies and associations enter the insurance field and issue protective malpractice policies for their members. Lusby, (29).

National: American Medical Association:

At the national level the American Medical Association study of the overall malpractice insurance problem should be continued and expanded. Only by sifting and straining all methods of claim prevention, underwriting, group buying, adjustment, and litigation, can a solid mass of information be developed.

What may well prove to be the American Medical Association's most important contribution to date in the field of legal medicine is a series of Medicolegal Institutes that the Law Department and the Committee on Medicolegal Problems will sponsor next fall. Like the custom of prior years, the Committee on Legislation is planning six regional legislative meetings. Three of these meetings will be held on Saturdays in Chicago on Oct. 8, in Omaha on Oct. 15, and in New York City on Oct. 29. On the three Sundays that follow, Oct. 9, Oct. 16 and Oct. 30, the Law Department will sponsor all-day sessions, discussing various medicolegal problems of interest to, and open to, the physicians and attorneys in the particular area. Definite programs have not as yet been worked out, but the Law Department sincerely hopes and believes that these programs will be both interesting and informative.

State Associations:

Group programs for purchasing malpractice insurance, where they are deemed to be desirable, will probably have to be organized on a state basis except in the large counties. Parenthetically, it is believed that group plans at the national level are unsound unless they can be administered and guided locally. The nation is too large a unit for effective advice on underwriting or within which to move with dispatch in claim situations.

A good job of stimulating acceptance can be done at the state level as is indicated by the New York State Medical Society's sixty-five percent eligible physician participation and the Oklahoma State Medical Association's approximately eighty percent.

Group malpractice and defense boards may well function within state associations, Where a state association professional liability insurance policy is in force, the board can conduct a statistical control of rates and classifications of coverage as indicated by experience, and be charged with final responsibility for underwriting-that is the responsibility for curtailing or refusing coverage, and recommending special riders excluding or limiting liability on certain procedures or methods.

Claim adjustment can profitably be centralized under the board. Inexperienced men should never be employed to adjust malpractice claims. A seasoned, tactful and wise adjuster may spell the difference between a fair, honest settlement and a lawsuit.

With or without a group insurance program, the state board can retain competent attorneys to defend all malpractice suits brought against members of the association, or to be available for consultation in such defense. This is a highly specialized field of law and an attorney's effectiveness normally bears a direct relationship to his experience.

County societies:

The spade work must be done in the county medical society. A complete county medical society program for malpractice prophylaxis will entail a public relations service which will bring to the attention patient-public the good things done by the society and its members; an emergency medical service; social welfare assistance, a competent and wisely directed collection service; and-most important- a grievance or mediation committee to which the public is urged to bring complaints as to treatment, results or fees. While certain of the elements of such an overall program may be beyond the financial

resources of many county medical societies, there is scarcely a society so small that it cannot have a mediation committee. And it is not enough simply to have such a group "on paper", it must work diligently and publicly with the society standing behind its recommendations. It should have among its members, or advisors, competent specialists who will go into court to testify either for doctor or for patient, depending upon findings. In the public and professional recognition of the authority and objectivity of such a committee will lie its relative success or failure.

1. Every county medical society should have a long range activity program to improve doctor-patient relations. This would include three main divisions:

a. An active well publicized grievance committee,

b. An emergency medical plan.

c. A carefully operated collection bureau.

2. In the event that a physician is once found guilty of malpractice if the situation is not serious enough to drop the doctor entirely three other things may be done.

a. Reduce his policy limits to 5,000-15,000. He then surely would be more careful than if he had 100,000-300,000.

b. Write a deductible clause of possibly $1,000.--in his

subsequent malpractice insurance.

c. Deny protection to him for special things if he is not qualified in the particular field involved, for example--Xray therapy, plastic surgery, electroshock therapy, anesthesia, etc.

3. Each local medical society should consider having a legal consultant on an annual retainer fee. This is a highly specialized field of law and an attorney's effectiveness usually bears a direct relationship to his experience and interest.

4. Physicians must constantly be careful of their comments since the origin of more than 60 per cent of all claims is in this area.

~~What can you do if you feel you have been the victim of malpractice?~~

Grievance committees:

In the interest of justice, both to patient and doctor, medical societies have set up grievance committees to aid in determining what the facts are in specific malpractice complaints.

Today, grievance committees exist in all state medical associations and in some 700 county medical societies. Only recently, Dr. Elmer Hess, president of the American Medical Association, went on record recommending that the

existence of these grievance committees be publicized so the general public might become aware of them and place its complaints before them.

"If negligence or malpractice on the part of the physician appeared to be present--just and prompt financial renumeration would be made to the patient. On the other hand, if there was no merit to the charges brought against the physician, the doctor would be vigorously defended. Under no circumstances would a"nuisance claim" payment be paid, as is so commonly done in other types of (professional) liability insurance."

This firm policy has helped Alameda-Contra Costa doctors. It has also produced firm facts about malpractice that may help doctors in other parts of the country.

As a further aid to justice, some of the larger medical societies have established panels of specialists in the various fields of medicine on whom a patient's lawyer can call for an impartial examination of the case, and who are prepared to testify in court.

You as the patient are under no obligation to accept ruling of a medical grievance committee-you can still go ahead and sue if you are convinced of the justice of your claim. Neither does your doctor have to accept the ruling. But it has happened repeatedly that

the grievance committee of a medical society has assisted a patient in pressing his claim against one of its own members. And it has happened that physicians have been expelled from membership in a county medical society solely on a charge of civil malpractice.

Rigid standards of practice:

Many medical groups are actively working to prevent or reduce cases of malpractice by setting up rigid standards of practice. To assure that every patient is cared for with meticulous attention, they are constantly bringing up to date the requirements of good practice in their respective fields. These medical-society programs have had a clearly recognized effect on raising the standards of medical and hospital care.

Public education:

The one thing that too many claims-conscious patients, and their lawyers, fail to recognize is that suing a doctor for malpractice is definitely not the same as trying to collect for real or imaginary damages to a dented automobile fender. The doctor who is falsely charged with malpractice suffers at the moment of the accusation as well as thereafter-an irreparable damage to his reputation. Even if the trial proves that the charge was totally unfounded, malicious, spitefully vindictive, or a dishonest

attempt to escape paying a bill, the damage has already been done to the doctor. Such suits frequently make sensational headlines, and the public rarely notices a much later and smaller news item revealing the injustice of the charge.

Proposed solution: Shindell, (192).

What are the remedies for this obviously unsatisfactory situation? In seeking a solution, we must determine (1) how the public can be assured the right to recover for injury; (2) how cases involving personal injury can be handled so expeditiously that recovery can be obtained at the time the patient needs the money; (3) how honest medical testimony can be assured; (4) how the legal profession can be assured that there will be no unreasonable protection or whitewashing of incompetent physicians; (5) how the medical profession can be protected from unwarranted attack and unsavory publicity by unjustified suits; and (6) how procedure can be modified to conserve the time of the physician as well as the court.

A plan of confidential procedure prior to filing an action could be postulated that would determine the merit of a case. If the case were found to be justified, a stipulation of fact would be prepared by a board instituted for examination of the medical facts. Such a board

instituted for examination of the medical facts. Such a board would have a rotating membership of both practicing physicians and attorneys approved by the medical society and the bar association. Panel members could be chosen from specialists in the subject matter under consideration. This preliminary procedure would need endorsement by the judiciary and agreement to abide by the stipulations arrived at if a case materialized and went to trial. If a serious disagreement occurred at the preliminary hearing, resort could be had either to arbitration or to standard trial procedure, with only certified experts used as acceptable witnesses. The right of trial by jury would thereby be reversed for issues of fact, the preliminary being a means of eliminating issue in appropriate cases.

A system of sanctions imposed by the court against the bar and by the medical licensure board and/or medical society against the medical profession would probably be required to enforce compliance with this procedure. Attorneys would be censured for filing an action after the impartial board had recommended against it. Physicians would be censured for refusing to give complete facts at the preliminary hearings. The whole procedure would be confidential, and unsavory publicity

would be avoided. Since members of both professions are accustomed to speaking with undisputed authority, the confidential nature of the proceedings would avoid any threat to the unique position each profession enjoys with the public.

A pilot plan would be significant if devised and supervised by persons of undisputed competence who had no special ties in the selected jurisdiction. Some communities, notably the District of Columbia, have attempted to reach compromise agreements through joint committees of the medical bar associations. Such a pilot plan would lend support to these local efforts.

