The truth about medical negligence

RAJINDER PAUL JINDAL

Assistant Professor, Department of Surgery, GGS Medical College, 32, Medical College Campus, Faridkot 151 203 INDIA e-mail: rpjindal2@hotmail.com

Sorry about that!

A vast majority of people believes that doctors are a negligent lot. This often implies that doctors are not courteous enough, are brusque to the point of being rude, are not available when needed, and prescribe unnecessary laboratory tests, scans and medicines. At a function organised by the Indian Medical Association on medical negligence, a veteran politician, otherwise very articulate, was at a loss to define it. Finally, he said, "Don't you people leave your scissors or gauze pieces in the stomachs of patients?" The usual complaints of being rude and unsympathetic pertain more to a lack of professional courtesy, which is our national trait. Doctors are no exception, though this national trait only explains their conduct and does not excuse or justify it.

Instances of leaving behind scissors and pieces of gauze in the abdomen of a patient are very rare. Such cases are uncommon to the extent of being anecdotal. Moreover, this would implicate only surgeons who operate on the abdomen and thus absolve a host of other surgeons, such as orthopaedic, neuro- and cardiothoracic surgeons, as well as all physicians. I do not think anybody will subscribe to the view that only abdominal surgeons are a negligent lot and, therefore, the question as to what constitutes medical negligence arises again. However, let us first consider the question of objects being left behind in the abdomen.

It is impossible for any non-medical person or even for many in the medical profession, be they physicians, nurses or paramedical staff, to understand how an object can be left behind in the abdomen of the patient. In fact, only those surgeons who have regularly performed major abdominal operations, especially in emergency departments, can understand how such an unfortunate accident may take place. Any surgeon, anaesthetist, or nurse who has seen or performed an exploratory laparotomy for a gunshot wound in the abdomen, multiple stab injuries or injuries sustained in a bomb blast, or laparotomies for internal bleeding in the abdomen due to causes such as a ruptured spleen or ectopic pregnancy, would understand what I mean. From the moment the patient is wheeled in to the ward, it is a race against time for the surgeon in charge of the patient. After what the surgeon considers reasonable resuscitation with intravenous fluids, blood, etc, he requests his anaesthetist colleague to take the patient to the operation theatre. A dialogue of the following nature, which often becomes acrimonious, usually ensues.

Surgeon: Come on, let's hurry. We can't afford to lose any more time.

Anaesthetist: What did you say was his blood pressure? Eighty? Do you think he will (with) stand anaesthesia?

Surgeon: I know what you mean. But we have no option. He will bleed to death.

Anaesthetist: Why don't you rush two (units of) blood and stabilise him a little more?

Surgeon: We have already pumped in two units. I am saving one for surgery. No more blood is available. Come on *yaar,* we have to do him.

Anaesthetist: Have you explained (the high risk) to the relatives?

It goes on like this for a while. Finally, the patient is moved to the operation theatre. The movements of the anaesthetist appear excruciatingly slow to the surgeon. Ultimately, the surgeon manages to open the abdomen. There is a wide gush of blood and intestines. Sponges are frantically inserted to stem the flow of blood. The surgeon sharply tells the assistant to help him find the source of bleeding. The nurse is told, for God's sake, to be prompt in passing the instruments. Someone is asked to speed up the drip and the infusion of blood. The anaesthetist says the blood pressure has fallen to 70 mmHg. The surgeon still cannot see where the blood is coming from. More packs are inserted. There is a free flow of adrenaline.

This goes on for what seems to be an eternity, though actually it may be only 10 minutes. At long last, the source of bleeding is identified and steps are taken to stop it (more packs are inserted). When the bleeding is under control, the surgeon examines the intestine end-to-end to locate the perforations and seal them. A search is made for any other injuries, which are corrected. Two hours have passed. The anaesthetist menacingly tells the surgeon to hurry up because the patient's pulse is very feeble and the blood pressure is still very low.

