Paparella: Volume IV: Plastic and Reconstructive Surgery and Interrelated Disciplines

Section 2: Disciplines Closely Associated With Otolaryngology

Chapter 28: Professional Liability

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When the great text *The History of US Medicine in the Twentieth Century* is written, where will be chapters on the discovery of antibiotics, human organ transplantation, bionic organ transplantation, and other great technologic advances. Unfortunately, there will also be long chapters on professional liability, the breakdown of the physician-patient relationship, and structural changes in American medicine.

> *Few issues in medicine have generated as much concern among physicians, exacted such high personal and financial tolls from them, or threatened to undermine the practice of high quality medicine as greatly as has the issue of professional liability.*

Although resident physicians learning their skill tend to be insulated from the winds of professional liability that swirl about them, their day-to-day activity regularly exposed them, their hospitals, and attending physicians to the possibility of suit. We are concerned that in the 1990s it will not be enough to teach our residents just Otolaryngology and Head and Neck Medicine and Surgery. Preparation for practice must now include a distinct awareness of the risks and consequences of patient care.

> *Some insurers and lawyers have tried to reassure physicians that being sued is just "the cost of doing business" in today's world. Doctors are told that they are providing a product and that the laws of negligence are not that far removed from those of product liability. Just as General Motors must take responsibility for the automobiles it provides society, so doctors must assume responsibility for the products they provide - health care ...*
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> *Some physicians have been able to adopt this mindset, have adapted to perceiving the work they do as a business, and, consequently, protect themselves from experiencing the threat and/or actuality of litigation as a personal affront.*

Those who have "achieved" this approach may very well be those who are perceived by their patients as being aloof and noncaring.

> *The tragic irony here is that because the doctor-patient relationship is at the core of medical practice, there is no protection from the hurt that litigation generates. Given the fact that most doctors become physicians because they "want to help people", they find that efforts to change their basic orientation toward their profession are unappealing, untenable, and, in most instances, unattainable.*

For these physicians, patient harm is personally felt and personally hurts. These physicians cannot accept a lawsuit for malpractice as "the cost of doing business". Already pained by adverse result of their care, they find it especially demoralizing and frustrating to have thrust upon them a legal document accusing them of malpractice. It is for these still idealistic physicians that this chapter is written. The hope is that they may be provided with both knowledge and tools to cope more effectively with the reality of professional legal liability.

Costs

It is ironic that as today's young resident physician contemplates entering the world of private practice, the older physician has been increasingly responding to the spiraling costs and pressures of practice by moving to other states, abandoning higher risk procedures, striking, and retiring earlier. Medical practice brokers have never been busier. Prospects are opening up; prospects for what? remains the big question.

To place costs of malpractice coverage in perspective, I can cite my own experience between 1963 and 1990. When I began my medical practice in 1963, a telephone cost a nickel, a New York City subway ride 15 c, and my office rent $400 a month; and my malpractice insurance cost $525 per year for the required amount of $100.000 in liability coverage. In 27 years the cost of the phone call has gone up 500 per cent, the subway ride 700 per cent, the monthly office rent for the same space 700 per cent; but the cost for the now basic minimum of $1 million of malpractice insurance has increased 50-fold!

No state or region appears to be immune to skyrocketing costs: North Carolina's obstetricians experienced a 547 per cent premium increase between 1980 and 1986, and in Indiana, where tort reform in 1975 had created a relative "haven", there was a 92 per cent increase in frequency of claims against MDs between 1980 and 1984. Malpractice settlements industry-wide in Michigan rose from $7.9 million in 1975 to $122 million in 1985, an increase of 1500 per cent or 33 per cent per year!

Who's to Blame?

If today's resident faces astronomical and intimidating malpractice premiums in the first years of private practice, he or she needs and deserves some answers to the questions "why?" and "who's to blame?".

