

Part IV

Professional Medical Liability

Chapter 25

Medical Malpractice Overview

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Plaintiff's Legal Theories or Causes of Action
against a Physician

Medical Malpractice Defenses

The purpose of this chapter is to provide an overview of the legal theories, or causes of action, by which the patient as a plaintiff may bring a lawsuit against a physician, and the defenses to a claim of medical malpractice. The majority of the legal theories presented briefly in this chapter are discussed in details in other chapters of this book.

The term *malpractice* refers to any professional misconduct that encompasses an unreasonable lack of skill or unfaithfulness in carrying out professional or fiduciary duties. The term *medical malpractice* is used in this chapter because of the common and traditional usage in claims alleging medical negligence by health care professionals. The term *physician* is used in this chapter to mean any health care professional.

The legal theories or causes of action by which the plaintiff may sue a physician are listed in Table 25-1. Negligence is the most common basis for a medical malpractice action imposing liability on a physician. However, physicians may be involved in legal actions based on the other legal theories listed. The physician must be aware that a medical malpractice lawsuit can be brought simultaneously under several legal theories. If the plaintiff patient wins under any of these theories, recovery of a monetary award from the defendant physician may result. The defenses to a claim of medical malpractice are listed in Table 25-2 (see page...), and they will be considered after a discussion of the basic principles of medical negligence.

PLAINTIFF'S LEGAL THEORIES OR CAUSES OF ACTION AGAINST A PHYSICIAN

1. Medical Negligence

Medical negligence is a breach of the physician's duty to behave reasonably and prudently under the circumstances that causes foreseeable harm to another. For a successful

suit under a theory of negligence or in legal terms to present a cause of action for negligence, an injured patient (plaintiff) must prove each of the following four essential elements by the preponderance of evidence.

Duty

Duty, the first element of the negligence theory of liability, is created by the physician-patient relationship. The "life" of medical practice, both generically and specifically, is generally a contract, referred to as the physician-patient relationship. Both medically and legally, it is considered a "sacred" or fiduciary relationship. The physician-patient contract may be entered into with the physician by a third party on behalf of the patient, as in the case of a managed care organization.

Duty requires that a physician possess and bring to bear on the patient's behalf that degree of knowledge, skill, and care that would be exercised by a reasonable and prudent physician under similar circumstances. The physician owes the patient a duty to act in accordance with the specific norms or standards established by the profession, commonly referred to as standards of care, to protect the patient against unreasonable risk. The defendant physician may fail to exercise the required skill, care, or diligence by either commission or omission (i.e., by doing something that should not have been done or by failing to do something that should have been done). It may not matter that the physician has performed at his or her full potential and in complete good faith. Instead the physician must have conformed to the standard of a "prudent physician" under similar circumstances.

There is no clear definition of the duty of a particular physician in a particular case. Because most medical malpractice cases are highly technical, witnesses with special medical qualifications must provide the judge or jury with the knowledge necessary to render a fair and just verdict. As a result, in nearly all cases the standard of medical care

254 Medical Malpractice Overview

1. Medical negligence
2. Wrongful death
3. Loss of a chance of recovery or survival
4. *Res ipsa loquitur* (“The thing speaks for itself”)
5. Battery and assault
6. Lack of informed consent
7. Abandonment
8. Breach of privacy and confidentiality
9. Breach of contract or warranty to cure
10. Products liability for drugs and medical devices
11. Vicarious liability for the acts of others
12. Negligent referral
13. False imprisonment
14. Defamation
15. Failure to warn or control
16. Negligent infliction of emotional distress
17. Outrage
18. Failure to report
19. Fraud and misrepresentation (deceit)
20. Loss of consortium

Table 25-1 Legal theories or causes of action of medical malpractice

of a “prudent physician” must be determined based on expert medical testimony. In the case of a specialist the standard of care by which the defendant is judged is the care and skill commonly possessed and exercised by similar specialists under similar circumstances. The specialty standard of care may be higher than that required of general practitioners.

Although courts recognize that medical facts usually are not common knowledge and therefore require expert testimony, professional societies do not necessarily set the standard of care. The standard of care is an objective standard against which the conduct of a physician sued for malpractice may be measured, and it therefore does not depend on any individual physician’s knowledge. In attempting to fix a standard by which the jury or the trier of fact may determine whether a physician has properly performed the requisite duty toward the patient, expert medical testimony from witnesses for both the prosecution and the defense is required. The jury or the trier of fact ultimately determines the standard of care, after listening to the testimony of all medical experts.

Breach of Duty

Breach of duty, the second element of medical negligence, must be proved by the plaintiff. The plaintiff alleges that the physician failed to act in accordance with the applicable standard of care and did not comply with, and hence breached, the requisite duty. The applicable standard of care must be proved before the plaintiff can prove that the physician breached that duty. In most cases, expert witnesses for the prosecution and the defense address the question of breach of duty while testifying as to the standard of care owed.

There are exceptions to this rule. Expert testimony may not be required if a plaintiff presents evidence showing that the defendant physician’s substandard care is so obvious as to be within the comprehension of a lay person.

Another exception is the judicially imposed standard of care. Generally, courts rely on medically established standards of care to determine a health care provider’s duty and breach of that duty. Some courts have required a “preferred” rather than the usual, ordinary standard of care. To that end, the courts have rejected the testimony of medical experts as to the accepted medical standard of care when they thought it inappropriate, and decreed their own, i.e., judge-made, standard of medical care.

Causation

Causation, the third element, must also be proved by the plaintiff alleging medical negligence. The plaintiff must show that a reasonably close and “causal connection” exists between the negligent act or omission and the resulting injury. In legal terms this relationship is commonly referred to as *legal cause* or *proximate cause*. The concept of causation differs markedly from that of medical etiology in that it refers to a single causative factor and not necessarily the major cause or even the most immediate cause of the injury, as is the case with medical causation or etiology.

Although causation may seem to be an easy element for plaintiffs to prove, it is frequently the most difficult and elusive concept for the jury to understand because of the many complex issues. Legal causation consists of two factual issues—*causation in fact* and *foreseeability*.