The physical and mental state of the surgeon at this point in time would make an interesting study for a psychologist. He is passing through this experience for the tenth, or perhaps the twentieth, time and certainly not the last one. His gloves, gown and feet are soaked in blood. Sweat flows freely from his forehead, even though it is December. He has a terrible and disgusting feeling that the patient might die before he can sew him up and send him out of the operation theatre. He silently curses the uncooperative anaesthetist. He berates himself for being overenthusiastic and conscientious. He prays to God to please bail him out this time and promises himself that he will never again operate on such a high-risk patient. A sense of extreme frustration and despair overwhelms him. He would like to spend some more time on tidying up the things in the patient's abdomen, but he knows he cannot afford to do that. He tells the nurse to make a sponge count to ensure that

none is left inside, while at the same time, he looks all around in the abdomen to make sure of the same thing. At last, he sews up the patient and sends him to the ward. The floor of the operation theatre looks like a place abandoned hastily after the perpetration of a violent crime.

In spite of the fact that a careful search is made for sponges or clamps, it is extremely easy for them to remain concealed in the mass of intestines or the various corners and cavities of the abdomen. This is not just because surgeons are tired, desperate to sew up patients and keep them alive. A blood-soaked sponge can be difficult to identify and remain hidden in the raw area from where the kidney or uterus was removed or deep in the pelvis. Nurses can make a mistake in counting. If they insist that one sponge is missing, surgeons will look around in the abdomen a second time, but the unbelievable irony is that a sponge can still remain elusive. When one is racing against time, as described above, one may even take a third look but finally decide that a living problem is better than a dead certainty, thinking, "Let's send him out alive; we shall deal with the sponge if he survives." I doubt if anybody who has not gone through this experience will entirely believe me or agree with me when I say that the surgeon could not see the big sponge. What happens inside the operation theatre often seems to follow Murphy's law and ends in humiliation for surgeons for no fault of their own.

One may argue that such a mishap can occur in desperate circumstances, but how can it be explained when the surgery is well planned and well organised? However, even in such "cold surgeries", unexpected situations such as sudden and torrential bleeding, which may become life-threatening, can develop. Even the anticipation of such a complication is likely to give rise to circumstances which result in this kind of lapse. Some years back, a very senior surgeon in one of the premier institutions was operating on a patient of idiopathic thrombocytopenic purpura to remove his spleen. The surgeon was keen not to waste even a second. The nurse was still organising her trolley of instruments when he extended his hand for the knife. When she took a second to hand it to him, he rebuked her sharply, "Stop decorating your trolley, sister; the patient is going to bleed." The spleen was taken out in the minimum possible time and the patient was promptly sewn up. A few days after the operation, an inexplicable swelling appeared in the patient's abdomen. When all investigations aimed at revealing its nature failed, the patient was opened up again. A sponge was found.

Although it is invariably the surgeons who have to take the blame for an accident of this nature, there are factors beyond their control that can lead to it. I have discussed this particular form of "negligence" in some detail because lay people place it on top of the list of crimes that a surgeon can commit, though, apart from the fact that the unfortunate patient has to undergo another small operation for the removal of the left over object, it is uncommon and not as disastrous as many other acts of negligence. Nobody is ever willing to condone it; certainly not the judges. There is even a Supreme Court judgment which implies that if such a lapse is proved, no expert opinion need be produced by the complainant. To surgeons, it seems that these patients are being ungrateful after they (the surgeons) have done their best to bring them back from the brink of death. The colleagues of the surgeon can barely conceal their glee.

There is no way to ensure that this kind of accident does not take place. All surgical centres the world over already take every possible measure to minimise the occurrence of such mishaps. In other words, such accidents are like a time bomb ticking in some operation theatre or the other. If it happened with me, I would wish to be judged with a little sympathy and understanding. All I could say in my defence is that I am very sorry about it. These things happen.

Saints with a past; sinners with a future

In 1997, a malpractice suit was filed against me by a patient for the first time. It came as a complete shock. The patient had successfully undergone major surgery and had then suffered a minor complication. Though I won the case, the intense outpouring of venom and bitterness by the patient in the courtroom left me completely baffled. I talked to many other doctors who had undergone experiences similar to mine. I then browsed through almost all the cases that had been reported from consumer courts across the country. I reached the following two conclusions.

1. The majority of cases of genuine medical negligence are directly attributable to a lack of professional knowledge on the part of the doctor treating the patient. The patient usually suffers grievously and sometimes even dies. Surprisingly, such negligence is mostly never noticed by anyone.
2. On the other hand, most of the cases brought to the consumer courts are petty in nature. The patients in these cases have usually suffered a complication, or the benefits derived from the treatment (usually surgery) are below their expectations. They have invariably consulted another doctor, who has played a pivotal role in inciting the patient's ire.

