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Anesthesiology and the Law—In the Long View

Carl E. Wasmuth, M.D., LL.B.

ANESTHESIOLOGY is the youngest of the medical specialties. Born of surgical parents, it was nurtured through its infancy by well-meaning and dedicated physicians. Its load from the beginning has been overwhelming. Immediately it assumed the responsibility for the life of the patient. This freed the surgeon from the worries of a medical field that he did not understand and in which, except for the results, he was not at all interested technically. Anesthesia was like a bastard child cast out into the world to seek its own way.

But the advent of the physician-anesthesiologist was met with resistance by some surgeons. The physician-anesthesiologist was a challenge to the supremacy of the surgeon in the operating room. No longer was the surgeon the "captain of the ship." Now another specialist exercised some of the control over the patient formerly enjoyed by the surgeon. Fortunately, the child was industrious, dedicated, and studious. Today he is coming of age. Recently one court held:

And even assuming that Dr. L. was "surgeon-in-charge" or "Captain-of-the-Ship," as urged, it does not follow that he is responsible for the negligence, if any, of an anesthesiologist such as Dr. X, exercising his own independent special medical knowledge in performing his duties without any specific directions from Dr. L. *Thompson v. Lillehei*, 164 Fed. Sup. 716 (1958).

If he is not of age, at least we may now hold that the minor child is emancipated.

But accompanying majority come legal responsibilities. Even now this specialty is one of the most litigated fields of medicine, rivaling radiology, surgery, and plastic surgery. This, however, is at best a dubious distinction. Considering the nature of the specialty, one can easily understand the reason. In the hands of the anesthesiologist rests the life of every patient undergoing a surgical operation. In former years, deaths on the operating table were common. All can recall friends or relatives who, while undergoing what are now considered simple surgical operations, died on the operating table. Frequently it was stated: "Poor Uncle Ben's heart just couldn't take the shock." With these crass words, the death was explained away. It was dismissed as probably an Act of God. Poor Doctor Jones just couldn't save his life by operating.

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Today such a death would not occur. Proper diagnostic studies preoperatively, coupled with the skill of a physician-anesthesiologist, new anesthetic agents, and new technics, would prevent such deaths. Still more important—the death of poor Uncle Ben would not be blamed on poor Uncle Ben or on his unsuspecting and probably normal heart. The blame would be placed on the culpable agent, technic, or person. At least a proper reason would be given or a search would be made and the defect found. No longer would the death be excused!

The childhood has been rugged but productive. No longer do patients die of “ether pneumonia.” They are assured of an adequate amount of oxygen delivered from a modern, accurate gas machine, through a patented airway via an endotracheal tube. The carbon dioxide (a waste gas produced by every patient) is absorbed by a chemical agent (soda lime). No longer do children suffer high fevers and convulsions after ether anesthesia for tonsillectomy.

Upon the accomplishments of anesthesiology are based all of the advances and strides of surgery. When the surgeon wants to remove a lung or to open the heart, he does so with relative anesthesiologic impunity. Before this bastard child was born, surgeons only dreamed of opening the chest. It never entered their most progressive minds to venture into the cavity known as heart. Today, in many hospitals, the heart-lung machine and the anesthesiologist sustain the life processes of patients undergoing open-heart surgery. No longer is it considered “difficult” to open the chest. Notice that all of these forward strides in surgery depend wholly on the man at the head of the table—the anesthesiologist. As a famous professor at Harvard Medical School stated, “I care little who operates on me, but I demand the best anesthesiologist. Upon him my life depends.”

Medicine has recognized the role of the anesthesiologist. The American Medical Association has established the Section on Anesthesiology. The American College of Anesthesiologists offers a qualifying system. The American Board of Anesthesiologists certifies adequately trained anesthesiologists as diplomates. Now the anesthesiologist has the same rating as a specialist as does the surgeon, the internist, or the radiologist.

The anesthesiologist is accepted and his services are demanded by the grateful patient. The public recognizes the great advantage of the physician-anesthesiologist. To them, he is the great protector during obstetric delivery or operation.

