



Medical Gray in a Black-and-White Legal World: The Rules of Medical Malpractice

Bryan A. Liang, MD, PhD, JD

Probably the most prevalent fear of all health care providers in relation to the law (and mistakenly, the only fear to some) is the threat of medical malpractice. There is much “lore on the floors” regarding medical malpractice—what it is and what it isn’t; how a friend of a friend was held to some arcane “standard of care” in court; stories by attending physicians about someone who was sued under some bizarre, one-sided facts, all of which required some special deviation in care. Although there is much misinformation disseminated about medical malpractice, there appears to be at least some truth to the view that the medical malpractice system does not appropriately change provider behavior.^{1,2,3,4} Nevertheless, understanding the basic concepts of the medical malpractice system *before* having to discover them in a lawsuit may allay fears and provide the best opportunity to deal with a lawsuit through an increased knowledge as to its operation. This article reviews some of these concepts. Because malpractice is a function of state law, each state will have slightly different characteristics; however, the fundamental concepts reviewed here will be generally applicable across state lines.

At the outset, it should be emphasized that the majority of medical malpractice cases brought to court are found in favor of the provider. But the extensive toll of time, money, and stress makes no one a winner in a medical malpractice suit, so the best strategy is indeed prevention.

It should also be noted that standard malpractice is not subject to criminal proceedings. However, being tried in civil court does not preclude trial in criminal court. There are circumstances under which a provider *may* be tried criminally—if the negligence claimed is considered a gross lack of competency, inattention, or wanton indifference to the patient’s safety, providers may face criminal prosecution.⁵

THE NEGLIGENCE RULE

The general standard for medical providers is deceptively simple: Medical providers are expected to ren-

der that level of care and skill that a member of the profession in good standing and relevant specialty would provide under similar circumstances.⁶ Thus, the focus in a malpractice case is theoretically on the care provided, not merely on untoward results that may have occurred through no fault of the provider. Bad results do not by definition constitute medical malpractice.

Medical malpractice claims are governed by the *negligence rule* in tort law (Table 1). The patient-plaintiff, in order to prevail, must show by a preponderance of the evidence (ie, it is more likely than not) that the provider had a *duty* to the patient to render non-negligent care (ie, care that a practitioner in good standing would have provided); that the provider *breached* that duty by not providing such care; and this breach *caused* the patient *injury or damages*. The plaintiff must prove each factor to obtain a judgment in his or her favor. If the case is so proved, monetary damages to compensate for the injury are awarded. Otherwise, the provider is entitled to judgment (ie, he or she wins).

The first and fourth factors are relatively simple to show in most cases: a provider has a duty to provide non-negligent care to a patient when a physician-patient relationship is established, and damage to the patient is the reason that the litigants are in court. Rather, usually at issue are the second and third factors: whether a breach in the standard of care occurred and, if so, whether this breach caused the injury. This is depicted by a 2 × 2 table such as that in Figure 1. Tort liability exists only in the upper left quadrant, in which both care that falls below the standard of care and causation are present. The upper-right quadrant—care that falls below the standard of care but no causation—can represent a scenario in which care did not meet

Dr. Liang is the Arthur W. Grayson Distinguished Professor of Law & Medicine, Southern Illinois University School of Law and School of Medicine, Carbondale, IL; Research Council Faculty Fellow, Instituut voor Sociaal Recht, Katholieke Universiteit, Leuven, Belgium; and a member of the Hospital Physician Editorial Board. Dr. Liang is supported by Katholieke Universiteit Leuven Grant No. F/98/084.

