CHAPTER XIX.

MEDICO-LEGAL POINTS.

There is not space here for a systematic consideration of the various legal questions that may arise in conection with gynecologic operative work. The author desires simply to call attention to certain pitfalls, in order to aid the surgeon in avoiding them. The following points will be considered:

1. Consent to operation.
2. Foreign bodies left in the abdomen.
3. Persistence of symptoms after operation.

CONSENT TO OPERATION.

Consent to operation for pelvic disease embraces two definite propositions —first, consent to the operation found desirable on examination and, second, consent to additional or different operative work that may be found necessary or desirable after the patient is anesthetized.

An adult patient of sound mind has the right to decide whether or not she will have a certain required operation. This is a self-evident proposition, and compliance with it would seem to be a perfectly clear-cut affair with no chance for a misunderstanding. However, serious misunderstandings have arisen on this point. In fact, in actual practice the question of consent to operation is not such a simple matter after all. There are many ramifications of the question in which too much or too little may be taken for granted, thus permitting misunderstanding.

The following quotation from an article by Taylor, of the New York Bar, published in the St. Louis Medical Review, 1905, presents an instructive discussion by an authority on this subject.

"Recent cases in court involving the question of consent to an operation have attracted considerable attention, and have been the source of discussions in the lay as well as the medical press, showing a danger, too little realized, to which the physician is constantly subjected.

"The physician must always bear in mind that before operating on a patient, consent to the operation is a legal prerequisite. It is only in approaching the questions of what constitutes consent and by whom consent is required to be given that he enters the realms of uncertainty.

"Ordinarily, when a patient, not knowing his real condition, places himself in the hands of a surgeon to be operated on, there is an implied consent to the operation which it may be found necessary to perform. The English court has gone further in finding such implied consent than have the American

courts. In the case of Beatty vs. Cullingworth, the patient, an unmarried woman who had placed herself in the hands of an eminent London surgeon for the purpose of having performed the operation of ovariotomy, said to the surgeon that if both ovaries were found to be diseased, he must remove neither. To this he replied, 'You must leave that to me,' which reply the patient denied hearing. Upon operating, both ovaries were found diseased and were removed. Upon trial, the judge charged the jury that the patient had tacitly consented to the operation, whereupon they returned a verdict for the defendant.

"The author of this article in commenting upon this case, more than five years ago, expressed the opinion that it could not be safely considered as an embodiment of the law of this country.

"We now have a case coming from one of the trial courts of Minnesota, which more than justifies the moderate expression of doubt that the English case would be followed in this country. Here the court swings to the extreme opposite end of the arc.

"In this case the physician was employed by the patient to perform an operation on his right ear. After the patient was placed under the influence of anesthetics, the physician, so his testimony shows, made a more complete examination than he was before able to do and found that the left ear was more seriously diseased than the right ear, and he therefore operated on the left ear instead of the ear which he had originally intended to operate on. The theory of the patient's case was that the physician inadvertently operated upon the wrong ear. The trial judge instructed the court that no consent to operate on the left ear could be implied from the circumstances of the case and that the physician was therefore liable for damages for a technical assault Whereupon the jury rendered a verdict for more than fourteen thousand dollars.

"This verdict was, upon motion, set aside on the ground that the damages as assessed by the jury were excessive. The setting aside of the verdict does not, however, affect the ruling of the court upon the question of law as to liability of the physician in such a case. The effect of this ruling is admirably expressed by the New York Sun in an editorial as follows: 'The case as it stands is a judicial declaration to the effect that where a patient expressly consents to a specified surgical operation, or an operation on a specified organ, the surgeon cannot perform a different operation, or operate on a different organ, without rendering himself legally liable to respond in money damages to the patient.'

"It may well be doubted whether the courts of this country generally will follow the extreme view of the Minnesota trial court. [In the subsequent trial an entirely different view of the case was taken—see a later quotation.] It seems that the better rule would be that, in all cases of doubt, the question of whether or not a patient had given tacit consent to the performance of the

operation actually performed should be left to the jury to decide from the facts proved in the particular case.

"It was attempted to raise the question of consent in a case decided by the Appellate Division of the Supreme Court of New York, Second Department, in 1903, but the theory upon which the case was brought, namely, that the physicians were employed to cure the patient of certain pains and that they carelessly and negligently and unskillfully conducted themselves in the treatment of the case, was such as to preclude the plaintiff from properly urging the question of consent. In this case, the patient, a boy, eleven years of age, who was suffering with pains in his right arm, was sent by his mother in care of a woman of mature years to a hospital for treatment. After an examination of the boy, it was determined that he was suffering from blood-poisoning and that an immediate operation was necessary. Whereupon, he was placed under the influence of chloroform from the effects of which he died while the operation was being performed.

"The testimony of the mother was that she sent the boy to the hospital with the woman to see what was the matter with his arm, just to be examined. It did not appear, however, from the testimony of the woman that she made any statement to the physicians of any limitation upon the purpose of the visit, but she did testify that 'neither of these doctors said anything else to me; they did not tell me that they were going to perform an operation on the boy.'

