6. Legal Medicine for the Surgeon

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The most prominent feature of the legal medicine landscape during the 1980s has been a dramatic rise in medical negligence claims. The numers of claims filed in 1983 was more than double the 1979 total, and the incidence of liability claims increased from one claim for every 8 physicians in 1979 to one claim for every 5 physicians in 1983. Furthermore, the midpoint award in 1984 jury verdicts for surgical error cases was $176.000, up from $127.000 in 1981. As the likelihood of involvement in professional liability cases increases, it becomes more important for the physician to understand the basic principles of legal medicine. This chapter is intended to sharpen awareness of those principles, to be supplemented by advice from legal counsel as the need arises.

Overview: Civil & Criminal Law

There are 2 kinds of law: civil and criminal. Medical malpractice belongs in the former category. When lay people discuss medical negligence, however, the 2 areas are often confused. For example, one is not guilty of negligence but liable for negligence; guilt is a criminal finding, and negligence is a civil wrong. Other essential distinctions between civil and criminal law should also be kept in mind. For example, the party who brings the complaint is always the plaintiff, but the civil complainant is a person or entity seeking redress for a personal injury whereas in criminal law "the people" bring the action against the defendant. That is why criminal cases bear titles such as "People versus Smith" and civil cases "Jones versus Smith". The victim in a criminal case is said to be the state, ie, even though a particular individual may have been murdered or raped, the crime is, in theory one against society.

The purpose of the criminal suit is punishment and deterrence of crime; the object of civil litigation is generally to remedy a wrong so as to place the plaintiff in the same position he or she would have occupied if the wrong had not occurred. The idea is to make the plaintiff whole. Thus, civil redress is usually seen in terms of compensation, although there are certain narrowly restricted situations in which punishment is allowed in the form of exemplary damages (discussed below).

The scale used to judge the plaintiff's allegations differs in criminal and civil law. In both criminal and civil law, of course, the plaintiff bears the burden of proving each element of the case. Every cause of action, whether it be a complaint for murder, robbery, negligence, or breach of contract, is composed of certain required elements which, taken as a whole, are known as the prima facie case for that cause of action. Both the civil and the criminal plaintiff bear the burden of establishing their prima facie case, but the standard by which the plaintiff's case is judged is different in civil and criminal proceedings. In a criminal case the defendand is assumed to be innocent until and unless the state can prove each element of its prima facie case beyond a reasonable doubt. In a civil action, the defendant remains blameless and free of liability until and unless the plaintiff can establish each element of the prima facie case by a preponderance of the evidence. Obviously, there is a significant difference between the 2 standards, although an exact definition of reasonable doubt remains elusive. It is quite clear that "beyond a reasonable doubt" is meant to be very close to certainty, as opposed to

a "preponderance of the evidence", which requires only that a fact be established as more likely to be true than not to be true.

The sanctions imposed for criminal guilt and civil liability are also different. Criminal guilt may be punished by death, imprisonment, or fine, whereas civil liability in most cases is imposed in terms of a judgment for money damages.

It is possible that the same act may involve both a criminal and a civil wrong, as, for instance, in the case of rape. That act may be prosecuted in a criminal court as rape and may also be the subject of a civil action for the intentional tort of battery. Where an act results in the possibility of both criminal and civil actions, the 2 cases must be tried separately and, given the difference in the required levels of proof, might well result in a judgment for damages but a verdict of not guilty on the criminal charge.

Litigation

The legal process in the USA is characterized by the adversary system. The adversary system does not guarantee justice, just as the physician practicing medicine does not guarantee a cure. Both the legal and medical systems employs sets of procedures that have been tested and found by experience to be sound. All of these procedures are constantly under review and are continually being refined in an attempt to improve the result. In the adversary system, the assumption is that a contest between 2 equally knowledgeable and equally well prepared adversaries, judged by an impartial third party, affords a thorough airing of each issue of fact and law, which in most cases leads to a finding or reconstruction of what actually happened. It is this process that is the immediate goal of the legal system, with "justice" generally appearing as the ultimate product. It is well to remember that in law the result depends on what is *proved* rather than what *is.*

The roles of participants in a civil trial are easily explained. Each client's attorney presents evidence of facts most favorable to that side, minimizing by deletion or explanation any unfavorable evidence and rebutting damaging evidence produced by opposing counsel. Testimonial evidence is presented by witnesses to fact (called percipient witnesses), who relate their first-hand experience of relevant subjects within lay comprehension. As to matters outside lay understanding, testimony is limited to expert witnesses (eg, physicians), who alone can offer opinions as evidence. Where there is a judge and a jury, the judge sits as the trier of law only; it is not the judge's task to decide which evidence presented, whether testimonial or physical, is true and which is not true. That decision is reserved for the jury, which sits as the trier of fact. After all of the evidence has been presented, the jury decides which are the facts based on the evidence. It disbelieves some evidence, believes other evidence, and weighs every piece of evidence according to each juror's knowledge, experience, and understanding.

The judge, as trier of law, controls the conduct of the trial and, most importantly, determines the admissibility of evidence sought to be presented to the jury by counsel for each side. If, at the completion of the plaintiff's presentation of the case, the judge finds that the plaintiff has not met the burden of proof in establishing a prima facie case, a nonsuit against the plaintiff may be directed, which terminates the action in favor of the defendant. The judge may also find that, although the plaintiff's presentation has met the burden of proof, the defendant's presentation substantilly rebutted the plaintiff's evidence, and the judge

may thus direct a verdict in favor of the defendant. The defendant may fail so completely to rebut the plaintiff's case that a directed verdict is entered by the judge in the favor of the plaintiff. The judge also has the option of allowing the jury to reach its own verdict, but even then, if the judge believes that there is no rational basis for the jury's decision, a jugdment may be directed "notwithstanding the verdict" in favor of either party.