Malpractice Actions

Along with maturity and acceptance of responsibility for life, other natural hazards occur—malpractice actions. From the preceding discussion, it is easy to understand why negligence suits are instituted. Never in the history of medicine has so hazardous a specialty been practiced. Nowhere in medicine is the patient so dependent upon one man. For upon the anesthesiologist rests

the responsibility of supporting the vital physiologic processes already altered, modified, or paralyzed by anesthetic agents and surgical manipulation. Never before has the human body suffered such onslaughts by the surgeon's scapel. But in spite of this, mortality has consistently declined, practically to the vanishing point. But malpractice actions do not take cognizance of this progress. Instead, the courts invoke *res ipsa loquitur* in a case of paralysis after spinal anesthesia or of cyclopropane explosion. Instead of equitable relief, the anesthesiologist is held strictly liable.

One of the purposes and objectives of the American Society of Anesthesiologists, through its Legal-Affairs Committee, is the education of anesthesiologists as to the legal pitfalls in the practice of their specialty. Most of the responsibility for such a program falls upon its chairman. Frequently, when speaking on these programs, I am aware of the great interests of the members as displayed in their attentiveness. The question most often asked of me after these talks is: "How much malpractice insurance should I carry?" Such interrogation discloses two basic fears—one for financial security and immunity for the anesthesiologist himself and for his family; the other, fear of malpractice suits. He practices a dangerous specialty. He realizes that some one person may take one unfortunate result and through the histrionics and silver-tongued exclamations of a plaintiff's attorney, explode it into a heinous, negligent act performed by a malefactor.

Historically, the physician has been protected by the law. The courts have taken judicial notice that the practice of medicine is not an exact science. In fact, there are many who subscribe to the theory that the practice of medicine is mostly an art. Therefore, there are many obstacles in the path of a would-be-plaintiff. Not only must he prove all of the elements of a negligence action by a preponderance of the evidence, but this evidence must be established by an expert witness. Although some courts have held the inability to secure such expert testimony as evidence of a "conspiracy of silence," cognizance must be taken of another factor. A conscientious physician, testifying as an expert, may not in honesty be able to subscribe to the plaintiff's contention in condemning the defendant as negligent. When a professional expert testifier cannot be found, the plaintiff will fail to make his case. This is as it should be. Experts give opinion evidence. If the practice of the defendant was reasonable care and skill, he must not be held negligent at law.

Res Ipsa Loquitur

How do the plaintiff's attorneys circumvent this obstacle? *Res ipsa loquitur!* For example, a mother is paralyzed by the spinal anesthesia given for her delivery. "Now, Doctor, explain why this mother cannot walk, and has no control over her

urinary bladder or bowel movements. You have as much time as you want. Just explain!"

The burden of going forward with the evidence now shifts. Instead of the plaintiff establishing her case at law, the defendant must overcome an inference—a creation of the law of evidence. Is this justice? The defendant owes only reasonable skill and care. He is not operating a bus or a train. He is not an insurer. He is practicing medicine. His duty, to reiterate, is only reasonable skill and care.

Frequently, the defendant-physician cannot account for untoward reactions. No one is more overwrought and sympathetic than an attending physician. His therapeutic misadventures are to him defeats in his quest to cure mankind of its ills. If he has not been negligent, then why do the courts invoke *res ipsa loquitur*—an inference of negligence?

One hard-shell plaintiff's attorney has said: "Malpractice is an occupational hazard!" In addition, he implied that malpractice insurance is cheap, and likened it to the cost of a few packages of cigarettes per day. Perhaps he was mathematically correct in his statement, but the situation leaves a great deal to be desired, morally and ethically.

We must look to the English courts for a ray of hope:

These two men have suffered such terrible consequences, that there is a natural feeling they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety, than the good of the patients. Initiative would be stifled and confidence shaken. . . . We must insist on due care for the patient at every point, but we must not condemn as negligence that which is misadventure. *Roe v. Health Service* (1958).