MEDICOLEGAL CASE REVIEWS

# The Elements of Medical Malpractice: An Overview

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*Physicians often fail to meet their patients' expectations. A suit for medical malpractice can follow whenever the level of patient dissatisfaction leads individuals to seek a legal remedy. In this review Gittler and Goldstein categorize the types of medical malpractice litigation and place them in the context of infectious disease practices. This is the third in an ongoing series of medical-legal cases and reviews. We intend to encourage dialogue, share our experiences, and begin to create a body of information that will be of value to physicians who provide patient care within an environment in which misunderstandings occur and patient expectations are not always met. As with most other infectious disease issues, prevention is the best strategy.*

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**Most physicians will be involved in a medical malpractice case sometime in their career in one of several capacities, such as a defendant, a treating physician, or an expert witness. Proving that malpractice has been committed is based on substantiation of a variety of elements and issues. This article offers an overview of the basic theories or types of claims of malpractice: 1) lack of due care; 2) lack of informed consent/battery; 3) vicarious liability/respondeat superior/negligent supervision; 4) injury to third parties; and 5) abandonment. While these elements hold true in general, the laws of malpractice, the procedures involved, and the judicial process vary from state to state and from country to country.**

Claims of medical malpractice are an important part of general patient dissatisfaction with modern health care [1]. According to surveys, only one in 30 calls of inquiry to legal firms about malpractice actually results in the filing of a suit [1]. Patients file malpractice lawsuits because of a variety of factors, including poor relationships with their doctors that antedate the alleged malpractice, medical advice to seek a legal remedy, and media advertising [1, 2]. If ~1% of hospitalizations result in adverse events because of potential physician negligence [3] and that figure is extrapolated to the ~33.5 million hospitalizations that occur in the United States annually, then each year there are ~340,000 potential cases of malpractice arising from care in hospitals [1].

In a study of 30,195 randomly selected hospital charts, it was found that 3.7% of patients had injuries and that negligent care was responsible for 285 of these injuries [3, 4]. Approximately 50% resulted from operations and included wound infections, which accounted for one of seven adverse events [4]. Complications related to treatment with drugs accounted for 19% of adverse events. The most frequent drug-related adverse events were associated with the use of antibiotics, which accounted for 16% of all adverse drug reactions [4]. Drug-related adverse events were more common in elderly patients (>65 years) than in any other age group while the 45–64-year-old age group accounted for the most wound infections. It was not noted whether the antimicrobial-related adverse events were the result of the practices of generalists or specialists or a combination of the two.

Consequently, during their professional career, most physicians will have some experience with a malpractice lawsuit, either as the defendant or as one of several named defendants. Others will be involved as a treating physician or as an expert witness. Regardless of the circumstances surrounding a lawsuit, it is helpful to be able to put malpractice claims in context and to understand the elements of malpractice.

Medical malpractice cases, while often grouped under the one heading of "medical malpractice" or "medical negligence," actually comprise several distinct areas of potential liability for medical professionals. This article presents a brief overview of the types of claims that physicians face under the

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broad heading of medical malpractice. We invite comment on these issues and hope to provide additional, detailed discussions on the topics mentioned below.

While each medical malpractice case has its own set of issues, the most common types of medical malpractice litigation, ranked in order of frequency, are as follows: 1. Lack of due care; 2. Lack of informed consent/battery; 3. Vicarious liability/respondeat superior/negligent supervision; 4. Injury to third parties; and 5. Abandonment.

## Lack of Due Care

Lack of due care is the most common stated cause for the filing of a malpractice lawsuit. This term is what most people would initially associate with the phrase "medical malpractice" and connotes a lack of proper medical care or improper medical treatment of a patient.

In order to prevail on this type of malpractice claim, the patient must establish at least three elements:

*The existence of a patient-physician relationship.* This means that the physician has formally consulted about, treated, or given advice to a patient, no matter how superficially or briefly. Informal "curbside," hypothetical consultations generally do not rise to the level of a patient-physician relationship. It is the existence of this relationship that creates the duty on the part of the physician to treat the patient and to treat him/her properly. In order to withdraw from a patient's care, a physician must give adequate notice to the patient, allowing him/her time (no specific time is defined, and this is decided on a case by case basis) to find other care.

*The violation of the "standard of care."* The plaintiff/patient must establish that the care he/she was given was inadequate in comparison with that provided by the majority or a respectable minority of physicians practicing under similar circumstances. This means that generalists and specialists are held to different standards [5] unless a generalist attempts to treat a specialized problem that would ordinarily call for a referral [6, 7]. In that case, the generalist will be held to the standard of the specialist. Similarly, circumstances may vary as to rural versus urban environments, although such geographical distinctions are generally disappearing.