When the plaintiff and defendant have concluded their presentations and the judge has decided to let the case go to the jury, it is the judge's duty to instruct the jury on matters of law relevant to the case. These instructions are generally framed to indicate that certain findings of fact by the jury require certain conclusions of law. The judge even has the power to reduce the amount of the jury's money verdict (remittitur) or to increase it (additur). Although there must be agreement by the plaintiff to remittitur and agreement by the defendant to additu, the judge can "jaw-bone" the agreement of either party by indicating that unless agreement is reached, a motion for a new trial will be granted and the judgment of the jury set aside. There are, of course, numerous other decisions of law that must be made by the judge, such as matters of jurisdiction, venue, and appropriateness of parties to the action, which can greatly affect the initiation, location, and outcome of the litigation.

In cases where there is no jury, the judge acts a finder of fact as well as trier of law.

The physician's defense counsel in a medical negligence action may prefer to present the case to a judge sitting as trier of fact as well as of law. A trial to the judge alone is conducted with a great deal more flexibility than a trial before a judge and jury, because the judge is not concerned so much about evidence that may be prejudicial. That is, a jury of lay people may be somewhat dumbfounded by emotionally charged or complex evidence. The evidence may be so technical, as in many medical malpractice cases, that it is hopelessly beyond lay understanding (perhaps even with the assistance of expert witnesses). The judge is probably better informed than the average juror and may be familiar with medical terminology from experience with other cases. The judge is much less likely to be influenced by emotional testimony or evidence that might be prejudicial to one of the parties. As a result, questions of admissibility before a judgle alone are more likely to be resolved in favor of admission, whereas a judge might hesitate to admit the same evidence in a jury trial because of the possibility of an effect on the jury out of proportion to the real weight of the evidence.

The matter of appeal is sometimes misunderstood by those unfamiliar with the legal process. When a case is appealed, the facts are no longer in dispute. The trier of fact has already heard all of the evidence and made its decision, and the facts are as found. Unless it can be said that there was no rational basis for the finding of fact, which is an exceedingly difficult standard to meet, the findings as to facts will stand on appeal. The issues being contested by an appear are questions of law decided by the judge during the trial. Any of the trial judge's decisions referred to above may become the basis for an appeal to a higher court. It then becomes a question of the opinion of an appellate judge, or panel of appellate judges, against that of the trial judge. Trial judges do not like to be overruled on appeal, so they try to keep their decisions and instructions on law to acceptable, frequently used standards.

Although criminal law in the USA is almost exclusively governed by the state penal codes, American civil law is still largely based on the common law system, which began with decision of English courts and acts of Parliament and was adopted by the American states at

the time of the Revolution. This inherited body of common law has since been augmented by decisions of appellate courts at both the state and federal levels. The key to understanding the common law system is the doctrine of stare decisis, which is the rule of legal precedent requiring lower courts to adopt decisions of higher courts. When the issue is "on all fours" with an earlier decided appellate court decision, the earlier decision will control the present case.

Contract Basis of the Physician-Patient Relationship

Civil law obligations are of 3 types: contract, quasi-contract, and tort. A basic understanding of these areas is useful to physicians because the doctor-patient relationship is a complex that may involve all of them. The essence of a contractual relationship is voluntary agreement between the parties, expressed orally or in writing, or implied by conduct. A quasi-contractual relationship is the result of a voluntary committment of only one of the parties and the imposition of an agreement on the other party to avoid unjust enrichment. The ordinary purchase of goods or services is the simplest example of a contractual relationship, where one party agrees to furnish the goods or services and the other party agrees to pay for them. An example of a quasi-contractual situation is providing essential medical care for a patient who is incapable of contractual assent, such as an unconscious person, a minor, or an incompetent. The law will impose a quasi-contractual obligation on the patient or his or her legal representative (eg, parent or guardian) to pay for the medical care (*Greenspan v Slate*, 97 A2d 390, (NJ 1957)).

If the doctor and patient enter into a written contract for treatment, or if a verbal exchange takes place in which the patient promises to pay and the physician promises to treat, or if there is conduct in place of a promise (patient comes to doctor's office, doctor treats), the doctor-patient relationship is contractual. Subsequent failure of the patient to pay would amount to a breach of contract. Once having undertaken the obligation to treat the patient, a physician who fails to do so commits a particular type of breach known as abandonment. This is true no matter how the physician-patient relationship was created. The fact of that relationship imposes the obligation.

The relationship that is formed is one of fiduciary trust, based on the unavoidable reliance of the lay person on the professonal. This means that, unlike the usual "arm's length" sales transaction, there is a special obligation on the part of the physician: a duty of affirmative disclosure. Physicians deal with patients at all times in the context of this special trust. The relationship continues in the ordinary course of events until the treatment is completed. However, there may be situations where the patient wishes to terminate earlier. The patient can terminate at any time without notice or may decide at any time for any reason not to see that doctor any more, and that is the end of it.

There is, however, the possibility that a patient who demonstrates an intent to terminate unilaterally might later claim abandonment by the physician when, for example, an incision is slow in healing or the doctor's bill is higher than expected. To guard against this situation, the physician should confirm the patient's intent to terminate by written notification to the patient with a return receipt to document the change in relationship for the office file.