Causation in fact may be stated as follows: An event A is the cause of another event B. If event B would not have occurred but for event A (known as the but for test), causation exists. The “but for” test is easily passed in some cases but not in others. Consider the following contrasting examples. The patient with an intestinal perforation resulting from a surgeon’s failure to remove an instrument from the abdominal cavity may suffer subsequent abdominal abscess, surgery, or death. But for the retained instrument, such a complication would not have occurred. In contrast, a physician’s delay in the diagnosis of a highly aggressive malignant neoplasm might not necessarily affect the patient’s chance of survival.

Foreseeability is the second causation issue. A patient’s injuries and other damages must be the foreseeable result of a defendant physician’s substandard practice. Generally the patient must prove only that his or her injuries were of a type that would have been foreseen by a reasonable physician as a likely result of the breach of the medical standard of care.

The law of causation varies widely from jurisdiction to jurisdiction, and its proof is currently in flux. In *Daubert v. Merrell Dow Pharmaceuticals*,¹ the U.S. Supreme Court addressed the admissibility of scientific evidence in a case involving expert testimony concerning causation. This decision, which is followed in most jurisdictions, allows judges great discretion in deciding what scientific evidence is or is not admissible, especially as applied to the causation element.

Damages

Proof of damages, the fourth element of the medical negligence suit, encompasses the actual loss or damage to the interests of the patient caused by the physician’s breach of the standard of care.

There can be no recovery of damages if the patient is not harmed. The exception to this rule is “nominal damages,” where a token sum, economically worthless, is awarded a plaintiff who has had his or her honesty, integrity, or virtue challenged and is vindicated by the satisfaction of having his or her claim honored. Although rare, the significance of an award of nominal damages is that it may serve as a prerequisite to the award of punitive damages.

The purpose of awarding damages in a tort action is to ensure that the person who is harmed is made “whole” again or returned to the position or condition that existed before the tort of negligence. Because it is generally impossible to alleviate the effects of an injury resulting from medical malpractice, public policy demands redress through the award of monetary compensation to the plaintiff. The legal fiction is that money makes the damaged patient whole.

Damages may encompass compensation for a wide range of financial, physical, or emotional injury to the plaintiff patient. The law has recognized certain categories of damages, but categorization is often imprecise and inconsistent because some of these categories overlap and are not strictly adhered to by courts of all jurisdictions.

Compensatory damages are awarded to compensate the patient for losses. There are two types of compensatory damages—*special* and *general*. General damages are awarded for noneconomic losses, including pain and suffering, mental anguish, grief, and other related emotional complaints without any reference to the patient’s specific physical injuries. Special damages are those that are the actual but not necessarily the inevitable result of the injury caused by the defendant and that follow the injury as foreseeable and natural consequences. Typical items of special damages that are compensated by a monetary judgment include past and future medical, surgical, hospital, and other health-care-related costs; past and future loss of income; funeral expenses in a case involving death; and unusual physical or medical consequences of the alleged injury, such as aggravation of a preexisting condition.

If a wrong was aggravated by special circumstances, *punitive or exemplary* damages, in addition to the injured patient’s actual losses, may be awarded. Punitive damages, which are rarely awarded in medical negligence cases, are intended to make an example of the defendant physician or to punish his or her egregious behavior. Such damages generally are awarded when the defendant’s conduct has been intentional, grossly negligent, malicious, violent, fraudulent, or with reckless disregard for the consequences of his or her conduct.

2. Wrongful Death

If negligence results in the death of a patient, recovery may be based on the doctrine of wrongful death. A wrongful death is a death that occurs earlier than it would have ordinarily. If negligence is the legal causation of the patient’s death, then his or her statutory survivors or personal estate may bring an action in “wrongful death”. The action is considered to be a derivative one; it cannot be brought

unless the decedent would have had a cause of action had he or she survived. Its rationale is to benefit the survivors. The action is thus a creature of statute, and allows the decedent’s survivors to maintain civil actions. Recovery includes *pecuniary* damages, or that amount which the decedent could reasonably have been expected to contribute if his or her death had not ensued, plus damages for emotional injury.

3. Loss of a Chance of Recovery or Survival

Loss of a chance of recovery or survival caused by the negligence of a physician has been recognized by the majority of states. Court weigh the diminished prospects for a plaintiff whose statistical future expectations are already severely impaired. Liability is imposed for negligence that merely increased the probability of an already probable negative outcome, as in case of failure to diagnose a malignancy or acute myocardial infarction.

However, the majority of U.S. jurisdictions retain the “but for” test, i.e., the negligently injured patient must prove that the chance for recovery or survival was probable, was more likely than not, or was better than even. The rationale for this all-or-nothing approach is that less than probable losses are speculative and unfairly impose liability based on unquantified possibilities. The majority position is that what the measure “might have caused” is an insufficient quantum of evidence.

Under the majority theory, a plaintiff with less than a 50/50 chance cannot be harmed to a compensable degree by negligent care.

4. Res Ipsa Loquitur

Res ipsa loquitur, which literally means “the thing speaks for itself,” is a legal doctrine that relieves the plaintiff from the requirement of proving duty and breach of duty through a physician expert witness. In other words, negligent care may be presumed. *Res ipsa loquitur* requires the plaintiff to show only that the outcome was caused by an instrumentality in the exclusive control of the defendant, that the plaintiff did not voluntarily contribute to the result, and that the injury was the type that normally does not occur in the absence of negligent care. After the plaintiff shows these elements, the burden of proof may shift to the defendant physician to prove otherwise. For example, the patient who discovers that a sponge or an instrument was left within his or her abdomen during surgery may have a *res ipsa loquitur* case. However, causation and damages may need to be proved by expert testimony.

5. Battery and Assault

In medical injury cases battery is not a negligence action but an intentional tort. The law in general recognizes that an individual should be free from unwarranted and unwanted intrusion. In legal terms, touching another person without that person’s express or implied consent

256 Medical Malpractice Overview

is a battery. The attempt to touch another person without consent is an assault. Assault can be considered an attempt at battery.

