Chapter 16
The Laws of Professional Negligence: What Is Malpractice – And How Does Litigation Work?

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Introduction

A "tort" is an English Common Law term for a civil wrong whereby an act or omission gives causes injury or harm to another and for which the courts will impose liability. "Tort" is the old Norman word for a "wrong." Torts include, for example, negligence, trespass, defamation, invasion of privacy, assault, battery, false imprisonment, conversion, product liability, and negligent or intentional infliction of emotional distress. The notion of torts is founded in principles of ethics and morality and therefore based on philosophies of normative behavior addressing issues such as justice, rights, and duties. The aim of the legal system, in addressing a tort, is to compensate the injured party, impose civil liability on those responsible, and deter others from committing similar actions. Torts, by definition, require that the plaintiff demonstrate a compensable harm, for which the judicial system can provide relief through compensation. Since torts are civil causes of action, they are differentiated from criminal actions, or crimes, which are governed by criminal statutes and where the judicial system can impose more than monetary compensation.

Thus, medical malpractice lawsuits are generally filed in state courts and are governed by state statutes and, generally, state case law (precedent). Nonetheless, federal courts may have jurisdiction if (1) there is a diversity of citizenship (between states) as between the parties; or (2) the Federal Torts Claims Act applies. The Federal Torts Claim Act (FTCA) [1] applied to medical malpractice lawsuits can be

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filed against physicians working at medical facilities operated by the federal government including, for example, the Veterans Administration. Through the FTCA, eligible Health Resource Services Administration (HRSA)-supported health centers may be granted medical malpractice liability protection with the federal government acting as their primary insurer; employees and eligible contractors are considered federal employees and are immune from lawsuits for medical malpractice, and the plaintiff must bring suit against the US Government. Nonetheless, even where the care is filed in federal court, substantive issues of law including the applicable standard of care are governed by state law.

Unintentional torts are differentiated from (a) intentional torts and (b) strict liability torts such as product liability. The civil laws relating to negligence are based on the statutes and case law; these laws may be similar but also can vary substantially and substantively between the states. "Negligence" is the most common form of unintentional tort in which an actor fails to "behave with the level of care that someone of ordinary prudence would have exercised under the same circumstances" [2]. Thus, "reasonable care" is fundamental to the concept of negligence, since notions such as "reasonableness" and "ordinary prudence" can be verified through either testimony and/or judgment of one's of peers. A negligent act may be either one of affirmative commissions of an act or failure to act when there is a duty or obligation to do so. The concept of duty represents a legal conclusion pertaining to relationships between individuals and determined by the specific circumstances under consideration [3]. Fundamental to the concept of duty is a foreseeability of harm. If there is a foreseeability that one's action (or inaction) may result in harm, then one owes a "duty of reasonable care." Not all risks are reasonably foreseeable; for example, "when determining whether a danger is foreseeable, we 'look at whether the specific danger was objectively reasonable to expect, not simply whether it was within the realm of any conceivable possibility'" [4].

In general negligence, the issue is then a general duty to act in such a way to reasonably prevent reasonably foreseeable harm to others; however, in the case of professional negligence, the duty is imposed by virtue of professional standing and fiduciary relationship.

A profession is an "occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society." [5] Thus, a profession is grounded on knowledge that generally is acquired through prolonged specialized education and training, accompanied by a certification of formal qualifications, and is held by society to maintain the highest standards of fiduciary obligations towards clients or patients.

Where the unintentional tort of negligence involves professionals engaged in the exercise of professional conduct, a negligent act is referred to as "professional negligence" or, more commonly "professional malpractice." Where the profession at issue is medicine, the professional negligence is referred to as medical malpractice.

A claim of medical malpractice can be predicated on various theories: (1) departure from the standard of medical care; (2) absence of informed consent; (3) responsibility for the actions of others under one's supervision and control (vicarious liability; *respondeat superior*; or negligent supervision); or (4) patient abandonment. Once again, the laws relating to medical malpractice are based in statutes and case law; these laws may be similar but also can vary substantially and substantively between the states [6].

The Requisite Elements of a Cause of Action for Medical Malpractice

The term "prima facie" refers to the Latin term "at first sight" and is used in the legal context to denote circumstances, which at first blush, or initial examination, seems to support a rebuttable basis for a cause of action. A rebuttable presumption is one which appears to be true and sufficient on its face to support a conclusion but is nonetheless subject to offers of proof which may contradict or disprove it. Thus, "since a presumption is an assumption of fact accepted by the court until disproved, all presumptions are rebuttable" [7]. A cause of action is a set of legal facts upon which a legal action may properly be initiated and, at least preliminarily, sustained. A civil cause of action can arise from an act, an omission, a failure to perform a legal obligation such as a contracted duty, a breach of duty, or an interference with another's right. The cause of action is the grounds for a complaint, and therefore, the basis for a legal right to initiate a lawsuit. Initiation of causes of action requires that each of the elements upon which that cause of action is predicted be alleged as true buy one who brings the action (the "plaintiff") against another (the "defendant"). In some circumstances, the facts or circumstances which entitle a plaintiff to seek judicial relief may create more than one cause of action.

