THE MEDICO-LEGAL RESPONSIBILITIES OF THE ANAESTHETIST*

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CANADIAN ANAESTHETISTS will always record 1942 as a year to remember in the annals of Canadian anaesthesia. During that year Griffiths and Johnson reported their observations on the first use of curare in general anaesthesia. The introduction of curare has been cited by many, as the greatest advance in anaesthesia in the past twenty-five years.

How many of us realize that in that same year there occurred, in the Province of Ontario, another significant event which was to have a momentous bearing on the practice of anaesthesia in Canada? The case of *Hughston* v. *Jost*(1) in that year was the first time in any court in Canada that an anaesthetist had been sued alone for alleged malpractice. From a legal point of view, anaesthesia came of age.

Prior to 1942, the surgeon was considered to have full charge of the operating room, including the anaesthesia and the anaesthetist. The surgeon was held responsible for any ill result from the anaesthetic, although the physician administering the anaesthetic could be held co-responsible.

In the Hughston and Jost case referred to above, the anaesthetist alone was sued for alleged ill result following intravenous Pentothal anaesthesia. The surgeon appeared as a witness, but was not involved in the action. Anaesthesia had become a speciality, and the anaesthetist a specialist.

In Great Britain, the United States, and Canada, anaesthetists in recent years have been subjected to many threats, writs, court actions, judgments and settlements.

The purpose of this paper is to draw attention to observations that might be helpful in the prevention of such threats, writs and court actions.

Let us remember that, as anaesthetists, we are physicians, and any physician may be sued. No one can prevent a patient from bringing action against us, justified or not.

What precautions must we take? I shall stress only a few.

Personal Contact with Patient: History and Physical Examination

On agreeing to administer an anaesthetic the anaesthetist accepts a fairly heavy responsibility. Modern anaesthesia carries many patients to the brink of death. It is therefore essential that the anaesthetist should be cognizant of the patient's medical history and most certainly his physical condition.

This implies personal contact between anaesthetist and patient. Personal contact will help to build up confidence in the patient, and a patient who trusts a physician is less likely to lay a complaint Many patients have refused to pay accounts on the premise that: (*a*) they had no contact with this phantom

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individual, the anaesthetist, and (*b*) that a contract was not made with this nebulous character to administer an anaesthetic to him.

All of us realize that knowledge of allergy to drugs and anaesthetic agents, previous spinal headaches, previous backaches, previous unfortunate experiences with anaethesia, etc., is essential to the proper selection of anaesthetic agents and techniques; and certainly we all know that specific medical conditions contraindicate the use of certain agents and techniques.

As practising physician anaesthetists, we should contact the patient personally and obtain the above knowledge, and, most important, pertinent medical history and physical examination should be recorded on the hospital chart previous to administration of an anaesthetic. Numerous writs have been issued for alleged damage to teeth—in what condition were those teeth prior to the administration of the anaesthetic? Our group was recently served with a writ for alleged hoarseness following intubation. The suit was dropped when the fact was established that the patient had been hoarse long before she received the anaesthetic.

These are just a few examples of how important it is to "know your patient" before you administer the anaesthetic.

Consent for Anaesthesia and Surgery

Consent for anaesthesia and surgery, signed by the patient while in his normal state of mind, should always be obtained before administering the anaesthetic. Otherwise, the anaesthetist could be liable for assault. "While in his normal state of mind" is essential. Consent while under premedication should never be accepted. Premedication produces amnesia. If the patient is under legal age, a parent or guardian's signature *must* be obtained.

In our hospital the policy is never to administer an anaesthetic until the consent form is signed. If the patient cannot sign because of his condition, we insist that an immediate relative give written consent or the surgeon sign an affidavit stating that the operation is an absolute necessity. For "staff," or "charity" patients a hospital administrator signs. You have read in the newspapers, many times, how patients have sued doctors for administering anaesthetics and performing operations without consent.

Identification of Patient

We have all heard of the wrong patient being operated upon, or the wrong leg being amputated, or the good eye enucleated. Judgments amounting to thousands of dollars have been rendered against doctors here in Canada for these and similar acts of carelessness. It is as much the anaesthetist's responsibility as it is that of the surgeon to ensure that the correct patient is in fact being operated upon, or that the correct part of the right patient is in fact being operated upon. Check the chart and make sure that you have the right patient—patients with identical names have come to the operating suite from the same ward, with entirely different surgical conditions.