The physican can also terminate the relationship unilaterally, but special conditions apply. Notice must first be given to the patient and information on past treatment provided to the new physician. In one case, a patient was brought to an emergency room with a gunshot wound in the neck. The patient was examined, admitted, and sent to the ward by the surgeon, who then went home. The surgeon was called shortly thereafter and told that the patient was having difficulty breathing and needed a tracheostomy. The admitting physician failed to return, and by the time another surgeon got the patient to the operating room it was too late. The patient died 4 hours after admission. Even though only a few hours had passed and there had been no formed intent on the part of the admitting doctor to permanently discontinue treatment, the court nevertheless ruled that the doctor had abandoned the patient (*Johnson v Vaughn,* 370 SW2d 591 (K 1963)). So the definition of abandonment is highly flexible. For instance, if a fracture has been set by an orthopedic surgeon, treatment might include checking the patient every few months until healing and rehabilitation are complete. Even though there is no contract between doctor and patient for months, the relationship remains intact. Thus, for a doctor to be protected in terminating the physician-patient relationship, notice must first be given to the patient. How much notice is required varies with the case. In general, the courts have held that 30 days is sufficient.

Of course, there are difficult situations, like the doctor who is working in a small community where there is literally no other doctor available, in which case termination may be impossible. The period of reasonable notice is based in large part on the availability of adequate medical coverage; it is the responsibility of the terminating physician not only to give the patient enough notice to find another physician but also to furnish information to the successor fast enough so that there is no delay in treatment. What constitutes unreasonable delay may also vary with the details of the illness. In the average case, a routine mailing of the records to the new physician and being available for telephone consultation would be sufficient.

Occasionally, a physician who does not intend to terminate care waits too long to start the necessary treatment, with resultant injury to the patient. In this case, the legal issue concerns a possible breach of the standard of care. There are situations where abandonment may result in both contractual liability and tort liability, and damages may be recovered for either.

Once the doctor-patient relationship is formed, the obligation of the physician is defined as the possession and application of care, skill, and knowledge common to other physicians of good standing. However, a physician may increase the level of this obligation by expressly promising or "warranting" a particular result or a cure, in which event the failure to achieve the promised result will render the physician liable in contract for breach of warranty. The prima facie case for breach of contract is simple, since it only requires proof of the contract and that the physician made a particular promise and then substantially failed to perform. Thus, there is a considerable legal difference between the obstetrician who promises to perform a tubal ligation and one who promises to sterilize the patient. However successful the surgeon's experience with a given procedure, the discussion with the patient should be limited to the results expected and hoped for, the statistical probabilities, and the sincere promise to spare no effort to achieve a satisfactory outcome.

Money judgments for breach of contract in most states are limited to the value of the patient's "loss of the bargain" (which assumes that the promised treatment was obtained elsewhere at a greater cost) or "out of pocket" cost to the patient for securing the treatment elsewhere. A minority of jurisdictions do, however, allow recovery of money damages for pain and suffering where it was foreseeable at the time of the breach that failure of the doctor to perform, or delay in performance, would result in such pain and suffering for the patient. Actions for breach of contract against physicians are rare. They may be brought by patients who wish to "punish" a physician for a bad result although they know the physician was not negligent, or may be the only recourse in instances where a negligence action is barred by the shorter statute of limitations for tort.

Intentional Torts

The third - and by far the most important - area of civil law for the physician is tort law. There are 2 kinds of tort: intentional and negligent. Although some categories of torts involve invasions of property rights, our concern here will be solely with invasions of personal rights, ie, those of the patient.

The category of intentional torts includes assault, battery, false imprisonment, defamation, invasion of privacy, infliction of emotional distress, and intentional misrepresentation. The prima facie case for the intentional torts is established by proving that the defendant's conduct was deliberate. If the conduct results in actual injury to the plaintiff, it is compensable in money damages. If conduct is established but injury is not, the damages will be limited to a nominal sum. But if the act (or omission) was particularly outrageous, punitive damages may be awarded in addition to compensatory or nominal damages. It should be emphasized that the only intent required for the commission of an intentional tort is the intent to commit the act, not an intent to bring about the ultimate injury. Another way of saying this is that the intention to bring about the ultimate injury is presumed from the commission of the act.

The act required to establish an **assault** is that which places another in immediate apprehension of harm. Traditionally, words alone without supporting gestures do not establish a cause of action for assault. A **battery** is simply an unauthorized touching of another. Of course, the authorization or consent for contact may not always be expressed. For instance, the fact that a patient has visited a physician for treatment implies consent to reasonable physical contact necessary for the examination. However, when the physician's treatment entails more than such customaty contacts, as in surgery, invasive diagnostic procedures, and drug treatment involving the risk of special harm, the consent of the patient to the specific procedures must first be obtained. In the absence of such consent, treatment by the physician would be battery, as would also be the case where consent was obtained to operate on a specific site and the consent was exceeded by operating on a different site, either instead of or in addition to the area of original consent. In situations where the issue is not whether **any** consent was obtained from the patient but rather whether the physician disclosed **enough** information for a reasonable patient to make an intelligent choice, the trend of the courts is to view the lack of so-called "informed consent" as a form of negligence in the disclosure of information by the physician. The matter of informed consent has been the subject of so much attention recently that it will be discussed below under its own heading.

The intentional tort of **false imprisonment** consists of an invasion of the personal interest in freedom from retraint of movement. Thus, a physician who orders a patient placed in restraints or drugged to the point of immobility by mistake or without a good medical reason may be liable for damages for false imprisonment. The physician most often involved in false imprisonment actions is the psychiatrist who orders involuntary commitment.

The intentional tort of **defamation** consists of injury to reputation by means of slanderous (oral) or libelous (written) statements to another person that diminish the respect in which the plaintiff is held by others and lessen his or her standing in the community. The extent of the injury caused by verbal defamation must be proved by the plaintiff except in the case of slander involving an accusation of criminal conduct, loathsome disease (eg, syphilis, leprosy), acts incompatible with one's business, trade, or profession, or unchastity of a woman. These are the 4 categories of slander per se from which general damages are presumed to result without need of proof.