Legal redress for a cause of action is through a lawsuit. A lawsuit is initiated through a formal presentation of legal papers ("pleadings") filed in court by the plaintiff, alleging that he or she was harmed, through the cause of action, and requesting judicial intervention to provide relief. Pleadings serve to (1) describe the alleged facts which support the cause of action; (2) give notice to the defendant regarding a pending lawsuit; (3) specify the relief that is being sought; and (4) facilitate the efficiency of the legal process. Traditionally, the summons and complaint are considered as the initial pleadings; however pleadings also include every other supporting legal document filed in a lawsuit including motions, petitions, answers, demurrers, and memoranda of law.

A summons and complaint are together one type of pleading which is filed in the court of jurisdiction and which both initiates the lawsuit and also informs the defendant of the lawsuit, containing, in general, (1) the legal basis for the court's jurisdiction over the matter and the defendant; (2) the cause of action from which the claim or claims are derived; (3) a concise description of the claim or claims of the claim itself; (4) the relief being sought; (5) the person claiming relief; (6) and a demand for judgment, or a "prayer for relief." Technically, the compliant initiates the lawsuit, and the summons provides notice of service and specifies a date for a court appearance. The format for the service of pleadings varies by jurisdiction; in most jurisdictions the two documents are served together, although this is not always the case. An important purpose of the complaint is to provide the defendant with notice so that he or she can initiate the process of defending against the claim. For example, under contracts for medical malpractice insurance, the insurer must be immediately informed of the receipt of pleadings, so that timely answers to the allegations can be formulated and formally submitted in defense of the complaint. The time period in which the answers to a summons and complaint are due, vary by jurisdiction and by circumstance, but may be as short as 20 days. In the event that the defendant does not file an answer to a summons and complaint with the court in the statutorily defined time period, a summary default judgment may be entered against the defendant who has thus lost the right to defend his or her case in court.

The manner in which a defendant receives his or her "notice" through delivery and receipt of the summons and/or complaint ("service of process") is extremely important and can have a significant bearing on the validity of the subsequent lawsuit. Proper notice regarding a lawsuit is required by constitutional due process and governed by federal and state rules and regulations. Potential defendants should keep track of the exact circumstances surrounding the service of process since these may later help in defense of the lawsuit.

A lawsuit alleging medical malpractice must be filed with the court within a statutorily prescribed time period, the statute of limitations. Each type of civil cause, and some criminal actions, is governed by a specified statute of limitations. The statute of limitations begins to run at the time that the cause of action occurred and runs until the pleadings seeking relief for such action are properly filed in court. If a lawsuit is filed ("commenced") after the statute of limitations has fully run ("run out"), the lawsuit is considered "time-barred," and the court no longer has jurisdiction over the matter. Failure to timely commence or file a lawsuit is potentially professional legal malpractice attributable to the plaintiff's attorney.

In general, the elements required to support a prima facie cause of action alleging medical malpractice are as follows: (1) the professional duty owed to the patient; (2) the breach of such duty; (3) injury caused proximally by the breach of duty; and (4) monetary damages (Table 16.1). "If the circumstances supporting a theory of negligence are of greater weight than the evidence supporting the theory of no negligence, then it becomes a question of fact for the jury to determine whether or not the cause of the injury was the negligence alleged" [8].

Table 16.1 Elements of medical malpractice

Duty
Breach
Proximate causation
Damages

Duty

There are many ways in which a provider or health system owes a legal duty to the patient. First, there is a fiduciary duty arising by virtue of an established patient-provider relationship. Fiduciary duties arise from the inequality of knowledge, training, and experience that the professional applies to his or her services on behalf of the patient; because of the provider's standing as a professional and the inequality of understanding, the patient must place his or her trust in the provider. The usual fiduciary duties involve (1) the duty of loyalty and (2) the duty of care. There can be no duty in the absence of a demonstrable patient-provider relationship; however, such a relationship has been increasingly broadened.

In the 1901 case of *Hurley v. Eddingfield*, the Supreme Court of Indiana opined that "the State does not require, and the [medical] licensee does not engage, that he will practice at all or on other terms than he may choose to accept" [9], thereby finding that a patient-provider relationship exists only when both parties consent to and accept their obligations and roles within the therapeutic relationship. A provider has no obligation to treat all comers, unless the provider meets certain criteria such as an employed provider or on-call provider treating emergencies.