"One of the physicians swore upon trial that he told the woman in charge of the boy the result of the examination and that an operation must be performed at once and that it would be necessary to administer an anesthetic. He says that the woman told him to go ahead and do what was best for the boy. In commenting upon the question of consent, Mr. Justice Woodward said:

" 'The employment of the defendants by Robert Wood (the boy) appears to have been with the knowledge and consent of the mother, the plaintiff in this action, and in the absence of some evidence that the defendants knew that they were not expected to act without further authorization, there was no question which might properly be submitted to the jury. Why should the defendants, employed by Robert Wood, with the consent of his mother, who had sent him there for the purpose, be expected to ask Agnes Evans for permission to perform an operation which to them appeared necessary, and which, under ordinary circumstances, would have been a very simple matter? When we call a physician or surgeon we submit our case to his care; we act upon the assumption that he knows more about the matter than we do, and consent is given by implication for him to do whatever appears to be necessary or proper for our relief, and in the absence of some evidence to show that the defendants had notice that their services were only to go to the extent of an examination, it cannot be said that the defendants were guilty of negligence

of any duty owed to the plaintiff or her son in not asking Agnes Evans for her consent to the operation. If the operation, considered in its surgical aspects, was one of great peril, it might be that the defendants would not be justified in proceeding without consultation with the mother or some person of suitable age authorized to act for her, but it appears from the evidence, without dispute, that the operation was of a very simple character, not likely to be attended with serious results, and that the cause of the patient's death was not the surgical operation, but the chloroform, which in the peculiar condition of the boy, resulted fatally. There was, as appears from the evidence, no reason which was apparent why the boy could not undergo the administration of chloroform and the operation without danger, and, as the plaintiff alleges the employment of these defendants to attend him and cure him of certain pains which he had in his right arm, it is hardly consistent in her to now claim that the employment was only for the purpose of an examination. The two positions cannot be supported at the same time, and if the allegations of the complaint are true, the defendants were not negligent in doing whatever in their best judgment was calculated to produce the result for which they were employed.'

"The Supreme Court of Maryland, in 1888, rendered a decision in the case of State, etc., vs. Housekeeper *et al.*, in which the words of the court were reassuring indeed. In this case the husband, who had brought suit, testified that the physicians had been employed to perform an operation upon his wife for the removal of what was supposed to be an innocent tumor from the right breast, but that the physicians operated for cancer, removing the entire breast. That he did not, and never would have consented to the operation which was actually performed. The evidence did not show whether the wife was informed of the character of the operation which the physicians proposed to perform. In passing upon this state of facts, the court said: 'The party who allows a surgical operation to be performed, is presumed to have employed the surgeon for that particular purpose.' Further, the court said: 'The consent of the wife, not that of the husband was necessary. The professional men whom she had called in and consulted were the proper persons to determine what ought to be done. They could not, of course, compel her to submit to an operation, but if she voluntarily submitted to its performance, her consent will be presumed unless she was a victim of a false and fraudulent representation which is a material fact to be established by proof.'

"The physician who reads the words of the court in this case, will undoubtedly be strongly impressed by the soundness as well as the justness of the position taken by the court. But he doubtless will be greatly perplexed when he attempts to harmonize the attitude of the court in this case with the attitude taken in the Minnesota case above referred to. In fact, it is impossible to harmonize the attitude of the courts in these two cases, except upon the theory that the evidence given in the one case, the character of the witnesses

who testified, their manner of testifying and the weight to which the court considered their testimony entitled, all differed so materially from that of the other case that the courts in the respective cases, directing the words used to the facts in the particular case, were justified in the different statements of law applicable thereto. *Accepting this theory, the physician is brought to the conclusion that he must in all cases either keep within the strict scope of the authority expressly given to him, or must surround himself by such safeguards that he can show to the court and jury, by the testimony of thoroughly credible witnesses, that he was employed to perform such operation as might be found necessary or desirable to be performed at the time of operating, and that the operation actually performed was so necessary or desirable to be performed at that time.*

The question from whom consent must be obtained, is one upon which there is some confusion, as indicated by the decisions of the courts. It is laid down as a general rule that the consent of the husband must be obtained before an operation is performed upon the wife. Such consent is, however, usually implied where the husband places the wife under the surgeon's care and especially where he understands the character of the intended operation.

"In fact in the case of State vs. Housekeeper, above referred to, the court took the position that consent of the wife was all that was necessary; that the positive prohibition of the husband would not legally hold the physician from operating, if the wife requested the operation to be performed. It would not be wise, however, for a surgeon to operate in the face of such prohibition, for by so doing he would surely invite litigation.

"In case operations are to be performed upon children or others incapable from mental weakness of understanding the import of the proposed operations, then consent should be obtained from the parents or other persons in *loco parentis,* or from the relations or those legally responsible for the care and protection of the person of the incompetent.

"Absence of consent may be made the gist of an action, not only in cases of operation, but wherever professional services are forced upon a protesting patient. A case in point, which is of considerable interest, arose in England some years ago. A woman, suspecting her housemaid of being in the family way sent for her physician and directed him to examine the maid. The girl objected to the examination but finally submitted, crying all the while. The physician found the woman's belief as to the maid's condition mistaken and so reported. The maid brought suit against the physician for assault, upon the theory that she submitted to the examination only through fear and duress. The verdict was for the physician. On appeal to the Manchester assizes, the two justices before whom the question of submission or consent was argued, disagreed, one being of the opinion that the submission of the girl under the circumstances did not represent her will and so could not be considered a consent; the other holding that she had consented to the examination. The court of appeals, upon further appeal, took the view that there

was consent; the judgment accordingly was permitted to stand in favor of the physician.

"Consent to perform a post-mortem must also be had except when performed in fulfillment of a requirement of law."