Have the surgeon identify the patient, and under no circumstances start an anaesthetic before the surgeon is known to be available. I know of an incident where an anaesthetic had been administered for an hour when the surgeon was

found to be operating in another hospital at the same time. What recourse would that anaesthetist have had if an "accident" had occurred during that anaesthetic?

Administration of the Anaesthetic

Precaution should be taken in administering an anaesthetic to patients with a known "full-stomach." More properly, one should state that an anaesthetic should never be administered to such a patient. Statistics have proven that the greatest percentage of "anaesthetic deaths" are due to aspiration of stomach contents. A street brawl in a large city sent a man to hospital with a fractured jaw. The patient's stomach was known to be full of food and spirits. Operation was not urgent, but was booked as an emergency. The anaesthetic was administered, the patient aspirated and died. The assailant was then charged with manslaughter, not assault, and a writ was issued against the anaesthetist also, for abetting manslaughter.

It is not feasible to have all stomachs empty, especially in maternity cases. But it is possible to delay most operations 4 to 5 hours, or to have the stomach aspirated, and to have a stomach tube inserted.

Our equipment should be in proper working order, and I would especially stress the anaesthetic machine. Soda lime burns of the face due to defective to-and-fro canisters have occurred; ether traps, improperly placed, have produced severe cases of pulmonary oedema; gas cylinders have been placed on the wrong outlets, and several deaths have resulted. Are your machines pin-indexed? Are you using the accepted colour codes for anaesthetic gas tanks?

Syringes, spinal sets, regional block sets should be sterilized by autoclaving. Ampoules ,especially those containing local anaesthetic solutions, should never be soaked in alcohol or formalin, or an antiseptic solution. You are familiar with the famous legal case in England three years ago, relating to spinal anaesthesia, in which the judgment implied that hereafter the use of ampoules sterilized in solutions would be tantamount to malpractice. Also, ensure that the drugs you use come from reputable pharmaceutical firms.

Place a blood pressure cuff on the arm, record the preoperative blood pressure and pulse, and operative blood pressure and pulse. An "anaesthetic death" occurred in the operating room; the anaesthetist's spymanometer was broken and blood pressure was never recorded. The anaesthetist's protective insurance company paid damages without attempting to contest the action.

Before starting a general anaesthetic, have the patient strapped on the table. Several hospitals and personnel have been sued over broken bones occurring from a fall from the operating table. Make sure that an orderly or nurse is present, especially the latter with female patients, for reasons I need not stress here.

Check the patient's posture. Pressure exerted over vulnerable nerves—ulnar, popliteal, brachial plexus, etc.—can and have produced serious neurological sequelae with resultant legal action. To play safe, have the hospital personnel posture the patient, and then you will not be held responsible if any untoward complication appears.

Amputations of legs and arms as a consequence of neglected tourniquets have occurred. If the anaesthetist aids in the adjustment of the tourniquet, he must also accept the responsibility of removing that tourniquet when the operation is completed.

Anaesthetic Mishaps

So called "anaesthetic mishaps" have produced the largest number of threats, writs, and court judgments. Time will not permit me to discuss these but I would like to mention a few.

Orbital area. Corneal abrasions from volatile anaesthetic agents, or corneal abrasions from trauma during or following an anaesthetic have led to a number of serious threats. Conjunctivitis and blindness due to pressure on the eye; or supra-orbital neuritis due to pressure have been known to occur. Do you take proper precautions in protecting the orbital region?

Teeth. Broken teeth, bridges, traumatic removal of teeth, especially in children, have led to the greatest number of threats. Are you protecting the teeth during intubation? If teeth are broken and parts cannot be found, do you X-ray the chest for the missing part? Broken teeth are an accepted hazard in modern anaesthesia, and you must never accept financial responsibility for their repair.

Mouth gags and packs. Several serious complications have arisen over the use of mouth gags which have been too hot. Judgments have been rendered where patients have suffered severe burns of the face. Check the temperature of the mouth gag before it is inserted into the mouth Mouth packs for dental extractions, and tonsil and adenoid packs have led to several severe and fatal accidents, with judgments rendered against the physicians. Count the number of packs inserted, and count the number removed, and above all only use packs which have strings attached. Many a pack has slipped and produced obstructed breathing and death.