The law in all jurisdictions places considerable importance on this principle of personal autonomy, which traditionally has been reinforced by legislation dealing with patients' rights. In the medical setting, battery most often involves undesired medical treatment or nonconsensual sexual contact. To successfully prove a claim of medical assault or battery, the plaintiff must show that he or she was subjected to an examination or a treatment for which there was no express or implied consent. The treatment provided must be substantially different from that to which the patient agreed. There also must be proof that the departure was intentional on the part of the physician. Unlike claims made under the negligence theory of consent, there is no need to prove actual harm in battery cases, although harm may have occurred. The amount of damages of course relates directly to the amount of harm in most cases. For example, an operation that is not consented to but saves the patient's life likely will not result in damages, except in rare cases. However, if the patient suffers painful, crippling, or lingering effects, significant damages may be awarded.

Specific examples of medical battery include the performance of sexual "therapy" by a psychiatrist or other mental health care professional in the name of treatment, the unauthorized extension of a surgery to nonconsented bodily organs unjustified by the original procedure, and the nonconsensual treatment of Jehovah's Witnesses or others whose religious convictions limit therapeutic alternatives. Expert testimony regarding standard of care and breach of standard of care is not necessary in battery cases.

Although in some jurisdictions recovery still may be based on assault and battery theories, through legislation (sometimes as part of reform measures) most jurisdictions have removed the right to bring such an action because it is subsumed under other medical malpractice causes of action. This change is a result of the now nearly universal acceptance of the doctrine of informed consent. A physician may be negligent if he or she diagnoses or treats a patient without obtaining informed consent or an adequate informed consent for such a diagnostic or treatment procedure.

6. Lack of Informed Consent

Patients must be capable of giving consent, must possess adequate information with which to reach a decision regarding a diagnostic procedure or treatment, and must be given ample opportunity to discuss alternatives with the physician. A failure to meet the requirements for an appropriate and adequate informed consent may be a departure from the recognized standard of care and may result in an action for failure to obtain "informed consent" against a health care provider.

Consent is a process, not a form. Physicians may fail in their duty to patients when they rely on a form or document for achieving "informed consent." Such a form can never replace the exchange of information between a patient and

a health care provider, which is necessary to fulfill the requirements of an adequate informed consent.

7. Abandonment

Generally a physician has no duty to provide care to a person who desires treatment. However, a physician who agrees to treat a patient accepts the duty to provide continuity of care. Legal recognition of this duty follows from the reality that a sick or injured person is at risk until cured or stabilized. No physician can be available at all times and in all circumstances. Yet, the physician must provide an adequate surrogate when unavailable. Many physicians meet this obligation by making arrangements with a partner or nearby colleague in the same or similar field of practice. Backup may be provided by directing ambulatory patients to a nearby, physician-staffed hospital emergency department. Brief lapses of coverage are generally reasonable. For example, it is unlikely that a physician would be successfully sued for failure to attend simultaneous cardiac arrests for which no other physician was available. Physicians are sued when the unavailability of coverage for several hours harms a patient.

This duty to provide continuing care is extinguished when the physician dies, when the patient no longer requires treatment for the illness under consideration, or when the physician gives reasonable notice to the patient of his or her intention to withdraw from the case. In the case of withdrawal, the physician must give the patient time to arrange for care from another qualified physician or must arrange for a substitute physician who is acceptable to the patient. The original physician must provide emergency care for the patient's condition and related medical problems until the patient has established a relationship with the new physician. A duty to provide care may generate a duty to third parties under certain circumstances.²

With the accelerated growth of managed health care plans, many physicians have become members of various health care networks. In some cases a physician may opt to leave a network to join another. Such an action *per se* does not necessarily end a physician-patient relationship, particularly if the patient opts to continue the relationship outside of the network payment scheme. Any physician who wishes to discontinue caring for patients previously seen in such a system may notify those patients of a change in managed care participation and arrange for appropriate transfer of care to a successor physician.

8. Breach of Privacy and Confidentiality

State and federal (HIPAA) laws impose on physicians a duty to respect the privacy interests and confidentiality of their patients' information. Generally, everything said by a patient or his or her family members to a physician in the context of medical diagnosis and treatment is confidential and may be revealed only under certain circumstances. In many states the physician-patient relationship is recognized by a statute that sets forth exceptions to the general

rule of confidentiality, including investigations by medical examiners, and possible cases of infectious diseases. Some states rely on common law in this area. Each practitioner should know the rules that apply in his or her state and establish procedures for his or her employees to act accordingly.

In general, health care providers can safely release medical information to other treating physicians or consultants. In life-threatening emergencies, certain information pertinent to the patient's treatment also may be revealed to other medical personnel, even if the patient is unaware.

9. Breach of Contract or Warranty to Cure

When a physician promises to cure or to achieve a particular result and the patient submits himself or herself for treatment, the physician is generally liable if the treatment fails to achieve the promised result. The unhappy patient in such a situation can sue the physician in contract rather than in tort. This form of medical malpractice suit has become less common in recent decades. The major advantage for the plaintiff in a contract suit is that a medical standard of care need not be shown. The plaintiff must prove only that a promise was made and relied on, the promise was not kept, and damages resulted because of the broken promise. The plaintiff in such a suit must prove how he or she was damaged by the physician's breach of promise. A successful plaintiff generally recovers an amount of money that would place him or her in a position comparable to the position he or she would be in had he or she not agreed to treatment. In many cases this amounts to a return of the surgeon's fees, plus a small sum for related expenses. Damages may be exceedingly high in some instances, however, such as when a professional performer is scarred or killed.

Most physicians at one time or another prognosticate for their patients. Courts understand this aspect of medical practice. Breach of contract or warranty actions usually arise when a physician sells a patient on a particular operation. To prevent a plethora of unwarranted suits, many states provide that no legal action may be taken for breach of a contract to cure unless the physician's promise is in writing.

10. Products Liability for Drugs and Medical Devices

Products or strict liability (i.e., not negligence-based liability) is imposed on manufacturers, sellers, and distributors of unreasonably dangerous and defective products for injuries resulting from their use. Such liability is independent of negligence law, and a defendant's degree of care is irrelevant in lawsuits based on the concept of strict liability. However, law recognizes that every drug and device used in medical practice is potentially hazardous. Therefore manufacturers, sellers, and distributors of such products are not liable for damages if they give adequate warnings about how to avoid the risks and make their products as safe as possible.