*The failure to meet "the standard of care" was a substantial factor in causing the damage.* This is the basic rule of "no harm, no foul." The patient must be able to prove that actual damage did occur, although in some situations, the patient will be assisted by the doctrine of *res ipsa loquitur,* which essentially provides that certain results do not occur in the absence of negligence.

While physicians are generally required to exercise the degree of care ordinarily possessed by fellow practitioners ("peers") under similar circumstances, there are numerous factual situations in which this basic rule can be applied, and the analysis must be adapted for each situation. For example, the nonspecialist may be held liable for medical malpractice for failing to call in a specialist [8]. The nonspecialist could be held liable if it were proven to a judge or jury that a majority of nonspecialists under the same circumstances would normally have called in a specialist. This rule applies to the ordering of diagnostic tests, the interpretation of test results, the institution of therapy, or the withholding of therapy. In addition, one must still prove causation for this element to be of significance.

Proof of the standard of care, i.e., proof of what a reasonable doctor would or would not have done under given circumstances, in most instances must be established by the "expert testimony" of another physician. Many physicians assume that there are general, concrete guidelines generated from textbooks, published peer-reviewed articles, or local customs for establishing, guiding, and evaluating their actions against "the standard." However, while such sources may be used in court, the standard is generally established by expert witness testimony as subjectively interpreted by the judge or jury.

Sometimes, verisimilitude can be a matter of the expert's credentials, the attorney's presentation of the credentials of the expert witness, or how well the expert withstands cross-examination. Ultimately, it is the believability of the particular expert's testimony by the jury, rather than any absolute medical doctrine, that usually determines the specifics of standard of care in any particular case. One would hope that the physician who chooses to become an expert witness would impartially review the case records, give advice to the attorney who has solicited the testimony on the basis of reasonable care guidelines, and not be influenced by the attorney's strategy. Unfortunately, this is often not the case.

Again, there are circumstances where the proof of damage does not require expert testimony. In instances where the negligence would be obvious, even to a layperson, such as that of a surgeon who cuts off the wrong leg, then there need not be expert testimony to establish this element. The doctrine of *res ipsa loquitur,* referred to above, would apply.

## Informed Consent

While usually included under the same heading of medical malpractice, the issue of "informed consent" usually arises apart from, or parallel with, issues of lack of due care. Except in very limited cases, failure to provide patients with sufficient information regarding their treatment to enable him or her to make an informed decision constitutes lack of informed consent. As noted below, a claim for more aggravated misconduct known as battery can also arise when there was no consent whatsoever to a particular procedure or treatment of a portion of the body.

### The Negligence Issue

Informing a patient about treatment options, including the option of no treatment, and the likely ramifications of each particular treatment is considered by the law to be an integral

part of the physician's overall obligation to the patient. In other words, the physician has a duty to make a reasonable disclosure of available choices with respect to a proposed treatment option and of the significant or common dangers potentially involved with each choice. Failing to provide such disclosure creates a basis for a claim of lack of informed consent.

In order to prevail in such a case, the patient must show 1) that the physician failed to provide the patient with adequate information to enable him or her to make an intelligent choice regarding the course of treatment; and 2) that a reasonable patient would not have consented to a given course of treatment or procedure, had the appropriate and pertinent information been disclosed.

The significance or material nature of the information is generally not the subject of expert testimony. Rather, the judge or jury is asked to determine for themselves whether or not a reasonable patient would have consented to or refused a given treatment or procedure if the omitted information had, in fact, been provided. Such information may be transmitted in writing or verbally, or it may even be implied in limited circumstances. In emergency situations, consent to treatment is usually presumed by law.

Verbal informed consent is inferior from the physician's perspective, since recollection of the exact discussion of consent by the plaintiff and the defendant often varies. Yet, written informed consent alone may not be sufficient and is merely a way of showing that the patient has been advised of certain risks. Blanket informed consents that a patient may sign on admission to the hospital will frequently not cover an individual situation, which must be specifically addressed by the physician. The infectious diseases specialist must consider various ramifications and situations. For example, what does one need to tell a patient about the potential nephrotoxicity or ototoxicity related to the use of aminoglycosides or about the use of a cephalosporin antimicrobial agent when the patient is allergic to penicillin? In some situations, it is preferable that the patient sign a form acknowledging such risks.

