THE

Journal of the American Medical Association.

EDITED UNDER THE DIRECTION OF THE BOARD OF TRUSTEES.

PUBLISHED WEEKLY.

VOL. XV. CHICAGO, JULY 12, 1890. No. 2.

ORIGINAL ARTICLES.

THE MEDICO-LEGAL ASPECT OF ABDOMINAL SECTION.

Read in the Section of Medical Jurisprudence, at the Forty-first Annual Meeting of the American Medical Association, Nashville, May, 1890.

BY A. VANDERVEER, M.D.,

OF ALBANY, NEW YORK.

A year ago I had the pleasure of presenting to the Section on Obstetrics and Diseases of Women and Children, American Medical Association, a paper on "Concealed Pregnancy, and its Relation to Abdominal Surgery." In the preparation of that paper considerable time was devoted to the compiling of a table of cases wherein abdominal section revealed an undiagnosticated pregnancy. This table is measurably complete, and journals, by extract and summaries, have given a wide circulation to the paper and the table. While that table was in preparation, from letters and other sources, my attention was called to the medico-legal aspect of abdominal surgery, in its general relations, and to the probable testimony of expert witnesses in the cases where an action for malpractice is brought. For this, and the other reason that two American surgeons have already been compelled to plead to an indictment of manslaughter, it seems to me profitable to join this paper rather as a supplement to the one of last year by considering certain medico-legal points of abdominal surgery. A letter from a very eminent American surgeon in relation to one of these cases, says, "For my part I do not see how the error occurred," and I have numerous other letters stating that we ought never to be unable to diagnosticate pregnancy, especially after the fourth month. Testimony such as this would have been very dangerous to such as Professor Freund, Karstrom, Wm. Varian, Professor Czerny, Professor Byford and others equally as competent, had they been placed on trial for malpractice.

We all may at any moment be placed upon our defense by clamor of the public press, which seldom, very seldom, gets down on the right side of any medical question. Dr. Mary A. Dixon Jones is a conspicuous example of newspaper persecution, which happily she overwhelmed. Designing attorneys, with prospects of good fees, may urge unwilling people into litigation, or avaricious relatives may, failing in levying blackmail, institute an action. Motives no different from these give rise to nine-tenths of all actions for malpractice.

In case of the death of the patient the surgeon may be proceeded against, criminally, by an indictment for manslaughter, and civilly, by an action for damages. One action criminal, is no bar to another civil, for damages, nor can the result in one prejudice the result in the other. If the surgeon be proceeded against by an indictment, in my own State, New York, the indictment is drawn under the provisions of the Penal Code, Section 195, viz.: "A person who, by an action of negligence or misconduct, in a business or employment in which he is engaged, or by any unlawful negligence or reckless act, occasions the death of a human being, is guilty of manslaughter in the second degree."

In States where no statutory provisions have been enacted, the indictment is drawn at common law. At common law, "If a physician or surgeon or any person assuming to be such, by his gross negligence, or gross ignorance, or by his rashness or want of proper caution, causes the death of his patient, it is manslaughter." (Field's Medico-Legal Guide.)

As the statutory provision is drawn from the common law and depends for its interpretation on the interpretation of the common law, we can find no clearer demonstration than that of Lord Ellinborough (Rex *vs.* Williamson, 3 C. & P. 635), in his charge to the jury. He says, "To substantiate the charge of manslaughter the defendant must have been guilty of criminal misconduct arising, either from the grossest ignorance or the most criminal intention. One or the other of these is necessary to make him guilty of that criminal negligence and misconduct which was essential to make out a case of manslaughter. It does not appear that there was any want of attention on his part and from the evidence of the witnesses, on his behalf, he possessed some degree of skill." (The defendant in this case had forcibly torn away a prolapsed uterus, following delivery). "I think the defendant could