These warnings must be given clearly, prominently, and in a timely manner, and they must be given to the proper person. Overpromotion of a product can negate the effect of otherwise adequate warnings.

Products liability is mentioned here because many medical malpractice suits also include claims for harm caused by the physician's alleged failure to inform and adequately warn the patient of a dangerous or defective product in his or her role as "learned intermediary."

Products liability reduces the plaintiff's burden of proof. It is much easier to prove that a product warning was not given or was inadequate than it is to show that a physician violated the standard of care. The plaintiff must show only that the product was defective or that the warning of its nondefective hazards was faulty and the deficiency of product or warning was a cause of the injury. Foreseeability is not required to make a case of strict liability against a defendant.

A products liability case can be brought when a defendant physician is uninsured or underinsured, and a solvent pharmaceutical house or device manufacturer may be found liable to pay a share of any judgment. Sometimes a defendant physician brings the drug manufacturer, or device company, into the suit as a "third-party defendant," requiring it to pay part or all of the plaintiff's damages, or the defendant treating physician also may be the seller of the drug or device.

11. Vicarious Liability for the Acts of Others

Physicians usually employ or supervise other less qualified health care professionals, and consequently owe their patients the duty to supervise nurses, technicians, and other subordinates properly. The duty to supervise may create vicarious liability, whereby one person may be liable for the wrongful acts or omissions of another. Several legal doctrines must be discussed in this context.

Respondeat Superior

Respondeat superior states that an employer is liable for the negligence of his or her employees. For example, if a physician's office nurse injects a drug into a patient's sciatic nerve, causing injury, that patient may sue the physician for the nurse's negligence.

Captain of the Ship Doctrine

Physicians also may be held vicariously liable for the negligence of hospital employees whom they supervise under other legal doctrines. For example, surgeons have been sued for errors and omissions by operating room personnel under the "captain of the ship" doctrine. This doctrine holds a surgeon liable based on the legal action that he or she has absolute control, much like the captain of a ship at sea who is responsible for all the wrongs perpetrated by the crew. This doctrine was intended to offer a remedy to persons injured by negligent employees of charitable hospitals, which were otherwise legally immune from suit under the doctrine of charitable immunity.

258 Medical Malpractice Overview

Borrowed Servant Doctrine

The “captain of the ship” doctrine has been largely replaced by the “borrowed servant” doctrine in such situations. This latter doctrine holds surgeons responsible for hospital employees’ negligent acts that are committed under their direct supervision and control.³

12. Negligent Referrals

Physicians frequently request consultations from other physicians, especially regarding hospitalized patients. A referring physician usually is not liable for the negligence of the specialist. However, the referring physician may be liable for the specialist’s misdeeds if each physician assumes that the other will provide certain care that is omitted by both or if they neglect a common duty (e.g., postoperative care).⁴

Physicians cannot attend or be available to all patients at all times. They have the duty to provide another physician to care for their patients when they cannot. Just as physicians generally are not liable for consultants’ malpractice, they need not answer for care provided by other physicians who cover their practice. Exceptions include the use of covering physicians who are also partners and the negligent selection of covering physicians.

13. False Imprisonment

False imprisonment is a tort that protects an individual from restraint of movement. False imprisonment may occur if an individual is restrained against his or her will in any confined space or area. The plaintiff is entitled to compensation for loss of time, for any inconvenience suffered, for physical or emotional harm, and for related expenses. A physician holding a patient against his or her will, in absence of a court order, could be held liable for false imprisonment. Such situations arise in cases involving involuntary commitment of a patient with a mental disorder, where a patient is held without compliance with laws governing civil commitments.

14. Defamation

A statement is defamatory if it impeaches a person’s integrity, virtue, human decency, respect for others, or reputation and lowers that person in the esteem of the community or deters third parties from dealing with that person. A defamatory statement can be made either in writing, which is called libel, or in verbal communication, which is called slander. In general, truth is an absolute defense to defamation. Some jurisdictions have a rule that a statement that is substantially true, when published with good motives and justifiable ends, shall be a sufficient defense, even though it may not be literally true. For example, if a physician states publicly that a nursing home has 50 complaints against it and there were only 30, the statement likely would not be held defamatory.

15. Failure to Warn or Control

The failure of a physician to warn the patient or a third party of a foreseeable risk is a separate and distinct negligent act.⁵ A physician’s duty of care includes the duty to identify

reasonably foreseeable harm resulting from treatment and, if possible, to prevent it. It is increasingly recognized that a physician has the responsibility to warn patients of dangers involved in their care. Failure to advise the patient of known, reasonably foreseeable dangers leaves the physician open to liability for harm the patient suffers and injuries that patient may cause to third parties.

The courts have imposed on a physician the duty to warn when medications with potentially dangerous side effects are administered. If an administered drug might affect a patient’s functional abilities (such as ambulation), the physician is obliged to explain the hazard to the patient or to someone who can control the patient’s movements (e.g., family members or others who can reasonably be expected to have contact with the patient). The same duty is owed to patients engaged in any activity that may be hazardous, such as driving a car or operating machinery.⁶ Similarly, when a physician learns that a patient has or may have a medical condition with dangerous propensities that may impair the patient’s control of his or her activities, the physician has a duty to warn the proper persons, such as the patient’s family members or others in contact with the patient. This duty to warn may apply whether the condition is completely diagnosed or is still under study.

In a number of cases, physicians have been held liable to injured third parties for failure to warn them of the potentially dangerous mental condition of a patient. Similarly, patients’ next of kin have successfully sued after the patients committed suicide, which could have been foreseen and potentially prevented by a physician.

The duty of the physician to warn has generally been narrowly construed in non-mental-health cases.⁷

16. Negligent Infliction of Emotional Distress

Some courts have recognized negligent infliction of emotional distress as an independent cause of action in which a patient’s harm was caused or aggravated by the patient’s reasonable fear for his or her own physical safety. Presently, third parties, such as the next of kin or bystanders to someone else’s injury, are also regarded as having a cognizable claim.

An action for wrongful infliction of mental distress may be based on either intentional or negligent misconduct. The action will not lie for mere insults, indignities, threats, or annoyances.