The further developments in the Minnesota case are given in the following quotation (Jour. Amer. Med. Assoc., April, 1906):

"A Minnesota physician some time ago found it necessary, in his judgment, to perform an operation somewhat different from that which had been first intended when the patient was put under anesthesia. As a result he was sued for damages, and the case has been before the courts now four times, the first trial resulting in a disagreement of the jury; the second, in a verdict of over $14,000 damages (set aside as excessive by the higher court), and the third trial, in a verdict of $3,500 damages. This verdict has now also been set aside. The judge says that had he known the evidence at the time of the third trial as he did afterward the result would have been different. The condition of the patient (with suppuration of the ear) demanded relief, because otherwise his life would have been left in jeopardy, and physicians called as witnesses testified that the procedure used was indicated. Therefore, decided the court, the surgeon would have been subject to criticism if he had not done what he did, and manifestly it is not right that he should be wrong both in doing and in not doing a certain thing. It appears from this that a surgeon who ventures to do what was not anticipated still undergoes a risk, yet in cases where his deviation was necessary or essentially life-saving and can be proved to be of that character, it is recognized that he ought not to be mulcted for damages."

The Supreme Court of Illinois, in a decision, discussed the points now under consideration. This instructive decision and comments thereon are presented in the following quotation from the Journal of the American Medical Association (1907, Vol. 48, p. 701):

"The decision of the Supreme Court in the case of Pratt vs. Davis emphasizes the necessity of surgeons having a clear understanding of their legal liabilities in undertaking important operations and the prudence of requiring explicit consent of the patient or his legal representative before beginning an operation. The decision covers three principal points of interest to surgeons: 1. What is sufficient consent to an operation? 2. How much is implied in consent once given? 3. What is the privilege and duty of the surgeon in emergencies arising in the course of an operation undertaken with previously obtained consent? When a patient is in full possession of his mental faculties his personal consent to a surgical operation on himself is a necessary prerequisite. It is obvious that this consent should be obtained after a clear presentation of the necessary facts in the case, and it would seem to be a judicious precaution to obtain such consent in writing. Unfortunately, the testimony in the case cited showed an attempt at deception that seems to

have been imprudent even if it might at the time have seemed justifiable. It would appear from the decision that whatever may be the implication involved in consent to one operation, it cannot be held to extend to a second operation, but explicit consent to this should be obtained. The decision on the third point is of great importance as it tends to put the duties of the surgeon in the course of an operation already undertaken in a clearer light. It is the duty and the legal right of the surgeon in the presence of unexpected conditions arising in the course of an operation to use his highest skill and judgment even if the consent of the patient or of his representative cannot be obtained. It is also right and the duty of the surgeon to act in accordance with the best teachings of surgery in emergencies in which consent cannot be obtained, even to the extent of performing operations.

"The Supreme Court of Illinois on the appeal of Pratt vs. Davis, an action by the latter, by next friend, for trespass to the person, has affirmed the judgment of the Appellate Court affirming a judgment in the plaintiff's favor for $3,000. The decision of the Appellate Court was reported at length in the Medico-legal Department of the Journal, March 11, 1905, page 822.

"In partial explanation of the case, the Supreme Court says that at the time of the wrong charged the defendant was engaged in conducting a sanitarium. The plaintiff, a married woman about forty years of age, came to the sanitarium for treatment for epilepsy, in May, 1896. She had been subject to epileptic seizures for a period of fifteen years, but up to this time she had been able to conduct her household duties and had borne four children, three since since she first exhibited symptoms of epilepsy. The seizures had been gradually increasing in frequency. Following each of them she would be very weak in body and dazed and uncertain in mind for several hours. The evidence of those who knew her in her daily life was generally to the effect that her mind, except during the periods immediately following these attacks, was normal. The defendant made an examination of the pelvic organs, and found that the uterus was contracted and lacerated, and that the lower portion of the rectum was diseased. On May 13 he operated for these difficulties. Thereafter the plaintiff remained in the sanitarium without improvement for several weeks and then returned home. On July 29, her brother-in-law, at the request of her husband, took her again to the sanitarium, and on the next day the defendant performed a second surgical operation on her, removing her ovaries and uterus. She continued at the sanitarium until August 8, and then was removed to her home. Neither operation was successful so far as improving her health was concerned. She grew gradually worse mentally, and on August 25 was adjudged insane and sent to a State asylum. The cause of action was based on the removal of the uterus at the second operation. It was not claimed that the operation was unskillfully performed but that it was performed without the authority or consent of the plaintiff and constituted a trespass to her person.

"The declaration, so far as here material, averred that the plaintiff had placed herself under the care of the defendant and that he, without her consent or the consent of anyone authorized to act for her, anesthetized her and removed the uterus. There was no pretense that the plaintiff herself consented to the removal of the uterus. In fact the defendant testified that he told her just enough about her condition, and what he proposed to do, to get her consent to the first operation. Consent for further work was not obtained. Thereafter the defendant contended that the plaintiff was so mentally unsound as to be incapable of consenting or of giving intelligent consideration to her condition, and that her husband authorized the second operation. Whether the defendant was then mentally incapable of consenting was a question as to which the evidence was conflicting.

"Ordinarily, where the patient is in full possession of all his mental faculties and in such physical health as to be able to consult about his condition without the consultation being fraught with dangerous consequences to the patient's health, and when no emergency exists making it impractical to confer with him, it is manifest, the court goes on to say, that his consent should be a prerequisite to a surgical operation. Where the declaration shows the act to have been a trespass to the person, or avers it to have been without the consent of the patient, it would seem to be unnecessary to go further and negative the fact that some other person, lawfully authorized to act for the patient, consented. The question of the consent of such other person, if in the case, might well be left to be presented by a plea in bar.

