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Chapter 2 - 5

Negligence

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NEGLIGENCE

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The purpose of this chapter is to present an overview of the types of medical negligence, which include: *Ordinary* negligence, *per se* (statutory) or *judicially imposed* (case law) negligence, *gross* negligence and *criminal* negligence. These represent various degrees of carelessness, divided by the probability of harm and the *imputed* mind set of the person causing that harm.

“Negligence” is carelessness. *Ordinary* human behavior is rife with careless actions, most of which cause no harm, or may do so little harm as to be easily forgiven. We have all received (and dialed) a “wrong number” phone call, excused the person who dialed it without thinking twice. It is only when the caller dials again we become upset, or when it becomes obvious the intrusion is somehow intentional that we take action to block the call. Ordinarily, as long as a behavior is not harmful or annoying, and as long as the person who was careless apologizes, negligent acts are forgiven and forgotten as part of our normal social structure, hardly causing a second thought.

To err is human. Medical practice is an error-prone human endeavor. As admirable as the oft-stated goal of eliminating all medical error might be, to avoid all error in medicine would necessarily involve eliminating both the patient and the physician from the encounter. Arguably, medical practice today is safer than at any time in our history, despite the increased risk of harm associated with increased technology and disease intervention. However, as medical practice has

become safer, so has the public expectation that relies on that safety, often racing ahead of what is possible to achieve.

A “bad outcome” is first treated as a possible or probable mistake, subject to proof otherwise, even in the mind of the treating physician. Malpractice case law is formed by the tension between acts that are *possible* causes of medical misadventures and acts that are *probable* causes of a medical misadventures. As it becomes more certain that any given act is the actual cause of an injury, liability for that act increases dramatically.

It is important to note that the most extreme form of medical malpractice, *criminal negligence*, does not involve a premeditated intention to harm another person. Premeditation to harm is an essential element of a criminal act that defines attempted or actual murder, not negligence. Rarely, an ordinary part of medical practice can become a charge of homicide (or murder) if a motive toward profit or a desire to harm a patient can be imputed to the physician, but such a motive must be beyond extreme carelessness. Such acts are unusual in medicine, as the following Case describes.

CASE PRESENTATION

The case presented is based in part an actual case, and is in part fictionalized. It raises several important issues concerning negligence which are discussed in details after the case presentation.

Dr. Bob was a Board Certified OB/Gyn, in practice for over 20 years. (His real name is Robert E. Lee; but his many grateful patients, including the greater than 1800 adult children he had delivered in those years, just called him “Dr. Bob.”) Dr. Bob held an appointment as an Adjunct Professor at the State College of Medicine, where he had trained and was on staff before

entering private practice. He has been the Chairman of the Department of Surgery at his local hospital, Valley View General, where he was also the Chief of Staff two years ago. Due to his long service and generous donations, Dr. Bob served on the hospital's Board of Directors.

Several years ago, Dr. Bob grew weary of the late hours involved in Obstetrics, never liked Gynecology, and wondered what to do. On a whim, he took a two week hands-on course in breast augmentation procedures, and a new world opened for him. His popularity and reputation paid off well. Until recently, he owned a free-standing surgical office, where he performed breast augmentation, liposuction and "tummy-tucks" from dawn to dusk.

One problem quickly became evident, however. At least to the Valley View's ER Staff, Dr. Bob was less than competent. His patients often presented to the ER within several hours after surgery with severe bleeding and early infectious complications. In addition, at least once a month, hospital admission was necessary, usually to the on-call surgeon, since Dr. Bob practiced alone and was always out of town on the weekends. A recent death in the ER from bleeding after a combined "tummy-tuck" and liposuction done late one Friday afternoon drew the attention of the local newspaper. After the case was reviewed by the hospital's Peer Review Committee, and no negligence found, the local newspaper forgot about the death. The Committee's sole recommendation, made in confidence, was to ask Dr. Bob to stay in town more often to avoid turning over care to a surgeon the patient has never met.

Dr. Bob was a widower, until he married for the second time last year. He did not remarry for several years because he was devastated by the death of his first wife. She died of bleeding complications in his office after one of his first breast augmentation/liposuction attempts failed. An investigation by the State Medical Board found him guilty of an ethical

violation of state law because he had operated on his wife, fined him \$2500 dollars and told him to take a course in medical ethics. Unfortunately for his current wife, he did not take the course.