not possibly commit such mistakes in the exercise of his unclouded faculties, and I own that it appears to me if you find the defendant guilty of manslaughter, it will tend to encompass a most important and anxious profession with such dangers as will deter reflecting men from entering into it." (The verdict not guilty was entered in this case). So far as I am able to learn, charges to juries have been uniformly that gross neglect or gross ignorance, or both, must be shown on the part of the prosecution beyond a reasonable doubt before conviction can be had. Then, as has already been shown, the prosecution must stand or fall upon the proof of gross neglience or gross ignorance, one or both, or in other words, criminal misconduct. Gross ignorance and gross negligence are both questions of fact, and must be passed upon by a jury. In consequence, the standard of care and skill form that, and other facts and conditions, must be a variable one. But they are not questions of fact purely. It is the duty of the court to charge the jury with reference to degrees of care and skill by definition and illustration. It has been maintained that it is impossible to make precise distinctions between negligence and gross negligence. Mr. Justice Bradley (U. S. S. C. Reports,) says, "In deciding the question of negligence where there is any conflicting testimony, and ordinarily where there is not, all the facts and circumstances should be submitted to the jury with instructions to the jury that in deciding whether there was ordinary care or gross negligence, they are to consider the position of the party, his business, his duties and responsibilities, and that the same act which under some circumstances would not show any degree of negligence might under others, show want of ordinary care; and under still other circumstances might show gross negligence, and this should be settled by the jury as a question of fact, and not by the court as a question of law."

Gross ignorance is open to the same objection that gross negligence is, viz.: of being relative. That which under some circumstances would be ordinary skill, in other circumstances would be ignorance, and, in still other circumstances, would be gross ignorance. The very favorable rule of law has been laid down that, "The least amount of skill therefore, with which a fair proportion of the practitioners of a given locality are endowed, is taken as a criterion by which to judge the physician's ability or skill." (Bouvier's Inst. 1004-5.) "The surgeon must adopt the means and apply the skill well settled by the highest lights of his profession. He must possess and practically exercise that degree and amount of skill, knowledge and science which the leading authorities have pronounced as the result of their researches and experience up to the time, or within a reasonable time before the issue or question to be determined is made." (Elwell on Malp., 55.)

Again surgeons residing in the large cities with hospitals and other superior advantages, will be required to possess greater skill than those living in localities remote from such advantages, and there seems to be a concensus of judicial opinion that unless specifically contracted for, the surgeon is only bound to exercise the ordinary care and skill.

By way of illustration let me present a single case the kind of which is not likely to occur again. Surgeon A. is called to a case of abdominal tumor. By examination he finds that the patient is thirty-six years, married twenty years, no children. The tumor has been growing eight months. Patient has never menstruated regularly, often not flowing for five or six months, and now has not menstruated for eight months. She has vomited and been constipated at intervals, has felt no quickening and does not believe herself pregnant. Vaginal examination reveals a cervix high up, somewhat enlarged, os uteri not patulous or particularly enlarged, unable to make out body of uterus. Upon abdominal examination a distinctly fluctuating tumor is made out located centrally and evidently from the physical signs contains fluid within a cyst. The diagnosis of ovarian cyst is made, and an operation proceeded with. Upon opening the abdomen the tumor appears. The walls are thin and not of unusual appearance; the trocar is introduced and six quarts of fluid withdrawn, after which the operator finds he has tapped a pregnant uterus. He completes the operation by a Cæsarian section, and in five days the woman dies of septicæmia. Surgeon A. is indicted for manslaughter, the indictment averring that he through gross ignorance, by gross negligence, by rashness or want of proper caution, caused the death of his patient. The indictment is drawn under the provisions of the common law of the State in which he resides. Surgeon A. pleads not guilty, and the trial is proceeded with. The prosecution prove the facts as have been heretofore stated, and call expert witnesses to prove gross ignorance, gross negligence, want of caution or rashness. The only way they can demonstrate the facts so essential for conviction, is by expert testimony. The chief question involved and presented with earnestness: Was there sufficient symptoms of pregnacy present to arouse the suspicion of pregnancy, and did the defendant exercise sufficient care and skill in making his diagnosis? The opinion of the witnesses for the prosecution is that sufficient symptoms, amenorrhœa, vomiting and the presence of a tumor was sufficient evidence of pregnancy to require a most searching examination before pregnancy could be excluded, and that the defendant was negligent and unskilled in his examination. It is shown that he did not examine the breasts for the changes that