Table 1. Rule of Negligence in Medical Malpractice

Rule of Negligence	Requirements	Standard
General rule	Plaintiff must show all 4 of the following factors: (1) Preexisting duty on the part of the physician; (2) Physician breach of that duty; (3) Causation between breach; and (4) Plaintiff injury or damage.	Plaintiff must show all factors by a preponderance of the evidence
Exception: doctrine of <i>res ipsa loquitur</i>	Plaintiff must show all 3 of the following factors: (1) The injury sustained was a kind that does not ordinarily occur in the absence of negligence (2) The injury was caused by an agency or instrumentality in the exclusive control of the defendant (3) The injury was not due to any voluntary action or contribution on the part of the plaintiff	If plaintiff meets requirements, defendant is presumed negligent; defendant must rebut breach of standard of care and/or causation by preponderance of the evidence

the professional standard, but fortuitously, no harm occurred.

Establishing a Breach of the Standard of Care

Because the standard by which the provider will be judged is a professional one, expert witness testimony will usually be required to show what care and actions a reasonable provider would have provided and performed in the circumstances. Because of the wide variations in care provided by practitioners (and perhaps in part due to the substantial fees available to testifying experts), there will be physicians and others who will testify to the plaintiff's claims as well as to the defendant's perspective regarding the standard of care. Such a circumstance results in the common "battle of the experts" in court.

The standard of care indicated by the expert witnesses must be appropriate for the circumstances existing at the time of the clinical activities in question⁷; some basis other than personal anecdote of the expert must support the standard.⁸ No expert can claim a standard of perfection for any physician.⁹

There are many circumstances in which experts disagree as to what the standard of care is. If there are alternative schools of thought that are applicable to a particular clinical circumstance, the defendant is entitled to be judged by the school that he or she follows.¹⁰ This is sometimes known as the *minority practice doctrine*. The defendant's school of thought, however, must be accepted and recognized by a respectable minority of the profession¹¹—the defendant cannot be a minority of one. But if the provider did correctly follow the minority practice, he or she is not negligent.

Ultimately, once the standard of care is indicated through expert testimony, it is up to the jury to apply that standard to the case at hand. Thus, the specific standard of care is critical in determining the end result of the case.

Establishing Causation

Expert testimony is also required to show that the breach actually caused the patient's injuries. The concept of causation, however, has certain legal subtleties that require attention. It is essential to note that plaintiffs, in order to win, do *not* need to show that the provider's action was the *sole* cause of harm; the provider's action merely needs to be one plausible cause of harm. In addition, the plaintiff does not need to show that all other possible causes of harm are negated. The plaintiff merely needs to show, by the preponderance of the evidence, that some injury was suffered as a result of the provider's conduct, and this must be supported by expert testimony indicating the provider's substandard care *proximately* caused the harm.¹²

Proximate cause has a specific definition in the law. Proximate cause has 2 components, and both must be shown. The first component is a basic one: the harm would not have occurred *but for* the physician's actions.¹³ The second component is a bit more subtle: the harm was *reasonably foreseeable* by the provider as a natural and probable result of the provider's actions.¹⁴ Thus, providers will not be liable for remote and unforeseeable results.¹⁵ Of course, what is remote and unforeseeable is a subject for expert testimony and jury evaluation in each case.

What is an “Expert Witness”?

A question often arises as to the qualifications that a person must have in order to testify as an expert in a medical malpractice trial. It bears emphasizing that *being an expert in the law differs from being an expert in medicine*. Experts in medicine may be high-level researchers in academic centers or medical practitioners with extensive experience in the field. However, for legal purposes, “experts” do not require this level of accomplishment, and a person may be considered an expert and may testify on the standard of care even if he or she has never treated the disease that afflicted the plaintiff, as long as he or she has some general experience with the clinical issue and causation.¹⁶ Furthermore, experts for legal purposes also do not necessarily need to be in the same specialty as the defendant-physician,¹⁷ nor do they have to be physicians, even when a physician is the defendant.¹⁸