"Furthermore, the Supreme Court is satisfied that the evidence as abstracted did not tend to show that the husband consented to the second operation. He testified that he did not, and that, when he first took his wife to the sanitarium, the defendant told him the operation would be a trifling one. The defendant said that, while he may have said this, 'Davis said he was willing that I should do anything I thought necessary, only he made the request that I do as little as possible,' and that he then told Davis, in substance, that two operations might be necessary. He also testified that while plaintiff was at home her husband 'told me she was no better. I told him to bring her back for the finishing work. I did not tell him what the finishing work would be. I had but one comprehensive talk with him. That was the time he was there with the plaintiff.' These two conversations were relied on by the defendant as authority given by the husband for the second operation. Without deciding what legal effect should be given to the husband's request or consent that a grave surgical operation be performed on his insane wife, the court thinks it manifest that the authority given by the husband in the conversation first quoted from was exhausted when the first operation was performed and the patient taken away. While it was true that the defendant said he told the husband in that conversation that he could not tell the extent of the surgery that would be necessary, and said that the

defendant gave him carte blanche to do whatever he saw fit, it was yet apparent that neither then contemplated that the wife would be taken home after the first operation and later brought a second time to the sanitarium for the purpose of undergoing a second operation, and the court thinks it equally apparent from the defendant's testimony that the husband did not, at the time he was directed to bring his wife again for treatment, understand that any such operation as the removal of the ovaries and the uterus was to be performed, and that the mere fact that he, after that conversation, had his brother take the plaintiff to the sanitarium, was not to be regarded as tending to show consent to surgery of that character.

"The defendant then contended that, in the absence of expressed authority to remove the uterus, the law would imply the necessary consent from the fact that consent was, as he said, obtained for the removal of the ovaries. But as there was no evidence which tended to show that any permission was obtained for the second operation, when the ovaries were in fact removed, the court holds that there was nothing to raise the implication in question.

"Again, it was urged that the evidence showed no actual damages, that the judgment must therefore be made up of nominal damages and exemplary damages, and that this was not a proper case for the infliction of a penalty, wherefore the judgment should be reversed. The claim that there was no proof of actual damages was based on this statement found in the defendant's argument: 'There is nowhere in the record a syllable showing any pain or suffering as a result of the removal of the uterus.' But the Supreme Court says that some facts require no direct proof. That pain and suffering following the removal of the uterus is one of such facts. The law infers pain and suffering from personal injury.

"Finally, the Supreme Court says that where the patient desires or consents that an operation be performed, and unexpected conditions develop or are discovered in the course of the operation, it is the duty of the surgeon, in dealing with these conditions, to act on his own discretion, making the highest use of his skill and ability to meet the exigencies which confront him, and in the nature of things he must frequently do this, without consultation or conference with anyone, except, perhaps, other members of his profession who are assisting him. Emergencies arise, and when a surgeon is called it is sometimes found that some action must be taken immediately for the preservation of the life or health of the patient, where it is impracticable to obtain the consent of the ailing or injured one or of anyone authorized to speak for him. In such event, the surgeon may lawfully, and it is his duty to perform such operation as good surgery demands, without such consent. The case before the court, however, does not fall within either of these two classes."

It would seem that consent to operation and to such details of operation as the surgeon may find best on examination or in the course of the operation, is implied when the patient accepts the surgeon's advice and goes through the prep-

aration for operation. The jury, however, does not always take that view of the matter. Consequently it is well to remove all chance of controversy on this point by having the patient sign a request for the operation and having the signature attested by a responsible witness, such as the nurse or an assistant physician or the family physician if he happens to be present. If convenient, it is well to have the husband also sign the request as indicated in the form below. The following, with place and date, is a satisfactory form:

> I herewith request the performance of the required operation and such additional work as may be found necessary or advisable at the time.
>
> Witness..... .....
> (Signature of Patient.)
>
> Witness..... .....
> (Signature of Husband.)

This request puts the matter entirely in the hands of the surgeon so that he may use his judgment for the best interests of the patient. If the lesion should prove to be some unusual one, quite different from that supposed, it may still be removed, for such operation then becomes the "required" one. Any additional conditions found may be taken care of as seems best. The request is simple and reassuring in form and need cause the patient no additional anxiety, particularly if it be presented to her as simply part of the routine of preparation for operation.

If the patient wishes to make any exception to the latitude of action, such exception should be noted in the request. This enables the operator and patient to understand each other clearly. For example, in a recent case of the author's requiring hysterectomy, the patient decided after full consideration that she wished both ovaries preserved even though they should be found diseased. The decision seemed to be against the patient's best interests, still it was her right to insist on it if she desired to do so. The exception to the latitude of action was noted in the signed request, and at the operation both ovaries were preserved, though one was so much diseased that it is very likely to give subsequent trouble.

The author has heretofore required a signed request for operation only in cases which seemed particularly liable to misunderstanding or subsequent controversy. He has concluded, however, that it is advisable to require the same in all cases of major operation.

A major operation is a serious matter, fraught with consequences which in some cases may not be foreseen. The prevention of misunderstanding or imposition, as the case may be, fully warrants the slight formality of a signed request, unequivocally giving the surgeon the right to do for the patient what in his judgment seems best according to the findings in the case. Any specific exception the patient wishes to make may be duly noted in request. From the standpoint of the patient the objection may be raised that such a signed request leaves too much to the judgment of the surgeon. This objection, however, is not justified.