occur in pregnancy, that he did not inspect the vagina for the change in color (wine leaf), he did not seek to illicit ballottement, that he did not lay sufficient stress upon these and other symptoms as to the probabilities of pregnancy, and that a proper explanation of the possibilities of her condition was not made to the patient and to her friends, previous to the operation. That no suggestion was made by the operator as to the necessity of exploratory incision, if at all in doubt as to the diagnosis.

The defendant showed by competent witnesses that he had exercised the average care and skill in examining the patient, that he had not acted with undue haste or rashness, and that he was honest in his belief that the case was one of ovarian cyst. He admitted having committed an error of judgment, which he believed was liable to occur in the hands of surgeons of good reputation under existing circumstances. The case was ably tried and the jury brought in a verdict of guilty. It was carried to the next court, and there the court on argument overruled the verdict, presenting some very strong points on the subject, part of the line of argument being that the surgeon was shown to have been a man of great experience, of large practice, a man who stood extremely well with his professional brethren, who had for years maintained a high reputation, very far above the average. That the verdict rendered by the jury was not for the public good and that the conviction ought not to stand. No further attempt was made by the prosecution.

Another case which illustrates ninety-nine per cent. of the cases of concealed pregnancy, where an operation has been done, is surely not so easy of diagnosis, being that of Surgeon B., having a patient aged fifty, married many years, always sterile. Fibroid had existed for twenty years or more, pregnancy not suspected. A hysterectomy was done for the removal of the fibroid, and when the uterus was opened, to his own and everybody's surprise, the surgeon brought out a buxom fœtus which seemed also very much surprised, for it immediately began to cry. It proved to be at least eight months old and all right. There was also a very large fibroid which was very vascular. Unfortunately the patient died soon after. Surgeon B. was tried for manslaughter and acquitted.

Perhaps one of the most unpleasant cases of malignant persecution is the case of Surgeon C., where after careful explanation to the patient of the physiological change that would take place, and her condition after the operation, it was finally decided to remove the uterine appendages. The operation was done, the patient recovered, and some months afterward a suit was brought against Surgeon C. for wilful mutilation. It was shown that all proper explanation had been made to the patient and to her friends, that the operation had been skillfully done, and the patient made a good and speedy recovery, and yet the jury disagreed. A second trial took place some time after and the surgeon was acquitted, yet he had been to great expense in his defense and had lost much valuable time, but the laws of his State afforded him no redress whatever. I might cite other cases, but can say earnestly, and for the comfort of the honest and well-meaning surgeon, that I have not been able to find a case where conviction has occurred and the higher courts have sustained the verdict. A careful study of the rulings of the courts and charges made by judges to juries in such cases, brings up prominently the fact that the law recognizes no one school of medicine. The doctor must practice the necessary skill in the diagnosis of his cases and he must exercise the average degree of ability in the doing of the operation, and that he is not supposed to do more than is required of the person possessing an average amount of skill. Another point that seems to have been presented with considerable force by some of the rulings, is contributory negligence on the part of plaintiffs. In several operations it was shown that the plaintiff wilfully withheld from the surgeon certain symptoms, and that she purposely misled him by making statements of conditions that did not really exist. This would have been the case had Drs. Prince and Varian's cases been presented for trial. Beyond a doubt on these points alone plaintiffs would have been ruled out of court.