CASE I PRESENTATION

Patient H¹⁹ was an unmarried, pregnant female with a significant smoking history. She had no prenatal care until her 26th week of pregnancy, when she was assisted by a church-based community service organization and became a patient of Dr. D, an obstetrician-gynecologist. Two months later, she began to have contractions. On 3 consecutive days, she was admitted to a hospital; however, on each occasion, she was released with a diagnosis of false labor/abdominal pain. On the fourth day, at 36 weeks’ gestation, Dr. D saw patient H as an outpatient. Her physical examination showed a thinning and dilation of the uterus. In response, Dr. D referred patient H to the hospital, where she was placed on oxytocin. The following day, she gave birth to a son. After birth, the infant’s Apgar scores were high. However, after a brief stay in the nursery, he developed respiratory distress syndrome (RDS) and was subsequently transferred to the neonatal intensive care unit (NICU). There, the infant’s condition worsened and on his second day of life, he was placed on a mechanical ventilator. Although the NICU physicians managed the RDS appropriately, the infant experienced complications including sepsis, thrombocytopenia, and a cerebral hemorrhage. These complications resulted in multiple disabilities, including blindness, cerebral palsy, diabetes insipidus, and severe retardation. The infant remained hospitalized for approximately 3 months. After his second birthday, the child died. The mother (H) then filed a medical malpractice claim against Dr. D, alleging that Dr. D fell below the standard of care in managing her pregnancy, and that this care resulted in the child’s death. Dr. D countered that medically appropriate care

	Causation	No Causation
Negligence	Liability	No liability
No Negligence	No liability	No liability

Figure 1. 2 × 2 table depicting the roles of negligence and causation in medical malpractice liability.

was provided and that H’s smoking contributed to the risks to her infant and his subsequent complications.

Legal Discussion

The court that decided this case held that H could not recover on the medical malpractice claim against Dr. D.¹⁹ Because Dr. D was H’s attending physician managing H’s pregnancy, Dr. D had a duty to provide H with medically appropriate, non-negligent care. According to the court, Dr. D may or may not have breached this duty. However, an assessment regarding breach of the standard of care did not have to be reached because there was no causation—Dr. D’s activities did not cause the damages or injury that H experienced (ie, her child’s death). Dr. D’s obstetrical expert testified that infants born at gestational ages of 20 to 37 weeks are premature and are likely to develop RDS because of the immaturity of their lung surfactant; approximately 20% of premature babies experience RDS, and premature babies are more susceptible to infection than those born at full term. This expert indicated that in his judgment, the infant’s prematurity caused the difficulties experienced; however, he deferred to the judgment of a neonatologist on the issue of RDS and its potential effects on babies.

Neonatal expert testimony indicated that even though the infant’s prognosis appeared favorable according to the Apgar scores, he was, in fact, premature, and this may have caused RDS. This expert further noted that the infant’s condition was very uncommon and that even if he had been born at full term, he could still have experienced RDS and its sequelae. Indeed, this expert stated that other than prematurity, she could discern nothing at birth to which she could attribute the child’s difficulties. Further, the severity of his illness made the contention that at full term he would not have experienced complications highly questionable. Finally, the expert indicated that maternal smoking, the mother’s low socioeconomic status, and the mother’s unmarried state could all have contributed to a fetus’ risk of premature delivery. Thus, even if Dr. D breached the standard of care by inducing

delivery prematurely, because the infant's condition would probably have been similar even 1 week later, Dr. D's action did not cause the child's significant disease and death. In terms of the grid depicted in Figure 1, without causation, this case falls into either the top-right or the bottom-right quadrant—no liability. Dr. D was therefore entitled to judgment in his favor.