The District Attorney has charged Dr. Bob with murder following the death of his second wife, Susan. She died in his office during a procedure identical to that of his first wife. When interviewed by the local television station, the Medical Examiner described the body as “having been filleted from side-to-side across the abdomen and breast. Mrs. Lee died of massive blood loss consistent with her unattended injuries. I have never seen a reputable surgeon make such incisions.”

On investigation, three facts stood out to the District Attorney. First, Dr. Bob employed untrained personnel to assist him in surgery and provide general anesthesia. One was a college student, the other a senior in high school. Second, no attempt was made to call 911 before Susan died. Only after the death occurred did anyone notify emergency services. Further, the surgical records documented that Susan was severely hypotensive throughout the last half of a 5 hour procedure, without any effort made to correct the problem. Finally, the newly-married couple had fought bitterly over the months before her death. Dr. Bob had discovered that his wife had continued to see an old boyfriend after the marriage, and broke off the relationship only after extensive counseling. Part of the agreement to break off the old relationship had been Dr. Bob’s offer to do the surgery that led to his wife’s death. Other facts of the investigation confirmed Dr. Bob’s gross incompetence, but were not part of the murder charge.

At trial, the defense team successfully convinced the jury that Dr. Bob was a grossly incompetent surgeon, that he may have violated medical-ethical standards by doing the surgery on his wife, but that Dr. Bob did not intend to kill Susan. The jury found Dr. Bob guilty of involuntary manslaughter, fined him one dollar and recommended 6 months’ probation. After all

of his appeals were complete, the Medical Licensure Board revoked his license. Susan's family sued Dr. Bob through her estate for ordinary and gross negligence, obtaining a judgment of \$5 million, including punitive damages. His malpractice carrier refused liability based on the criminal conviction. Today, Dr. Bob practices as a volunteer physician in another state.

DISCUSSION OF ISSUES

Practical Definitions of Negligence

The definition of medical negligence most familiar to physicians is the definition of *ordinary negligence*. As commonly phrased, ordinary negligence is: the failure to exercise that degree of care that a careful or prudent physician would have exercised under like circumstances. Such definitions involve the exposure of a patient to an "unreasonable" risk of harm, as judged by a jury (or by a judge) after expert testimony has been given to establish the ever-changing standard of care. Negligence can occur due to something we do or do not do, if the act we fail to do was necessary to prevent an injury.

In the United States, common law and statutory law form an interlocking and complementary set of rules and standards that define all the forms of negligence, including medical negligence. Common law is *case law*, or rules and standards determined by previous court decisions in specific cases. *Statutory law* is law made by the legislature of any given state that is intended to "codify" or to "make certain" case law. Most statutory medical malpractice law merely reflects or enforces previous findings by judges and juries, and does not create new liabilities for physicians. However, statutes can also be a reaction to a finding by a court that is contrary to public policy, as defined by the legislature. In a sense, these laws are an attempt to "put to right" a finding by a court that the legislature considers outrageous. Some states have

statutes that create “safe havens” for physicians who follow certain protocols in the treatment of selected diseases, but these statutes have not been challenged in court and have had limited impact.

Negligence per se (or “statutory negligence”) is behavior that “can be said without hesitation or doubt that no careful person would have committed.” Some states have defined certain medical acts or omissions to be negligence as a matter of law (that is, *per se*). Committing an act defined by such statutes effectively eliminates the plaintiff’s need to prove negligence. Operating on the wrong part of the body or leaving surgical equipment inside the body are classical examples of negligence *per se*. However, a minority of states define violations of a statute to be evidence of negligence, not negligence itself. Such evidence is still left to the jury or the judge to weigh, to accept or reject.

Ordinary negligence does not include reckless or intentional behavior. It also does not include the legal concept of a “battery,” which is defined as an unpermitted touching, with or without an injury. Until the middle of the 20th century, many successful malpractice cases included some aspect of a charge of battery, especially those cases raising what we now know as “informed consent” issues. A battery occurs only in the absence of any consent. Under current law, it is possible for a patient’s consent to be so defective as to be non-existent, but such a finding is very unusual. (*See* discussion, below.)