On the other hand, in *Mead v. Adler*, a patient presented to an emergency department where an on-call neurosurgeon was consulted for the patient's possibly evolving *cauda equina* syndrome, the neurosurgeon examined the patient and recommended that she be admitted but determined that surgery was not needed; in the interval between the initial presentation and the subsequent deterioration, the neurosurgeon did not re-examine the patient since he did not believe that a patient-provider relationship had been formed. The issue in *Mead v. Adler* was whether the circumstances of that communication gave rise to a physician-patient relationship between the defendant and plaintiff. The court opined that "in the absence of an express agreement by the physician to treat a patient, a physician's assent to a physician-patient relationship can be inferred when the physician takes an affirmative action with regard to the care of the patient" [10].

Thus, opinions rendered, even without other interventions, may create a relationship; such is also the issue with informal curbside consultations (also known as "sidewalk," "elevator," or "hallway" consults which are informal consultations between often sharing thoughts on complex cases and sometimes even seeking informal suggestions regarding patient management). The general rule has long been that "a physician who gives an 'informal opinion,' however, at the request of a treating physician, does not owe a duty to the patient because no physician-patient relationship is created" [11].

However, in the 2019 case of *Warren v Dinter*, a patient, Susan Warren, was evaluated by a nurse practitioner (NP) in the outpatient facility of the Essentia healthcare system in Minnesota where the NP determined that the patient probably had a serious infection and should be admitted to the hospital and by following a standard procedure called a hospitalist Fairview Hospital. The hospitalist never examined the patient, accessed the patient's medical record, or charged for the consult but determined that the patient did not need hospitalization. The NP accepted the recommendation of the hospitalist and sent the patient home where she died 3 days later of sepsis caused by an untreated staphylococcal infection. At trial, the trial court granted summary judgment to the hospitalist, opining that a patient-provider relationship had not been established. The court of appeals affirmed. The case was then further appealed to the Minnesota Supreme Court which reversed the lower courts' decisions, noting that a physician-patient relationship is not a necessary element of a claim for professional negligence, holding that (1) a physician owes a duty of care to a third party when the physician acts in a professional capacity and it is reasonably foreseeable that the third party will rely on the physician's acts and be harmed by a breach of the standard of care and (2) it was reasonably foreseeable that the patient in this case would rely on the hospitalist's acts and be harmed by a breach of the standard of care [12]. Thus, at least in a minority of states, informally consulted clinicians may be liable for negligent advice. The American Medical Association has issued a memorandum calling out the *Dintner* case "abusive litigation against physicians" and "very unfavorable" [13].

Where a patient-physician relationship is established, the physician has an ethical and legal duty to continue care. In general, "abandonment" occurs when the relationship between physician and patient is terminated either (1) at an unreasonable time or (2) without affording the patient time to find a qualified replacement [14]. Patient abandonment is often actionable not only under malpractice laws but also under state disciplinary statutes governing the practice of medicine.

The second element of duty is the "duty of reasonable professional care to the patient" or "duty to practice in accordance with prevailing standards of care." The definition of the standard of care is complex and varies by jurisdiction. In the 1860 case of *Richie v West*, then defense attorney Abraham Lincoln defended a physician and in which the court stated that "[w]hen a person assumes the profession of physician and surgeon, he must…be held to employ a reasonable amount of skill and care" [15]. The traditional standard of care for physicians is to exercise "the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances" [16]. The standard of reasonable professional care is generally that of a "reasonably prudent" physician [17].

Medical malpractice is a legal fault by a physician arising from a failure to provide the quality of care required by law. When a physician undertakes to treat a patient, he or she assumes an obligation, contract, or duty, enforceable at law, to use minimally sound medical judgment and render minimally competent care during the course of the provision of care. Physicians do not guarantee recovery or success. If a patient sustains an injury because of a physician's failure to perform that duty, the physician may be liable for damages. A competent physician is not liable per se

for a mere error of judgment, mistaken diagnosis, or the occurrence of an undesirable outcome or result [18].

Traditionally, when defining the applicable standard of care, courts would rely on the standard established in the case of *Small v. Howard*, that the standard to be applied in a particular case was that prevailing within the particular locality where the alleged tortious act took place: the "locality rule" [19]. Specifically, the "locality rule" recognizes "as a rule of substantive law that a physician is bound to bestow to each patient such reasonable and ordinary care, skill, and diligence and to exercise such good medical judgment as physicians and surgeons in good standing in the same neighborhood or locality, in the same general line of practice, ordinarily have and exercise in like cases" [20].

Through the rise of national medical organizations and national board certification bodies and in accordance with increased mobility of physicians and their practices throughout the United States, physicians became responsible for adhering to a national standard of care as applicable to their specialty and/or subspecialty. Although the majority of jurisdictions have abandoned the "locality rule," the states of Arizona [21], Idaho [22], New York [23], Tennessee, Virginia [24], and Washington [25] continue to rely on the locality rule. In all, 29 states and the District of Columbia have adopted a national standard of care, whereas 21 states maintain a version of the locality rule, in which the standard of care by which a physician is judged is the standard of care in a particular locality [26]. The State of Louisiana uses a "modified locality rule," whereby general practitioners are held to a community standard and whereby specialists are held to a national standard of care. A normative approach to defining the standard of care requires a formal definition of how a reasonable physician would have done under the circumstances.