Special (actual) damages need not be proved in the case of libel inherent on the face of a publication, but where reference to extrinsic information is needed to create the libelous meaning (known as libel per quod), general damages will be presumed only in the same 4 areas as above. Otherwise, special injury must be proved to establish the prima facie case of libel. The defendant may avoid liability for defamation by establishing a privilege of immunity that covers the statement or by establishing that the statement was true. It should be noted that one who repeats or "republishes" defamatory statements faces the same liability as the original purveyor.

Invasion of privacy is a new and still developing are of tort law dating in broad acceptance from the 1930s. The types of invasion recognized in this category are public use for profit of personal information about another or some type of intrusion on one's physical solitude. The most common defenses to an action for invasion of privacy are the privileges that exist for publication of information of public interest or concerning public figures. Specific state statutes define exceptions to the restrictions of defamation and invasion of privacy law. Such statutes commonly include infectious diseases, gunshot and stab wounds, seizure disorders, and child abuse. (*Examples:* California Penal Code 11160, 11161, 11161.5; California Health and Safety Code 410, 3125.) Giving out details of medical treatment concerning patients (eg, celebrities), even if the information is truly newsworthy, can exceed the privile. Without a signed release from the patient, caution is the rule: "If in doubt, don't give it out". The same caution extends to identifying a patient if a description of the case is published. Also, no outsiders are allowed in the operating room without the patient's advance consent. (Standard consent forms usually allow observers to view surgery for educational purposes.)

Infliction of mental distress as a cause of action independent of contemporaneous physical injury has only recently achieved judicial recognition. The conduct or language must be outrageous and extreme and the emotional upset apparent (most successful suits have involved resulting physical illness). The law requires an individual to be somewhat tough-skinned, and annoyance or insult alone is not actionable. Nevertheless, the special closeness and reliance that characterize the fiduciary relationship between doctor and patient add weight to possible liability for ill-considered conduct by physicians, who have a duty to protect and comfort their patients.

Intentional torts are not covered by professional insurance and are not included in the protection afforded by governmental immunity statutes. Where liability for an intentional tort is established, the judgment comes out of the doctor's own pocket.

Negligent Torts

Although few physicians will ever have to face a suit for intentional tort, fewer still will complete a career without some involvement in a medical negligence action, whether as defendant, percipient witness, expert witness, or forensic consultant. A basic understanding of negligence law lessens the physician's chances of becoming a defendant and increases the prospects for making an effective, rational response if a legal proceeding does become necessary.

The prima facie case for negligence consists of 4 elements: duty, breach, causation, and damages. Each of these elements must be proved by the plaintiff by a preponderance of evidence, and failure to do so will be fatal to the plaintiff's cause of action. In the case of a medical negligence action, the duty owed is coextensive withthe doctor-patient relationship. It consists of the obligation on the doctor's part to acquire and maintain the same level of skill, care, and knowledge possessed by other members of the profession in good standing and to exercise that skill, care, and knowledge in the treatment of patients. There is no duty to accept a patient for treatment, and the physician may refuse to accept any person as a patient for any reason or for no reason at all.

There is one situation in which a physician may undertake treatment of an individual without creating a doctor-patient relationship and thus without incurring the obligation to treat, ie, by rendering emergency treatment outside the normal scope of the physician's practice. Public policy in favor of physicians stopping to aid victims is so strong that the states have enacted special statutes, known generally as Good Samaritan Acts, which provide immunity from liability arising out of ordinary negligence in treatment of such victims and often even for injury due to gross negligence. In addition, some states have enacted special statutes that provide for immunity of medical specialists who are called in emergencies as consultants to "bail out" another physician whose patient has deteriorated despite (or as a result of) earlier treatment. The following statutes enacted in California are typical examples: Section 2395 of the Business and Professions Code, entitled "Emergency Care at Scene of Accidengt," contains the following wording: "No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as result of any acts or omissions by such person in rendering the emergency care". Note that "scene of an emergency" encompasses not only location but also normal scope of employment. Therefore, if a doctor treats a patient while performing normal duties in the emergency room or as part of the responding "crash cart" team in a hospital, the Good Samaritan statute would not apply (*Colby v Schwartz,* 144 *California Reporter* 624(1978); *McKenna v Cedars of Lebanon Hospital,* 155 *California Reporter* 631 (1979)).

Section 2396 of the Business and Professions Code, entitled "Emergency Care for Complication Arising From Prior Care by Another", reads as follows: "No licensee, who in good faith upon the request of another person so licensed, renders emergency medical care to a person for a medical complication arising from prior care by another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by such licensed

person in rendering such emergency medical care". Scene of an emergency is defined as above.

One problem under the general heading of the physician's duty is the **unintentional** formation of a physician-patient relationship. This situation usually arises where a doctor is consulted very briefly and usually very casually by an individual seeking a quick (and free) "curbstone opinion". Where such an opinion is rendered by a physician in surroundings that quite clearly indicate that no professional relationship was intended, such as a social gathering, the courts have not found the existence of a doctor-patient relationship. The findings may be otherwise, however, where the doctor is consulted in the hospital and - for example - instead of tellling the questioner to come to the office for a regular appointment or referring to another doctor for medical advice, or even saying nothing at all, gives an opinion on which the "patient" relies. Even late-at-night advice by telephone to call another doctor in the morning may be held to constitute treatment, since it assumes that the patient can afford to wait until morning before seeking care. The best course to follow when confronted with such a request, unless the doctor does intend to treat the patient, is to offer no advice at all other than an immediate referral to another source of medical treatment (eg, a hospital emergency room).