Because of the importance of this question, the only feasible recommendation at this time would be for serious consideration of these proposals. If leaders in both professions, representatives of insurance companies, members of the judiciary, specialists in the academic fields involved, and representatives of the public all were given an opportunity to consult on this matter, a satisfactory solution could be evolved. Shindell, (192).

Washington State Medical Disciplinary Law:

Seattle- The first Medical Disciplinary Act ever incorporated into state law was put into effect here this last month by the Legislature in the State of Washington.

The Disciplinary Act is to be administered by a Board consisting of a physician from each congressional district. The Attorney General of the State is empowered to act as advisor and legal representative in all legal proceedings of the Board. Members of Board are immune from suit for actions taken in their official capacity.

Minor offenses covered:

Sponsored by the Washington State Medical Association, the Disciplinary Act is unique because it legally authorizes the medical profession to "clean its own house" with the aid of State authorities.

Physicians here urged passage of a new measure because of the limitations of the existing Medical Practice Act. This law provides only one penalty for unprofessional conduct--revocation of the license to practice. Such a form of punishment is so severe, however, that it is seldom applied except in major infringements. The new Act, however, calls for either revocation or suspension of the physician's license.

In campaigning for the new Disciplinary Act, Dr. M. Shelby Jared, former president of the Washington State Medical Association, pointed put that heretofore there was no machinery for suspension of the license or any

other disciplinary action that could be taken for minor offenses. The new act now provides for varying degrees of punishment.

Basis of Charges:

Charges of "unprofessional conduct" may be made against a physician by "any person, firm, corporation or public officer," or by the Board itself. Such charges may be based on any of the fourteen points specified in the Act. Some of these are:

Conviction of any offense involving moral turpitude; criminal abortion; deceptive advertising, habitual intemperance; misuse of narcotics; using secret treatment methods; wilful betrayal of a professional secret; rebating; aiding or abetting an unlicensed person to practice medicine; and mental incompetency.

Physicians may appeal:

Accused physicians are given full opportunity to appear with counsel to present their defense before the Board and may appeal the Board's decisions to the courts. Provision is made for reinstatement of licenses after revocation.

If the Board dismisses the complaint, the physician under charges may request <u>full public exoneration</u> to be cleared of "any possible odium that may attach by reason by reason of the charges." Medical News, (193)

Dr. Levinson, (194) suggests that Legal Medicine be required in all medical colleges. Only twelve medical colleges require it at present. This could be a great aid in reducing malpractice suits. Especially would it aid the embryonic practitioner.

SUMMARY OF PLANS TO REDUCE MALPRACTICE SUITS

1. The Canadian Medical Protective Association composed and operated by the physicians of Canada protect their members by insurance and legal protection for approximately $20.00 per annum. (See Appendices #1, #2)

2. Suggestion: Medical societies issue their own malpractice insurance to their members,

3. Nationally: American Medical Association studies of malpractice and medico-legal institutes with the legal profession.

4. State Medical Association:

(1) Group programs for malpractice insurance purchase.

(2) Hiring competent attorneys to protect members of the state association in suits.

5. County medical associations:

(1) Grievance committees--impartial to find facts.

(2) Nuisance claims are never to be paid.

(3) Self discipline of own members.

(4) Hiring medical-legal consultant for aid in suits and prophylaxis.

6. Public education:

(1) Costs of suits to public.

(2) Damage to the doctors who serve them so well.

7. Washington State Law sets up a physician board to

discipline own members.

8. Legal medical instruction with emphasis on medical malpractice avoidance a requirement in all medical colleges.

CHAPTER XX

Summary of Medical Malpractice

This thesis summary includes summaries of each chapter.

Chapter I: Introduction

1. The mission of this thesis is to prevent malpractice suits.
2. Most malpractice suits are avoidable.
3. Medical malpractice suits may be reduced by:
   (1) knowing what medical malpractice is.
   (2) studying its causes.
   (3) examining the plans for its decrease.

Chapter II: Definition

1. Medical malpractice is the failure to do or not to do what the ordinary, average, reasonably prudent physician does or does not do in the locality in which he practices.
2. The general practitioner is compared to the ordinary general practitioner.
3. The specialist is compared to the ordinary specialist in his field.

The physician's legal duties are:

1. correct licensing.
2. exercising the ordinary reasonable care of the physician

in his locality.

3. good judgment,
4. testifying in court when summoned.
5. giving proper instructions to patients.
6. referring patients when necessary.
7. keeping abreast of the medical advance of physicians in his community.
8. obtaining consent for surgical procedures.
9. non disclosure of certain facts to third parties.
10. keeping utmost good faith with patients.
11. employing reasonable diagnostic procedures.
12. employing reasonable therapeutic procedures.
13. making reasonable prognosis.
14. refraining from experimentation.
15. disclosure of certain information to the patient.
16. complying with all medical ordinances, statutes, laws. (ignorance of the laws are no excuse.)

If the physician does not meet these standards he may be liable in a civil action at law by the plaintiff-defendant for money damages.

Chapter III: History

Historically, e. g. 3000 B.C. in Egypt, the physician was held responsible for producing good results.

Chapter IV: Prevalence of Medical Malpractice Claims

Medical malpractice surveys show:

1. suits have increased 300% to 1000%.
2. there is considerable variance in the number and type from area to area.
3. New York, Los Angeles, Washington, D.C. and Missouri have had the most suits.
4. the middle west trend is toward more suits.
5. there will be one suit per physician in the next twenty years in the average locality if the present trend continues.

Chapter V: Causes of Medical Malpractice Suits

The general underlying causes of medical malpractice suits are:

1. Derogatory comments by one physician about another's treatment lay the basis for more malpractice suits than any other cause.
2. Second is the failure to maintain the old, close doctor-patient relationship.
3. Physicians assuring patient that "they will be as good as new".
4. Publicity by the press of present and past malpractice suits generates more suits.
5. Law changes in certain areas. (statutory changes)

6. Guaranteeing satisfactory results.
7. Excessive fees and patients failure to understand charges.
8. Improper collection methods.
9. Specialization with loss of loyalty to physician.
10. Admission of negligence by physician.
11. "Soak the rich" attitude by some patients and attorneys.
12. Notoriety of a few sordid suits involving not physicians but unlicensed people which cast a cloud on all medicine.
13. More liberal court interpretations (common law changes).
14. Public getting more claim conscious.
15. Patient's feeling that physician is indifferent to his problems.
16. Unwise adjusting by insurance companies.
17. Bad public relations.
18. Failure to educate public to their share in the responsibility for their health.
19. Failure to proceed wisely after claim is made.
20. Failure of prompt referral to specialist. (very important).
21. Acts of others may sometimes cause liability on part of physician. (See Chapter XI).
22. Grossest negligence may also be a cause for criminal prosecution by the state.

The specific causes of medical malpractice suits are:

1. Failure to use accepted methods of diagnosis.
2. Insufficient attention.
3. Failure to use accepted methods of treatment.
4. Misrepresentation as to the seriousness of a procedure.
5. Res ipsa loquitur. Matter speaks for itself e. g. Sponge left in abdomen.
6. Failure to maintain standard of the locality.
7. Negligence.
8. Failure to exert the ordinary, reasonable skill of the general practitioner or specialist. (whichever the defendant is).
9. Failure to limit his practice to his capabilities and training.
10. Failure to keep adequate records.
11. Failure to get consent. A complicated field of legal requirement.
12. Violation of privileged communications of patient by physician.
13. Abandonment by physician.
14. Concealment of medical information.
15. Failure to get Xrays in fractures and foreign bodies.
16. Telephoning prescriptions.
17. Testifying at coroner's inquest on former patient without legal counsel.

18. Fee disputes and excessive charges.

19. Failure to write prescriptions legibly.

20. Experimentation on patients.

The actual general allegations in the legal suit of plaintiff patients against the defendant physicians are:

1. Examination without consent.

2. Injury during examination.

3. Error or delay in diagnosis.

4. Failure to use laboratory aids.

5. Failure to administer standard treatment.

6. Failure to leave instructions for treatment of patient.

7. Failure to leave instructions for protection of attendants and of other contacts.

8. Failure to hospitalize.

9. Aggravation of existing condition.

10. Abandonment.

11. Infection resulting from injection.

12. Infection, slough.

13. Burns-xray, diathermy, infra-red, heating pads, etc.

14. Breach of warranty to cure.

15. Error in prescription or in dispensing.

16. Overdosage.

17. Use of harmful drugs.

18. Unnecessary medical treatment.

19. Death from injection, from vaccination, etc.

20. Improper quarantine.

21. Carrying contagion.

22. Defective equipment.

Unwarranted suits are amazingly high. They are estimated from 78% to 90% of all medical malpractice suits. Some appear to be legal blackmail. Physicians may be preyed upon because of their abhorrence of publicity and being tried in court. This, physicians careless comments, and poor physician-patient relationship are our largest problems.