One problem with the locality rule is that where malpractice is alleged within a small community, the expert witnesses necessary to establish the prevailing local standard of care would need to come from the accused physician's community peers [27], potentially or practically immunizing any physician in that community from liability [28]. Thus, the locality rule may jeopardize the application of basic principles of justice on behalf of patients who are harmed as a result of suboptimal local care standards.

Nonetheless, a core validity to the concept of local standards of care may rest within the notion of resource availability, based on the circumstances and the availability of resources, treatment options, and equipment. In such cases, the determination of the standard of care may need to include an analysis of the feasibility and options for the transfer of patients to a "higher level of care."

On the other hand, under a competence-based national standard of care, physicians "may with reason and fairness be expected to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice throughout the United States, to have a realistic understanding of the limitations on his or her knowledge or competence, and, in general, to exercise minimally adequate medical judgment. Beyond that, each physician has a duty to have a practical working knowledge of the facilities, equipment, resources (including

personnel in health related fields and their general level of knowledge and competence), and options … reasonably available to him or her as well as the practical limitations on same" [29].

In 1923, the landmark case of *Frye v. United States* [30] established that the admissibility of scientific evidence required "general acceptance" in the scientific community, leading to the possible use of medical treatises under this condition of admissibility. Frequently the issue of admissibility of treatises, textbooks, journal articles, or other published material arises when discussing the standard of care; in general, such material, in itself, is generally not admissible to prove the standard of care, under the hearsay rule of evidence, since the author is not usually present to verify the statements directly. Nonetheless, clinical practice guidelines (CPGs), including algorithms, statements, and protocols, are increasingly considered by many to represent persuasive outlines of "best practices" to be at least considered during individualized clinical decision-making [31]. Electronic medical records are also increasingly incorporating decision support. In general, although guidelines are frequently referred to as "standards" they are not in themselves considered to represent legal "standards of care, since, arguably, it is individualized medical judgment rather than 'cookbook medicine" that drives individualized clinical decision-making. In addition, guidelines are frequently updated or revised; and, different societies within the same specialty may publish conflicting guidelines. Finally, CPGs may be authored for nonmedical reasons such as utilization review or claims management and therefore are designed to meet the needs of a drafting organization, rather than defining a true clinical standard of care [32].

Nonetheless, in some circumstances, guidelines may be, and have been, introduced as "learned treatises" and bypass the hearsay rule. Thus, CPGs may be used to bolster the testimony of an expert witness, impeach an expert witness, defend a physician for following the document as the standard of care or to suggest physician deviance from the document as deviance from the standard of care [33]. Arguably, CPGs have had a greater effect by the plaintiff's bar for inculpatory evidence than by the defense as an exculpatory standard [34]. Treatises such as CPGs may also be admissible as demonstrative evidence if defendant physicians relied on such guidelines when rendering medical treatment.

In 2006, the New York Court of Appeals decided *Hinlicky v. Dreyfuss* [35], a case in which a patient underwent a successful carotid endarterectomy but suffered a postoperative myocardial infarction and died 25 days later. The plaintiff's cardiology expert witness asserted that as a "mandatory minimum," the patient should have had a preoperative cardiac stress test. At trial, the defendant anesthesiologist testified at length regarding his deliberate adherence to the American Heart Association (AHA)/American College of Cardiology (ACC) guidelines which represented an algorithm ("a link in the chain of data") on which he relied for his decisions regarding preoperative cardiac testing. The value of the AHA/ACC exhibit was underscored when all defense experts agreed that the algorithm not only "represented the standard of care' but actually represented the "state of the art." The court subsequently ruled in favor of the physician; however, the case was subsequently appealed to New York's highest Court of Appeals. The verdict for the defense was upheld

where the court recognized that clinical practice guidelines represented "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" and as "standardized specifications for care, either for using a procedure or for managing a particular clinical problem" [36]. The Court of Appeals ruled that it had been appropriate for the lower court to admit the guidelines into evidence, not for the purposes of defining the standard of care but to illustrate (for the jury and the court) the process of clinical decision-making used by the defendant physician in the care of the patient.

Medical judgment involves a careful balancing of factors that are both intuitive and data-based. Medical judgment embodies the art, training, and experience which become critical when complex decisions are made in clinical settings where data is incomplete or inconsistent. An error in judgment is, in itself, insufficient to sustain liability. The "error in judgment rule" maintains that malpractice cannot be predicated solely on an error in judgment in choosing among different therapeutic approaches or in diagnosing a condition [37]. Physicians and other providers who choose between two reasonable alternatives (e.g., diagnoses, therapies, procedures) may be not liable where the documentation supports good medical care. "The art of healing frequently calls for a balancing of risks and dangers to a patient" [38]. The Canadian physician and one of the four founding professors of Johns Hopkins Hospital, Sir William Osler, expressed the uncertainty of medical practice stating both that "Medicine is a science of uncertainty and an art of probability" [39] and that "Errors in judgment must occur in the practi8ce of an art which consists largely of balancing probabilities" [40]. Nonetheless, the "error in judgment" and the "respectful minority" rules are increasingly being challenged [41]. The outcome of litigation in such cases will depend heavily on the documentation, and specifically the clinical reasoning memorialized in the medical record to support the reasonable weighing of alternatives at the time of decision-making.