Such latitude of action is implied in every verbal assent to an abdominal operation, for it is well understood by the informed that unusual and unexpected conditions may be found in any case. The written request simply clarifies the matter. Again, whatever the conditions present, the surgeon is the one qualified to know what is best for the patient. If the patient so doubts the surgeon's judgment or conscientiousness that she feels he could not or would not do what is best for her, then she should seek another surgeon. From the surgeon's standpoint, he certainly would not wish to assume the responsibilities of operation for such a doubting patient.

FOREIGN BODIES LEFT IN ABDOMEN.

This is a subject the importance of which is frequently not appreciated by the physician until he is involved in a lawsuit concerning the same. Consequently in the following pages the author details some illustrative cases to call attention to the subject, that the danger may be recognized and avoided.

Lawsuit, Small Gauze Strip Extracted from Abdominal Sinus. In a case of retroflexion, Wiggin did a vaginal fixation and also removed the left ovary. Suppuration followed presumably from the stump. Later, laparotomy was performed for the removal of the ligatures. This was followed by an abscess in the abdominal wall and a persistent sinus. The patient then went to another institution, and later a small gauze strip was taken from the sinus. Suit was entered for $10,000.

Dr. Wiggin contended that the gauze was not the kind he used in sponging, and that the small strip had probably been left in the sinus while the patient was being dressed at the other institution. Verdict for the defendant.

Lawsuit, Small Gauze Sponge Removed by Secondary Operation. The patient was operated on for appendicitis by Gillette. After the abdomen was open it was found that the trouble was tubal pregnancy. The appendix excision was closed and a median incision made, and through that the operation was completed. About four days after the operation the appendix incision began to discharge pus. Gillette treated this sinus persistently under the impression that it was kept up by unabsorbed kangaroo tendon, which might at any time be wholly absorbed and thus permit healing. After twelve months of this treatment the patient went to another physician, who, eighteen months after the first operation, did a secondary operation and found a small gauze sponge, after which the patient recovered. Suit was entered for $5,000.

In the trial court the verdict was for the defendant on the ground that the cause of action, if any arose, was barred by the statute of limitation. The Circuit Court held that the trial court was in error and reversed the decision. The Supreme Court was divided equally on the subject, hence the decision of the Circuit Court was allowed to stand—verdict for the plaintiff.

Lawsuit, Sponge Left in Abdomen. Baldwin was made defendant in a suit, and a question that assumed much importance in the case was as to whether the responsibility for the count of the sponges lay with the surgeon or with the nurse. The suit against the surgeon was finally withdrawn, and legal action was begun against the hospital where the operation occurred.

Lawsuit, Sponge Removed at Secondary Operation. The patient was operated on for an abdominal tumor by Thorne. Several months later a secondary operation was performed by another surgeon and a sponge was found in the abdominal cavity. The patient recovered. Legal proceedings were begun against the first operator (Miss May Thorne) on the ground that she was guilty of negligence in not personally counting the sponges used in the course of the operation before the wound was closed.

The defendant denied negligence and held that the leaving of a sponge was an accident that could not always be avoided. She further said that, like a large number of other operating surgeons, she left the counting of the sponges to a responsible nurse—considering that it was the duty of the surgeon to keep his or her eyes continually upon the patient until the wound had been closed.

The judge, in summing up the case, said there was no doubt that the defendant was a skillful surgeon, but the question in this case was not as to her skill, but whether she had been guilty of want of reasonable care. The points for the jury were: (1) whether the defendant was guilty of want of reasonable care in counting or superintending the counting of the sponges; (2) whether the nurse was employed by the defendant and under her control during the operation; (3) whether the nurse was guilty of negligence in counting the sponges; and (4) whether the counting of the sponges was a vital part of the operation which the defendant undertook to see properly performed.

After a lengthy consideration the jury returned a verdict for the plaintiff.

Criminal Trial, Sponge Found at Autopsy. The patient was subject to exploratory laparotomy by d'Antona. A carcinoma of the liver was found, and an unfavorable prognosis given. The patient recovered from the immediate effects of the operation, but died after a month. At the autopsy a gauze pad, 70 by 40 cm., was found and also two liters of pus. The physicians who made the post-mortem examination gave out a statement to the effect that the death was due to the presence of the sponge and the peritonitis and secondary pleuritis resulting therefrom. The public prosecutor then had d'Antona indicted and placed on trial for criminal negligence.

The verdict was that the patient would have died from the other causes present. The prosecutor then claimed that the hospital records had been falsified, hence a new trial was granted. In the second trial ten experts were called and they all testified that there was sufficient cause for death outside of

any influence which the sponge within the abdomen might have had. The trial was then discontinued because of the absence of prosecuting evidence.

This case was reported by Prof. Pio Foa, who stated that, if the autopsy had been conducted by competent pathologists, such an erroneous report would not have been made, and the unfortunate trials would not have occurred.

Lawsuit, Sponge Left in Abdomen. The patient was subjected to abdominal section by Schooler. Later developments indicated that a sponge, sixteen inches square, had been left in the abdomen. Suit was entered for $1,500. Verdict for the plaintiff.

Lawsuit, Sponge Left in Abdomen. The husband of the plaintiff was operated on for appendicitis by Hageboeck. It was charged that a surgeon's sponge had been left in the abdomen and that this caused an abscess which resulted in death. Suit was entered for $50,000.

In two trials the jury disagreed. It was reported that in each trial the jurors stood 11 to 1 in favor of the plaintiff. The case was to come up for a third trial the latter part of the year.

Criminal Trial, Forceps Found in Abdominal Cavity at Autopsy. A patient with a large fibroid was operated on by Lassallette. Death occurred a few hours after the operation. Autopsy disclosed a forceps in the peritoneal cavity.