Like all generalisations, the two mentioned above are also subject to exceptions, but on the whole, they hold water. To understand how this happens, we shall have to digress a little and see how doctors are trained.

Until the late 1970s and early 1980s, there were hardly any private hospitals in the country. Most consultants were attached to major medical institutions and all but very routine work was done in the hospitals attached to medical colleges. It was commonplace for a patient to travel 300–500 km for the treatment of a hernia. The consultants in these hospitals were generalists: a professor of surgery used to perform every surgery, be it abdominal, urological, cardiothoracic, neurological, orthopaedic, or plastic surgery. Teaching and training of medical students and doctors has never been methodical or professional, with a few exceptions here and there. Surgical "registrars" (present-day equivalent of senior residents), who used to be the de facto bosses of their units, were only at the threshold of their surgical career and their training was their own responsibility. There is a motto

frequently quoted in surgical circles: "Watch one (operation), do one, teach one." In practice, this is never followed. Actually, it is more a matter of learning by trial and error. The surgical units of medical colleges used to be flooded with patients requiring major emergency surgery and it was the registrar who would take decisions regarding the need for surgery, and the timing and nature of the surgery. Taking these decisions was, again, the registrar's own responsibility. As a result, the morbidity and mortality rate was disturbingly high, but it used to get diluted due to the large number of patients. The professor used to perform only cold, elective surgeries, such as the removal of the gall bladder or kidney stones. While the professors performed operations, the assisting registrars learned only by watching, and their role was strictly limited to mopping up the blood to keep the operative field clean. Asking a question during surgery was a gross misdemeanour. To confront professors with a book which said something contrary to their opinion on a particular subject was an act of blasphemy. As the registrar moved up the ladder, he gradually honed his fingers and his knowledge, became more and more stubborn about the things he did not know and finally, became a professor with 20 years' experience (of making the same mistake every time) behind him. He had arrived. On his arrival, however, the new professor suffered from two major handicaps: (i) since he was supposed to be good at everything, he was just about average at most things and less than that at many others; and (ii) since his training had been, by and large, his own responsibility, he had no peers to look up to. This was a perfect setting for disasters.

Some years ago, a junior resident was on duty in the emergency unit of a medical college when a young man was admitted following a head injury. After some time, the resident noticed that the patient had become unconscious and there were other signs of intracranial haemorrhage. A burr hole had to be made in the skull urgently; otherwise, the patient would die within minutes. The house surgeon rushed to the registrar, who was sleeping in his room, and told him about the situation. The registrar did not even bother to come down and see the patient. He told the house surgeon, "Go down and keep quiet. We don't do burr holes. Our boss has never done one." The patient died within half an hour. His parents quietly picked up the dead body and left.

I would consider this a typical example of sheer medical negligence. Making a burr hole is an extremely simple operation and can usually be carried out under local anaesthesia. Such situations are so desperate that they need to be handled promptly. There have been numerous cases in which the operation has been performed at the patient's bedside with unsterile equipment and with successful results. One does not need to be a neurosurgeon to do it; it is within the capabilities of every surgeon. Yet just because this gentleman (the registrar) had never seen his boss performing the operation, he did not know how to do it and the patient paid with his life.

The manner in which a registrar reached the peak to become a professor – just by standing in a queue and not doing anything after three years of registrar ship – led to a kind of apathy and sloth which discouraged any initiative to improve upon the prevailing treatment practices. A middle-aged woman who was suffering from jaundice due to stones in the gall bladder and common bile duct (CBD) underwent surgery in a premiere institution. The two senior most surgeons operated on her, removing her gall bladder and the stones from the CBD. After the operation, her jaundice continued to worsen. The X-rays showed that all the stones had not been removed from the CBD. She was operated upon again and eight more stones were removed. She nearly died from the trauma of the two operations. However, her troubles were not over yet. Some 15 years later, she developed jaundice again. She was operated upon and two stones were found in the CBD. Two weeks after the surgery, X-rays revealed two more stones had been left inside the CBD.

This kind of mishap should not occur. The remedy is very simple: all the surgeon need do is to take an X-ray on the operation table. This does not involve any additional surgery and takes only five extra minutes. It would cost the patient Rs 300, but save him or her an additional major surgery. Yet the story is repeated day after day, and the surgeons' apathy is inexplicable. As I said, genuine negligence is never discovered.