If the medical profession fails either in training programs or in private or hospital practice to weed out its incompetents, it is to blame. If plaintiff's attorneys encourage litigation without first investigating, they are to blame. If defense attorneys delay settlements in order to prolong the process and increase their fees, they are to blame. If the public sees every medical complication as a potential gold mine, it is to blame. If juries attempt to punish doctors rather than justly compensate the injured, they are to blame. If hospitals fail to exercise good risk management, if witnesses testify for money rather than truth, if people equate technology with perfection, if attorneys buy "experts" or take cases for "nuisance value" and not for merit, they all are to blame. And if, as Consumer Reports has charged, the insurance industry has manufactured the liability crisis to cover up years of mismanagement and greed and has orchestrated the country-wide campaign for meaningful tort reform in order

to protect its profits, it is very much to blame.

Future

Imaginative attorneys seem to have little difficulty in introducing new and novel theories of liability. The past decade has seen the emergence of the concepts of wrongful birth (the birth of a child after a supposed sterilization procedure), wrongful life (the birth of a child with genetic defects that could have been foretold), and wrongful death (the suicide of a patient under psychiatric care).

New technologies, new treatments, and even new diseases undoubtedly will bring both new responsibilities and liabilities. At the moment the brightest prospect for plaintiff attorneys is the wide-open frontier of "lesser levels of care". The proliferation of contract care plans (HMOs, IPAs, PPOs) with their gatekeeper systems (often controlled by the medically untrained), together with DRGs (diagnosis-related groups) and other government- and industry-inspired schemes to slash medical costs, will significantly raise the liability risk for the doctor who is under increasing pressure to test less and to discharge earlier. It is not likely that courts or juries will differentiate between adverse results due to mandated cost cutting and those due to physician error.

> *Somehow we must find some reasonable ways to resolve legitimate claims equitably, to discourage claims without merit, and to minimize the possibility that a patient will be harmed in the process of receiving medical care. The ultimate solutions must be ones that not only physicians and hospitals but society can afford, since ultimately it is the public that absorbs these growing costs.*

Maloccurrence and Malpractice

In most medical malpractice trials the defense attorney will ask the plaintiff's expert: "Now doctor, you'll agree, won't you, that just because there's a poor result of medical or surgical care, it doesn't mean that the doctor was negligent, does it?" Of course, the answer is "No" and the time of summary, this attorney will tell the jury: "You heard plaintiff's expert admit that a bad result does not mean there was malpractice!".

Maloccurrence means a bad result or bad outcome and when we discuss risks with patients we are basically talking about the known and unavoidable complications of treatment, what in other enterprises would be called "tough luck". When the injured patient is able to show that the complication was avoidable, were it not for the provider's negligence, we have the essence of malpractice.

Malpractice is simply defined as a departure from accepted standards of care that causes an injury. This definition promptly raises three issues: standards of care, causation, and injury, and all have to be explored at a trial before a jury can conclude that the defendant did or did not commit malpractice. For example, a jury might find that the physician was negligent (did depart from accepted standards of care) and that there was an injury, but that there was no relationship between the two. This is not an infrequent verdict in tumor cases in which the claim is that the defendant failed to make a timely diagnosis. The plaintiff must

also claim and prove injuries as a result of the missed diagnosis. If the defendant can show that the surgical procedure and its complications would have been the same with an earlier diagnosis, a jury can correctly find that there was no causation and thus no malpractice.

Another situation that may result in a verdict for the defendant is one in which the jury finds that the doctor departed from accepted standards of care, but is unimpressed with the claimed injuries. In an illustrative case tried in a rural Eastern Court, the jury agreed that the doctor should have operated on an 8-year-old's chronic ear a year earlier, obviating a large constant-care cavity. There was no demonstrably greater hearing loss, regardless, and the jury was not sympathetic with the claims that the child would require lifetime ear care and would need special swimming precautions. Departures, yes - injuries, no: no damages were awarded.