Breach

An allegation of medical malpractice will hinge on whether there was a deviation from the standard of care; such a deviation represents a breach (Table 16.2.)

Since a definition of the standard of care is outside the realm of knowledge possessed by laypersons, it must be established through the testimony of medical professionals with expertise regarding the subject matters or expert witnesses. In a legal proceeding alleging medical malpractice, as in any civil action, the plaintiff had the burden of proof to establish the prima facie elements of the cause of action. In order to maintain a case through its initial stages (or withstand a motion for a directed verdict), the plaintiff must first qualify its medical witness as an expert; demonstrate to the court that the witness will assist the jury or judge in weighing the evidence; and, present the expert opinions in accordance with the rules of evidence. On the issue of breach, expert witnesses are called upon to offer proof regarding two issues: (1) opinion as to the relevant standard of care and (2) opinion as to the failure of the

Table 16.2 Examples of breaches of the standard of care

Failure to treat
Failure to diagnose, or misdiagnosis
Failure to timely diagnose or treat
Misreading or ignoring laboratory results
Unnecessary surgery
Surgical errors or wrong site surgery
Improper medication, route, or dosage
Poor follow-up or aftercare
Premature or unsafe discharge
Disregarding or not taking reasonable patient history
Failure to order proper testing
Failure to note symptoms
Failure to document allergies
Failure to warn

defendant physician to conform to the standard of care. The plaintiff's expert need not explicitly render an opinion as to whether the defendant physician actually committed "malpractice."

The expert physician will be examined directly by the plaintiff's attorney, during which time he or she will educate the court on the medical issues by answering open-ended questions at length, showing models or illustrations, and translating the medical terms and evidence into plain English. The expert will then under a cross-examination by the physicians' defending attorney who will attempt to undercut the assumptions, credibility, substance, or reliability of the expert.

Causation

Causation is the third element of a prima facie case of medical malpractice. In order to establish medical malpractice, it is necessary to prove, on a balance of probabilities, that the breach of duty is directly caused by the alleged harm or injury. Legal proof of medical malpractice will next hinge on whether the deviation from the standard of care, or breach, directly caused the alleged injury. Causation is often more difficult to prove than is the breach in the standard of care. Proof of causation generally requires expert testimony. Causation may be proximate or actual. However, "To establish causation, the tortfeasor's conduct must be both the cause in fact and the proximate, or legal, cause of the plaintiff's injury" [42]. Causation is an issue to be determined by the jury.

Cause in fact, or factual causation, refers to injuries which would not have occurred "but for" the defendant's actions. The "but for" test of causation requires the plaintiff to show that '"but for" the defendant's negligent act, the injury would not have occurred.' In other words, had the provider not been negligent, the patient

would not have been harmed. "In all but those rare cases where two independent forces concur to cause an injury, causation, in fact, is evaluated through the familiar "but for" test; that is, it must be shown that, but for the tortfeasor's conduct, the injured party would not have been damaged" [43].

Some jurisdictions use the "substantial factor" test, as opposed to the "but for" test to establish factual causation. Under the substantial factor test, the court considers whether a defendant's actions or omissions represent a substantial factor, or material factor, in causing injury [44].

The second facet of causation is proximate cause, which is often described as a limitation on liability, absolving those actors whom it would be "unfair" to punish because of the attenuated relation which their conduct bears to the plaintiff's injury. Proximate cause is also referred to as "legal causation." Here, if the court determines that a particular cause is an actual cause, the inquiry turns to whether that cause is also the proximate cause [45]. Proximate cause is a legal limitation on causation that basically indicates the defendant's actions are the most likely cause of the plaintiff's damages, requiring that the breach of duty be the primary cause of the injury. Legal causation is an essential element in the proof of negligence. Thus, even if a defendant's action is established through the "but for" test as the cause of an injury, liability the defendant might not be liable for damages if the actions were not the proximate cause of the injuries.

Proximate or legal causation requires that the injuries be "foreseeable." A defendant in a negligence case can only be liable for those injuries which could have been foreseen to be a consequence of one's actions. A breach may not be an initial action that results in an injury; similarly it may not be the last event that immediately precedes an injury. The proximate cause is a breach of duty with foreseeable consequences.