17. Outrage

The courts have been imposing an additional liability for the tort of “outrage.” As applied to health care providers, “outrage” is an extension of the doctrine of strict liability, i.e., liability without the proof of negligence. The tort of outrage involves deliberate infliction of mental suffering on another, without physical injury. The aggrieved party may be either the actual victim, or merely a third party affected only indirectly.

There are four elements to outrage:

1. The wrongdoer’s conduct was intentional or reckless; that is, the wrongdoer deliberately caused emotional distress in a given individual, or the wrongdoer knew—or should

have known—that emotional distress would be a likely result of his or her action.

2. The conduct was outrageous and intolerable, offending the generally accepted standards of decency and morality. This requirement serves to limit frivolous “outrage” suits and avoids litigation in situations where only bad manners, unpleasantness, or hurt feelings are involved.
3. There was a causal connection between the wrongdoer’s action and the emotional distress.
4. The emotional distress was severe.

18. Failure to Report

Every jurisdiction has a list of diseases that must be reported to the authorities. The physician’s failure to conform to the statutory requirement may make him or her liable for criminal penalties. Failure to report also has been held to be negligence *per se* (not requiring proof of negligence) in civil suits brought by injured patients or third parties. Statutes in many states require physicians to report battered children and abused elderly patients to the proper authorities. The physician is generally exempt from any civil or criminal liability for making a report pursuant to the terms of the statute. If the physician fails to report such abuse, he or she may be held liable to any individual who is damaged by this failure.

19. Fraud and Misrepresentation (Deceit)

Fraud and misrepresentation are intentional torts that involve deceit. They have sufficiently common features and are treated collectively in this discussion. A showing of deceit requires proof of all of the following:

1. The defendant knowingly made a false representation.
2. The false representation was made in order to benefit the person making the representation or to cause harm to another person.
3. The plaintiff relied on the misrepresentation as true.
4. The plaintiff was injured as a result of his or her reliance.

Fraud and misrepresentation can be applied to the practice of medicine; for example, a physician who left a foreign body in a patient during an earlier procedure but fails to tell the patient the real cause of complications or symptoms. The patient’s consent for the second surgical procedure is obtained on a false basis. This constitutes fraud or misrepresentation. In such a case, expert medical testimony is not required. Furthermore, most professional liability insurance carriers will not provide defense counsel or reimbursement for damages to a physician in this situation except under a reservation of right. Punitive damages may be awarded as well.

20. Loss of Consortium

Courts are increasingly recognizing a physician’s liability to third parties when the physician’s negligence results in emotional injuries and damages as an isolated phenomenon or as a consequence of or in conjunction with physical injury. *Consortium* is that conjugal fellowship of husband

and wife, and the right of each to the company, cooperation, affection, and aid of the other in every conjugal relation. Because all family members suffer emotional injury when one is injured, damages for loss of consortium are being awarded to husbands, wives, certain unmarried partners, parents, and children.

Loss of consortium includes loss of services, and loss of companionship, security, society, aid, comfort, love, affection, solace, and guidance.

MEDICAL MALPRACTICE DEFENSES

The physician’s defense theories against the plaintiff’s claims alleging medical malpractice are listed in Table 25-2.

1. Absence of One of the Four Essentials Elements of Negligence

A defendant physician can defeat a negligence claim by showing the absence of one or more of the requisite elements of medical negligence.

Absence of Duty

Where there is no duty owed to the patient by the physician, a negligence claim generally fails. If a physician can show that no physician–patient relationship exists, this “no duty” defense may suffice to defeat the plaintiff’s action.

Physicians generally have no duty to treat new patients or patients of years past, with some exceptions. This may be true even where the physician is “on call.”⁸ In some cases, even though a physician treats or diagnoses a condition, a duty exists only between the physician and the patient’s

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| <ol style="list-style-type: none"> 1. Absence of one of the four essential elements of negligence: <ol style="list-style-type: none"> (i) Absence of duty (ii) No breach of duty (iii) Lack of causation (iv) No damages 2. Good Samaritan laws 3. Agreement with patient to exempt health care provider from liability 4. Statutes of limitations: failure to file a malpractice claim in a timely manner <ol style="list-style-type: none"> (i) Standard rules (ii) Discovery rules (iii) Fraudulent concealment rule (iv) Continuing treatment rule 5. Arbitration agreement 6. Federal and state institutional immunity 7. Charitable immunity 8. Assumption of the risk 9. Contributory and comparative negligence 10. Last clear chance and avoidable consequences 11. Prior and subsequent negligent physicians 12. Satisfaction and release 13. Exculpatory agreements and indemnification contracts 14. Settlement of malpractice claim |
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Table 25-2 Defenses to a claim of medical malpractice

260 Medical Malpractice Overview

employer (e.g., in certain occupational settings in which a physician, such as a plant physician, is employed).

Courts rarely hold that the “no duty” defense applies and have even held that a simple telephone consultation between a physician and emergency department personnel may be sufficient to create a professional relationship between the physician and patient, with the attendant requirements to comply with such duty.⁹ Pre-certification review of a case may also create the potential for liability.¹⁰

A physician who wishes to withdraw from the care of certain patients, plans to relocate his or her practice, or simply retires must notify affected patients in a manner in which an ordinary and reasonably prudent physician would do so in the same circumstances. Such notice is best made in writing and mailed postage paid to the patient’s last known address. All patients receiving ongoing care for potentially serious ailments should be notified by certified mail, return receipt requested, at the last known address. Such patients should be informed that their physician will continue to see them for emergencies during a certain fixed and reasonable period of time. The physician may recommend a successor physician, provide a list of suitable physicians, or offer to forward records or copies of records (at reasonable or no cost) to another physician chosen by the patient.

In practice, when a physician retires or moves and sells his or her practice to a succeeding health care provider, patients’ records are often sold as part of the transaction. However, physicians should be warned that many states have medical record retention acts, and these acts usually do not provide an exception for record-keeping requirements even in such a transfer.