At the trial the operator was condemned to two months in prison for homicide through negligence. The sentence was served.

After serving the sentence, Lassallette put in a plea that the patient's death had not been caused by the retention of the instrument, but by nux vomica. The death occurred too soon to have been due to the presence of the instrument. It was proved that a midwife of bad reputation had a bottle of nux vomica in her hand at the house on the day of the death. This was an entirely new phase. The body was exhumed. Lassallette was acquitted.

Criminal Trial, Two Artery Forceps Found in Abdomen at Secondary Operation. The patient was operated on for ovarian cyst, December 22, 1897, by Prof. Kosinski and Dr. Solman, in the latter's private hospital. After a few days there appeared fever and a mass, which continued. In the meantime two artery forceps had been missed, and it was thought they might be in the abdomen. The disturbance persisted, and six weeks after the operation the abdomen was reopened and the mass of exudate investigated, but neither forceps nor pus was found. The patient was better afterward and went home, but did not get well. Later a hard mass developed near the umbilicus. Kosinski still thought the forceps might be in the abdomen, and insisted on another operation and offered to perform it gratis. But the sons would not hear to this, and the patient was taken to several other physicians, one after another, hoping to be cured without operation. Finally, six months after the primary operation, the symptoms became acute and threatening, and the physician who was called in insisted that the patient be taken to Kosinski at

once, that he might perform the operation, which had then become imperative. This the family refused to do and called in another physician, who operated. On opening into the mass at the pelvic brim he found a cavity in which lay the two artery forceps. Both forceps had forced an entrance into the external iliac artery. The removal of the forceps was attended with a furious hemorrhage, from which the patient died on the table.

Legal action was entered against Kosinski and there was an extensive trial, with an imposing array of legal and medical talent. Six experts were appointed to testify in the case—Przewoski and Troichij to consider the pathologico-anatomical features, Krajewski to describe a modern laparotomy, Maksimow to criticize the operation as performed in this case, Pawlow to consider the various complications and mistakes that may occur in a laparotomy, and Neugebauer to supply the statistics which might be required in the trial. It was for use in this trial that Neugebauer complied the list of cases that he published the following year (1900), which publication has done so much to enlighten the profession on this subject.

The trial resulted in the acquittal of the accused as far as causing the death of the patient was concerned—it having been shown that he strongly insisted on a line of treatment which would probably have prevented the patient's death had the treatment not been peremptorily rejected by the family.

A curious clinical feature of this case was that, during the patient's illness, a number of radiographs of the suspicious area were made, but not one of them showed the forceps—the failure being due doubtless to defective technique.

Lawsuit, Artery Forceps Extracted From a Sinus. The patient was subjected to operation for a sarcomatous growth in the abdominal wall by Dollinger. The patient was three months pregnant at the time of the operation. She recovered from the operation and was delivered at term without any special disturbance. She became pregnant again. Her health was excellent and she was able to do all her housework. In the latter part of the pregnancy there appeared in the operative scar a swelling, which opened and discharged much offensive pus. The abscess was still further opened by the family physician. Within a few days she was delivered. A few days after the delivery an artery forceps was discovered in the abscess wall. The patient was sent to the hospital and the forceps removed by operation. The patient died two days later.

The husband of the patient demanded money of Dollinger, which demand was refused. He then went to the public prosecutor and endeavored to have a criminal prosecution brought against the surgeon. The prosecutor asked Dollinger for a written statement of the case, which was given. The prosecutor saw no evidence to warrant criminal proceedings, and dropped the matter.

The husband then brought civil suit, and for thirteen months Dollinger spent all his time defending himself. Sensational reports appeared in the public press, and it is said that the comic papers made capital of it and pamphlets on the subject were sold at the cigar stands. Though acquitted, Dollinger suffered irreparable damage from the sensational newspaper reports and the consequent notoriety. He urges strongly that some means should be provided by which reputable physicians may protect themselves from this species of blackmail and newspaper persecution, which necessarily results in serious loss.

Criminal Trial, Piece of an Instrument Left in Abdomen. A Paris surgeon lost part of a broken instrument in the abdominal cavity. The patient died. The surgeon was put on trial for manslaughter due to negligence. Result of trial not stated.

Lawsuit, Pair of Spectacles Found in Abdominal Cavity. The patient had three operations—the first in America, the second in Germany and the third in France. The French surgeon found a pair of spectacles in the abdomen. The patient sought redress in the courts.

The outcome of the trial is not given, neither is it stated definitely who was sued. Neugebauer, who cites the case, blames the German surgeon—noting that he either left the spectacles himself or missed finding them if left by the previous operator.

Lawsuit Threatened, Gauze Compress Discharged Per Rectum. The patient had been subjected to vaginal section, for pelvic suppuration, by MacLaren. It was a very severe case. There was persistent bleeding requiring packing, and there were two secondary hemorrhages requiring repeated packing. The patient recovered. Two months afterward a very offensive discharge appeared and the patient extracted a twelve-inch strip of iodoform gauze from the vagina.

Suit was threatened, and, on the advice of his attorney, MacLaren paid the patient a considerable sum to avoid further proceedings.

Lawsuit Threatened, Cotton Compress Discharged Per Rectum. The patient had uterine fibroids, which Borysowicz removed by abdominal operation. Three weeks later a gauze compress was passed per rectum. Evidently the compress had been left in the peritoneal cavity at the time of the operation. The patient recovered and thanked the operator most gratefully for his services and left him her photograph. Six years later he received a number of letters from the patient's husband, threatening prosecution for malpractice if he did not at once pay a certain sum. The husband had no doubt heard of a lawsuit (Kosinski's?) then on at Warsaw, and thought it an easy way to obtain some money from Borysowicz, Apparently nothing came of the effort.

