Lessons From Malpractice -- Apropos of 1000 Cases

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My involvement with malpractice cases over the last 25+ years has been the greatest education of my adult life. It has been an opportunity to operate at the interface of medicine, the law and commerce and has been unstinting in its lessons about the fallibility of human conduct and communication, the misapprehensions and fears of obstetrical practice, the pitfalls of CTG, and the timing and mechanisms of fetal injury. I shall briefly touch on all of these areas.

In the field of obstetrics a lawsuit most commonly refers to a "bad baby case" where the mother alleges that as a result of substandard care her child has been injured. Complaints (not allegations) about physicians are common and almost certainly contribute to the pursuit of lawsuits. In filing a lawsuit, mothers are more influenced by health care providers than by lawyers. Many need money for long-term care, some cite physician deception, some sue to find out what happened and others want to deter future malpractice (*JAMA 1992;267:1359.).* How often does a patient seek out an attorney? How often is she turned down? How often does she wind up with naught? How often does the physician or patient learn the cause of the child's injury or the principles of tort law?

The allegation of malpractice has become one of the most feared, intrusive and expensive complications of medical care. Claim frequency is rising as is the payout. Frequently cited reasons include: medical care with its new technology, patient awareness and expectations, etc. But beyond these there is myth, actual malpractice, the problem of medical records and finally the features of the legal system itself. We have accepted broadly the myths that the legal system is unfair, that it favors the plaintiff; that "Anyone can sue, and everyone wins," that it is a system where extravagant verdicts are reached by those who cannot understand the intricacies of care, and that people who suffer injury are "greedy ingrates who expect too much."

Unfortunately, the dissemination of information about malpractice amongst physicians is often rumor, the database is often myth, the approach to solution is often denial, and notions of plaintiff experts are often unprintable. Curiosity, reason and science have disappeared or been disfigured. The spectre of malpractice influences (adversely) many encounters with patients and most deliberations of committees including-g peer review. It is tempting to say that the malpractice-induced increase in such clinical activities as testing, documenting, and more staff presence represent enlightened care, but fear of being sued may be a better explanation (ACOG).

In fact, the law gives physicians considerable advantage in malpractice, an advantage they often squander. The physician is entitled to the presumption of non-negligence. His/her actions do not have to be right, just reasonable. Our system, in fact, denies the trier of fact the right to decide medical issues. This job falls to the expert witness drawn from the profession itself. Their conduct is sometime less than honorable.

Proof of Malpractice requires the establishment of a duty, a deviation from standard of care, an injury and a direct relationship between the conduct and the injury. Breaking the link anywhere precludes malpractice.

Is medicine Science, or Art or both? Irrespective, there are rules to both. Satisfying the requirements for the standard of care involves doing, not what is right, but what is reasonable under the circumstances. It applies to every aspect of care and may embrace mutually exclusive choices. The exercise of medical judgment involves making a reasonable decision under greater or lesser degrees of uncertainty. A decision is reasonable when it takes proper advantage of information that was or should have been available. The allegation of malpractice is not the allegation of malice (intent to harm) or incompetence (bad doctor) but of fallibility (capable of error)

Negligence is more common than we admit. A Harvard study concluded that "If anything there are too few suits, not too many." A review of 64 serious obstetric accidents in the UK found inadequate CTG monitoring, mismanagement of forceps, and inadequate supervision by senior staff. *(BMJ. 1990; 300:1365)* A recent study of ventouse deliveries found that the majority of fetal injuries developed during the second stage of labor *prior* to application of the ventouse. The CTG was critical in determining the timing of injury. Risk factors for adverse outcome included the availability of the physician, the interpretation of CTG tracings and the conduct of the second stage of labor. Insights often omitted from the medical record.

Medical records should provide a common basis for communication, provide understanding of what was done and why, and should give credit for the thought process. They are "Witnesses whose memory never dies." Often, however, they do not permit the determination of either the adherence to the standard of care or the exercise of proper medical judgment.

Dealing with medical error requires dealing with certain paradoxes: To lower the risk of malpractice we must *raise* the standard of care. We must deal forthrightly with error and remain the patient's advocate -- even in the courtroom. We must understand the advantages and weaknesses of the system and not squander one of our greatest assets - the medical record. The greater the communication and the more forthright the explanation of an adverse outcome the lesser is the liability. The larger the award the greater the likelihood that the *defense* has offended the jury. We may also be offending our society. (Editorial -Times London 19 Jan 2001)