Standards of Care

> *In most states, a physician's care is expected to measure up to "standards", but often standards are nebulous or not relevant, or even non-existent. How, for example, can the soon-to-retire senior physician possibly pursue the same standards of technical care as last year's chief resident, or how can that resident measure up to the senior physician's professional maturity in his "standard of carefulness"?*

Neither can, of course, but we should recognize that there are varying proportions of technical care and prudent carefulness that will protect patients and keep physicians out of trouble. In the extreme, if a physician has little technical skill, recognizes this lack, and refers patients requiring this skill, his prudent standard of carefulness should be more protective than if he possesses unrivaled skill but uses it with abandon.

Local or community standards of care, long a staple in court, have rapidly vanished to be replaced by national standards. It is expected by the public, the courts, and the legislatures that a specialist is crossfertilized in his training, reading, and meetings and courses. An attorney cannot with impunity ask an out-of-state "big city" expert: "Doctor, are you familiar with standards of care that ENT specialists practice here in Backwoods Falls?". One should at the same time appreciate that the traditional "standard of care" was once interpreted as "what is", while today society is moving toward "what should be". As an example, the law of the State of Washington, as it defines an applicable standard for determination of negligence in medical malpractice cases, appears to be "of the time". It says:

> *Any conduct (including non-action) which deviates from an assumed normative standard of carefulness. The term carefulness more closely approaches the reasonable prudent person/prudent physician standard than does the word care which indicates only the current and usual practice standard. And the Washington Supreme Court has taken the law a large step further by stating: "It is the standard of carefulness of the reasonably prudent health provider as judged by the jury which supervenes".*

At trial, the issues of standards of care and carefulness are often quite tricky. The plaintiff usually has two burdens of proof. First, he or she must produce evidence to show that there is a standard of care that a reasonable and prudent member of the medical

profession (or similar specialist) would have employed under the same or similar circumstances. Second, the plaintiff must show that the defendant breached this standard of care. As these "proofs" usually are obtained through expert testimony, with two sides in dispute, one can be sure that there will be testimony in opposition. The jury will weigh the credentials (experience, writings, appointments) of the conflicting experts; their evidence and cited authorities; their credibility, honesty, and personality; and other less defined qualities in deciding which are more believable. Of course the testimony of the parties and the abilities of the opposing attorneys play a major role in the jury's deliberations, but when it comes to standards of care and carefulness, or injuries, or causation, it is the experts' show.

Malpractice Suits

If the basic cause of medical malpractice claims is patient injury, real or imagined, the usual catalyst is a breakdown in communication between physician and patient. As the number of significant patient injuries is demonstrably far greater than the number of claims, it is instructive to examine those other determinants that either bring injured parties to lawyers or, conversely, keep them away.

What Brings Patients to Lawyers' Offices

Belief that the Injury was Caused by Physician or Hospital Error. Although this is usually obvious, injured patients often never suspect physician error until some chance incriminating remark is overheard or a subsequent treating doctor offers a gratuitous critique. Hospital elevators are notorious suit-breeding grounds. Patients with significant complications often latch on to and misinterpret random pieces of information not meant for their ears. On occasion, a response to a lawyer's ad in a newspaper or bus first raises a patient's curiosity about doctor error.

Resentment, Anger, or Outrage. Lawyers are free to admit that their medical clients are often angrier about their doctor's lack of courtesy and consideration than about the injury itself. "They complain that the doctor was short, uncommunicative, unfriendly, kept them waiting unmercifully and/or failed or refused to explain properly and communicate what was happening to them.

Catastrophe. Catastrophic results inevitably trigger visits to attorneys if for no other reason than that, in these situations, the patient or family needs independent expert review and this requires, at the least, subpoenaing records. It is unreasonable for surgeons to expect a family to meekly accept their explanation of why their child arrested during a T&A or why a beautiful daughter now has a paralyzed face after "routine" ear surgery. When catastrophic results mean immense medical expenses or a serious reduction in earning capacity, a suit is a foregone conclusion.