Women, children and new patients bring the most malpractice suits.

Chapter VI:Medical Malpractice in Ophthamology

In eye suits the frequent causes have been:

1. failure to adequately explore the eye with ophthalmoscope and xray.
2. delay in referring serious eye disorders to ophthamologists.
3. failure to adequately follow the more severe cases.

The common allegations in eye cases are:

1. Failure to remove eye--sympathetic ophthalmia.
2. Failure to remove foreign body.
3. Wrong solutions.
4. Cataract improperly treated--blindness.

5. Wrong glasses.
6. Injury to tear ducts.
7. Treatment caused scarring and deformity.
8. Examination without consent.
9. Injury during examination.
10. Error or delay in diagnosis.
11. Failure to use laboratory aids.
12. Failure to administer standard treatment.
13. Failure to leave instructions for treatment of patient.
14. Failure to leave instructions for protection of attendants and of other contacts.
15. Failure to hospitalize.
16. Aggravation of existing condition.
17. Abandonment.
18. Infection, slough.
19. Breach of warranty to cure.
20. Error in prescription or in dispensing.
21. Overdosage.
22. Use of harmful drugs.
23. Unnecessary medical treatment.
24. Defective equipment.

<u>Chapter VII: Medical Malpractice Cases Involving Anesthesia</u>

The anesthesia cases indicate that the anesthetist is liable for:

1. the pre-operative anesthetic evaluation.
2. the post-operative recovery from the anesthetic effects.
3. unnecessary anesthesia.
4. the acts of students under his control.

The anesthetist is not liable for:

1. the surgeon's acts.
2. the nurses acts not under his control.
3. bad results alone (negligence must be proved).

The common allegations in anesthesia suits are:

1. No preliminary examination.
2. Too much anesthetic.
3. Death from anesthesia.
4. Injury to eyes and skin.
5. Injury from mask; from mouth gag.
6. Injury during struggling(improper administration).
7. Pneumonia caused by fluid ether in lungs.
8. Examination without consent.
9. Injury during examination.
10. Error or delay in diagnosis.
11. Failure to use laboratory aids.
12. Failure to administer standard treatment.
13. Failure to leave instructions for treatment of patient.
14. Failure to leave instructions for protection of attendants and of other contacts.

15. Abandonment.

16. Infection resulting from injection.

17. Overdosage.

18. Use of harmful drugs.

19. Defective equipment.

20. Death from injection.

Chapter VIII: Malpractice in Radiology

Radiology cases illustrate:

1. That showing poor or bad results such as Xray burns do not cause liability.
2. The plaintiff-defendant must show actual negligence on the part of physician defendant.
3. There are, however, an increasing number of suits brought for this cause even though they are usually denied recovery.

Common allegations in radiology cases are:

1. Xray burns.
2. Xray tissue slough.
3. Loss of life.
4. Excess radiation.
5. Loss of hair.
6. Examination without consent.
7. Injury during examination.
8. Error or delay in diagnosis.

9. Failure to use laboratory aids.
10. Failure to administer standard treatment.
11. Failure to leave instructions for treatment of patient
12. Failure to leave instructions for protection of attendants and of other contacts.
13. Failure to hospitalize.
14. Aggravation of existing condition.
15. Abandonment.
16. Infection, sleugh.
17. Burns-diathermy, infra-red, heating pads, etc.
18. Breach of warranty to cure.
19. Error in dispensing or in prescription.
20. Overdosage.
21. Use of harmful drugs.
22. Unnecessary medical treatment.
23. Defective equipment.

Chapter IX: Malpractice in Surgery

Surgery suits are usually because of:

1. Operations without consent.
2. Foreign bodies(sponges) left in incisions.

Common allegations in surgery suits are:

1. Breaking and slipping of instruments.
2. Foreign bodies left in patient's tissues.
3. Operation without consent.

4. Operation more extensive than that consented to.
5. Operation on the wrong part,
6. Unnecessary operation.
7. Delay in operating.
8. Failure to operate.
9. Unsuccessful operation.
10. Needle broken off in tissues.
11. Bad results from operation--severed nerve or tendon, hernia, injury to sphincter, etc.
12. Failure to follow up.
13. Failure to discover severed tendon.
14. Failure to use Xray.
15. Failure to discover fracture; second fracture overlooked.
16. Failure to diagnose dislocation.
17. Injuries from application of cast.
18. Insufficient immobilization.
19. Deformity and loss of function (fractures, dislocation).
20. Cast too tight; removed to soon, left on too long.
21. Failure to use traction.
22. Failure to employ fixation.
23. Failure to institute active and passive motion.
24. Unnecessary scarring.
25. Use of unsterile needle or instruments.
26. Experimentation.

27. Examination without consent.

28. Injury during examination.

29. Error or delay in diagnosis.

30. Failure to use laboratory aids.

31. Failure to administer standard treatment.

32. Failure to leave instructions for treatment of patient.

33. Failure to leave instructions for protection of attendants and of other contacts.

34. Failure to hospitalize.

35. Aggravation of existing condition.

36. Abandonment.

37. Infection resulting from injection.

38. Infection, slough.

39. Burns-xray, diathermy, infra-red, heating pads, etc.

40. Breach of warranty to cure.

41. Error in prescription or in dispensing.

42. Overdosage.

43. Use of harmful drugs.

44. Unnecessaru medical treatment.

45. Death from injection,

46. Defective equipment.

Surgery apparently causes the most suits, especially orthopedic surgery by the general practitioner.

Chapter X: Medical Malpractice in Obstetrics and Gynecology

In obstetrical-gynecological suits the common allegations are: "Obstetricians:

1. Failure to attend at time of delivery.
2. Wrong baby given parents.
3. Poor or no prenatal care.
4. Unnecessary cesarean section.
5. Negligent delay in performing caesarean section.
6. Unnecessary use of instruments.
7. Instrumental injury to mother, to baby.
8. Placenta not completely removed.
9. Hemorrhage from cord.
10. Injury to baby, fracture, paralysis, etc.
11. Failure to protect perineum (and rectum).
12. Failure to repair birth canal injuries.
13. Eclampsia not properly treated.
14. Lack of sterile techniques...infection of mother.
15. Diagnosis of pregnancy as tumor(operation, miscarriage).
16. Diagnosis of tumor as pregnancy (special tests not employed.)
17. Examination without consent.
18. Injury during examination.
19. Error or delay in diagnosis.
20. Failure to use laboratory aids.

21. Failure to administer standard treatment.
22. Failure to leave instructions for treatment of patient.
23. Failure to leave instructions for protection of attendants and of other contacts.
24. Failure to hospitalize.
25. Aggravation of existing condition.
26. Abandonment.
27. Infection resulting from injection.
28. Infection, slough.
29. Error in dispensing and in prescription.
30. Overdosage.
31. Unnecessary medical treatment.
32. Defective equipment.
33. Use of harmful drugs.

Gynecologist:

1. Slander in charging patient had venereal disease.
2. Operation resulting in sterility.
3. Negligent puncturing of uterus during curettage.
4. Injury to ureter.
5. Stricture of cervix, caused by too extensive cauterization.
6. Fistulae-bladder, rectal.
7. Illegal abortion performed without consent.
8. Many of the allegations set forth for the obstetrician.

9. Examination without consent.
10. Injury during examination.
11. Error or delay in diagnosis.
12. Failure to use laboratory aids.
13. Failure to administer standard treatment.
14. Failure to leave instructions for treatment of patients.
15. Failure to leave instructions for protection of attendants of other contacts.
16. Failure to hospitalize.
17. Aggravation of existing condition.
18. Abandonment.
19. Infection resulting from injection.
20. Infection, slough.
21. Breach of warranty to cure.
22. Error in the prescription or in dispensing.
23. Overdosage.
24. Use of harmful drugs.
25. Unnecessary medical treatment.
26. Death from injection.
27. Defective equipment.

For abortion suits see chapter on criminal malpractice section on abortions.