Physicians are frequently charged with reckless behavior in the initial complaint or summons in a case that actually involves only ordinary negligence. This is often done to allow the plaintiff’s attorney to later argue that the facts support a charge of “*gross negligence*.” Gross negligence is a matter of degree, just as is wonton or reckless behavior. For example, it is certainly gross negligence and reckless behavior to perform surgery while intoxicated, but it is

not necessarily negligent or reckless to do the same surgery while sleep-deprived. If carelessness of an extreme degree can be shown, *punitive damages* can be sought. Punitive damages are difficult to obtain, since they are both defined (and limited) by statutory law and are given for a type of behavior that is unusual among competent physicians. Since the purpose of punitive damages is to teach the responsible party a lesson they and others will not easily forget, the court reserves such damages for the most culpable physicians.

There is no clear or bright line between ordinary negligence and gross negligence. It is usually possible to characterize “sloppy” medical practice as either ordinary or gross negligence. However, reckless or wanton behavior (essential to a finding of gross negligence) has important characteristics. It is behavior that involves a known or obvious risk of harm that is done with a conscious indifference to the welfare of another, such that it is the *close equivalent of a willingness that the harm will occur*. Such behavior does not require a proof of the actual motivation of the physician, but if a secondary motive (such as profit or personal fame) can be shown, recklessness is far easier to prove. Any motive other than the general welfare of the patient can be enough to turn an inattentive error into a charge of recklessness. Finally, and possibly most important, negligence that is both offensive and of a type that a non-professional lay juror would consider reckless, without the help of expert testimony to establish that it is reckless, will often be found to be gross negligence.

Informed consent law is complex, and is not the subject of this discussion. However, if a physician takes the time to tell the patient of his or her risks, and they are the risks that are normal to the actual situation, it is much more difficult to impute an improper motive to any act of negligence. Therefore, good informed consent indirectly protects against a charge of gross

negligence by showing deference to the patient's welfare, evidenced by obtaining his or her consent to a (reasonable) risk, even when that risk actually materializes.

Informed consent is not, however, a permission slip to behave irresponsibly. No person can legally permit another to intentionally cause them harm. That is, if an injury is the certain or logical outcome of a high risk intervention, and the harm is far more likely than any other intended benefit, no amount of informed consent can legally permit the act. Simply put, a physician cannot avoid criminal or civil liability for a patient's death by obtaining the patient's consent to kill him or her, even if the patient's death has some benefit for the physician. In the same sense, even though death is a *possible* unintended outcome of a surgery, no one consents to actually die when death is made *probable* by recklessness. Reckless or indifferent behavior can completely destroy the liability protection afforded by informed consent, creating instead a battery (an unpermitted touching). Because a battery that causes harm is a criminal act (a felony or misdemeanor), it is a short step from gross negligence to an act that is prosecuted under the criminal law. Prosecution for *criminal negligence* associated with medical care is at the *discretion* of the public prosecutor, who often looks for (1) patterns of behavior or a single behavior that (2) offends all public decency, and is an (3) offense described by the criminal statutes of the state.

CASE ANALYSIS

Most of the issues raised by the Case Presentation are probably evident after consideration of the various levels of negligence (above), but it is useful to briefly look at the behavior of Dr. Bob in some detail as an example to avoid.

Ordinary Negligence and per se Negligence

Among the most important issues being addressed at the state and national level by both the medical profession and lawmakers are uniform standards of care for outpatient, office-based procedures. Not only was Dr. Bob poorly qualified as a plastic surgeon, but he also failed to provide minimal safety standards for outpatient surgery. Normal sterility procedures, pre- and post-operative assessment and skilled provision of anesthesia are essential to any invasive surgery of the degree practiced here. State statutory law mandates elaborate protections for free-standing surgery centers, and federal law expands those protections through Medicare and Medicaid regulations. However, unless a clinic bills Medicare/Medicaid or falls within the state guidelines of the definition of a “surgi-center,” remarkably little statutory law applies to the physician’s office. Dr. Bob managed to avoid inspection by his local Department of Health by carefully structuring his billing and office organization to avoid falling within the definition of a surgery center in his state. Evidence of the state’s standards for outpatient surgery was entered by the defense into the trial, not to assert *per se* liability, but as evidence of how far Dr. Bob had deviated from expected practice. The public often assumes a level of safety in a physician’s office that is not present in all situations, clearly not in Dr. Bob’s office. The only protection afforded Dr. Bob’s patients was the post-event recovery possible under his malpractice policy, and any general restraint on his behavior caused by the threat of a malpractice suit. Ordinary negligence is the subject of most malpractice suits, as it was in the subsequent suit brought by the Susan’s family. The proof of ordinary negligence is a “fact-intensive” enquiry, subject to various defenses, none of which were raised here.