The courts have recognized that clinicians could not reasonably be expected to fully disclose every possible risk. The California Supreme Court articulately expressed this rationale as follows: "The patient's interest in information does not extend to a lengthy, polysyllabic disclosure on all possible complications. A minicourse in medical service in not required; the patient is concerned with the risk of death or bodily harm, and the problems of recuperation. Second, there is no physician's duty to discuss the relatively minor risks inherent in common procedures when it is common knowledge that such risks are of very low incidence"[9]. The use of experimental agents or participation in a research protocol has its own set of guidelines and comes under the heading and province of Human Use (a.k.a. Human Protection or Research) Committees. More stringent federal guidelines may apply in such situations.

### Battery

Informed consent issues are almost always treated as a subcategory of medical negligence. However, in certain instances, the fact that the patient has not consented to a given treatment or procedure in the first place can give rise to a claim of battery (unconsented touching), with claims for punitive damages. The law generally discourages punitive damage claims against physicians, and legislatures have enacted statutes that place additional hurdles in front of patients seeking to make such claims [10].

For example, California law states that "In any action for damage arising out of professional negligence of a health care provider, no claim for punitive damages shall be included in the complaint . . . unless the court enters an order allowing an amended pleading." That section further requires that to obtain such a court order, patients must establish that there is a substantial probability that they will prevail on such a claim.

Nevertheless, such suits can, and do, arise. For example, should a surgeon receive authorization to perform a given operation and then performs an additional or alternative procedure without the patient's consent, such conduct can give rise to a battery claim. In other words, receiving consent to perform a given procedure—such as tubal ligation—and failing to inform the patient of possible complications of the procedure and/or alternative methods of sterilization could give rise to a negligence claim on the basis of lack of informed consent. Receiving consent to perform a tubal ligation, and instead performing a hysterectomy, could give rise to a battery claim.

### Vicarious Liability

Under the doctrine of vicarious liability or *respondeat superior,* physicians may be held liable for the negligent acts of their agents, i.e., those persons actually acting or appearing to act on their behalf, including employees, even though the doctor is innocent of wrongful conduct. Such liability can be imposed when the agent's or employee's negligent conduct occurs while acting within the scope of the agency or employment. For example, a doctor may be held liable for the negligence of a nurse committed while acting as the doctor's employee or under his instruction. Generally, however, a physician will not be held liable for the negligence of another doctor who has been called in on a given case, because the relationship between physicians is typically that of independent contractors. On the other hand, theories of negligent supervision and hiring might create liability if the referring doctor should have known that the consultant was not competent.

### Third-Party Claims

Generally, a physician's duty does not extend beyond the patient to a third party, who is not a patient. However, under certain limited circumstances, a duty to nonpatients can arise. For example, a person could suffer emotional distress as a witness to a doctor's negligent conduct, i.e., a mother could suffer emotional distress witnessing the medical abandonment of her child.

In addition, some courts have found that a physician owes a duty to a person when the physician knows a patient may cause harm to that person. Specifically, a psychotherapist has a duty to protect certain third parties from a patient's dangerous propensities. For example, one *California Jury Instruction* [11] states: "If in exercising the degree of learning and skill required . . . a physician is, or should be able to reasonably foresee or predict that a patient's condition poses a serious danger of injury or damage to a third person, then the physician owes a duty to the third person to exercise reasonable care under the circumstances. . . ." In support of this concept, the court found that a doctor was liable to a person injured in an auto accident when the doctor failed to warn the patient not to drive in an uncontrolled diabetic condition [12]. More specific illustrations affecting infectious diseases doctors will be the subject of a future article.

## Abandonment

Once the physician or other health care practitioner undertakes the responsibility of treating a patient, the physician has a duty to continue that treatment as long as immediately necessary, unless they mutually terminate the relationship, or the patient dismisses the physician. For the physician to withdraw from a patient's care, the physician must give the patient due notice and ample opportunity to secure other medical attendants. For example, one *California Jury Instruction* [13] states: "once a physician has undertaken to treat a patient, the employment and duty . . . to a patient continues until ended by consent or request of the patient or the physician withdraws from the case after giving the patient notice and a reasonable time to employ another doctor [or] [the condition of the patient is such that the physician's services are no longer reasonably required]. . . . A physician may limit his or her obligation to a patient by undertaking to treat the patient only for a certain ailment [or only at a certain time or place]. . . ."

## Conclusion

These are the elements that make up most malpractice actions. Each case should be evaluated using these criteria as a general guide. However, local laws and peculiarities of local law vary and take precedence.

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