No Breach of Duty (Compliance with the Standard of Care)

The defendant physician must controvert the second element of the plaintiff’s proof of negligence—breach of the standard of care. Because the plaintiff has the burden of proof, if all expert testimony and other evidence are equally balanced, the defendant physician will prevail. Because the rules of evidence generally prevent nonphysicians from testifying about the medical standard of care, the physician should attempt to prove compliance with the standard of care through the testimony of a credible medical expert. Because the jury or the trier of fact usually considers treating physicians (other than the defendant) credible, both the plaintiff patient and the defendant physician may seek to recruit one of the treating physicians to give supportive testimony. In practice, especially in past years, nondefendant treating physicians were often reluctant to appear, particularly if they received referrals from the defendant physician or were otherwise socially or professionally connected with him or her. For this reason, physicians engaged to testify for the plaintiff often are nontreating physicians who have no personal connection with the parties.

Other sources of evidence, in addition to expert testimony, include medical textbooks and other published medical data. The admissibility of such evidence as proof of the standard of care varies among jurisdictions. Medical texts or treatises may be effectively used to cross-examine the adverse

medical expert; such cross-examination is accomplished by framing a proposition in the exact language used by the author of the medical text and asking if the witness agrees or disagrees. In such a situation, of course, the text must first be endorsed as being authoritative and relevant to the issue under consideration. Medical negligence cases tried in federal court, under the Federal Rules of Evidence, allow statements from authoritative texts or medical journals to be read directly into evidence.

The defendant physician is not necessarily held to a standard of care advocated by the patient’s medical experts. If there are alternative methods of diagnosis or treatment and a substantial minority of physicians agree with such alternatives, the physician may not be found negligent for using such alternatives, even though the majority of physicians do not adhere to such an alternative.¹¹ In other words, employing a different method of diagnosis or treatment from that commonly used is not by itself evidence of a violation of the standard of care, especially if a “substantial minority” of “respected” physicians would have acted similarly under similar circumstances.

Lack of Causation

The plaintiff cannot recover damages from a defendant physician unless the physician’s malpractice caused the plaintiff’s injuries. Under most theories of recovery, a plaintiff is required to prove that such malpractice was the actual cause-in-fact of injuries and that those damages were reasonably foreseeable. This element frequently affords an adequate defense for the physician, particularly in cases involving the misdiagnosis of cancer.

Traditionally the patient cannot be compensated for a delay in diagnosis and treatment if the delay did not materially affect the outcome of the disease. For example, a minimal delay in the diagnosis of a fatal high-grade malignancy may not have made a difference in the patient’s outcome and therefore would not be compensable. In other words, death would have ensued despite earlier diagnosis and treatment. Jurisdictions following this traditional approach hold that in such a situation a plaintiff cannot recover any damages unless he or she can prove that there was a greater than 50% chance of survival if the diagnosis had been made earlier and treatment had been timely.

Recently a growing trend has been to allow recovery for “loss of a chance” of a cure or improved outcome, which was described above. Thus some jurisdictions allow a plaintiff’s case to reach the jury even if the patient did not have a greater than 50% chance of survival or improved outcome in the absence of the physician’s negligence. This “loss of a chance” doctrine, when applied by these courts using a “relaxed causation” or “substantial reduction” standard, focuses on the degree to which the defendant physician “cost” the plaintiff access to an improved chance of survival or recovery. The measure of damages is based on the portion of harm suffered by the patient as a result of the delay. The physician’s defense is to controvert or minimize, through expert testimony, the percentage allocated to his or her delayed diagnosis.

Some jurisdictions no longer require plaintiffs to show that they have already suffered an actual loss because of a

delay in diagnosis and treatment but require only some potential loss. In these jurisdictions the lost chance is viewed as a separate form of compensable injury. The focus is not on the ultimate physical harm but rather on the increased risk of harm because of the lost opportunity. In such “separate injury” jurisdictions the lower burden of proof allows the plaintiff recovery even if the plaintiff has been treated and is apparently healthy at the time of trial.

No Damages

The prevention or reduction of awarded damages is the defendant’s primary goal in a lawsuit. To recover a monetary award, a plaintiff must introduce testimony and other evidence of damages, which often is difficult. In some cases the patient receives insurance or government benefits to cover expenses. In states that have eliminated the “collateral source” rule, evidence of such payment may reduce or obviate monetary damages.

2. Good Samaritan Laws

Under certain circumstances, where a physician who happens to be present, or is readily available, renders emergency service where he or she has no legal obligation to do so, the Good Samaritan laws of most jurisdictions protect the physician even if negligent. For example, Good Samaritan laws protect the physician who renders medical care to emergencies that take place in areas outside the health care setting, such as in an airplane, at the scene of a car accident, in a restaurant, and other public places. Sometimes, the rendering of medical care to emergencies inside a health care facility by a physician who is not responsible for the individual may also be covered under the Good Samaritan laws. Presently, many Good Samaritan laws specify guidelines where malpractice claims of ordinary, but not gross, negligence may be dismissed before reaching the jury.

3. Agreement with Patient to Exempt Health Care Provider from Liability

A physician or an institution may attempt to enter into an agreement with a patient whereby the medical services will be offered at a reduced price to the patient in consideration of exempting the health care provider from liability for ordinary negligence. The limitation of liability for negligence by contract is referred to as an exculpatory clause, and it has been utilized, for example, in a charitable research hospital. Such an agreement has uniformly been held *unenforceable in medical malpractice cases*, being contrary to public policy.

4. Statutes of Limitations: Failure to File a Malpractice Claim in a Timely Manner

Standard Rules

The statute of limitations (or repose) is that period of time during which a plaintiff can bring a malpractice action

against a physician, which varies depending upon the circumstances of the case. In general, that period of time is governed by state statutes and may be limited to two years. However, the statutes of limitations may be extended for patients who cannot discover the misdiagnosis in time, for those with legal disability, and for children. For example, in Wisconsin, a five-year statute of limitations (repose) was held unconstitutional where the patient (child) did not discover the misdiagnosis until four years following the expiration of the limitations period.¹²

The statutory period of limitation commences when the malpractice cause of action accrues, that is, when the allegedly negligent act occurs, or when the allegedly negligent act results in injury or damage, depending on the jurisdiction. In some jurisdictions a mere misdiagnosis, without injury or damage, may not trigger the statute of limitations; the latter is triggered by the injurious result of the misdiagnosis.¹³

In the case of minors and the disabled, courts have interpreted conflicting state statutes of limitations by considering the constitutional issues that the malpractice case may raise.¹⁴

The statutory period of limitation may be modified by other state statutes, for example, to allow for administrative reviews of malpractice claims by a State Department of Insurance prior to commencement of the malpractice lawsuit.