Referring once more to the case of Dr. Jones, which has been so recently before the profession, she says in answer to a letter of mine that "She is glad to know that the subject of the medico-legal aspect of abdominal section is to come up for discussion at this meeting," and states as follows: "There is a necessity to look into these subjects. Under the existing laws of the State of New York, a surgeon has no protection. If, in his efforts to relieve the sick and suffering, he decides to do abdominal section, or indeed to perform any surgical operation, and if, notwithstanding his best directed efforts, the patient should die, he is liable to, or may have a suit for malpractice or an indictment for manslaughter in the second degree. If the patient lives and does well there may still be a suit for malpractice. The surgeon may spend his strength, his time and give his best efforts to relieve the suffering poor, yet under the law, and by the law, these same persons, for whom he has labored, may turn and rend him and use every effort for his destruction, personal and professional. Malice at any time may so construe the law that at any unexpected moment the surgeon or physician may find himself in the most serious and unpleasant difficulties. Thus it is simply dangerous to practice medicine and surgery in the State of New York.

A distinguished lawyer said to me the other day, that however well prepared he might be, yet he would not, as the law at present stands, *dare* to practice medicine, and he thought he had about as much courage as most people.

Section 200 of the Penal Code, says:

Liability of Physicians.—A physician or surgeon who being in a state of intoxication administers a poisonous drug or does any other act as a physician or surgeon to another person which produces the death of the latter is guilty of manslaughter in the second degree.

But according to Judge Bartlett's ruling, "Physicians are also liable under Section 193 of the Penal Code in connection with the proceeding provisions." Subdivision 3 of Section 193 says: "By any act of procurement or culpable negligence." This comprehends a great deal and can be made to mean anything. A physician or surgeon though he may have the best preparation, yet by any act of procurement as administration of medicine or surgical operation, if the patient dies he may be found guilty of culpable negligence. There will always be found physicians who would have used different procedures, or advised another course as preferable.

If a surgeon for the welfare of a patient deems it best for him or her to perform abdominal section and death ensues, malice can, under subdivision 3 of Section 193, have him indicted for manslaughter in the second degree.

If a surgeon neglects to perform abdominal section, when in the estimation of another it should have been performed, and the patient dies in consequence of the pelvic conditions, that surgeon under Subdivision 3 of Section 193, of the Penal Code, can be found guilty of culpable neglect, and indicted for manslaughter in the second degree.

Judge Bartlett says further: "If a person assumes a certain amount of skill, and does not develop that amount of skill, his act is guilty of culpable negligence." How largely malice or blackmail may misjudge this skill and use the law for direct persecution, or as the *New York Medical Journal* puts it, for "Roasting Physicians."

Notwithstanding the strong points she presents, I am of the opinion that the courts have ruled in justice to all concerned in these cases. It is necessary that the public have proper protection, that while we must advance in our profession only by experience and accumulated skill in the doing of untried operations, yet in their performance great caution and the careful study of cases becomes a necessity. It will be observed that, while it has been a great hardship and required much resolution for the surgeons who have been attacked to defend themselves, yet they have in the end triumphed.

What I would like to see as the result of this discussion is, the betterment of our laws in this, that surgeons may have better protection in the recovery for loss of time, for expenses they have been put to, when it is proven that the case was urged by some disreputable lawyer, or by those personally malignant, within or without the profession.

My conclusions would then be:

1. That we should exercise the greatest care in the examination of our cases of doubtful diagnosis.

2. That when in doubt we should lay great stress upon the necessity of an exploratory incision, and make a very proper explanation of what this means to the patient and friends.

3. That in the cases thus far brought to trial, we have reason to believe that the judges in their rulings have treated our profession with great fairness, the strong points being, that the public good is not subserved by undue and wilful persecution of the surgeon who has shown the proper amount of intelligence in his profession.

4. That we should seek still to have the law so made in our favor as to eliminate the cases of wilful prosecution.

5. That in the careful study of these cases we have presented the lamentable condition of expert testimony. Men absolutely ignorant upon the subject, men who have never done an operation of any merit in surgery, being allowed to come upon the witness stand and testify as experts.

THE MEDICO-LEGAL ASPECT OF EXPLORATORY LAPAROTOMY.

Read in the Section of Medical Jurisprudence at the Forty-first Annual Meeting of the American Medical Association, held in Nashville, Tenn., May, 1890.