Chapter XI: Physician's Liabilities for Acts of Others

The physician is civilly liable for:

1. the malpractice of his partner.
2. where two physicians are treating the same patient, one may be liable for the negligent acts of the other performed under his direct supervision.

The physician is not usually liable for:

1. the negligent acts of nurses employed by the hospital.
2. the post-operative care conducted by the internes and nurses unless they are carrying out his specific orders.
3. the acts of another physician to whom he has referred a patient, unless he was negligent in the selection of this physician.
4. the negligent acts of the laboratory and xray technicians employed by the hospital.
5. the ordering of necessary wet packs for a psychiatric patient though it damaged the patient's hands.

Chapter XII: Attitude on Malpractice by Critical Public

Criticisms made of doctors are:

1. They won't testify against each other.
2. They make mistakes and won't admit them.
3. They frighten nurses into not testifying against them.
4. They assume a flippant joking attitude toward serious error in diagnosis.
5. Doctor's don't go in sufficient numbers to rural areas.
6. Doctor's won't take night calls.
7. Too concerned only to make money.

8. No hospital or government board to handle grievances.

Chapter XIII:Who Gets Sued

The most suits are in the fields of surgery, obstetrics, radiology. Fracture treatment and cosmetic surgery are especially hard hit.

General practitioner suits are on the increase because of a break-down of the doctor-patient relationship.

One per cent of the physicians cause twenty five per cent of the suits.

Chapter XIV: The Noxious Aspects of Medical Malpractice Suits

The noxious, ulcerogenic aspects of malpractice litigation are:

1. "Trial by newspaper" Condemnation without a hearing. The sensation-seeking press plus vicious gossip in the wake of the suit.
2. Unwarranted claims are estimated to be 90% of all claims. Many may be "legal blackmail" preying on the physicians dislike for such notoriety.
3. Delays in filing suit. 25% are not filed till well over a year after the alleged cause.
4. Delays in disposition of cases. 75% are not disposed of until one year after they are first filed. Many cases hang over the physician's head for years.
5. Expense in time, insurance, attorneys may be consider-

able even if the judgment is denied.

6. The physicians disadvantage in the courtroom. would be comparable to a lawyer in the operating room.
7. Attachment of physician's property to protect a potential judgment may prevent desired conveyance or improvement in a physician's property.
8. Insufficient insurance due to limitation of amount on beginners may result in an embryonic physician being forced to pay part of a large judgment.

Chapter XV: Criminal Medical Malpractice:

Criminal medical malpractice facts:

1. Definition: gross breach of physician's duty.
2. Prosecution: by the state.
3. Trial: by judge or jury at defendant-physician's option.
4. Punishment: fine and/or imprisonment in state penetentiary.
5. Occurrence: uncommon.
6. Judgment: lenient in favor of defendant-physician.
7. Proof necessary: grossest dereliction of duty.
8. Mistake of judgment is not sufficient.
9. "Foolhardy presumption" causing damage has been the basis of quilty verdicts.
10. Improper instructions for administration of medicine has caused criminal prosecution.
11. Consent is no excuse for recklessness or gross want of

skill.

12. Abortion's legal definition is producing young before term by artificial means.
13. Abortion is legal in most states to save the mother's life. The number of physicians signatures required by law stating same varies.
14. Mental health as a cause for legal abortion is increasing in numbers in many states.
15. Some states require definite threat of suicide before mental health is a legal reason.
16. Abortion because of diagnosed fetal abnormality is highly questionable in most jurisdictions.
17. Rape and poverty do not constitute reasons for therapeutic abortion.
18. Hospitals often limit number and type of abortions.
19. Some jurisdictions (Texas and Colorado) do not require that the act be actually capable of producing abortion.
20. Some jurisdiction, e.g. Illinois, require actual "miscarriage" as a requirement for prosecution.
21. All parties to the abortion are criminally liable.
22. Consent of the abortee is not a defense.
23. A physician who doesn't get the sufficient number of physicians signatures to a therapeutic abortion is

under the legal duty to prove that the life of the mother was endangered.

24. Getting the statutory number of physicians signatures is not a defense if in fact the operation was unnecessary to save life.

25. Delivery of dead fetus is not a defense.

Chapter XVI: Hospitals in Medical Malpractice.

1. New York and Pennsylvania Supreme Courts have ruled that blood typing and other hemtological laboratory acts in a hospital were not medical acts but administration acts and held the hospital liable for damages caused by their incorrect results.

2. Hospital was held liable for failure to notify physician of a change of diagnosis by the hosptial roentgenologist of a fracture. Court held this negligence in an "administrative act".

3. The hospital not held liable for giving wrong baby because of failure to secure psychiatric testimony that patient suffered a "nervous shock" from the error. No actual damage to plaintiff was shown; therefore no recovery.

4. Plaintiff recovered from hospital for not properly restraining a mental patient and his subsequent jumping out a window to his death.

5. "Profit" hospitals are liable for the acts of their employees. Non-profit governmental hospitals are not. In each instance individuals are liable for their own acts.

Chapter XVII:Medical Malpractice Insurance

Important facts of malpractice insurance:

1. Some companies, hard hit by heavy malpractice insurance losses have already withdrawn from malpractice inusrance in certain areas. e. g. United States Fidelity and Guaranty will not insure Nebraska physicians.
2. Starting physicians, who need insurance the most, are often unable to get more than $35,000. coverage. The average suit is for $65,000.
3. Insurance rates are from two to five times higher than they were a few years ago.
4. Malpractice insurance usually covers accidents connected with treatment as well as for the treatment itself.
5. An insurance company should be selected with care, because in case of legal suit, the better companies have staffs of attorneys who conduct the bulk of the defense of the doctor. This should be looked into before buying insurance.

Chapter XVIII: Legal Defenses of Defendant-Physician in Malpractice Suits

In general the physician's best defense is the fact the plaintiff patient must prove his entire case or fail to recover. The "burden of proof" is on him. If any part of the plaintiff's case fails, the entire case fails.

The plaintiff patient must show all these factors:

1. The existence of the doctor-patient relationship.
2. Culpable dereliction of duty by physician-defendant.
3. There was damage to the patient.
4. The breach of duty was the legal cause of the patient's damage.

Physician defendants legal defenses are:

1. General denial.
2. Affirmative defenses.
   (1) res adjudicata.
   (2) contributory negligence of plaintiff patient.
   (3) statutes limitations.
   (4) assumption of risk by plaintiff patient.

Practical defenses:

1. Expert testimony by physicians is necessary to prove medical breach of duty. This is not always obtainable.
2. The better insurance companies provide staffs of attorneys to aid their insuree physician in his defense.

Chapter XIX: Plans by Organizations to Reduce Malpractice Suits

1. The Canadian Medical Protective Association composed and operated by the physicians of Canada protect their members by insurance and legal protection for approximately $20. per annum. (See Appendices #1, #2)
2. Suggestion: Medical societies issue their own malpractice insurance to their members.
3. Nationally: American Medical Association c.. studies of malpractice and medico-legal institutes with the legal profession.
4. State medical association.:
   (1) Group programs for malpractice insurance purchase.
   (2) Hiring competent attorneys to protect members of the state association in suits.
5. County medical associations:
   (1) Grievance committess--impartial to find facts.
   (2) Nusiance claims are never to be paid.
   (3) Self discipline of own members.
   (4) Hiring medical-legal consultant for aid in suits and prophylaxis.
6. Public education:
   (1) Costs of suits to public.
   (2) Damage to the doctors who serve them so well.
7. Washington State Law sets up a physician board to discipline own members.

8. Legal medical instruction with emphasis on medical malpractice avoidance a requirement in all medical colleges.

CHAPTER XXI

Conclusions

I. Medical malpractice suits can be decreased by:

1. studying their causes.
2. examing plans for decrease.

II. The physicians principle legal duties are to:

1. use the degree of skill, knowledge, care, attention, diligence and judgment ordinarily exercised by the average reputable physicians in his locality who are engaged in the same field of medical practice.
2. have consent to the treatment.
3. keep abreast of the medical progress and utilize standard accepted procedures in diagnosis and treatment in his locality.
4. act toward his patients with the utmost good faith at all times.

III. Statistics indicate that there will be one suit per every physician in the next twenty year period.

IV. Underlying causes of malpractice are chiefly:

1. Derogatory comments by one physician about another's treatment lays the basis for considerably over one half of all malpractice suits.
2. Deterioration of the close doctor-patient relationship.