The physician's duty to the patient is performed within the "standard of care", and it is the failure of a physician to meet the standard of care in a given case that constitutes the "breach" element of the prima facie case for negligence. In the great majority of medical negligence cases, determining what the specific standard of care should be is beyond the comprehension of the lay persons on the jury. In these cases, the law requires that the standard be established by expert medical testimony. This method of setting the standard requires a physician to take the witness stand and testify about the treatment required in the particular case. Although technically any physician may testify as an expert on any medical specialty, in practice, the medical expert will be of the particular specialty appropriate to the facts of the case.

At one time the standard of care was established by comparison with good medical practice in the same community in which the defendant was practicing. This so-called **locality rule** has undergone extensive change, until today most jurisdictions have broadened the standard to include treatment by physicians in good standing **under similar circumstances** - one of those circumstances being similarity of locale in terms of proximity to major medical centers and accessibility of medical information generally. Some states have gone so far as to abolish the locality rule entirely, holding that dissemination of medical advances, especially in the newer specialties, is so effective today that there is, in effect, a national standard of care for those fields of medicine. The well-established trend is away from the narrow confines of the locality rule and toward a national standard (and perhaps, eventually, an international standard of care, beginning with English-speaking countries). Obviously, it is the efficacy of the treatment that is important in setting the standard of care and not the country or city that is the source of the treatment. The courts have increasingly recognized that geographic isolation should not offer protection for the use of modes of treatment that have been discredited and discarded by physicians in general.

Even in situations where one mode of therapy is preferred by the majority of specialists in the field, the law does not require that this particular form of treatment be

adopted as the standard of care by which all physicians in that field shall be judged. It is sufficient that the treatment actually rendered be approved by a "respected minority of medical thought" in order for it to come within the standard of care.

The requirement of expert medical testimony to establish the standard of care has one well-established exception, ie, where the alleged negligence is within the lay understanding of the jury. In such cases, which include the "foreign object" cases, the judge must decide as a matter of law whether a medical expert will be required to establish the prima facie case in any particular respect. The judge may let the jury decide whether leaving a sponge, needle, clamp, or other object inside the patient is negligent (ie, a breach of the standard of care) but may require medical expert testimony on the element of causation.

The standard of case based on the modes of treatment employed by members of the medical specialty group in good standing is a **minimum standard.** There are 2 situations in which that minimum standard can be raised to require a higher level of treatment by a medical defendant. The first is that a physician who has made representations to the patient of greater skill or experience than is the case will be bound by them. In other words, a generalist who claims to possess the skill and experience of a specialist (or, if a specialist, that of a subspecialist) will be bound as a matter of law by the higher standard of care. The second situation rarely arises and occurs when the court itself determines that the standard of treatment in current use is simply not high enough to protect society. The likelihood of such a finding by a court is increased in cases where the added burden on the physician in meeting the higher standard proposed is very slight and the benefit to patients is very great. Where the existing standard of care is not adequate to protect the patient, the court may impose a stricter standard. This type of reasoning was demonstrated in the informed consent case of *Cobbs v Grant,* 502 P2d 1, 8 (Cal 1972).

It is plain from the decisions on standard of care that the law requires every physician to know his or her own limitations. The physician who attempts too much in a nonemergency case is risking liability for failure to consult or refer.

The element of causation has been the source of considerable confusion in the law. The plaintiff's case must include 2 types of causation: causation in fact and proximate cause. The test used most often in determining the presence of factual causation is simply that the defendant's conduct must be a substantial factor in bringing about the injury complained of. A minority of jurisdictions approach factual causation somewhat differently and require that the defendant's conduct be an indispensable antecedent to the plaintiff's injury, but in most cases the result is the same whichever test is used. Under either of these tests, the substance of the factual causation element is the same: proof of a sequence of events that connects breach of duty to conform to the standard of care with injury to the plaintiff.

The importance of the factual causation element is demonstrated by cases in which the treatment rendered is palliative and does not affect the course of the underlying disease process. In such cases where the patient dies as a result of the disease, a breach of the standard of care by the physician in administering the palliative treatment does not as a matter of law lead to liability for the death because the treatment was not a cause in fact of the patient's death.

For the purposes of this discussion, it is best to thing of the second type of causation, known as either proximate cause or legal cause, as a set of limitations on causation in fact. Having established causation in fact, the court may nevertheless fail to find liability if the injury is too far removed from the physician's conduct or where some abnormal force intervenes to break the chain of events connecting the conduct with the result. The effect of the proximate cause requirement is that, in addition to proving the chain of events connecting the conduct and the result, the plaintiff must also establish a close and direct relationship between the conduct and the result.

Res Ipsa Loquitur

The 3 elements of duty, breach, and causation are commonly referred to collectively as the liability aspect of a negligence case. With 2 basic exceptions, the plaintiff must establish the defendant's liability by a preponderance of the evidence in order to recover. The first of these exceptions is the doctrine of **res ipsa loquitur** ("the thing speaks for itself"). Considering the reams of print and judician contention that have been generated by this doctrine, its origin was rather prosaic. The term was first applied by Baron Pollack in the 1863 case of *Byrne v Boadle* (2 H&C 772, 159 *English Reports* 299 (1863)), tried on appeal before the English Court of Exchequer. In the words of Pollack: "There are certain cases of which it may be said res ipsa loquitur, and this seems one of them". In some cases the courts have held that the mere fact of the accident having occurred is evidence of negligence: "... The present case upon the evidence comes to this, a man is passing in front of the premises of a dealer in flour, and there falls down upon him a barrel of flour. I think it apparent that the barrel was in the custody of the defendant who occupied the premises, and who is responsible for the acts of his servants who had the control of it; and in my opinion the fact of its falling is prima facie evidence of negligence".