I could go on with examples of this nature. These clearly illustrate the first part of my thesis which argues that genuine medical negligence is the result of ignorance of the subject and technique on the part of the surgeon. It escapes notice because it is very difficult to prove. If a patient with a head injury dies following surgery, negligence may be suspected, but if no surgery is performed, how can anyone prove that surgery was needed or feasible in the first place? Therefore, it is safer to do nothing. In the words of AH Clough, "Action is dangerous." Unfortunately, what is safe for the surgeon can be fatal for the patient. The term "trial and error" has been replaced by the new dignified "learning curve", which means that it takes time to learn a procedure and with the passage of time, the surgeon becomes better. Complications are swept under the carpet in the name of the learning curve. What is not stressed is that during the steep slope of the learning curve, the surgeon should work only under the supervision of a fully competent senior colleague. Dr JP Mitchell, a world-famous figure in urology, has said that a surgeon cannot be considered adept at performing a transurethral resection of the prostate unless he has performed a hundred under supervision. No urologist can claim to have had this kind of training.

In contrast to cases of this serious and genuine kind of negligence, which almost always go unnoticed, the cases that go to the consumer courts are trifles. It would seem heartless and cruel to call a case a trifle if a patient has died due to alleged medical negligence, but the fact is that even in most of the cases of death, genuine negligence plays hardly any role. More often than not, death occurs due to a natural complication (cardiac arrest under anaesthesia) or the natural outcome of the disease (cardiac arrest following a heart attack). However, if the doctor or hospital staff have not seemed too prompt or concerned, the patient's attendants interpret the

situation as one caused by negligence or deficiency in service, and sue the doctor and the hospital. Most of the cases, or at least the key issues involved, are outright frivolous. However, the lawyers, with their dilatory acumen, bring in so many additional accusations – the doctor did not answer the telephone call; the hospital was not clean; this or that investigation or test was not done and so on – that the real issue is lost in the confusion. This may sound too simplistic an example, but most of the cases brought to the consumer courts fall in this category. Apart from causing endless harassment to the doctor concerned, these cases do not achieve any worthwhile goal.

I strongly feel that doctors need to look into their own backyards and put their own houses in order. Yesterday's saints are safe with their past, but today's sinners will have a difficult future if urgent remedial measures are not taken. These are not difficult and good results are not unattainable. The first step in problem-solving is the identification of the problem. If the causes of genuine medical negligence are identified correctly by the medical profession, the solutions will be easy to find. It is as imperative and urgent to find these solutions as a cure for AIDS.

Thou shall not judge

The medical profession was brought under the purview of the Consumer Protection Act with the apparent purpose of providing speedy redressal of the grievances of ordinary patients. The medical community felt it was unjustified and unwarranted, and a discriminatory move that allowed others to poke their noses into their profession. It was up in arms against the Act and when neither the politicians, nor the judiciary listened, it ultimately resigned itself to it sullenly. The public treated the Act as something of a windfall and made a beeline to the consumer courts. At this point in time, the only people who seem to have benefited from the whole exercise are a few judges, a lot of lawyers and all insurance companies. Unwittingly, the patient is still at the losing end. In fact, his candle burns at both ends now: medical care is no better than before; it is only more expensive. The lawyers have obviously benefited from a legislation that brings them a lot more business. One look at the immense volume of advertisements on the Internet for legal services for medical malpractice will make you wonder if there is any doctor who is not negligent. The insurance companies have benefited likewise. All doctors have to buy a personal indemnity policy now and the insurance premiums have suddenly gone up. These will regularly rise further.

If any genuine benefit was to be expected from this legislation, it should have been that deterred by the exemplary punishment slapped by the court on some doctors, the rest of the errant lot would mend their ways, becoming more caring and less negligent. On the other hand, the mud-slinging has pushed the plunging image of the medical profession further downwards and has embittered the doctor–patient relationship. It is also proving counterproductive as far as medical expenses are concerned. As soon as a minor or major complication sets in, the doctor begins looking upon the patient as a potential litigant and starts taking precautionary measures, which would sound good in a court but may be of only arguable benefit to the patient. For example, at the slightest indication of infection setting in after an operation, the doctor prescribes the most exotic and expensive antibiotic, which may be only marginally more effective than one that is a lot less expensive. A host of blood tests and scans are ordered routinely. One obvious reason is that the doctor does not want to be confronted by a lawyer in the courtroom and asked a pointless question such as, "Do you mean to tell me, doctor, that you did not get my client's uranium levels in the blood tested?" The lies that patients concoct are original and creative; the way doctors manipulate the records would put the best card sharpers in Las Vegas to shame. Both things are done under the able guidance of the respective lawyers. Why can the judges not see through the whole charade?