3. Physicians assuring patient that they will "be as good as new".
4. Failure to keep adequate records. (a basic consideration).
5. Publicity of the press of malpractice suits.
6. Failure to explain charges.
7. Improper collection methods.
8. Changes in law both statutory and common law.
9. Unwise adjusting of claims by insurance companies and physicians.
10. Failure to limit practice to his capabilities.
11. Failure to proceed wisely after claim is made.
12. Acts of others.

V. Specific causes of malpractice suits:

1. Failure to use accepted methods of diagnosis and treatment.
2. Negligence, inattention.
3. Misrepresentation as to the seriousness of a procedure.
4. Failure to refer a patient to a specialist when indicated.
5. Leaving sponges in body cavity (incidence still high).
6. Removal of wrong limb, (happens too frequently).
7. Failure to secure consent.

8. Abandonment.

9. Violation of privileged communications.

10. Failure to get Xrays of fractures and where foreign bodies may be involved.

11. Telephoning prescriptions.

12. Writing prescriptions illegibly.

VI. The common allegations filed in court by plaintiff-patient against the defendant-physician are listed for each specialty in the summary. They are not listed here because of their length.

VII. Unwarranted suits are estimated from seventy-eight per cent to ninety per cent. Some are considered "legal blackmail". The average physician has a horror of the notoriety of the publicity and the court trial. Some suits are settled out of court because of this factor instead of the actual liability.

VIII. Ophthamology suits have most frequently involved:

1. Failure to adequately explore the eye with ophthalmoscope and Xray.

2. Delay in referral to ophthamologist.

3. Failure to adequately follow.

IX. Anesthesia suits have most frequently involved:

1. Inadequate preoperative education.

2. Inadequate post-operative to follow-up.

3. Use of improper anesthesia.

X. Radiology suits most frequent cases.

1. Burns.

2. Slough.

3. Loss of hair.

4. Loss of life.

XI. Surgery suits most frequent causes:

1. Inadequate consent.

2. Foreign bodies left in body cavities.

XII. Obstetrics and Gynecology most frequent causes:

1. Failure to attend at time of delivery.

2. Inadequate pre-natal care.

3. Sterilization without adequate consent.

XIII. The physician is civilly liable for the malpractice of his partner.

XIV. Criticisms of physicians by public:

1. Won't testify against each other.

2. Won't admit mistakes.

3. Have no board to hear patient grievances.(Important)

4. Have flippant attitude toward serious errors.

5. Only interested in making money.

XV. Most common fields of suits:

1. Fractures.

2. Xray therapy.

3. Cosmetic surgery.

4. Obstetrics.

XVI. Noxious aspects of suits often cause the most ulcers.

1. "Trial by newspaper!" Condemnation without a hearing.

2. Unwarranted claims. Legal blackmail preying on a physician's distaste of notoriety and trial.

3. Delays in filing and settling suits.

4. Disadvantage of physicians in courtroom.

5. Attachment of physician's property while the suit is pending.

6. Insufficient insurance.

XVII. Criminal medical malpractice is usually based on:

1. Grossest negligence.

2. Abortion. Statutes and judicial interpretations vary from state to state.

XVIII. Hospitals have been held liable for incorrect hemotological reports. The basis was that they were "administrative" and not medical acts.

XIX. Medical Malpractice Insurance:

1. Insurance companies usually furnish the defendant-physician with attorneys. Important in the selection of an insurance company.

2. Beginning physicians are often unable to get more

than $35,000. of malpractice insurance. The average suit is for $65,000.

XX. Defenses of the defendant-physician:

1. "Burden of proof" is on the plaintiff-patient to prove all of these factors:
   a. doctor-patient relationship.
   b. culpable dereliction of duty.
   c. damage.
   d. physician's act was the legal proximate cause.
2. Affirmative defenses:
   a. res adjudicata.
   b. contributory negligence.
   c. statute of limitations.
   d. assumptiom of risk.
3. Practical defenses:
   a. Usually testimony by a physician is necessary to establish the negligent act.
   b. Specially trained attorneys furnished by insurance company.

XXI. Plans to decrease malpractice suits by county medical associations.

1. Grievance committees to hear patient's grievances.
2. Never to pay nuisance claims.
3. Self discipline of own members.

4. Hiring legal medical consultant to aid members proplylactically.

5. Public education covering:

   a. Costs of suits to public. Since most suits are lost by patient.

   b. Damage to the physicians who serve them so well.

6. Malpractice avoidance taught in all medical schools.

XXII. In Canada the suits per physician have been decreased. (See Appendices #1, #2)

CHAPTER XXII

Statement of Purpose

This paper has aimed at being thought-provoking. If the physician will think of the problems connected with malpractice he can avoid many of the pitfalls.

Therefore special emphasis is on the causes of malpractice underlying and specific. The actual allegations filed in court by the plaintiff-patient defendant are listed by specialty..

Aspects such as insurance, criminal, defenses, statistics, noxious, liability for others are covered in order to stimulate more thought.

The reader may disagree with every word in this thesis yet its mission will be accomplished if he will just THINK.

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XXV APPENDIX

Appendices have been added because:

1. This material was not available at the time the main body of the thesis was completed.
2. The Canadian system study is especially valuable as the Canadians have decreased their malpractice suits per physician.
3. The appendix allows incorporation of current material.

APPENDIX #1

Constitution and By-Laws of the Canadian Medical Protective Association

Extracts of the Constitution and By-Laws of the Canadian Medical Protective Association (revised July 13, 1954, Ottawa, Canada)are presented in this appendix because.

1. This material was not available early enough to incorporate into the main body of the thesis.
2. A study of the Canadian system of handling malpractice may help in the solution of some of the United States problems in this field.

The extracts are as follows: (Underlining is my own addition.)

Instructions to members:

1. When any threat is made against you, notify the Association immediately. Do not wait until the patient takes further action.
2. Instructions to members who have received threats or against whom charges of malpractice are being made:

(1) Be sure your own records are complete.

(2) Notify the Secretary-Treasurer at once.

(3) Send a case history with dates of first and last visits.

(4) Wait for instructions from the Association.

These will be sent by wire if necessary.

(5) DO NOT TELL THE PATIENTS YOU ARE INSURED OR A MEMBER OF THIS ASSOCIATION. Suits are more likely if patients think money is obtainable from an association.

(6) DO NOT consult a lawyer without instructions from the association.

(7) DO NOT discuss the case with patients or their lawyers after stating once that your work was the best possible.

(8) DO NOT notify the Association after a case has been decided and then expect the Association to pay any costs. Payment is possible only when the Association has conducted the defense.

<u>Assistance offered by the Association may include:</u>

1. Advice about the best way to avoid suit when threats have been made.
2. The actual defense of the suit and the payment of costs thereof.
3. The payment of damages should they be assessed.

<u>Objects:</u>

(a). To support, maintain, and protect the honour, character and interests of its members.

(b). To encourage honourable practice of the medical

profession.

(c). To give advice and assistance to and defend and assist in the defence of members of the Association in cases where proceedings are unjustly brought or threatened against them.

(d). To promote and support all measures likely to improve the practice of medicine.

That in pursuance of the said objects, this Association has undertaken to assist in defending civil actions for damages for alleged malpractice in the practice of medicine or surgery, where such actions appear to the Executive Committee and to the General Counsel of the Association to be unjust, harassing or frivolous, or where it appears otherwise to be reasonable to afford the member whose conduct is impeached, an opportunity of defending himself before a court of law.

BY-LAWS OF THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION:

1. The Officers of the Association shall consist of a President, first and second Vice-President, and a Secretary-Treasurer, all of whom shall be members of the Association, in good standing. They shall hold office for one year, or until their successors are appointed, and in case of death or removal from Canada, the Executive Committee shall appoint a

successor, who shall hold office until the next meeting of the Association.

The Executive Committee, which shall be known as the 'Council', shall be composed of the President, Vice-Presidents, Secretary-Treasurer and ten other members elected at each annual meeting. They shall have the general management of the affairs of the Association, subject to the by-laws and shall report annually to the general meeting of the Association.

The General Counsel of the Association shall be appointed by the Council annually and shall attend the meetings of the Council when requested to do so.

2. A Local Advisory Committee of one or more members shall be appointed for each province, to be known as the Provincial Executive of such province, whose duty it shall be to keep the aims and objects of the Association before the profession, to enlarge the membership and otherwise to assist and advise the Council of the Association. They may also be required to pass on nominations for membership in their respective provinces, when occasion requires, or when requested to do so by the Council.