The doctrine evolved steadily from that case down to the landmark decision of the California Supreme Court in *Ybarra v Spangard* (154 P2d 687, (Cal 1944)), a case which applied the doctrine of res ipsa loquitur to medical negligence. The holding of the court in *Ybarra* was that "where a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control of his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the interference of negligence by giving an explanation of their conduct".

The doctrine itself serves as a substitute for the elements of breach and causation, although the plaintiff must still establish the existence of the duty element and must show damages. In order to gain the benefit of this substition, the plaintiff must establish, first, that the accident is of a kind that ordinarily does not occur in the absence of someone's negligence, second, that it must be caused by an instrumentality within the exclusive control of the defendant; and third, that it must not have been due to any voluntary action on the plaintiff's part. If the court finds as a matter of law that these requirements have been met by the plaintiff, the court will instruct the jury that it may infer breach and causation by the defendant unless the inference is successfully rebutted by defendant's proof. As an inference of negligence, the doctrine of res ipsa loquitur operates as a substitute for evidence that whould be especially difficult for the plaintiff to produce. The threshold issue - whether the injury is of a type that ordinarily does not occur in the absence of negligence - may itself call for expert testimony. If such testimony establishes that the injury occurs as an inherent risk

in a documented percentage of cases not involving negligence, the doctrine will not be applied.

Vicarious Liability

The other method of bypassing the prima facie case for negligence against a particular defendat is by imputed negligence. This method relies on the rule of law known as **respondeat superior,** which holds the principal responsible for the acts of his or her agents. This doctrine is manifested in the operating room in the form of the so-called "captain of the ship" doctrine. As the captain of the ship, the surgeon is held responsible for negligent injury to the patient while the surgeon is directing theoperation. It is the exercise of control over others by the surgeon that is the key to the application of the doctrine. For this reason, the actions of the anesthestiologist are generally not imupted to the surgeon. Of course, to the extent that the surgeon issues specific orders to the anesthesiologist, a secondary liability is assumed if the anesthesiologist is negligent in carrying out the orders. In addition, in a medical partnership, the negligence of one partner is imputed to the other partnets, and all partners become equally liable for damages that ensue. These instances of vicarious liability are exceptions to the general rule requiring that the elements of the prima facie case be established against the particular defendant only in the sense that once they are established as to one defendant they may fix liability on another defendant as well, based onthe legal relationship of the parties.

Damages

Of course, even when the plaintiff has established the elements of duty, breach, and causation by a preponderance of the evidence as to each, there is still the requirement of proving the last element of the prima facie case: damages. Considering that the average cost today of bringing a medical malpractice case through trial is over $20.000, it is plainly impractical for a plaintiff's attorney to bring a case to trial unless the alleged injury to the plaintiff has been substantial and offers a potential money judgment well in excess of expenses incurred.

The 2 categories of compensatory damages in personal injury cases are general damages, which include such intangible elements as pain and suffering; and special damages, which include documented economic loss from costs of medical care and diminished income. In a wrongful death action, the general damages do not include pain and suffering but do include the family's loss of "comfort and society"; and the special damages include loss of economic support along with funeral expenses. In both personal injury and wrongful death actions, proof of gross negligence or especially outrageous conduct may result in exemplary (punitive) damages, which are fixed in relation to the wealth of the defendant

Defenses

Common defenses to medical negligence actions are the statutes of limitations and contributory or comparative negligence. The purpose of **statutes of limitations** is to avoid litigation over stale claims by requiring a plaintiff to initiate suit within a fixed number of years after the negligent act or omission. Although the number of years varies from state to state, the effect of the running of the statutory period is the same everywhere - the plaintiff

is forever barred from instituting suit based on that particular act or omission. The period begins to run on the date of the occurrence of the alleged negligence unless the negligence results in an injury that the plaintiff would typically be unaware of, such as the foreign body type of case. To cover this situation, most states and all federal jurisdictions apply the "discovery rule", under which the statutory period does not begin to run until the plaintiff knows, or in the exercise of reasonable diligence should have known, that the injury suffered was the result of treatment. Also, in many states the statutory period is tolled (suspended) by a legal disability on the part of the plaintiff such as minority or incompetency, by misrepresentation of the facts surrounding the treatment by the defendant physician, or by the "continuing care rule", which tolls the statute until the physician-patient relationship is terminated. The importance of a detailed medical record to the maintenance of limitations defense cannot be overemphasized.

The defense of **contributory negligence** operates in a minority of jurisdictions as a complete bar to the maintenance of the plaintiff's action when it is established that the injury was *in any way* the result of the plaintiff's negligence. Thus, even if it were found that the surgeon was 75% responsible for the injury and the plaintiff only 25% responsible, a verdict for the defendant must result. A bare majority of states now employ the **comparative negligence** approach, which apportions the total amount of damages according to the relative negligence of the plaintiff and the defendant. Thus, in comparative negligence jurisdictions, if it is found that the plaintiff has been injured to the extent of $100.000 in damages but was 25% negligent, the defendant would be assessed $75.000 in damages.

Informed Consent

Much attention has been paid to the topic of informed consent in recent years, but, for all the reams of analysis, the new case law onconsent does not actually affect the basic process of securing consent for medical treatment. The big question has always been, "How much should the patient be told?"

The new cases on consent, foounded on *Canterbury v Spence* (464 F2d 772, (DC Cir 1972)) and *Cobbs v Grant* (supra), do not change the priority of the question; neither do they answer it. Common sense is still the best guideline. The exchange between physician and patient in securing consent need be no different for any given treatment now than it was 8 years ago. The requirements are a description of the procedure, its chances of success, the risks, and the alternatives. The physician has always compared risks and benefits in deciding what mode of treatment to recommend. Explaining them to the patient in plain language is all that was ever required and is as sound in law today as it has always been good medical practice.