The classic case illustrating the importance of distinguishing between actual causation and proximate causation is *Palsgraf v. Long Island Railroad Co*., where a plaintiff standing on a railroad platform purchasing a ticket, was injured when the defendant dropped a package containing fireworks fell and the contents exploded. In brief, the facts of the case relate that the plaintiff, Mrs. Palsgraf, was standing at the end of a train platform waiting for a train at the Long Island Railroad Station when at the other end of the same platform, a man raced to board a departing train carrying a box of fireworks. That man jumped onboard the moving train but lost his balance and was assisted by railroad employees, both on the train and on the platform, who both pushed and pulled at the man, to help him get on the train, during which time he dropped his package of fireworks which exploded. The noise of the exploding fireworks startled the crowd on the platform, causing one person to tip over a set of scales, which then landed on Mrs. Palsgraf, injuring her. Mrs. Palsgraf sued the railroad, claiming that the workers were at fault for her injury, by being negligent in their handling of the man who was clearly holding a package of fireworks. The case went to the Court of Appeals of New York which reversed the rulings of the lower courts finding that although there was evidence for the actual

cause, there could be no legal cause the railroad workers could not have possibly foreseen, that any passerby, in particular Mrs. Palsgraf, would be hurt as a result of their helped another train passenger board a train. Therefore, without proximate cause there could be no negligence [46].

The causal chain of causation can also be affected by intervening or superseding events and such events may affect a defendant's liability. Jurisdictions vary as to whether they use the interning cause or the superseding cause. An "intervening cause" is a "separate act or omission that breaks the direct connection between the defendant's actions and an injury or loss to another person, and may relieve the defendant of liability for the injury or loss" [47]. Similarly, in those jurisdictions using superseding cause, the "superseding cause relieves from responsibility (liability) the party whose act started the series of events which led to the accident, since the original negligence is no longer the proximate cause" [48].

Res Ipsa Loquitur

Breach of duty is generally demonstrated by expert testimony because knowledge of both the standard of care and a practitioner's deviation from it are not generally known to the laypersons of a jury. However, there are instances in medical practice trials where expert testimony about the standard of care is not required. Courts may waive the need for expert witness testimony where negligence may reasonably be *inferred* from facts which laypersons may understand based on common experience.

Res ipsa loquitur is a Latin phrase meaning either "the thing itself speaks" or "the thing speaks for itself." The phrase *res ipsa loquitur* is merely a form of circumstantial evidence which depends upon the common understandings of mankind for its application. It has been said that the doctrine is properly applicable in those situations which "contain within themselves a sufficient basis for an inference of negligence" [49]. Courts may also use the doctrine of *res ipsa loquitur* in the analysis of cases where the actual negligent act cannot be proved, but it is clear that the injury was caused by negligence. Thus, the doctrine of *res ipsa loquitur* is a rule of evidence [50], which creates a legal foundation through which negligence can be inferred in situations in which there is no direct evidence of negligence or wrongdoing (Table 16.3).

Table 16.3 Examples of *res ipsa* medical malpractice cases

Unintentionally retained foreign object after surgery or other invasive procedure
Intraoperative burns to a patient during a surgical procedure or operation
Operation performed on the wrong body part
Positioning injuries
Intraoperative burn injury (or burn in a sedated patient)
Fall out of bed in an anesthetized or sedated patient

In the general negligence context, the doctrine of *res ipsa loquitur* has its origins in the 1863 British case of *Byrne v Boadle*, a case arising when a barrel of flour that fell out of the defendant's shop window struck the plaintiff [51]. Medical application of *res ipsa loquitur* doctrine was developed through the 1944 court case of *Ybarra v Spangard* wherein Ybarra developed appendicitis and presented for an appendectomy. During anesthesia and surgery, Ybarra was allegedly positioned in such a way that his upper back was rested against two hard objects, about an inch below his neck. Following the operation, Ybarra could not move his arm and was diagnosed with a permanent neurologic injury to his brachial plexus. Since Ybarra was unconscious under anesthesia during the surgery, he could not determine who had positioned him improperly; the operative team also could not determine the person who had done the positioning. Thus, the court proceeded by shifting the burden of proof to the defendants, citing the *res ipsa loquitur* doctrine and held that "where a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct" [52].

Res ipsa allows a jury to *infer* negligence, *if* the preponderance of the evidence supports that "(1) the defendant had exclusive control of the instrumentality causing the occurrence, (2) that the circumstances were such that in the ordinary course of events the incident would not have occurred if the defendant had exercised reasonable care and (3) plaintiff's voluntary act or negligence did not contribute to the occurrence" [53]. In short, *res ipsa loquitur* requires the plaintiff to demonstrate that the alleged injury cannot ordinarily occur unless there is medical negligence and that the circumstances which caused the injury were at all times always under the exclusive control of the defendant and the plaintiff could not have contributed to his or her injuries.

Res ipsa is difficult to apply in cases of misdiagnosis, rare complications [54], or poor outcomes [55]. Furthermore, the inference of negligence is not mandatory but is rather permissible. Thus, the *res ipsa* doctrine is not synonymous with liability. *Res ipsa* creates a rebuttable presumption of negligence; the presumption can be nullified by a convincing defense argument.