Discovery Rules

A major exception to seemingly rigid statutes of limitation is the so-called “discovery rule.” Some medical injuries may not be discoverable by the patient during the period applicable to the statute of limitations, because an injured patient may be unaware of the injury or may not be able to reasonably associate injury with an act or omission of the physician. Additionally, in some jurisdictions, a plaintiff must first obtain favorable expert medical testimony that negligence has occurred before filing a malpractice lawsuit.

Simply stated, the “discovery rule” allows the injured patient to file a malpractice action within a specified period of time from the date that the injury is actually discovered, or should have been discovered, if the injured has exercised reasonable diligence. Virtually all jurisdictions recognize the “discovery rule” as an exception to the statutes of limitation. Many jurisdictions apply the discovery rule only to situations where the injury is inherently unknowable, or to malpractice actions where a foreign body is left in the patient postoperatively, such as sponge-in cases.

The “discovery rule” is further subdivided into pure and hybrid. Pure discovery rules permit a malpractice claim to be brought in some states for an indefinite period of time, so long as the injury has not been discovered, or reasonably should not have been discovered. Some states follow the hybrid discovery rule, which states that the discovery of the injury triggers the running of the statute of limitation, although an ultimate cap or limit is placed upon the time within which discovery must occur.

Fraudulent Concealment Rule

There are other situations that toll the statute of limitations, thereby extending the time for bringing a malpractice action.

262 Medical Malpractice Overview

If a physician is found to have “knowingly concealed” a negligent act or omission, i.e., fraudulent concealment, the statute of limitations may be tolled. The statutory period of time to file a complaint begins when the plaintiff “should have known” about the negligent act or omission.

Continuing Treatment Rule

Another situation arises where patient treatment continues for a period of time, during which it is difficult to ascertain when the negligence occurred. Some jurisdictions have adopted a “continuing treatment” rule to determine the time of injury for purposes of the statute of limitations. The continuing treatment rule provides another exception to the statute of limitations by extending the time allowed for the filing of a complaint. The malpractice action would only accrue, thus activating the statute of limitations, when treatment of the medical condition ceases.

The tolling of the statute of limitations has been the subject of legislative reform in a number of jurisdictions, and several reform measures have been initiated to provide clarification of the discovery rule.

5. Arbitration Agreement

A physician or an institution may privately, or pursuant to legislation, enter into an agreement with a patient to arbitrate a medical malpractice claim. The purpose of the agreement is to avoid litigation, and *not* to avoid liability. Arbitration is merely an alternative to a full-blown litigation. An agreement to arbitrate a medical malpractice claim, particularly one that follows statutory procedure, is generally enforceable because it does not violate due process and is constitutional. If an agreement to arbitrate is accepted by the parties, basic requirements of due process must be met, and there must be a fair composition of the tribunal or arbiters.

6. Federal and State Institutional Immunity

The Eleventh Amendment of the United States Constitution prohibits an individual from bringing a private claim against the state. Hence medical care facilities, which are providing health care by state or federal government, were historically immune from liability, based on governmental immunity. More recently, federal and state governmental immunity has been substantially eroded.

In 1946, the federal government enacted the Federal Torts Claim Act, which permits an individual to sue the federal government for most torts, including medical malpractice. The limits of liability are \$100,000.

Similarly, state government immunity has seen erosion in modern times. A state hospital may not be sued for negligent acts by its employees, which are considered discretionary tasks, as opposed to ministerial tasks. A discretionary task involves a decision about what medical care is needed. In contrast, a ministerial task by a state hospital employee is the act of actually carrying out the discretionary decision. If a jury finds that the task performed by

the state hospital employee is a discretionary decision, then the hospital would be protected by the state governmental immunity. On the other hand, if the act performed by the state hospital employee is ministerial, the hospital would not be protected by the state government immunity.

The military and other federal employees may not be permitted to sue the government for service-related injuries. Military physicians are granted immunity from prosecution for medical malpractice under the Military Medical Malpractice Statute. The Federal Employee Compensation Act does not allow relief under the Federal Torts Claim Act. Instead, most military and federal employees are entitled to various administrative benefits for personal injuries.

7. Charitable Immunity

Historically, charitable institutions were afforded either absolute or qualified immunity from liability for acts of negligence. The doctrine of charitable immunity was applicable to nonprofit charitable institutions, whose financial resources were limited, and because such institutions provided medical care for all regardless of the ability to pay.

More recently, the doctrine of charitable immunity has been abrogated in a number of states, because of the recognition that injured patients should be compensated for breach of standards of due care. In 27 states, charitable immunity has been totally abrogated. Some states have placed limits on liability of hospitals and other charitable organizations to \$20,000 or less per occurrence, thereby retaining charitable community beyond those limits.

Some states have abrogated charitable immunity in medical malpractice cases, which involve reckless disregard of the patient’s rights, wanton or willful misconduct, or gross negligence.

8. Assumption of the Risk

Before a physician subjects the patient to a diagnostic or therapeutic procedure, the patient is informed about the risks of the procedure. If the informed patient chooses to proceed with knowledge of the risks, that patient may assume the responsibility for a resultant adverse outcome. Emphasis is placed on what the patient actually knew. If the patient knew that a certain risk was associated with a medical procedure, and he or she willingly submitted to that procedure, the patient will not be permitted to file a malpractice lawsuit for any injury that resulted from the known risk.

The patient may *expressly* assume the risk of a medical procedure or treatment, for example, by signing a consent form, which clearly indicates that the patient had knowledge of the risk, understood and appreciated the nature of the risk, and voluntarily elected to incur that risk. Under certain circumstances, assumption of the risk may be *implied*.

Nontraditional experimental therapies may constitute an inherent risk, unless the treatment was negligently selected. An informed patient who chooses nonconventional experimental treatment, in lieu of traditional medical treatment, might be assuming the risk of aggravating his or her medical condition.