Traditionally, American courts have used the "customary practice" standard to determine whether enough information was presented to the patient to support a rational decision. The new line of cases, which now constitutes a growing minority trend, holds that reliance on the custom of doctors in good standing is an illusory standard. These courts have substituted a standard of materiality to the patient. Under this minority approach, the test becomes whether a reasonable person would have refused the treatment if the risk of the complication that occurred had been clearly explained.

The effect of this materiality test is that the more important the procedure is to the patient's health, the less likely the claim that the procedure would have been refused. Conversely, the less important the procedure, the more credible will be a later complaint that it would have been refused had the risks been fully identified.

Put in its simplest form, a fully detailed informed consent is less crucial where the procedure may save life or limb and more important where the treatment objective is cosmetic. The principle finds its ultimate expression in the long-established rule that consent is implied in a medical emergency. There is one caveat to the rule of implied consent: the physician cannot assume that consent is implied if a competent adult refuses treatment.

The above discussion of the consent process is rooted in 2 basic premises. The first is that the physician determines which forms of treatment are appropriate for the patient's condition. The second is that once these therapeutic options have been explained to the patient, the patient will decide which of the options (including the option of no treatment at all) will be elected. The legal right of a competent adult to accept or decline proposed medical treatment has its foundation in the common-law and constitutionally guaranteed right of personal privacy. The patient's right to refuse treatment is not affected by the gravity of the consequences of refusal. Even if pain, disability, or death will be a probable consequence of a refusal of consent, a competent adult has the legal right to make that decision.

In cases involving patients whose condition is irreversibly and imminently terminal, there may be no treatment the physician can offer. Where there is a consensus among the treatment team, next-of-kin, and the known wishes of the patient, a "do-not-resuscitate" or "no code" order may be appropriate. If such an order is given by the attending physician, it should be a written order in the patient's chart. The order should be supported with a progress note that includes diagnosis and prognosis, wishes (if known) of the patient and family, consensus of the treatment team, and confirmation of the patient's competence.

If a person in need of medical treatment is incapable of giving informed consent, substituted consent must be obtained from the next of kin. In most states, the order of intestate succession controls the identity of next of kin. The order is generally spouse, adult child, parent, sibling. For a person who has been adjudicated incompetent, consent of the court-appointed guardian must be obtained. If a minor is in need of care, consent of one parent is required. The courts have recognized, however, that refusal by parents to consent to emergency care for a child is subject to judicial review.

The signed consent form is merely evidence that the consent process occurred. It should always be backed up by the physician's own brief entry in the progress notes, with date and time. If the need to alter an entry arises, there is only one safe method: Line out the error (without obliterating it), initial and date the deletion, and enter the correct information.

Medical Insurance

Discussions of the present status of the availability of medical malpractice insurance are usually phrased in terms of crisis. For the physician approaching private practice, sufficient understanding of the basics of professional insurance is imperative so that at least the right questions can be asked.

The insurance crisis was generated by the loss of profitability of medical liability insurance. This resulted from reduction of surpluses owing to investment losses by the insurance companies, large increases in the cost to the primary insurer of reinsurance (beginning in 1970), and the combination of unpredictability of occurrence claims and the small physician base from which to generate the premium pool. Of the many proposals to remedy the problem, several have found nationwide application. First, there has been a direct shift in the type of policy written from "occurrence" to "claims made".

Briefly, an occurrence policy provides coverage for events that become the basis for claims in the year that the event occurs, while the claims made policy provides coverage only for the year in which a claim is presented to the insurer, regardless of when the underlying event took place. The practical effect of the change from occurrence to claims made policies is that the physician is only secure so long as coverage continues to be purchased every year without lapse. For claims made policies, therefore, it is imperative that the insurance contract include provision for purchase by the doctor of the "tail" of coverage. In other words, there must be liability coverage for the years following the doctor's retirement or change in practice from patient care to nonpatient care. Care should also be taken that "presentation" of a claim under a claims made policy be defined, since some contracts allow presentation only by a third party (plaintiff or attorney) and not by the physician. Attention must also be given to exclusions from coverage, which may place certain high-risk operations outside the scope of the policy.

The purposes of medical liability insurance are protection against costs of defending a suit (commonly as high as $20.000) and payment of adverse judgments. Any physician considering "going bare" (practicing without liability coverage) must weigh the potential impact of these costs. As difficult to achieve as it is, attaining "judgment-proof" status (eg, irrevocable transfer of assets to another person prior to threat of suit) only protects against payment of a judgment. The only way to avoid litigation costs as well would be to submit to default judgment. The hazards of going bare thus make the cost of insurance more palatable.

Following the medical liability insurance "crisis" of the mid 1970s, the number of malpractice claims filed actually leveled off between the years 1976 to 1978. Unfortunately, claims-filed activity rose again in 1979 and has continued to rise steadily. We are faced now with a new crisis in medical insurance. Largely because of the growth of doctor-owned insurance companies, there is no availability problem. There is, however, a serious affordability problem, which is getting worse. With increasing claims activity and uncertainty of long "tail" coverage, the cost of liability insurance may actually prevent newly licensed physicians from practicing in high-risk surgical specialties. One possible solution that has worked in some areas is state-sponsored reinsurance pools for coverage of awards over a certain amount (eg, $250.000). Another solution may be found in state-run physician-supported patient compensation funds set up to cover amounts over a statutory limit on what can be awarded.