Lawsuit Threatened, Forceps Alleged to Have Been Passed Per Rectum. The patient was operated on for a suppurating ovarian cyst by Tuholske. It was an extremely severe case, but the patient recovered and regained her health rapidly. Twenty months later she wrote that she had given birth to a fine baby and felt

well. Labor had been uncomplicated. The account continues: "Some five or six months after that (more than two years after the operation) the husband called on me and stated that for two or three months his wife had had some rectal trouble, supposed to be piles, and that a week ago, under considerable suffering, she had passed a forceps at stool. He brought it to me; it was a forceps such as is usually carried as dressing forceps in a pocket case—not a hemostat. I did not claim ownership. At any rate, if that forceps had been in the pelvis for two and a half years, during pregnancy and labor, without giving rise to a symptom or modifying labor, it was a remarkable occurrence. Three months after this episode the patient was reported well." In a later reference to the case, Tuholske stated that several demands were made for money, accompanied by threats of a suit. No attention was paid to the demands and finally they ceased. He expressed the opinion that it was an attempt to obtain money by blackmail.

The Question of Deception, Intentional or Otherwise. The repeated occurrence of this accident in the past and the possibility of its occurrence at any time gives an opportunity for designing persons to obtain money under false pretenses. Neugebauer calls attention to this fact, and remarks that, following the newspaper publicity given the Kosinski trial, a number of damage suits, alleging the accident, were filed, and that in most instances they were cases of blackmail of extortion.

A case has been reported of a patient who, following convalescence from an abdominal operation, expelled pieces of gauze or thin cloth from the mouth. The patient claimed that the expelled pieces were vomited sponges, which had worked their way into the stomach from the peritoneal cavity. Suit was threatened. The matter was dropped, however, when the practical impossibility of the occurrence, as detailed, was explained to the patient.

When discussing the subject of foreign bodies left in the abdominal cavity, a physician related to the author some of the details of a case in which he had been involved. He performed an abdominal operation, and, some time following the convalescence, the patient came to him and exhibited a surgical needle and stated that the needle had been passed per rectum. The patient's statement was confirmed by a physician who claimed to have treated him at the time the needle was passed. Suit was threatened. On examination of the needle the operator found it was not the kind he used at the operation, and he became convinced that the alleged occurrence was an attempt at blackmail.

The matter dragged along for some time. The operator accumulated all the information he could concerning the subject and concerning the parties involved, and finally confronted them in such a way that they were forced to make a written statement, acknowledging that the needle had not been passed per rectum, as alleged. The needle exhibited had been obtained elsewhere for the purpose of threatening suit and extorting money.

Porter gives an account of a peculiar case bearing on this subject. The operation was for a parovarian cyst and hydrosalpinx and chronic appendicitis. The

convalescence was normal and the patient left the hospital twenty-two days after the operation, feeling well. Eight days later, Porter received a telephone message from the patient's family physician, stating that he had removed several pieces of gauze from her vagina.

Quoting from the report, "On inquiry from him I learned that the pieces did not tear off, but came away, or rather were removed with forceps, in the shape of rolls about the length and size of a lead pencil, and after all presenting were removed others would present in a few hours, requiring that he visit her two or three times a day to take them away. The doctor thought that the pieces came from the pelvic cavity through an opening in the right side of the vagina about the size of a lead pencil.

"On the next day after learning of the matter, I visited the patient at her home with her doctor, and found the patient on a cot apparently suffering some pain, which she said was due to more pieces 'coming down.' She did not look sick. In reply to my question she said she felt well until she got a jolt on the car on her way home and that since then she had been having pain, which was worse at times, and had not been so severe since the pieces began to come away. The first knowledge the doctor had of the nature of the trouble came through the patient's husband, who told him that there was a piece of gauze protruding from the vagina. I asked to see what had been removed and was shown a large number of pieces of different texture, whereupon I remarked that the goods were not such as I had used as sponges, that there were more pieces than had been used all told in the operation, and that consequently they had not been left in the woman's belly by me. It was averred that they could get into her belly only through the wound made by me and at the time it was made, because it had been closed, healed by first intention, and was still closed. The patient facetiously remarked that she 'supposed she swallowed 'em.' 'No,' I replied, 'had you swallowed them they would not come out through the vagina.'

"Dr. F. now asked the patient if she thought more 'pieces were down.' Being answered in the affirmative, he introduced a speculum and found that she was right. I removed the speculum, and, introducing my finger, came upon a small wad of something which, upon removal, proved to be a piece of ordinary white muslin about three inches wide by seven inches long, twisted into a rope and doubled upon itself so as to make a small ball or wad. It was perfectly clean, and was so saturated with what looked and smelled like urine that on squeezing between the fingers several drops were squeezed out. I examined the vagina with my finger, assuring myself that there were no more 'pieces' there, that there was no hole leading into the pelvic cavity and that, in fact, it was a perfectly healthy vagina and in nowise unusual except its cleanliness, for which, of course, the frequent wipings it received were accountable.