9. Contributory and Comparative Negligence

The patient who contributes to his or her own injury may either be precluded from recovery of damages, or may not recover fully, for the injuries from an alleged negligent physician. Some states follow the traditional doctrine of *contributory* negligence, which requires the plaintiff to be free of any fault or negligence, in order to recover damages.

Other states follow the doctrine of *comparative* negligence, where the fault or negligence by the plaintiff operates to decrease the plaintiff's damages, based on the percentage of fault by the parties. The defendant physician may also prove comparative negligence against other physician(s) who may have subsequently treated the patient in a negligent manner.

10. Last Clear Chance and Avoidable Consequences

A patient, who is not responsible for his or her injury, may have some opportunity to either avoid or mitigate the damages resulting from the injury, based on the doctrine of avoidable consequences or the doctrine of last clear chance. These two doctrines are applied after the negligent act has caused the harm. Thus the plaintiff may not recover the damages that he or she could have avoided or mitigated.

11. Prior and Subsequent Negligent Physicians

There are situations where one physician causes an injury to the patient, who then goes to another physician and sustains an aggravation of the same injury. An alleged negligent physician may also be liable for aggravating injuries caused by a subsequent negligent physician. However, the court may choose to apportion the percentage of fault and damages by the defendants.

12. Satisfaction and Release

Satisfaction simply means that the injured person has received full compensation by someone for the injury that he or she sustained. *Release*, on the other hand, is the surrender of the cause of action, which is the basis of a lawsuit, regardless of whether the injured has received *satisfaction* or not.

Traditionally at common law, where there are multiple defendants, for example an individual who was injured in a motor vehicle accident and who sues the auto insurance company, the hospital, and the treating physicians, a *release* of one of the joint defendants releases all of them. Thus, an express settlement with the auto insurance company for all injuries sustained constitutes a *release*. Consequently, to avoid unjust enrichment by the plaintiff, a malpractice action against the hospital or doctors is no longer permitted.

Many states have modified by statutes the common law interpretation of *release*. Under the Uniform Contribution Among Tortfeasors Act, the release of one defendant does

not automatically release all. Instead, the defendant would only be released from liability *if the release so provides*. Thus a general release may not be adequate to relieve all defendants. The release should be more specific and preferably inclusive of all parties concerned.

In the absence of a release, subsequent claims against other defendants would, under applicable statutes, be set off by the amount of damages that had been received by the plaintiff.

13. Exculpatory Agreements and Indemnification Contracts

Exculpatory agreements between physicians and patients appear to relieve the physician of liability for negligence. Although such contracts occasionally are upheld in other theories of liability, they are consistently struck down in the medical malpractice context. The rationale for not acknowledging such agreements is simply that they are contracts of adhesion. The fact that an ill patient is not in a position to negotiate terms or to reach a fair meeting of the minds, which is essential for binding contract equity, dictates such an approach.

Contracts of indemnification usually arise between physicians and other individuals or institutions. For example, a hospital may agree to pay (indemnify) any damages incurred by the president of its medical staff for any liability resulting from carrying out the duties of that office.

Conversely, the chief of anesthesiology may agree to indemnify the hospital for any malpractice damages arising from the operation of the department, if no hospital employee is found to be negligent. Both types of contracts are generally upheld and effectively transfer enormous financial burdens from one party to another. Although such agreements often are represented as standard terms in an employment contract, they must be considered carefully.

14. Settlement of Malpractice Claim

Practical aspects of defending any particular malpractice claim dictate the need for consultation with counsel and the malpractice insurer. In most cases a malpractice insurer provides counsel under the policy to defend the claim. Although a physician may believe that the best time to settle a malpractice claim (from his or her point of view) is at the time such a claim occurs, procedural matters and substantive matters must be considered, and the physician's personal legal counsel may be able to give the best advice on this point.

The physician should contact his or her professional liability carrier as soon as there is even a suggestion of a potential claim and ask for a representative to handle the matter. The physician should always insist that an attorney rather than a claims adjuster handle the matter, even if the physician is willing to admit fault. Private legal counsel should be retained to handle potential liability not covered by the policy or to advise the physician regarding negotiating a settlement in the course of the litigation. This advice is particularly important because the Health Care Quality

264 Medical Malpractice Overview

Improvement Act of 1986 requires that the settlement of any medical malpractice claim for any amount in excess of \$1 be reported.¹⁵ In practice, negotiation and settlement of a medical malpractice claim rarely occur before the phase of formal discovery procedures, which take place during the months between the filing of the suit and the scheduled trial.

Endnotes

1. 509 U.S. 579 (1993).
2. *Grimsby v. Samson*, 85 Wash. 2d 52; 530 P. 2d 291 (1975).
3. *Lewis v. Physician's Ins. of Wisconsin*, 627 N.W. 2d 484 (2001).
4. *Craig v. Murphree*, 35 Fed. Appx. 765 (10th Cir., 2002).
5. *Weitz v. Lovelace Health Systems*, 214 F. 3d 1175 (10th Cir. N.M., 2000).
6. *Cram v. Howell*, 680 N.E. 2d 1096 (1997).
7. *Martinez v. Lewis*, 969 P. 2d 213 (Colo., 1999).
8. *Anderson v. Houser*, 523 S.E. 2d 342 (Ga. App. 1999).
9. *Diggs v. Arizona Cardiologists Ltd.*, 8 P. 3d 386 (Ariz. Ct. App. 2000).
10. *Fulton-Dekalb Hosp. Authority v. Dawson*, 270 Ga. 376, 509 S.E. 2d 28 (1998).
11. *Perez v. U.S.*, 85 F. Supp. 2d 220 (S.D.N.Y., 1999).
12. *Makos v. Wisconsin Masons Health Care Fund*, 211 Wis. 2d 41, 564 N.W. 2d 662 (Wis. 1997).
13. *Paul v. Skemp*, 242 Wis. 2d 507, 625 N.W. 2d 860 (Wis. 2001).
14. *Chaffin v. Nicosia*, 261 Ind. 698, 310 N.E. 2d 867 (Ind. 1974).
15. 42 U.S.C. §§11101 et seq. (1986).