Consumerism and Consent. In the age of consumerism, people insist on playing an increasing role in their health care. Laws and courts have given them this right. When a person has made the decision to undergo a proposed form of therapy or surgery but has not been made aware, for example, that a serious voice impairment could occur after thyroid surgery, that ethmoid surgery could result in an intracranial complication, or that an ear operation could mean inability to drive, there is an acute sense of betrayal when such a

catastrophe results. Lack of informed consent is a major factor in sparking malpractice suits.

Guilt. Parents often violently disagree about surgery for a child. When has his or her way and serious complications ensue, a lawsuit may act as the cement for the marriage. Shifting blame on to the doctor may be therapeutic.

Injudicious or Excessive Billing. If patients or families are pursued by way of claim letters, collection agencies, or suits to pay for results or services they consider marginal at best, a suit is their way of fighting back. It is patently foolish to hound a patient for a few hundred dollars when there has been a problem, and then end up with a $500.000 lawsuit. Writing off the balance is more a recognition of reality than an admission of fault.

Retribution. People do see attorneys saying "I don't want the money - I just want to be sure that what happened to Mama will never happen again". Or "I owe it to my son to see that bastard sweat and squirm when I get him into court!".

Why People Don't Sue

The Golden Rule. The physician who adheres to this basic law of ethics is a less common target for suit. Injured patients will find it difficult to seek out an attorney if they believe the physician prepared them openly and fully for the complication encountered and showed genuine feelings when it did. Even in our high-speed, high-tech, consumer-oriented, and medically enlightened society, people still want and revere truthful and compassionate doctors. Despite even serious injury, such a patient might easily say "Why, I couldn't sue Dr. Jones - she *cared* for me".

Lack of Awareness. More often than can be imagined, some people are just unaware that their poor result was due to error, or even that there was a bad result. For example, the harm created by a negligent medical act or by a defective medical product may not surface until years after the doctor's services are concluded. Late complications from radiation are a prime example.

Personal Factors. Passive personality structure and religious or philosophical convictions may keep injured patients away from lawyers. Many people are afraid of lawyers and courts, and their distaste and distrust of them are prohibitive at the threshold. Some people are more accepting of pain, discomfort, and disfigurement than others.

Why Cases are Rejected

Generally, only lawyers experienced in tort and negligence trial work will consider handling medical malpractice claims. Even those lawyers will reject some prospective cases on a variety of grounds, listed below.

No Merit. If expert or in-house review clearly demonstrates no merit to the claim, the lawyer may tell the patient "You've had a bad result but we can show no improper care". If a patient relies on this advice and loses his time to sue, but the lawyer has not obtained and documented available medical expert corroboration, a suit for legal malpractice could conceivably result.

Statute of Limitations. The statute of limitations has run and the patient has lost the right to sue.

Lack of Proof. The claim may have merit but there is little likelihood of assembling proof to make out a case. A good example of this is when the involved physician is so prominent, respected, or powerful that there is no likelihood of getting an expert witness to testify. Time is a factor here, too. Stale cases are harder to put together.

Little Monetary Value. The claim may have merit but the injuries are not impressive enough. The plaintiff's attorney usually must make a significant investment of personnel, time, and money in bringing a case to trial, and under the contingency payment system may not receive his fee until years later. If the case has limited "money value", it may be turned down.

Personal Factors. Some claimants are very passive or unappealing and are deemed to be poor or unsympathetic witnesses.

Suit Prevention

Know Your Limitations and Stay Within Your Skills

I doubt that many training programs provide their senior residents with a frank analysis of their technical, intellectual, and personal strengths and weaknesses. However, who is better equipped to do this than those who run our programs? The emerging resident is well advised to push for this evaluation.

It is hard on both ego and purse for a newly trained otolaryngologist to refer a complicated case to a more experienced "senior"; it will be harder still if a serious injury occurs because he exceeded his abilities. The suit aside, staff reappointment may be at risk. Knowing one's limitations is a respected sign of maturity, and beyond that, it points one in the appropriate direction for help.