The reason is that the lawyer is as ignorant as a babe in the woods about matters which are of a highly technical nature. It is unfair to expect one professional (say, a doctor) to comment on the work of another professional (say, an engineer). In fact, an expert and unbiased professional alone can judge the work of a colleague with some degree of objectivity. Neurosurgeons watching urologists at work cannot say whether the latter are doing a good job or a bad one. At best, they can make only a vague assessment on the basis of the movements of the operating surgeon's hands or the amount of blood spilt.

Even if we accept that judges do not reach any verdict when a matter of technicality is involved and seek expert opinion in such cases, the fact remains that they are not competent to adjudicate on matters of a broad general nature either. One form of medical negligence to which patients, lawyers and judges react with a knee-jerk reflex is that of delay in providing treatment to a patient. The majority of cases of medical negligence in the consumer courts revolve around establishing that the patient was not given prompt treatment, as a result of which he suffered grievous injury. Who is to define "reasonable" delay? Certainly not the litigant. One may, therefore, justifiably ask if a judge can define what constitutes delay in a given medical case.

I think not. If a nurse pages a doctor to inform him/her that one of his/her patients has suffered cardiac arrest and the doctor takes just five minutes to arrive (maybe to finish his/her coffee), he/she is too late. Promptness here would mean that the doctor has to be on the scene instantly. Since this is practically impossible, every person, be it a resident doctor, nurse or laboratory technician, has to be adept at providing immediate treatment until the right person arrives. Any hospital that employs staff members incapable of providing this service is negligent in terms of maintaining a proper set-up. This will disqualify virtually all hospitals. However, the point I wish to make is that in this situation, a seemingly prompt response ("the doctor was there within five minutes") is anything but prompt. On the other hand, there may be a patient who has been hospitalised with a small kidney stone and the doctor in

charge may get a call from the resident doctor late at night, saying that the patient has severe pain. The consultant would probably tell the resident doctor to give the patient another dose of the painkiller injection. The next morning, when the doctor visits the patient and asks him/her how he/she is feeling, the likely answer is, "Fine. When can I go home?" A delay of more than 12 hours in visiting the patient is no delay in this case.

These two may seem to be oversimplified and extreme examples, but they underscore the point that a layman, whether he is a litigant patient or a judge, is really not competent to decide if there was a delay in providing treatment to the patient. A lot of complications and even fatalities that can occur as the natural outcome of the disease process can easily be paraded as the result of an alleged delay by crafty lawyers, whose version is accepted by the unwitting judge. In a recent case, it was held by a court that "though there is no evidence (in this case) to show that the treatment would have saved the patient, yet the fact remains that there was delay in providing the same and, therefore, the hospital is guilty of negligence."

In a case that came before an English court, Lord Denning, the presiding judge, told the jury, "Every surgical operation involves risks. It would be wrong and, indeed, bad law to say that simply because a misadventure or mishap occurred, the hospital and doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining a patient or a surgeon operating at a table, instead of getting on with his work, would be forever looking over his shoulder to see if someone was coming up with a dagger – for an action for a negligence against a doctor is for him like unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body. You must not, therefore, find him negligent simply because something happens to go wrong." (*Hatcher v Black. The Times.* 1954; Jul 2).

We are only on the threshold of a hell that threatens to break loose if matters are not tackled dispassionately and objectively. If the situation in the USA is any pointer, listen to Lord Denning again, "Medical malpractice suits there (in the USA) have become the curse of the medical profession. The legal profession gets 'contingency fees'. So they take up cases on speculation. The jury gives enormous damages. Insurance premiums are high. The doctors charge large fees to cover them. All this is very worrying." I am not arguing that the medical profession should be taken out of the ambit of the Consumer Protection Act or that every other profession should be brought under its purview for the cause of fair play and non-discrimination. However, people who matter should probably realise that it is time to review whether the legislation is doing any good to the people for whose benefit it was intended.

The defence rests its case.