CASE 2 PRESENTATION

Patient W²⁰ was a generally healthy 21-year-old African American woman who experienced severe pelvic and abdominal pain. She was taken to the emergency department (ED), where she was treated and then released. Approximately 5 weeks later, W returned to the ED with abdominal pain, vomiting, neck pain, lethargy, and a red, pruritic rash on her arms and thighs. The ED physician diagnosed a "viral illness" and prescribed aspirin and medication for pain and nausea and discharged W. Four days later, W experienced 2 grand mal seizures and again was brought to the ED, now with fever, lethargy, and headache; she was also "hot to the touch." After being given an initial diagnosis of encephalitis and stabilized by medical staff, W was referred to Dr. A, an internal medicine physician. Dr. A admitted her to the hospital. During her 5-day stay, Dr. A did not take her medical, social, or family history. Furthermore, Dr. A did not review W's medical records from the previous 2 ED visits.

On admission, W was tachycardic, and blood work showed elevated levels of liver and cardiac enzymes, as well as other abnormalities. Based on W's symptoms and laboratory results, Dr. A diagnosed either viral encephalitis or viral meningitis. Dr. A treated her with doxycycline. Dr. A did not repeat any laboratory studies, nor did he ask for a neurologic consultation to investigate W's grand mal seizures.

During this 5-day hospitalization, W again broke out into a generalized rash, which Dr. A believed was an adverse reaction to the doxycycline; in response, Dr. A substituted erythromycin and gave her calamine lotion and diphenhydramine for the rash.

One day after W's discharge from the hospital, she visited Dr. A's office because the rash had gotten worse; Dr. A treated her with a diphenhydramine injection and increased her oral dose of diphenhydramine. At this time, Dr. A noted that W had a swollen face and swollen lymph nodes behind the ear. Dr. A did not treat these symptoms.

Two days following the visit to Dr. A's office, W returned to the ED because of a generalized rash that was unresponsive to diphenhydramine. The ED physician started her on high-dose prednisone. W present-

ed the next day to Dr. A's office, and because she was feeling some relief from her symptoms, Dr. A continued her on the regimen of prednisone and diphenhydramine.

W continued this treatment for approximately 1 month, at which point Dr. A discontinued the prednisone. Three days later, W went back to Dr. A's office with complaints of chest pain; Dr. A did not order an electrocardiogram (EKG) and continued her on diphenhydramine. Five days after her visit for chest pain, W again returned to Dr. A's office, but saw Dr. A's colleague, who believed that W was suffering from "collagen vascular disease lupus E." Dr. A's colleague spoke to Dr. A regarding the lupus diagnosis. Dr. A did not perform additional studies or an EKG. W returned to see Dr. A the next day with complaints of labored breathing, lethargy, and chest pains. Dr. A diagnosed a viral infection and again treated her with doxycycline. Dr. A did not perform any tests at that time. Later that afternoon, W experienced fever, severe chest pain, tender abdomen, and was shown to have an enlarged liver, and an enlarged heart surrounded by fluid on return examination. Dr. A admitted W to the hospital, and admission laboratory tests showed significant organ failure and tissue death. In response to these test results, Dr. A treated W with doxycycline. W's condition deteriorated to such an extent that Dr. A called a cardiology consult. The cardiologist ordered tests for lupus and strongly recommended steroid treatment owing to the likelihood of collagen vascular disease. Dr. A did not initiate steroid therapy until 10 hours later; 9 hours after that, W died due to cardiac arrest.

W's family sued Dr. A for medical malpractice, claiming that Dr. A's management of W's treatment was below the standard of care. Dr. A claimed that there was no malpractice because the standard of care was met and that the cause of W's death was undetermined.

Legal Discussion

Dr. A was found liable for malpractice in this case.²⁰ Because Dr. A was W's attending physician, Dr. A had a duty to provide non-negligent care to W. The court indicated that Dr. A breached that duty by providing substandard care. On the basis of testimony given by an expert witness, Dr. M, Dr. A provided substandard care in several aspects of W's treatment: Dr. A did not obtain a full medical, social, or family history from W; Dr. A did not properly evaluate or follow up W's seizures; Dr. A incorrectly used doxycycline to treat a diagnosed viral infection; Dr. A did not obtain additional tests to follow up on abnormal results of liver function tests, heart studies, and other diagnostic tests

that were obtained during the time W was in Dr. A's care; Dr. A failed to note that terminating W's steroid treatment was associated with her clinical deterioration; and Dr. A failed to arrange for appropriate consultations when faced with W's diagnostic challenges. In addition, the expert witness noted that W fell well within the standard presentation of a lupus patient owing to her race, age, gender, symptoms, medical signs, and laboratory values; indeed, lupus was a diagnosis that the other physicians favored.