Obtain Second Opinions and Consultations

The young surgeon is well advised to offer second opinions freely to patients. Although this is becoming less of an option and more of a necessity as it relates to third party payers, patients are often embarrassed to ask for another opinion. By offering it first, the doctor conveys self-confidence, shows a willingness to be "second-guessed", and demonstrates concern for the patient's welfare.

Keep Good Records

Careful documentation of what you heard, found, thought, advised, and did is essential. Records should be *C*oncise, *L*egible, *E*ssential, and *A*ccurate *R*eporting, and CLEAR records may be all that are needed to persuade a plaintiff's attorney to drop a case. Conversely, sketchy and overwritten charts raise serious questions as to a physician's carefulness, memory, and veracity. Attorneys rarely find it difficult to convince a jury that if it is not recorded, it was not considered and was not done.

The single most important entry in an office chart is a reference to follow-up. In cases in which the claim is "failure to make a diagnosis", winning or losing may be a matter of this entry alone. Typical examples might be "Return in 2 weeks", "endoscopy if not better 1 month", "complete otoneuro ± CT if Sx persist 2 mo". These entries provide some measure of the physician's thinking and carefulness, and if the patient's failure to return leads to serious consequences, the physician will at least have a strong defense. At a trial the plaintiff's attorney will have to show that the doctor's failure to call the patient back for reexamination was the proximate cause of the injuries sustained, and this not an easy matter to prove.

When a doctor is served with papers in a lawsuit, he or she may be horrified to first discover just how abysmal the chart really is. The temptation toward "creative retrospective charting" may be heavy, but morality aside, the risks are even heavier. Unfortunately, some doctors may succumb to weakness.

When the potential damages are high enough, lawyers will hire experts in handwriting and ink and paper analysis to pin down just when an entry could have been written. If the doctor can be shown to have altered a record, the case becomes indefensible on that fact alone. Do not underestimate the power of courtroom cross-examination. All "rearrangers of the truth" are subject to crumbling on the witness stand and co-conspirators run for cover.

It is also good practice to record the essence of phone conversations, to note on the chart when and to whom copies have been sent, and to enter any missed or cancelled appointments.

Finally, good records help refresh one's own recollection. Memory alone is both unreliable and suspect years later.

Time

Take time; be on time; give time. When health is the issue, no one wants short shrift. The physician's time is wanted, needed, and paid for; good communication takes time, and communication is at the heart of the doctor-patient relationship.

Just asking the patient "Have we covered everything?" or "Any questions?" is often all that's needed to convey concern and give the patient the feeling that it was time well spent.

A young doctor needs to understand that, in private practice, a patient's time is as important as the doctor's. When patients are kept waiting for no good reason and with no good explanation, the doctor and staff are seen as arrogant or uncaring; resentment builds. Nowhere is this more apparent than in a hospital waiting area. Too often, friends and relatives are kept waiting hours on end without news ("Was it cancer?", "Did they get it all?", "Did they save Papa's voice box?") only to discover later that the doctor was on the next case, went to lunch, or left for the office. This anger and resentment will simmer and go nowhere if all goes well; if a complication occurs, watch out!

No Time for Heroes

Medical heroes tend to have the life span of a mayfly. Far too often, we see those at the leading edge of therapeutic medical science reporting in their second paper the contraindications and complications missing from their first. Following the leader may not be ego-fulfilling, but it is far safer for the patient, and incidentally the doctor, and is usually much more justifiable.

In the same vein, the doctor who talks patients into elective procedures that they do not come for is inching way out on a limb that will be chopped off the minute something goes wrong. The very same limb invites those who allow patients to talk them into a course of therapy or surgery against their good judgment.

In summary, do not be first; do not be last; cut out salesmanship, and do not be an easy mark for a persuasive patient.

Be Truthful

In medicine, as in other sciences, truth is relative and fleeting; truths of today will be the vapors and phlogistons of tomorrow, and our medical heirs may patronize us as we do our forebears. However, in dealing with others and especially those who depend on us for healing, it is not truth that is sought and needed, but truthfulness. In medical no less than in other human relationships, being truthful means being open and revealing what you know and do not know, what you have gained and where you have failed, what are the risks, and what are the rewards.