3. The Provincial Executives may be consulted by the

Council in all matters pertaining to their own province, and they shall in turn use all reasonable care in making enquiry in regard to cases of alleged malpractice, in order to enable the Council to determine as to the merits of the proposed defence.

4. (1) Any member of the profession duly licensed in any province in Canada shall be eligible for membership in the Association. Upon acceptance by the Council of his application for membership he shall become a member and be entitled to the assistance and protection of the Association. Members of the Canadian Medical Association or of its Provincial Divisions or of its Provincial Divisions or of affiliated Provincial Medical Associations may become members of the Canadian Medical Protective Association on their own application and upon payment of the annual dues. Other duly licensed practitioners applying for membership in the Association must be nominated and seconded by two practitioners who are already members of this Association. The qualifications for membership in the Canadian Medical Association shall be the basis for membership in the Canadian Medical Protective Association.

5. The Council shall have the power to terminate the membership of any member whose conduct or membership is considered to be detrimental to the Association. Such action shall be taken only if such member has been given twenty-one days' notice of the meeting at which his case will be considered and the opportunity to make such representation as he may think fit.

6. The annual membership fee shall be twenty dollars payable on or before the 1st day of January in each and every year. Any person joining after July 1st shall pay half rates for the balance of the year. Membership shall be permanent and collections may be made through a bank or other agency if remittance are not promptly made.

   In the event of the neglect or refusal of a member or the estate of a deceased member to pay the annual fee, retirement subscription or estate fee on or before the date due, the member or the estate of the deceased member as the case may be shall cease to be antitled to the assistance and protection of the Association.

7. Each member will be required to guarantee the payment of a further amount per annum equal to the

annual fee for the time being in force if called upon, but such call will be made only in the event of a financial emergency arising, the existence of such an emergency to be determined by the Council in consultation with the Association auditors.

8. The Association shall not undertake to assist in the defence of any action in which the negligence charged depends upon facts arising in the practice of said member prior to his joining the Association.

   The Association shall not undertake to assist in the defence of any action on behalf of any person who is not a member in good standing of the Association at the time the action is instituted. The Association may, however, undertake to assist in the defence of any action brought against a former member of the Association in respect of work done by him while a member of the Association and while serving as an interne in a hospital recognized by the Association if such action is brought within one year after he has ceased to be a member of the Association.

9. It shall be the duty of every member of the Association to aid in the defence of any action when

Undertaken by the Association.

10. Upon any action for alleged malpractice being threatened or brought against any member of the Association, it shall be the duty of such member forthwith to communicate the facts to the Secretary, who shall at once submit the same to the Council for consideration.

11. Upon the request of the member and upon receipt of the statement of facts in writing, the Council shall decide whether the defence of the said claim is one which the Association should assist, and the Association after investigation may assist as it deems proper and expedient, and such assistance shall in every case be made as the Council may deem proper, and it shall be in the discretion of the Council in every case to limit or restrict such assistance or altogether to decline to grant the same. If it appears to the Council at any time that the action should no longer be defended or that any further proceedings by way of appeal should be abandoned, it may discontinue such assistance.

12. The Council shall take such steps to instruct solicitors and retain counsel as it may deem necessary. In all cases the employment of solicitors and counsel

and the conduct of the defence shall be subject to the approval of the General Counsel.

13. Fees for special expert medical testimony will not be paid by the Association unless specifically authorized by the Council.

14. When a member is assisted in the defence of an action, the Association shall be entitled to an assignment of any right to recover costs which may be awarded or adjudged in his favour as costs of the action and he shall execute such assignments in such form as and when required by the Association.

15. In assisting in the defence of an action against one of its members the Association undertakes, subject to the by laws, to pay the taxable costs of his defence reasonably and properly incurred exclusively on his behalf together with reasonable and proper witness fees and counsel fees to be settled by the General Counsel of the Association. In every case the Association reserves the right to have such costs taxed. Such costs shall be paid out of the funds of the Association.

16. Subject to these by-laws if any such case a verdict awarding damages or costs shall be given ag-

ainst such member, the Council in its discretion may assist in any appeal from such verdict to a higher court, or may assist in the payment of the whole or any part of the damages and costs so awarded.

17. The Association will not assist in the payment of damages or costs or any part thereof in any action in which an adverse verdict is given by reason of evidence which establishes that the damage, or any part therof, was caused by the act, default, negligence, error or mistake of any person other than the defendant member; or by the member having been under the influence of intoxicants, anaesthetics or narcotics; or by the member acting in the violation of any statute, law or ordinance, or in the commission of any criminal act, or act with criminal intent.

CONCLUSIONS of Appendix #1

1. Immediate notification of threatened suit is required.
2. Only unjust suits are defended.
3. Members may be expelled if they are detrimental.
4. The duty of every member is to aid in the defense of any suit against a member.
5. Cost per year is $20. per member. An extra $20. may be assessed if needed.

The Canadian Medical Protective Association
Suite 603, 180 Metcalfe Street, Ottawa, Canada
Founded at the Thirty-Fourth Annual Meeting of the Canadian Medical Association held at Winnipeg August 28th, 29th and 30th, 1901.

An Act to Incorporate The Canadian Medical Protective Association

3-4 George V.
Chap. 91.

As passed by the House of Commons, 27th February, 1913, and assented to May 16th, 1913.

Revised July 13, 1954, Ottawa, Canada.

APPENDIX #2

Annual Report, 1955, of the Canadian Medical Protective Association

Extracts of this report are included in this appendix because:

1. The material was obtained too late to encorporate in the main body of the thesis.
2. Studying the Canadian system gives many helpful hints as to how the United States may be aided.

Extracts are as follows: (the underlining is mine).

General instructions to members:

1. Any case settled or last in any district makes practice more difficult for every doctor there.
2. Make sure you are operating on the right patient and the right area before surgery is done.
3. Surgeons be sure a sponge count is
   (1) done.
   (2) correct.
   (3) recorded.

Report of the President, J. F. Argue, M.D.:

Gentlemen:

Your Council wishes to report on the work it has undertaken in the past year for the assistance of members who were, or feared they might be, faced with medico-legal action because of alleged malpractice or negligence in a

a professional sense. The numbers of cases in the various categories, those where advice only was needed, the threats and the actual legal actions, will be given by our General Counsel in his Annual Report. Association membership has been increasing steadily at the rate of six to eight hundred a year. It is interesting that in 1945 membership was 3,767 and last year it was 8,502. In spite of the larger membership the number of Writs and Court cases has changed remarkedly little. The amount of correspondence through the office has increased tremendously because, and this is something desirable, more and more members are writing at the first sign of dissatisfaction and are getting advice before legal moves are made.

The Association's activities seem to be attracting attention outside of Canada and the Association has received enquiries from far afield. It is a gratifying form of recognition for two or three reasons. The Association is a semi-professional as well as a commercial organization. It thinks it has a duty to attempt to provide not only the best possible help to individual members but help that will be of value to the profession at least in the district where the doctor lives if not to the profession as a whole. This has been possible because the Assoc-

iation is in fact doctors helping themselves and determining the form their own help will take. The Association thinks it is correct when it claims some credit of the relatively happy medico-legal situation in this country and for the fact that doctors are seldom faced with the stultifying need of leaving some necessary things undone or doing unnecessary things to avoid possible unjust nuisance claims. There are places where this happens, places where some types of investigation, very valuable on balance but carrying some risk in individual cases, are not done because of the fear that a poor result will be followed by a legal claim. This situation does not hold in Canada and it means that doctors are freer to decide on purely medical grounds what investigation or treatment is best so patients receive better care.

Despite all the publicity that can be given a regulation, the reasons for which should be obvious, occasionally members ignore it and arrange for legal services before consulting the Association. The Association this year felt it necessary to refuse to pay for legal expenses incurred without its prior approval. A short time ago one member of a group of doctors, who himself was killed in an accident before the case against him was known, had an indefensible action brought against his estate. Though

the Association's Officers can be reached at any time by wire and telephone, and indeed are, both day and night, the group with which this doctor worked had placed the matter in the hands of two solicitors, one acting for the group, and another for the deceased member's estate before notifying the Association at all. The first notification, in fact, came from one of the solicitors. There was no question that the deceased member's estate would need assistance and the Association immediately accepted full responsibility and took charge. Some time later it became apparent that the action might include the group was asked whether if that happened, it would be looking to the Association for help. This group said it would so, when it was implicated, and the Association wrote that the solicitor for the group should allow the Association's solicitor to take charge. After the case had been settled, among the accounts received was one from the group's solicitor for services most of which had been rendered before it was known that the group would be implicated and before, therefore, the Association had authorized the services. After very careful consideration by Council, in the full knowledge that the group felt it was receiving unfair treatment, Council had to refuse to pay this solicitor's account. The doctors in the group felt strongly enough

about it that they resigned membership in the Association and Council regrets sincerely that they felt it necessary to do this. It is, however, perfectly obvious that if the Association were to attempt to accept responsibility for expenses which it has not authorized its existence would be jeopardized because it would never know what expenses it might have to meet.