BY W. C. WILE, A.M., M.D.,
OF DANBURY, CONN.

All abdominal operations which involve section of the peritoneum are in a measure exploratory. The parts we seek are out of sight, and it is only from the signs, symptoms and history of the case that we can make a diagnosis; and the diagnosis warranting it, we are justified in entering the cavity. We are justified in entering the abdominal cavity, I say, for in the present light of antiseptic surgery, and with the statistics which we have to-day of successful laparotomies, hesitation on the part of the surgeon to attempt *e. g.* to free an obstructed intestine when the symptoms pointing to it are manifest; or to proceed to surgical interference in a case of appendicitis when the indications for such interference are clear; or to explore in cases of abdominal tumors where diagnosis is probable and the life of the patient is endangered; or even to explore where, in cases of profound shock proceeding from some internal source which points to lesion of the abdominal viscera or pelvic contents—hesitation to proceed to surgical relief in such cases is negligence on

the part of the surgeon, as much so as delay to open a knee-joint filled with pus, or to tie a severed femoral artery. Abdominal surgery to day is a recognized proceeding, and given a case, with diagnosis as clearly defined as is possible, where prolonged suffering or death is imminent from a continuation of affairs, nothing short of exploration to ascertain exactly what the matter may be and with a view to affording relief, is warranted. How true is the affirmation of A. W. Mayo Robson, F.R.C.S., that an exploratory operation has frequently proved curative when apparently nothing beyond incision and exploration by the fingers has been effective. The following case probably explains the nature of these cures. In the Hospitals ("Tidende," 1889), Dr. Howitz describes a case of strongly adherent omentum, with displacement of the stomach and intestines. The patient had been treated for gastric ulcer, also for "the womb;" pessaries had been applied, and douching and massage of the hypogastrium practiced in vain. Dr. Howitz carefully liberated the omental adhesions, so that the displaced viscera returned to their normal positions. All the pain and discomfort from which the patient had so long suffered rapidly disappeared.

How much assurance can we obtain from the successful statistics of Mr. Lawson Tait, who is reported to have performed 135 consecutive laparotomies without a death! Successful abdominal operations with different degrees of extensiveness have been performed upon every abdominal organ. The progress of surgery in this direction is truly marvelous, and as we review in our minds the list of operations which have been successfully performed for gastrotomy, pylorectomy, gastro-enterostomy, gunshot wounds of the stomach and intestines, gunshot wounds of the stomach and liver, resection of the intestines, intestinal obstruction, typhlitis, perityphlitis and appendicitis, colotomy, extraperitoneal hepatotomy, hepatorraphy, hydatid cysts of the liver, cholecystotomy with ligature of the cystic duct, cholecystenterostomy, cyst of the pancreas, abscess of the spleen, splenectomy, hydatid cysts, wandering or floating spleen, rupture of the kidney, nephrorraphy, nephrectomy, diaphragmatic hernia, and the operations for inguinal hernia, we cannot stop short of wonder at the scientific perfection of surgery at the present day.

Now, in the light of all these attainments in abdominal surgery, what shall we do when we are consulted in reference to some condition existing within the abdominal cavity which we recognize as probably jeopardizing the patient's life? Shall we mask the only possibilities of relief through interference, by simple palliation? Shall we put our trust off, assuming ignorance as to any further relief than simply the relief from pain, and keeping the vital machine in motion, until the wheels become clogged, or some pipe bursts? Shall we, because the operation is attended with some danger, deprive the patient of the only possible chance of escape? And shall the reward be awaiting us, that if the condition of that man or woman is in whatever manner made worse from the attempt, we shall have to suffer the penalty of the law for our efforts? How grand, on the one hand, the idea; on the other how small! But it is with all possible care and precaution that any such surgical step should be undertaken. The first great step to be considered before proposing, or consenting to operate, is *diagnosis*. The symptoms of obstructed intestine or of ruptured extra-uterine pregnancy are fairly well defined, and, placed in one side of the balance, operative interference; what can be found to counterbalance the other side, when on the one hand the obstruction has remained for three days, if forsooth so long; or on the other hand, our ruptured tube has been recognized?