A common aphorism: "Truth will out" is balanced by another: "The truth will set you free", and both have great relevance in doctor-patient relationships. Sooner or later, people do find out what went wrong; and if they have been misled or lied to by their doctor, the resultant fury may be relieved only by a suit.

It is astounding to see, for example, how often a patient has not been told by the surgeon that the submucous resection resulted in a septal perforation or that a small piece of an instrument broke off and could not be retrieved. Most medical cover-ups are uncovered eventually, so honesty is really the best policy.

Informed Consent

> *A basic underlying theme in any discussion of informed consent is uncertainty. We doctors, individually or in groups, have no consensus as to what we ought to tell our patients, nor have the courts (case law) or the legislatures (statutes) developed a national standard of disclosure that we may refer to before embarking on a course of therapy or surgery. Although we may have developed national standards of care, the law has given us no uniform signal as to what informed consent to this care should be. As nearly every malpractice action includes a claim of lack of informed consent, and as the number of cases won or settled on this basis alone has increased significantly, it is demonstrably important that we pay serious attention to this area of*

liability.

Meaning of Consent

In 1914 the renowned Judge Cardozo, writing for the New York Court of Appeals, gave this classic statement of the consent doctrine:

> *Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. This is true, except in cases of emergency when the patient is unconscious, and where it is necessary to operate before consent can be obtained.*

This relatively simple exposition of the consent doctrine held sway until the 1950s, when courts began to develop the concept of "knowledgeable" or "informed" consent. The crucial change in the consent doctrine came about in a landmark 1972 case, *Canterbury v. Spence.* Spence was a 19-year-old who had been paralyzed after a laminectomy. The District of Columbia Circuit Court of Appeals gave this opinion:

> *True consent to what happens to oneself is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement of a reasonable divulgence by physician to patient to make such a decision possible.*

Still, up to this point, the standards for disclosure had been the medical or doctor's standard - what most doctors in the community or nationally would tell the patient under similar circumstances. The District of Columbia Circuit Court of Appeals changes this focus 180 degrees so that disclosure would be measured and determined from the patient's and not the doctor's point of view. The Court ruled:

> *That the patient's right to self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision ... All risks potentially affecting the decision must be unmasked.*

Similarly, and more recently, other courts around the country are adopting the "reasonable patient" or the "patient need" standard. The Supreme Judicial Court of Massachusetts in 1982 stated that the customary practice standard overlooks the purpose of requiring disclosure, which is protection of patients' right to decide for themselves. The Court attempted to come to some accommodation between sufficient information to decide and the almost limitless number of possible risks:

> *A physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo the proposed treatment ... Materiality may be said to be the significance that a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment.*

Under this opinion, a physician was required to evaluate the various risks, consequences, and alternatives from the perspective of the medically unsophisticated lay person. The Court was saying that physicians had to err on the side of overdisclosure when discussing a proposed treatment or procedure, or run the risk of a court action for failure to disclose.

What To Do

> *For the surgeon, at least, there is probably no more crucial part of the physician-patient relationship than the in-depth discussion of the procedure, the disclosure process as it is now interpreted. It is here that the physician reveals him- or herself and his or her honesty and depth of caring. When the physician has been open and aboveboard, an injured patient is far less prone to anger than if he has discovered that material factors had been withheld. Complications may be overlooked, lack of consideration or communication never.*

The Law Department of the American Medical Association has set forth some guidelines for obtaining informed consent. These are for the good of the patient and also serve as protection for the doctor. First, the physician should personally discuss the proposed treatment with the patient. Obtaining an informed consent is the physician's responsibility and should not ordinarily be delegated to a nurse or other person. Even if the proper information is provided, a jury is less likely to believe that the patient was adequately informed if the patient received the information from someone other than the physician and had no opportunity to ask the physician questions about the procedure. In addition, if the physician showed concern for the needs and feelings of the patient, the patient is less likely to *want* to sue if something goes wrong.