Gross Negligence

By the time the criminal prosecution was complete, all the discovery for the malpractice suit was part of the public record. One unique aspect of Dr. Bob’s case was that his defense in

the criminal trial was gross negligence. He pled gross incompetency in order to avoid the charge by the District Attorney that he intended his wife's death, motivated by anger and jealousy. Absent the *mens rea* (mental state) necessary for a conviction of murder, the jury agreed that his surgical practice *in general* was reckless and that this recklessness was the specific cause of Susan's death. It became impossible for Dr. Bob to defend a malpractice claim against gross negligence based on his own testimony and that of his experts at the criminal trial. Dr. Bob attempted to defend himself by claiming he had told Susan that death was a possible complication of the surgery, and even pointed to a signed consent form as proof. However, as mentioned above, informed consent only applies to ordinary negligence, since no one can give legally binding consent to a surgery performed in a reckless, wonton manner. Thus, that defense was not allowed by the judge.

SURVIVAL STRATEGIES

Since ordinary negligence is carelessness, and since all humans are careless, it is impossible to defend against all human error. It is therefore impossible to practice medicine without error, despite our personal sense that we are doing so on nearly all occasions. The illusion that our practice is (nearly) error-free is exactly that: an illusion. Careful studies of human error, and specifically error in medical practice, point out that the source of most medical error is not a lack of personal concern or care, nor of skill or training, but of "systems" failures, largely out of the control of the physician. It is literally true that most medical error cannot be solved by the personal resolve and concerted effort of an individual physician to do well. As essential as professional integrity and training are, those qualities will not solve the ongoing problem of medical error.

A number of strategies for avoiding error, limiting liability and surviving a malpractice suit have been proposed. The literature on these issues is voluminous, impossible to summarize easily. Other authors in this volume deal with some of these issues and The References section of this Chapter contains several of the best articles in this regard.

That said, two thoughts come to mind as more important than others. One concerns avoiding error, the other, surviving a malpractice suit.

First, avoiding error requires objective, thoughtful restructuring of how we practice medicine. Systems analysts advise hospitals, incident reports and peer review attempt to identify problems pro-actively, and manufactures of drugs and medical devices build in safety. However, none of these efforts reach into our office. We need to begin recognizing risks and developing systems that include redundancy to prevent errors in our offices. Defending a malpractice suit normally involves a bad outcome for which there was some medical intervention. Avoiding adverse events, with or without fault, is our best defense, our best survival strategy.

Second, when sued for malpractice, get good legal and personal counseling. Most malpractice carriers retain experienced attorneys that provide good legal defense. If you have a choice, select your malpractice carrier based on their legal panel. However, the most ignored injury of a malpractice suit is the emotional injury caused to the physician. We tend to blame ourselves for bad outcomes that have little to do with what we did. In addition, the isolation and shame that accompanies a malpractice suit can effect both the professional and personal life of any professional. All state medical associations have a committee whose role it is to provide confidential counseling for the emotional devastation of a malpractice suit. Experience has clearly shown the value of such counseling, but has also documented its under-utilization by

most physicians. Help is available with a phone call, and can dramatically help us survive malpractice.

GOLDEN RULES of Negligence

- Ordinary Negligence is common in all human behavior
- The best protection against ordinary negligence is error prevention, not legal strategy or risk prevention
- Negligence *Per Se* (Statutory Negligence) is uncommon in medical malpractice suits, and the effect of such negligence varies from state to state
- Gross Negligence is commonly alleged but rarely proven. It is the basis of punitive injury claims
- Good Informed Consent is an important defense against any claim of negligence, but is especially important to disprove gross negligence
- Criminal Negligence is charged for rare, egregious behavior, and is based on reckless and wonton acts, outside normal medical ethics and practice

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