The Loss-of-Chance Doctrine

In a negligence action, such as medical malpractice, the plaintiff has the burden to prove to the trier of fact, either the judge or the jury, that (1) the defendant physician was negligent by deviating from the standard of care and that (2) the injuries were "more likely than not" a direct result of that negligence. "More likely than not" defines the "preponderance of the evidence" standard necessary to prove liability in a civil case and means that the probability of negligence must be greater than 50%; if it is not, the plaintiff loses and recovers nothing [56].

In cases where there is a treatable pre-existing condition, and a provider negligently fails to the condition from spreading or worsening, through a delay in proper diagnosis or treatment, the plaintiff can be compensated for the extent by which the defendant's negligence reduced the plaintiff's chance of survival or a potentially more favorable outcome. The "loss-of-chance doctrine" or the "lost chance doctrine" is a legal principle which permits a plaintiff to recover damages from a defendant if that plaintiff was exposed to a heightened risk of death or injury; even if the plaintiff cannot prove the defendant's negligence by a preponderance of the evidence. It is very important that providers understand the "lost chance doctrine" and its implications.

The doctrine is premised on the theory that a plaintiff should be compensated for the loss of potentially achieving a more favorable outcome [57]. The loss of chance doctrine is not uniformly accepted by all state courts in the United States. In New York, courts generally require the plaintiff to prove that negligence deprived him or her of a "substantial possibility" of recovering from the underlying ailment [58]. Furthermore, in some states, such as South Dakota, the legislature has expressly prohibited the use of the doctrine [59].

Thus, the relaxed standard of causation inherent in the doctrine makes it possible for a plaintiff to recover when the defendant's actions have substantially harmed the plaintiff by decreasing his chance for survival, even if the actual probability of negligence is less than 50%. The doctrine allows a plaintiff to be compensated in direct proportion to the probability of a more successful outcome if the opportunity had not been lost. For example, if it can be shown that a defendant physician deprived the plaintiff of a 30% chance of a more successful recovery and plaintiff's ultimate injury would otherwise be compensated with a $100,000 verdict, the plaintiff's award would be $30,000.

The doctrine is most often applied in cases where there is a failure to diagnose; for example, breast cancer spreads after a prior mammogram was read as "normal"; a treatable lung cancer spreads after a prior nodule was missed on radiology reading, or a treatable infection is misdiagnosed. For example, in the case of *Cudone v. Gehret*, the United States District Court for the District of Delaware permitted recovery on the basis of a "lost chance" claim where there was an alleged delay in the timely diagnosis of Ms. Cudone's breast cancer. Plaintiffs' experts testified that based on a reasonable medical probability, Ms. Cudone's breast cancer would not have metastasized if there had been an earlier diagnosis. The experts also testified that based on a reasonable medical probability, the defendant's negligence resulted in the progression of Ms. Cudone's cancer from a "stage I" lesion to a "stage II" lesion with a concomitant increase in the chance that Ms. Cudone will experience a recurrence of her cancer. Although the court reasoned that it could not be stated with a reasonable medical probability that the physician's negligence was the cause of the patient's death, the plaintiff should nonetheless be compensated proportionately for the increased risk of death attributable to the delayed diagnosis.

The Iowa Supreme Court case of *DeBurkarte v. Louvar* addressed the issue of a plaintiff who claimed a failure to diagnose palpable breast cancer at an early stage. Elaine DeBurkarte "found a lump in her left breast. Because her sister died of breast

cancer, she made an appointment the next day with Dr. Louvar, who examined her and ordered a mammogram, an x-ray of the breast. The results of the mammogram were negative." The lump did not go away, and Elaine DeBurkarte returned to Dr. Louvar, less than a month later where he assured her the lump was only a cyst, and not cancerous. He advised her to perform self-examinations, and not to return for a year. When Ms. DeBurkarte discovered another lump in her breast, Dr. Louvar referred her to a surgeon, Dr. Robert Brimmer who performed a biopsy the following day, and test results indicated the lumps were cancerous. Elaine subsequently underwent a mastectomy and later underwent oophorectomy. The DeBurkartes then brought suit, alleging Dr. Louvar has failed to diagnose her cancer at a stage when removal of the lump could have arrested the cancer; claiming damages for disfigurement, past and future pain and suffering, emotional distress, medical expenses, shortening her life, and death; and, her husband claimed damages for the lost consortium. Relying on expert testimony regarding relative survival probabilities of lesions resected early versus late, the plaintiff recovered under Iowa's lost chance of survival statute [60].