Second, the information should be presented in a manner that is intelligent to the patient. A lengthy polysyllabic discourse on all possible complications is neither helpful not in order. Rather, the nature of the procedure and the possible complications should be described as straightforwardly as possible. Some attorneys recommend that, at least for routine procedures, the patient is given a written description of the procedure to read before discussing it with the physician. Such a practice should increase the level of the patient's understanding and may allow the physician to spend less time explaining the procedure. This practice ensures that all the bases are covered each time. In any case, once the general explanation of the procedure and possible risks has been given, the physician should give the patient an opportunity to ask any questions he may have and answer such questions as fully as possible.

Third, the physician should avoid affirmatively misleading the patient by false assurances that there is "no risk", as distinguished from expressing hopefulness that the procedure will be successful.

Fourth, in situations in which, because of an emergency or for therapeutic reasons, it is not possible and is inadvisable to inform the patient, the physician should, if possible, explain the risks to someone close to the patient, such as the patient's spouse. In most cases, this is advisable, not because of any legal requirement, but because it shows that the physician is concerned for the welfare of the patient.

Finally, the physician should always make some record of conversations with the patient and of the patient's consent to treatment that can be used to refresh both parties' recollection later.

More specific requirements for obtaining informed consent may be found in the September 1982 issue of the Malpractice Reported:

1. The nature of proposed surgery.
2. The reasons for the proposed surgery.
3. The nature and extent of the substantial risks of the proposed surgery, and the likelihood that they will occur.
4. The nature and extent of the substantial risks of the alternatives, and the likelihood that they will occur.

Documentation

Despite a physician's careful adherence to the foregoing guidelines and suggestions, all may come to naught in the courtroom if there is not proper documentation of disclosure discussions. When it boils down to a dispute between the doctors' and the patients' memory of the facts, believability will win out. Therefore, it certainly behooves the physician to have adequate documentation of discussions with the patient. This documentation can simply be a note in the chart giving the date, time, and location of the conversation, and who was present. The note may be brief, but it should indicate the specific elements of the conversation, as indicated above, and it should accurately reflect the patient's reaction.

"Having one's own consent form is a preferable alternative, provided it is not unnecessarily prolix. In large print, it should include all the elements of any appropriate consent as outlined previously. Above the patient's signature, it would be advisable for the printed form to include the following three sentences: (1) I understand that this operation may result in serious complications. (2) I have read and understood everything on this consent. (3) I have discussed the proposed operation with Dr _____.

It is my hope that this discussion brings the reader to the realization that informed consent is a process, not a piece of paper.

Consent reminds the physician of the individuality of the patient, respects the patient's self-determination and ultimately affirms for both parties that the physician's authority to heal is given by the patient.

What to Do If Sued

As there are no areas of medical practice that are totally free of liability, this section addresses the lawsuit itself.

The action against the doctor starts with personal service of the Summons and Complaint.

1. *Notify your insurance company. Send the papers immediately and get a receipt.*
2. *Review all records.*
3. *Make no changes.*
4. *Avoid any contact with the plaintiff or the plaintiff's attorney.*

You will be asked to provide your carrier with copies of all relevant records. Be cooperative.

5. *Assume that copies of hospital records and even your own records have previously been sent out. Alter nothing!*

Within a few weeks, the plaintiff's Bill of Particulars with specific allegations of departures from proper practice and claims of injuries is delivered. Shortly thereafter, you will be asked to confer with an insurance company investigator or a defense attorney or paralegal to discuss all aspects of the case.

6. *Consider hiring your own legal counsel.*

The insurance carrier is obligated to defend you, but there are situations in which conflicts of interest may arise between you and the carrier or between you and the assigned defense attorney, and you may require separate legal advice. Moreover, you may be exposed to liability in excess of your policy limits.