With regard to causation, although the absolute cause of W's death was not known, lupus was more probable than not to be the cause of her death; Dr. A's incorrect treatment eliminated her chance of surviving this illness. W, through W's family, fulfilled all of the factors necessary to show malpractice—a breach in the standard of care, causation, and damage (in this case, W's death). Thus, the court held that Dr. A was liable for damages in tort for medical malpractice.

RES IPSA LOQUITUR: MAKING THE PROVIDER PROVE INNOCENCE

As is illustrated in the previous 2 cases, it is the plaintiff's burden to prove all the requisite factors of a negligence claim by a preponderance of the evidence. However, circumstances do occur in which the law allows the roles to be switched—the *provider* must prove he or she was *not* negligent. This is a situation of application of the doctrine of *res ipsa loquitur*—"the thing speaks for itself"—to shift the burden of proof to the defendant physician regarding breach and causation.

This doctrine is based upon the superior and often exclusive knowledge of the circumstances of patient injury that is within the purview of the treating physician(s).²¹ *Res ipsa loquitur* is therefore an evidence doctrine that allows an inference of physician negligence. Classically, 3 factors must be shown by the plaintiff in order for the court to apply the doctrine (Table 1): (1) the injury sustained was a kind that does not ordinarily occur in the absence of negligence, (2) the injury was caused by an agency or instrumentality in the exclusive control of the defendant, and (3) the injury was not due to any voluntary action or contribution on the part of the plaintiff.²²

Note that under factor 1, there is *no need for expert testimony*. Although expert testimony can be the source of this information,²³ it can also be supported simply on the basis of "common knowledge."

CASE 3 PRESENTATION

Patient M²⁴ injured her back, causing a great deal of discomfort. M was referred to surgeon Dr. D for diag-

nosis and treatment. M underwent a myelogram; after seeing the results, Dr. D indicated that the best treatment was a laminectomy. M agreed to the procedure. Cottonoid sponges were used to retract tissues in the surgical field during surgery. Each sponge contained a radiopaque marker that is generally visible radiographically. Each sponge was attached to strings that led outside of the surgical field and M's body to allow for assessment of the sponge count and location. Close to the end of the operation, a nurse indicated to Dr. D that one of the sponge strings had separated from the sponge. Dr. D asked the circulating and scrub staff for a sponge count; Dr. D also searched M's incision and the entire operating room without success. An intraoperative radiograph was taken of M, but Dr. D, Dr. D's assistant, and the radiologist could not locate the marker on the film. Dr. D then closed the incision and sent M to the recovery room. Several days later, M began experiencing severe pain out of proportion to the surgery. Dr. D ordered additional radiographic studies, which revealed the missing sponge. M then underwent another surgery to remove the sponge from M's body. M sued Dr. D for medical malpractice, claiming that Dr. D fell below the standard of care when the sponge was left in M's body and requested that the court apply the doctrine of *res ipsa loquitur* to the case. Dr. D countered that expert testimony was needed to prove negligence in this case.

Legal Discussion

In this case, the court ruled that the doctrine of *res ipsa loquitur* did apply.²⁴ The court first noted that during surgery, when a foreign object such as a sponge is left or lost inside a patient, a presumption of negligence is possible because these events generally do not occur in the absence of negligence. No expert testimony was needed for this conclusion because it was, according to the court, a matter of common knowledge. Next, it was clear that the instrument in question, the sponge, was in the exclusive control of Dr. D and his agents. Dr. D, as the surgeon in the case, placed these sponges in the locations necessary for the operation. Finally, because M was unconscious during the operation, there were no voluntary actions or contributions on M's part to the medical injury that was sustained. M was therefore entitled to have the doctrine of *res ipsa loquitur* applied by the court and to shift the burden to Dr. D to rebut the claims of negligence.