Spinal anaesthesia. Complications of spinal anaesthesia, such as paraplegia, broken needles, nerve root injuries, are familiar to all. It is sufficient to say here that we must use sterile equipment, with sterile technique; spinal drugs that have been autoclaved, not soaked; and *never* administer a spinal anaesthetic to an unwilling patient; to one who is suffering from low-back pain, or to one who has disease of the peripheral nervous system.

Intravenous anaesthesia. Barbiturates injected extra-vascularly have produced necrosis of tissue, and nerve damage, especially to the median nerve in antecubital fossa. Intra-arterial injections are not rare. Suffice it to say that we should use the weakest solution which will produce the desired result, and ensure that we are injecting into a vein by palpating the vessel for pulsation Remember that a tourniquet will obliterate arterial pulsation, and that aberrant ulnar arteries are not rare.

Explosion. Explosion will be mentioned only briefly, but in Canada during the past year there have been two court actions over anaesthetic explosions. A judgment of several thousand dollars was rendered against an anaesthetist. Do you use the proper choice of anaesthetic agents in the presence of explosion

hazards, and does your operating room meet the accepted Canadian hospital standards in the matter of explosion hazards?

Blood transfusions. Several suits based on deaths due to incompatible blood transfusions, and one based on a death due to air embolism during a pressure transfusion, have been tried recently in Canadian courts. There has been no effective defence.

Recent reports in the U.S.A. indicate that for every 3,000 blood transfusions, there occurs one death. We must ensure that we administer the proper type of blood to the patient; we must ensure that a proper cross-match has been done, and we must ensure that the blood designated for a certain patient is given to *that* patient. We must take extra precaution that so-called "unmatched" blood is really necessary.

Minimal analgesia. The technique of controlled apnoea with relaxant drugs plus minimal analgesia has been introduced in many centres. The advantage of this method of anaesthesia must be carefully weighed. In the United States, writs have been issued against anaesthetists employing this technique, in which patients have claimed, with proof that (*a*) they were "awake" during the operation, and heard the surgeons discussing the prognosis of their case, and (*b*) they experienced pain during the operative procedure. The judgment in these cases will be interesting.

Postoperative visits Postoperative visits are most important. Some threatened actions, and some actual actions against anaesthetists would be avoided if we saw the patient postoperatively and had a friendly chat, and discussed their complaints.

Records. Accurate detailed records of the preoperative examination, the actual anaesthetic procedure, and postoperative visit must be kept. Hospital or physician's records are always demanded in a medico-legal case

If a serious complication should occur, such as to the eye, the vocal chords, or the spinal nerve roots, always obtain the best consultant opinion available. The consultant should write his report on the hospital chart An anaesthetist should never consider himself an authority in a medical field outside his own specialty.

Many physicians have needlessly involved themselves in legal complications by a careless "slip of the tongue" in the presence of a patient. An acknowledgment of a mistake or mention of a protective insurance plan can be fatal. However, notify your insurance company if you feel that dissatisfaction is evident and follow the advice offered by them. These protective insurance companies have excellent lawyers, trained in medico-legal matters.

The incidents above are just a few of the many pitfalls that anaesthetists encounter during their every-day practice. Whether we like it or not, we will be threatened or sued if we slip on some minor detail. The public is "suit" conscious, and we must protect ourselves and try to avert as many of these suits as possible.

I know this presentation may have sounded like a sermon. Sydney Smith, a London clergyman and wit of the nineteenth century, said: "Preaching has become a by-word for long and dull conversation of any kind; and whoever wished to imply, in any piece of writing, the absence of everything agreeable and inviting, calls it a sermon."

A medical-legal case is neither agreeable nor inviting, and I feel that we, as anaesthetists, could take better precautions; that we must realize that even the best of us have human frailties and that even the best of us may sometimes be careless. Remember, *"it could happen to you"*

REFERENCES

1. *Hughston* v *Jost*, Ontario Weekly Notes 1943, p 3
2. GRAY, K. G. Law and the Practice of Medicine. Revised edition Toronto: Ryerson Press. (1955).
3. REGAN, LOUIS J. Doctor and Patient and the Law C V Mosby Co., (1951)
4. MEREDITH, WILLIAM C J. Malpractice Liability of Doctors and Hospitals Carswell Co. Ltd. (1956).
5. HILTON, J. H. B. Medico-Legal Aspects of Anaesthesia. Canad M.A.J 69.641–645 (1953).