Members are advised to notify the Association promptly at the first sign of real dissatisfaction from a patient or when any threat of legal action is made against them and they should do this before consulting a lawyer. The Association services are given as promptly as need be, by return mail, by wire or by telephone, so the conduct of no case need be prejudiced by the need to notify the Association before doing anything else.

Again several cases have come to the Association's attention where doctors have done surgery on the wrong part of the body, the wrong leg or the wrong foot or the wrong finger. Every busy surgeon recognizes the possibility of such an error, fears it and takes the utmost care to avoid it. Hurry or tiredness or preoccupation with a patient's problem or too complete reliance on hospital routine, however, in very rare cases allows an error to be made. No matter how seldom the error, no matter

how plausible the reason, such an error should never occur. It cannot be stressed too strongly that there is not the faintest hope of anyone else that the surgeon being held responsible for such an error; no matter how specific his instructions and no matter who contributed to the error it is highly likely a Court would expect a doctor to detect an error of this kind and correct it. Doctors must, invariably, themselves identify each patient before they begin an operation; they should take whatever precautions are applicable and necessary to identify beyond doubt the side on which they are to operate. A previously written record can be sent with the patient and checked before the surgery is begun; plainly marked Xray may be on view or an affected limb may be clearly marked.

During the year a doctor notified the Association that a possible claim against him might be complicated by the fact that no written permission for treatment, had been obtained. He had used the same treatment sucessfully on the patient a year or two previously, had explained its nature and its dangers and had obtained written permission. For the second treatment he did not get written permission and its absence was worrisome because of an ill result. If specific written permission ordinarily should be obtained for any procedure it is wise to assume that it should be

Obtained each time the procedure is repeated.

Cases have been reported to the Association where trouble has followed the application of elastic adhesive dressings. Apparently the elasticity allows the application of a dressing tighter than it is realized. Because patients judge some pain to inevitable after an injury they fail, often until harm is done, to recognize and report the pain being caused actually by the dressing. Great care should be taken that elastic dressings are applied loosely enough and that, if at all possible, patients are kept under observation for a number of hours after the application. If the patient cannot be under the observation the doctor must give careful instruction and advice about signs and symptoms that should be reported whenever they occur, day or night.

Actions have been threatened or brought against four doctors because remnants of broken surgical needles have remained in wounds. In some of the cases the loss was not known and the presence of the remnant was discovered later during Xray examination for something else. In the majority, though, the loss was known, a search failed to find the fragment, the presence of the piece of needle was proved immediately by Xray and appropriate advice was given patients at the earliest possible moment. It seems that these accidents are unpreventable but when they are thought to have

occurred two or three things are wise. The part of the broken needle which has been recovered should be saved carefully. Prompt steps should be taken to learn whether or not the lost piece actually remains in the patient. If it does, the patient, or a responsible member of the patient's family should be informed of the accident. The explanation should make it clear that the accident happened in spite of due care, that a search was careful and extended as was wise or safe was made and was unsuccessful. Then such advice as is applicable should be given; if it seems that the broken piece will do no harm it should be so stated, if it is in a position where it may do harm the patient should be advised to have it removed and the doctor always should make it easy for the patient to seek a consultant. At the same time the Association should be notified of the accident so that any other applicable, detailed advice may be given.

Foreign bodies, instruments, abdominal sponges and swabs continue to give trouble. It is well established now that a sponge count should be routine at every operation in every hospital. The surgeon not only has the responsibility of knowing that all sponges are removed from the patient's body, he has the right to demand that adequate help be given him to ensure their removal. As well, surgeons are wise not

to depend on sponge counts so completely that they fail to confirm the fact that all sponges are removed. They should insist too that a record of the sponge count be made, be signed by the person who did it and that it be retained. Such a record may well be the surgeons's best defence, if later, it is found that a sponge was overlooked. Advice is more difficult to give about lost instruments. It seems to the Association that the time may have arrived when some system or systems must be devised to allow an instrument count at each operation. Meanwhile, a careful search should be made before the end of the operation if instruments have been used in places where they could be concealed and overlooked. After all, instruments are hard and unyielding objects and can be identified by touch if they cannot be seen.

One group of doctors had to have a settlement made for them because they did not administer anti-tetanic serum and the patient developed tetanus. The patient was seen by one person who gave him a hypodermic to control pain and then sent him to another person for treatment of his injury. The second person enquired whether he had been given an injection and interpreted the answer to mean that he had been given anti-tetanic serum. Fortunately the patient recovered and was fair-minded enough not to demand

an excessive settlement. Failure to give anti-tetanic serum or a booster dose of tetanus toxoid under circumstances where one or other would be thought necessary by an ordinarily competent doctor is hard to justify under any circumstances and if the patient develops tetanus the physician who failed is in a very vulnerable position. The circumstances under which tetanus toxoid or anti-tetanic serum are considered necessary are well known to all doctors and he who fails to use them exposes his patient and himself to quite different but equally unnecessary and unjustifiable risks.

Report of the General Counsel for the year 1954-1955:

During the year under review your Association has extended advice to its members in sixty instances and fifty-seven of your members have reported threats of action for alleged malpractice, During the year in question thirteen Writs were issued. Of the new actions commenced during the year and those outstanding at the beginning of the year, six cases were settled out of Court and eight went to trial. The action was dismissed in three of the cases tried, but one of such Judgment is, at the date of writing, under appeal. In two cases the Court found against the doctor and in one of such cases the Judgment is presently under appeal. Three cases are at the moment awaiting Judgment.

While the figures given above may show a slight increase over the previous years, they are nevertheless heartening in one respect at least, in that they have not increased in the same proportion as has membership in the Association. This is more particularly significant in relation to the large number of members who write for advice in that it suggests that the members are becoming more consciously aware of the existence of the Association and the guidance which it is prepared to extend should circumstances arise which could conceivably lead to legal difficulties. It is encouraging to note that more and more members are writing to the Association immediately anything occurs which might have the remotest possibility of causing trouble at a later date. As your General Counsel I cannot stress too strongly the desirability of following such a practice since there is reason to believe that early action of an appropriate nature can often avoid serious repercussion later on.

There have been no new developments in the law of a significant nature during the year in question on which comment might be made. Suffice it to say that the law continues to impose a rather heavy onus and burden on the practising physician of which the physician should at all times be fully aware, both in his own interest and in the

interest of his patient. I quite appreciate that doctors are human and that, being human, mistakes will occur from time to time, but I consider it my duty as your General Counsel to continue to emphasize that from both the humanitarian and the legal aspect there is no substitute for the constant exercise of the utmost care in carrying on your day to day practice.

At the risk of being repetitious, I must again refer to the leaving of foreign bodies in the body of a patient and more particularly, of course, sponges and instruments. Cases continue to occur of sponges being left in a wound and it is significant in this respect that in very few of such cases has a sponge count been made and recorded correct. This emphasizes the importance of the sponge count and, speaking as a lawyer, I can strongly recommend that the practice should be instituted in any centre where it is now not standard procedure and that the count should be taken meticulously in every operation. Fortunately an accurate sponge count is now standard practice throughout almost all of Canada and in practically every class of operation. Instruments left in the body continue to represent a hazard of the operating room and while an instrument count is done, I understand, in some centres, my information is that this is by no means a general practice. I am not, of course, familiar with operating room techniques

and the difficulties experienced during the course of an operation by the surgeon and attending staff but, again speaking as a lawyer, I would like to recommend that the profession give consideration to devising some scheme whereby the taking of an instrument count might be made practical. Such a procedure would, I am convinced, greatly reduce the number of actions as a result of foreign bodies remaining in a patient following an operation.