This "loss-of-chance" theory of recovery is being increasingly applied in medical malpractice cases involving reduced life expectancy or increased risk of future harm. "Lost chance" is mostly invoked where a plaintiff suffers from a pre-existing condition sufficiently grave as to undermine the causal chain of events necessary to prove negligence. In *Hicks v. United States*, a physician, following a 10-minute physical examination, diagnosed the decedent with gastroenteritis and discharged her home where she died later the same day of a small bowel obstruction. The United States Court of Appeals for the Fourth Circuit stated that "[w]hen a defendant's negligent action or inaction has effectively terminated a person's chance of survival, it does not lie in the defendant's mouth to raise conjectures as to the measure of the chances that he has put beyond the possibility of realization. If there was any substantial possibility of survival and the defendant has destroyed it, he is answerable." Thus, the court opined that the physicians' negligence nullified whatever chance of recovery the decedent would have had and therefore the misdiagnosis represented the proximate cause of her death [61].

In *King v. St. Barnabas Hospital*, a man at a gym playing basketball suffered a cardiac arrest. Upon the arrival of medical personnel, the patient's cardiac rhythm was found to be a mixture of asystole and ventricular fibrillation which the defendants attempted to defibrillate unsuccessfully. The plaintiff's estate sued on a theory of medical negligence alleging that it was a departure from ACLS protocols to defibrillate a patient who was in asystole and that defendants failed to timely administer epinephrine and atropine; the defendants argued that their actions could not be proven to have a detrimental effect on the outcome. The trial court agreed noting that even under "the best circumstances, plaintiff's expert cannot predict whether [plaintiff] could have been saved or if cardiac function could have been restored." The first department, however, reversed on appeal stating that New York permits claims for negligent resuscitation efforts to the extent the defendants departed from life support protocols and deprived the plaintiff of "any possibility of survival." According to the court, "the very fact that advanced life support protocols exist for

patients in asystole means that adherence to the protocols afford a chance of reviving the patient, notwithstanding the grave nature of the condition. It necessarily follows that failure to follow the protocols reduces the chances of reviving the patient." [62]

Therefore, under the "loss-of chance" doctrine, a provider could be liable in damages if even a 1% reduction of a patient's optimal outcome can be proven. Relaxing the standard of causation increases the plaintiff's odds of a favorable outcome in two possible ways: (1) a plaintiff is more likely to present the case to a jury; and (2) it reduces the plaintiff's burden of persuasion, requiring the plaintiff to establish only that the act or omission was "more likely than not" a "substantial factor."

Damages

Civil lawsuits seek to compensate a plaintiffs for a wrong that is committed against them. The intent of compensation in a civil lawsuit is to make the plaintiff "whole", understanding that monetary compensation may never compensate adequately for physical or emotional injuries. The amount of the compensation, claimed or awarded, is referred to as "damages." Damages compensation may be for economic or noneconomic damages or both. The pleadings served at the onset of a lawsuit as the "complaint" will usually outline the nature of the damages sought.

Economic damages, or special damages, seek to reimburse a victim for financial costs related to the injury; these may include, for example, past, present, and future medical expenses; lost wages; costs of therapy, rehabilitation, or custodial care; and medical equipment or renovations to a home to ensure access. Economic damages are fairly quantifiable.

Noneconomic damages, or general damages, seek to compensate a plaintiff for pain and suffering, loss of enjoyment of life; loss of spousal companionship or consortium; and earning capacity. Noneconomic damages are distinguished by a speculative and extrapolative nature such that they are not easily amenable to a definitive mathematical accounting. A foundation for a noneconomic damages claim may be based on pain, mental anguish, disfigurement, aggravation of a pre-existing condition, and an inability to participate in the enjoyment of life.

Punitive damages seek to punish actions that the court finds to be egregious. The intention of a plaintiff to pursue punitive damages may sometimes be evident in the use of words such as "wanton," "reckless," or "intentional" within the complaint. The intent of punitive damages awards is to both punish the defendant and deter future potential defendants.

Proof of damages also requires expert testimony. In order to quantify damages, the experts may be both medical, such as physiatrists, therapists, psychologists, and rehabilitation specialists, and nonmedical such as accountants, actuaries, and financial experts.

Defense of Medical Malpractice

The defense of a medical malpractice cause of action will involve a skilled and experienced litigator, who, in collaboration with the defendant and experts in support of the defendant, will seek to establish that the care provided was either (1) not a departure from accepted medical standards of care; (2) an unforeseeable event; (3) a known complication for which the defendant gave informed consent; or (4) that the plaintiff was contributorily negligent. In addition, there are a number of procedural, or affirmative, defenses, such as the statute of limitations, for example. Contributory negligence can be important in cases where the plaintiff failed to disclose an element of his or her history such as substance abuse, ingestion of food on the morning of surgery despite instructions to the contrary, or noncompliance with prescribed treatment, medications, or instructions. The issue of causation, especially in cases where there are multiple providers over a period of time, or where supervening or intervening causes can be established, can be used by the defense to argue on behalf of the defendant.

One of the most important elements in a malpractice defense is good and thorough documentation in the medical record, especially with respect to medical judgment [63]. It is important to note that the plaintiff has the burden of proof; the defendant is innocent until proven guilty.

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