Although the doctrine of *res ipsa loquitur* is daunting and makes the defense of a medical malpractice suit quite difficult, it should be noted that *res ipsa loquitur* is not applicable in situations in which a patient's injury is

THE NATIONAL PRACTITIONER DATA BANK

In addition to the emotional and financial strains that accompany a malpractice suit, another aspect of a lawsuit against a health care provider may affect his or her practice for an indefinite period of time: a report to the National Practitioner Data Bank (NPDB). Hospitals must use the NPDB to evaluate applications for privileges and every 2 years to evaluate current staff privileges. It is therefore important for all providers to ensure that their records with the NPDB are accurate.

The NPDB is a databank of records that includes physician malpractice payments. The NPDB was created to try to prevent unethical or incompetent practitioners from moving from state to state to avoid discovery of the low-quality care they render. If a physician in a malpractice case is adjudicated negligent, or if a settlement payment is made to a plaintiff on behalf of a physician, this event must be reported to the NPDB within 30 days of final adjudication or payment by the party who makes the payment (eg, an insurer or hospital).¹

In addition to malpractice adjudications or payments, other events are also included in the NPDB and must be reported. State licensing boards must report any actions that result in revocation, suspension, or other restriction of a physician's license, as well as any actions that result in censure, reprimand, probation, or surrender of a provider's license. The response of state medical boards to the action must also be reported.

Further, any adverse action against a physician that restricts, reduces, suspends, limits, or denies clinical privileges or membership in a health care entity for greater than 30 days must also be reported to the NPDB. Such actions must be reported by the hospital, health care entity, managed care organization, or professional review committee from which the action arises. For actions relating to clinical privileges, however, only activities related to

patient care are considered reportable. Actions based on nonclinical deficiencies (eg, poor staff meeting attendance or inappropriate advertising) are not reportable. Professional societies are also required to report any revocation of a physician's membership in the society, after appropriate peer review, if the revocation is based upon clinical care deficiencies.

If a physician has been reported to the NPDB, he or she automatically receives a copy of the report. Reported physicians may file factual challenges to the report with the entity that reported them. If the dispute cannot be resolved, the physician may appeal to the US Department of Health and Human Services, which makes the final decision regarding the contents of the report and/or its correction. Physicians may also submit a rebuttal to a report (limited to 600 words); this rebuttal does not have to go through the formal review process necessary for factual challenges. A physician may file both a factual challenge and a rebuttal.

The information in a provider's NPDB file is confidential and public access is not allowed. Other groups that may access the NPDB include group practices, professional societies, state licensing boards, and managed care organizations.

REFERENCE

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SUGGESTED READING

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merely an uncommon complication or an inherent risk of the operation or medical treatment.²⁵ Furthermore, merely because injury occurs does not provide a valid basis for application of the doctrine.²⁶ This concept is founded on the premise that an injury alone does not usually indicate negligence. Thus, there are many situations in which the court will refuse to allow the plaintiff to use the doctrine of *res ipsa loquitur*; in these cases, which represent the majority, the plaintiff will have the standard burden of showing by a preponderance of the evidence the presence of all of the factors of negligence.

CONCLUSION

Malpractice is one of the aspects of law most known and feared by health care providers. However, most cases that go to trial are won by the provider; poor results are not generally grounds for a successful suit. Yet because of the emotional and financial toll that any suit extracts, understanding how the legal game is played is the best approach. By understanding the rules and basic nuances of malpractice, inappropriate actions based on legends and myth surrounding the law of malpractice can be avoided. **HP**

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