To me, one of the most alarming developments during the past year has been the number of cases in which the surgeon operated on the right patient but on the wrong limb. From a legal point of view this can only occur as a result of carelessness on the part of the operating surgeon and it would be impossible, in my opinion, to convince a Court otherwise. This type of case in which the Courts decided some years ago that the Court need not rely on the testimony of expert witnesses, but was entitled to reach its own conclusion as to whether or not the facts of a particular case constitute negligence. I do not believe for a moment, nor do I feel that the profession would suggest, that any Judge could be convinced that an experienced or even an inexperienced surgeon could not tell the difference between the right leg and the left leg had he taken the trouble to examine his charts and the leg on

which he was operating before commencing the operation. This fact seems to be so elementary as to be unworthy of comment and in fact comment would not have been made had this type of mistake not been made on a number of occasions. It is the type of error which can be avoided by the exercise of the simplest precautions beforehand; it is also the type of error which cannot satisfactorily be explained after the event.

It is significant to observe that by far the largest number of actions are brought against men who have been in practice for many years and who are recognized and competent specialists in their fields. I say this to impress upon you that "it could happen to you" unless you and every member of your profession continue to exercise that vigilance and concern for your patients' welfare which has been characteristic of the medical profession over many scores of years.

All of which is respectfully submitted.

DUNCAN K. MAC TAVISH, Q.C.
General Counsel

Ottawa, May 26th, 1955

Conclusions from Annual Report of the Canadian Medical Protective Association:

1. The percentage of association members sued has decreased.
2. The association can be contacted day or night for immediate legal advice and help.
3. Sponges are still left in body cavities. Therefore there should be
   (a). sponge count.
   (b). correct sponge report.
   (c). recording of the sponge count.
4. Elastic bandages applied too tight have caused suits.
5. Broken surgical needles have been left in wounds.
6. Anti-tetanus serum has not been given when indicated.
7. Immediate notification to Canadian Medical Protective Association is imperative to reduce suits. Correct advice at that time has been invaluable.
8. Instruments are left in body cavities. Instrument counts have been instituted in a few centres.
9. Amputations of wrong limbs are difficult to explain in court. Courts need not rely on medical testimony in these cases to reach the conclusion of negligence.

APPENDIX #3

This extract of a medical malpractice suit is added to the thesis because:

1. Too recent (published March 3, 1956) to get into main body of thesis.
2. Shows that even in 1956 foreign bodies are still being left in body cavities.
3. It is an interesting discussion of the doctrine of res ipsa loquitur.
4. Holds only the two primary surgeons responsible.
5. Illustrates the way the lay press sometimes handles a malpractice case.

The extracts of the case are presented with the embellishments of the lay reporter.

From the "Weekly Underwriter", Volume 174, No. 9, published March 3, 1956, page 562:

California

Leonard v. Watsonville Community Hospital et al.

MALPRACTICE-HEMOSTAT LEFT IN ABDOMEN--RES IPSA LOQUITUR

THE CAST

Grace Leonard.....the victim
W. M. Lacy, M. D.....principal surgeon
L. Slegel, M. D.....his assistant
G. M. Northrup, M. D.....anesthetist
Miss Pogatschnik, R. N.....surgical nurse

Mrs. Craig.....hospital superintendent
E. H. Eiskamp, M. D.....a participant
Kelly Clamp.....a hemostat and the villiam

Act I. Operating Room at the Hospital

"A sufferer from gall bladder trouble, Mrs. Leonard employed Dr. Lacy to operate on her. He engaged Doctors Slegel and Northrup to aid him; the hospital furnished the room, the instruments and the nurse. The operation started as a laparotomy (a safari into the abdomen) aimed at Mrs. Leonard's gall bladder. Incision was made in the upper right quadrant (where some time later the villian of this drama--a Kelly clamp or hemostat--was left and forgotten) and, upon reaching their goal, the surgeons found symptoms of disease. Dr. Eiskamp, a more experienced surgeon who was in an adjoining room, was shown what they found and he agreed with them what should be done."

"Scouting around in the vicinity, Drs. Lacy and Slegel ran across a tumor on the sigmoid colon in the lower left quadrant and again summoned Dr. Eiskamp who palpated the tumor, agreed it might be cancerous, and figured its removal was more important and urgent than that of the gall bladder. He scrubbed himself and helped the others complete the operation. Kelly clamps were popped in and out during the process, although Dr. Eiskamp did not use them, his favorites being curved Mayo clamps, and he left before the

sewing-up was completed. The usual practice at Watsonville was for the nurses to maintain a sponge and needle count, but not an instrument count."

Act II. Santa Cruz County Courthouse

"In some way, plaintiff came out of the operation a possessor of one more Kelly clamp than she had when she went under the anesthetic. No doubt this had bad effects on her, although same are not detailed in the report, and she sued all the parties we have named and some more besides. She relied mainly on res ipsa loquitur, contending that under the key case of Ybarra v. Spangard, 25 Cal. 2d 486, 154 P. 2d 687, that doctrine applied to all defendants who had any control over her unconscious body or the instrument causing the trouble, and that they had the burden of meeting the inference of negligence on their part. She further contended that it was a jury question whether no instrument count by the nurse amounted to negligence."

"At the close of Mrs. Leonard's case, motions for nonsuit on behalf of Dr. Northrup, Dr. Eiskamp, the nurse and the hospital were granted. As to Drs. Lacy and Slegel, the case was settled and the jury was dismissed. Plaintiff appealed from the nonsuits as to Dr. Eiskamp, the nurse and the hospital.

Act III. The District Court of Appeal Room

"Held: A hemostat, not being something normally found in a patient's abdomen, is an indication that someone has been negligent and, under the rule of the Ybarra case, the three surgeons were under a duty to meet the inference. As for Dr. Eiskamp, the testimony was clear and unimpeached that he was not at fault and the trial court properly took the case from the jury as far as he was concerned."

"As for the hospital and its nurse, the rule of the Ybarra case should not be applied to a case where the injury to the patient clearly stems from the negligence of specific defendants, i.e., Drs. Lacy and Slegel. The Ybarra case is an exception to the normal rule that res ipsa loquitur applies when it is apparent not only that the injury probably was the result of the negligence of some one but also that the defendant is probably the one who is responsible. There is no need for the Ybarra exception where the cause of the injury clearly points to the responsibility of one or more defendants. Nonsuit as to the hospital and nurse was properly granted." Judgment of the Santa Cruz County Superior Court affirmed by the District Court of Appeal, 1st Dist, Div. 2, of California. 291 P. 2d 496. Reported: February, 1956.

CONCLUSIONS to Appendix #3 -

1. The case indicates the publicity given malpractice suits.
2. Foreign bodies are still being left in body cavities. (March, 1956).
3. Leaving a foreign body in a body cavity in California invokes the rule of res ipsa loquitur. (The matter speaks for itself).

Therefore, the burden of proof is placed on the defendant-physician to prove he was not negligent.

Appendix #4

Higher Malpractice Coverage Urged

"Physicians should have malpractice insurance coverage of $100,000. per single suit and $300,000. per year."

"In California within the past few months verdicts of $225,000. and $250,000. have been awarded. Allegations were paraplegia following spinal anesthesis in one and aortogram in another.

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"Higher Malpractice Coverage Urged"

Dr. J. F. Sadusk, Jr.
Head of Medical Review Board and Adivsory Board of the California Medical Association.

Appendix #5

The Do's and Don'ts

Do:

1. Do care for every patient with scrupulous attention to the requirements of good medical practice. Be sure to render sufficient care in the way of general instructions, frequency of visits, clinical and Xray laboratory investigations, etc.
2. Do exercise tact, as well as professional ability, in handling a patient. If he isn't doing well, suggest consultation. If he or his family is dissatisfied or complaining, demand consultation.
3. Do keep "ideal" medical records in every case-i.e., records that will stand up in court by clearly showing what was done and when it was done; by indicating that nothing essential was neglected; and by proving in writing that the given care met the standard demanded by law.
4. Do check the condition of your equipment often; and make use of every available safety installation.
5. Do arrive at an understanding about fees before undertaking treatment.

Don't:

1. Don't get in over your head by trying to treat conditions that are beyond your training and experience.
2. Don't undertake surgery or an autopsy without getting prior written consent from the parties concerned.
3. Don't examine any female patient, except in actual emergency, without first insuring that a third person is present.
4. Don't delegate to assistants and employes duties and responsibilities that would be more wisely restricted to yourself.
5. Don't let yourself or your employes make any statement to the patient or a third party that could be construed as an admission of fault on your part.
6. Don't leave town or your practice without first advising your patients and recommending, or making available, a qualified substitute.

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"How We Can Lick The Malpractice Menance"

By Louis J. Regan, M.D.,LL. B.