Hospital Staff Privileges

The nature of the physician-hospital relationship has changed drastically since the turn of the century as the hospital's status has graduated from that of essentially a quarantine facility for the isolation of the ill to the modern health care center. With that development,

the importance of access to the hospital facility (ie, staff privileges) by the individual physician has become a professional and economic necessity. Until the Illinois Supreme Court decision in *Darling v Charleston Community Memorial Hospital,* 211 NE2d 253 (1965), *cert denied* 383 US 946 (1966), it was generally accepted by the courts that the private physician with staff privileges was an independent contractor with the hospital and that the hospital would not be vicariously liable for contractors' malpractice under the doctrine of respondeat superior. *Darling* and its progeny now represent the majority position in the USA, creating a cause of action for direct hospital liability for failure to adequately supervise the quality of care in the hospital, including evaluation of the abilities of physicians granted staff privileges. Since the *Darling* decision, the Joint Committee on Accrediation of Hospitals has increased pressure on hospitals to tailor staff privileges to the ability of the individual physician in order to raise the quality of care. There has also been increased emphasis by medical malpractice insurance carriers on the limitation of privileges in the hope of reducing exposure from high-risk specialties. These factors will undoubtedly result in closer scrutiny by hospitals of applications for new privileges and for renewal of privileges. Those applications that are granted will be more narrowly drawn than in the past to match the applicants' education, training, and experience. We can also expect to see a proliferation of "closed shop" specialty units in hospitals, such as hemodialysis and cardiac intensive care units.

The physician whose application for staff privileges has been denied or restricted is entitled to a fair hearing before a reasonably impartial tribunal of the hospital with adequate notice of the reasons for denial or restriction; a right to examine documentary evidence in the case; and a right to cross-examine adverse witnesses. Such a hearing provides the minimum procedural due process without which the denial or restriction of privileges would constitute an improper infringement of the physician's liberty or property interests under the 14th Amdendment of the US Constitution. The standard the hospital must meet when restricting or denying staff privileges is that there must be a rational basis for the action which is reasonably related to the hospital's operation. Hospital action that is unreasonable, arbitrary, or capricious is likely to be reversed on judicial review.

Fees for Medical Witnesses

The single most common source of dispute between physicians and attorneys is the medical witness fee. This is due to the lack of understanding by doctors of the righs and duties of such witnesses and the willingness of the trial bar to take advantage of the ignorance. A treating physician is a witness to fact (in legal terms, a percipient witness) in any suit in which the patient's condition is at issue, and in that role the physician has the same duty to testify as if, for example, an automobile accident were witnessed by the physician. If subpoenad, the physician must testify. That is the obligation of every citizen, and the standard witness fee (presently $30 per day and 20.5 cents per mile in federal courts) is all the physician is entitled to.

On the other hand, if a physician is hired by either side as a medical expert to analyze and render an opinion on treatment rendered to the patient by others, reasonable compensation is justified. A physician who is approached by an attorney seeking the services of a medical expert to testify or a medical consultant to evaluate the case and report to the attorney should reach agreement with the attorney *in advance and in writing* on hourly charges for medical-legal services. The hourly fee paid by the federal government for medical expert and

consultant services in 1987 is usually $100 per hour. Remember that the AMA Code of Medical Ethics does not allow a physician to charge a fee contingent on the outcome of the trial.

Today, most local medical societies have panels of physicians available to the trial bar for the impartial review of medical-legal cases. If these panels find substandard care, they will furnish medical experts to testify in the case. The establishment of such panels should be supported by all physicians because the panels benefit patients deserving compensation, the public image of the medical profession, and the private conscience of the expert medical witness.

Coroner's Investigation

The coroner is a county government officer acting under statutory authority to investigate certain classes of deaths. These classes generally include violent deaths such as homicide, suicide, and accidents. Also included are deaths for which no physician can certify the cause, either because no physician was in attendance, the physician was in attendance for less than 24 hours before death, or the physician is *unable* to state the cause of death. (***Note:*** This means truly unable, not merely unwilling.) Often the coroner is charged with investigation of deaths in operating rooms, deaths where a patient has not fully recovered from an anesthetic, and deaths in which the patient is comatose throughout the period of the physician's attendance. When a death falls within one of these statutory classes, it must be reported promptly to the coroner. The coroner makes a brief inquiry, perhaps by telephone, and decides whether to take jurisdiction over the case. Thus, simply reporting the case tot he coroner does not make it a "coroner's case". The coroner may decide not to take the case and may instruct the reporting physician to sign the death certificate. When a physician is instructed by the coroner to sign the certificate, the contact, the instruction, and the identity of the coroner's official must be immediately entered in the physician's or hospital's patient chart.

Malpractice

The most comprehensive study yet published on medical malpractice in the USA is the Report of the Secretary's Commission on Medical Malpractice (DHEW Publication No (OS) 73-88, 1973). The commission found that the primary factor generating medical malpractice claims was injurious or adverse results of treatment. Factors such as poor physician-patient rapport, patient frustration with the handling of specific complaints concerning treatment and complications, unrealistic expectations about what can be achieved with treatment, and increased patient suit-consciousness are of only secondary importance. A rational prescription for curing the medical malpractice problem would be to reduce patient injury by instituting aggressive risk management programs (especially in the hospital setting), improving personal communication between health care providers and their patients, and adoption of arbitration provisions at the outset of the physician-patient relationship.

When the physician recognizes that the patient has been injured as a result of iatrogenic error, the best course it to tell the patient right away and in plain language exactly what happened. The explanation should stick to the facts and avoid opinions and conclusions of law (such as admissions of negligence). It is essential to document in writing that this

discussion has occurred, because the statute of limitations in most jurisdictions is much shorter when the patient has knowledge of the treatment error than when the patient is left to discover that a mistake has been made.