It was my sad lot during the past year, to be obliged to stand by, and witness the life-blood ebb away from a ruptured pregnant tube, because the family would not consent to an operation. Slowly and surely the lamp of life grew dim, until in eight hours from the time I was called to the patient, she had breathed her last.

In this case the diagnosis was absolute: Profound shock, dulness, gradually increasing in the left hypogastric region, the os uteri tilted forwards and high up, irregular menstruation, and the onset of the rupture, caused by a strain from lifting. Here a young life was lost, through what? The consent of the Church had been obtained (the patient was a Catholic)—through ignorance of the family and their friends, who preferred letting her die, rather than submit to a simple (comparatively so) operation which offered the only possible chance of recovery.

In this case, had the operation not saved the patient's life, of course the surgeon would not have been blamed, and no legal question would have arisen; but let us suppose a case where the symptoms are not so clearly defined. We are summoned in the night to see a woman suffering with intense pain in the left ovarian region. No tenderness can be found upon vaginal examination, the pain and tenderness are limited to the one spot over the ovary, no tumor can be felt.

Relief is obtained by the use of anodynes and counter-irritants, and in a day or two the patient is quite improved. A week or so passes and the doctor is summoned again. The pain is returned with all its vigor. The patient is once more relieved from pain, and continues so for two weeks, when she decides to visit New York City for a pleasure trip. While there the pain again returns and a specialist is called in, who diagnoses ovarian, or tubal disease, and proposes that she be removed to the hospital for the purpose of an exploratory operation, with the view of removing

the diseased parts if such be found. Thus far this case is actual, and occurred in the writer's practice. But she did no go to the hospital, neither did she have an exploratory incision made; but dismissing the specialist and returning to the family doctor of the friends in the city, and finally consulting two other physicians after her return home, she was finally cured by the last doctor, who rubbed on some smarting liniment, for the rheumatism which he said she had in the *end of the spine*, and which he said was the cause of her trouble. Now, laparotomy is not often advised for rheumatism in the end of the spine; but had she been operated on and recovered, all would have been well and good. But suppose (and here is the question of the paper) an exploratory laparotomy had been made and she did not recover, having succumbed, *e. g.*, from the shock of the operation, and the husband brings suit against the surgeon for damages, *what defensive argument can the doctor present in answer to the charges made against him?* This is what is meant by the title of this paper: "The Medico-legal Aspect of Exploratory Laparotomy." It seems to me that the answer as to the responsibility on the part of the surgeon resolves itself into the following: Laparotomy to-day is in skilful hands a recognized operation. There are certain conditions of disease or accident which can be reached only through abdominal section. The surgeon must be certain as far as possible from his diagnosis, that a given condition, or conditions warranting exploration exist. He ought to be accurately informed as to the correct method of reaching the parts through operative interference. He should know just when the operation ought to be performed in order to obtain the best, or safe results. Beyond this the responsibility lies with the patient, or the patient's friends. They should be informed of the danger of the disease as it exists unrelieved; they should be informed as to the gravity of the operation, and its risks, and they should be warned that in the event of unfavorable result, either through failure of the vital powers to stand the shock, or from a too great extent of diseased parts to permit successful manipulation; or even in the case of a possible mistaken diagnosis after sufficient consultation has been held, the doctor shall not be blamed.

Gentlemen, this is not too great precaution when undertaking such operations. We may be skilful operators; there may be money in the operation; it may bring us fame if we succeed—but the operation of opening the abdominal cavity and handling its contents is no child's play, it is a dangerous proceeding at its best, notwithstanding 135 successful consecutive operations; and a failure might bring the hands of the law heavily down upon the head of the would-be benefactor. But, bringing our best and cautious efforts to bear in a case where we are firm in our conviction that the only salvation lies in operative procedure, we should not hesitate to give the patient every advantage of the enlightenment which is ours, the outcome of skilful experience.