7. *Insist on an interview with the assigned defense attorney to evaluate his or her qualifications, abilities, and determination to defend you.*

8. *Demand a change in counsel if you have serious questions about the quality of your defense.*

This is one area in which having separate legal counsel for guidance pays off. He or she can advise you of your obligations and rights under your policy, can help you evaluate your defense attorney, and can put the squeeze on the carrier if your defense appears to be inadequate.

Separate legal counsel may be helpful when there are multiple defendants and you are not primarily responsible for the alleged injury, when there are multiple defendants and one

common carrier for all, and when the "prayer for damages" exceeds your coverage. You will *require* separate *defense* counsel if the suit alleges immoral conduct and if the carrier claims an exclusion from coverage for any damages claimed on this basis. If there is a likelihood you will be charged with perjury or other violations of the law, you will also need your own defense attorney.

9. *Play an active role in the choice of your defense experts.*

At some point, you will be notified that the opposing lawyer will take your pre-trial deposition (EBT or Examination Before Trial). This will be a discovery proceeding and your attorney will be there.

10. *Do not underestimate the importance of the deposition. Be certain that your attorney fully prepares you for this "mini-trial" and is fully prepared him- or herself.*

11. *Review your case with your defense experts.*

It is at the deposition that the plaintiff's attorney may discover you are a much more formidable presence than expected, or that his leading theories of causation are more theory than fact. To make this more reality than hope:

12. *Prepare! Prepare! Prepare!*

Preparation is the keystone of your defense, and if you are lazy, do not assume that your attorney will take up the slack. At deposition, your answers should be terse but accurate; elaboration is not called for and may open up unwanted areas for exploration.

As a defendant, you should fully understand "that deposition commit you to the facts and opinions you will have to live with at trial, that accuracy is essential, and that even false impressions or incomplete answers may jeopardize your credibility at trial.

If the case proceeds inexorably to trial:

13. *Reevaluate your options.*

All trials are emotionally draining challenges of endurance. Plan on closing your office for at least 2 weeks. Expect unfair publicity with no opportunity to respond, and above all, do not count on winning.

Although the "merits" of a case do count for something, good attorneys lose good cases just as good doctors encounter unexpected complications. The many variables at trial make predictions of outcome unreliable. The makeup of the jury, the ability of opposing attorneys, the credibility of expert witnesses, the jury's sympathy for the plaintiff, the ability or bias of the judge, the finger pointing of other defendants, and how you come across to the jurors as a caring and compassionate doctor and human being are all factors. None are measurable before the trial gets under way.

If, on the advice of your attorney, you decide to settle, you may first discover that your carrier is unwilling to cooperate! When a claim is filed, the insurance company sets aside what is called the "loss reserve" or what dollar exposure it might be liable for. This reserve is a book entry as an expense against income, and a liability on the balance sheet, but in reality the underlying funds are part of the insurer's general assets and continue to earn interest. By the time your case reaches a court-room, the company has recouped a considerable amount of money and may also conclude that the plaintiff's injuries do not seem as great as they did 4 or 5 years earlier. Having set aside $500.000 then, but seeing only $200.000 as their top exposure now, the company might decide to "go for it" and, depending on your policy, may have the right to do so, your wishes notwithstanding. If this indeed occurs, your own legal counsel must put the insurance carrier on notice that if there is an adverse verdict in excess of your coverage, you will hold it liable on the basis of "bad faith" negotiations.

The answer to "Shall I settle or should I fight?" will never be easy. Settling may seem like giving in to blackmail, like an act of cowardice or a confession of incompetence, while in deciding to fight on, you may anticipate weeks of exhaustion and only a bittersweet victory. And you may lose. Understand, a settlement is *not* a concession, but a defeat in court brands you. Pragmatism is also part of practicing medicine.

Even if being a defendant in a medical malpractice suit is a draining and lasting lesson in humility, for those physicians who see it through and win, "victory in the courtroom is not only a resounding vindication of their effectiveness as a physician, it is also a real badge of personal courage ... Lawsuits are painful experiences, but in that respect, they are no different than most other valuable learning experiences".