"In the presence of the patient, her mother-in-law and the doctor I said, pointing my finger at the patient, 'Doctor, I don't know where those rags came from, but that woman knows very well, and could tell if she would.' The mother-in-law

objected to my statement rather forcibly, but the patient said nothing. I then took the doctor outside, told him that the woman was a malingerer and that we would give her a chance to put some more rags in for removal. We received one more piece before we left. Before leaving I insisted upon both the doctor and myself making a thorough inspection of the vagina with the eye and the finger as well. This was done, but no abnormality was found. It should be stated that some of the 'pieces' were tinged with blood, but not any of those removed at my visit."

Dr. Porter exhibited ten pieces of different size, shape and texture, and continued: "Eight days after my visit, Dr. Fisher reported 'no more exhibits.' So far as I know, no threat was made of a suit for damages, nor did the patient or her mother seem out of humor with me. The husband was at work and not present during my visit, although he presumably knew the day before that I was to be there, as I had sent word that I was coming."

In regard to the possible cause for the deception, Dr. Porter mentioned: 1 desire for money; 2, desire for sympathy; 3, desire to avoid work; 4, sexual perversity. He stated that during the patient's stay in the hospital nothing pointing to a neurotic condition was noted.

Schaefer gives the details of a case which emphasizes the fact that when a piece of gauze is found in the abdominal cavity it does not necessarily follow that it was left there in a previous operation. The case occurred in the practice of Pryce Jones. Jones was called to see a woman with an abdominal swelling. This proved to be an abscess, which was opened and discharged a piece of cloth.

There had been no previous operation. The woman was insane, and had been in the habit of tearing up pieces of cloth and swallowing them. The swallowed cloth had evidently caused ulceration of the stomach wall, with subsequent perforation into the peritoneal cavity.

The noted intestinal "hair-balls," requiring operation, constitute another class of foreign bodies in the abdomen which were not left there by the surgeon.

Again, the professional "knife swallowers" and "glass eaters" and their amateur imitators must be kept in mind. Fortunately the menu of these persons is limited, as a rule, to household articles. However, some such "actor," who has been relieved of his accumulated load by surgical art, might, from the intimate acquaintance, acquire a taste for surgical forceps instead of the usual nails and pocket knives. In that case a condition might easily develop that would make it very uncomfortable for the previous operator, though wholly without fault on his part.

The Remedy.

To make absolutely certain that no sponge or other foreign body is left in the peritoneal cavity at operation is a hard problem. The solution of this problem. is considered in Chapter xv (see continuous sponges and long instruments).

PERSISTENCE OF SYMPTOMS AFTER OPERATION.

The persistence of troublesome symptoms after an operation which was expected to give relief, is a source of disappointment to the surgeon and the patient, and the latter sometimes seeks solace in legal action. The action is usually based on all allegation of (a) want of care and skill or (b) nonfulfillment of promise. This brings up two questions, as follows: 1. What constitutes proper care and skill within the meaning of the law? 2. How much should we promise our patients?

What Constitutes Proper Care and Skill?

This question is discussed instructively in the following quotation from an article by Haberman (St. Louis Medical Review, 1909):

"The question of the degree of care and skill which a physician or surgeon must exercise arises in every action for damages on account of alleged malpractice. There are certain standards to which a practitioner must conform. If he does so, of course, there is no element of liability even though the result be unsatisfactory on the part of the patient. If, on the other hand, a practitioner has fallen short of the measure of care and skill which the law requires of him he may be liable in damages. The question of what degree of skill and care should be accepted as the standard in a given case depends always upon the facts and circumstances of the case, and is, like any other question of fact, to be determined by the jury under appropriate instructions of law to be given by the court. The court will apply the appropriate principles to the facts in hand and instruct the jury accordingly. It then remains for the jury to determine whether the practitioner has been remiss or not.

"In view of the fact that many practitioners specialize along certain lines and others undertake to fill the more ancient calling of a general practice, the legal principles applicable to a case of malpractice arising under the one or the other are different.

"A physician is said to impliedly hold out as a representation to a patient that he possesses that degree of skill and will exercise that degree of care which is ordinarily possessed and observed by others in like callings and in similar localities. The question of locality necessarily plays an important part, as a physician practicing in a settled community, having readily accessible instrumentalities which would not be available to a practitioner in a rural and sparsely settled community, would be held to a degree of care much higher than the latter.

"The rule is strict against the trying of experiments without the knowledge and consent of the patient. It is necessary that established and accepted forms of treatment be followed and if a physician, whether he be a general practioner or specialist, undertake an experiment, the same is undertaken by him at his own peril. If the ordinarily and generally accepted practice is that a given ailment

be treated in a certain manner and some other method is adopted which results in injury to the patient, it is not a matter of any consequence how much skill was possessed by the physician, and his failure to follow the accepted form of treatment would be held to constitute negligence."

There is a point here which the quotation does not touch upon, viz., the improvements constantly being made in the "established forms of treatment." These improvements are possible only through pioneer or experimental work, using the term experimental in its largest sense. Without such work all progress would stop—and surely such a state of affairs is not contemplated by the law and should not be encouraged by any interpretation of the same. The "experiments" referred to in the above quotation are evidently innovations for which there is no justification in the nature of the case considered in conjunction with contemporaneous practice. Where "improvement" ceases and "experiment" begins, is a point which might be difficult to decide in a disputed case. The danger of subsequent trouble from designing persons, as well as care for the best interests of the patient, should make the surgeon very careful in the adoption of new methods. Such methods should not be taken up for general use until they have been tried out in a reliable way by competent authority.

Continuing the quotation:

"The fact that the service is gratuitously rendered does not change the principles applicable for the purpose of determining whether the physician or surgeon is chargeable with malpractice. The same degree of care and skill is exacted of a physician or surgeon in the performance of gratuitous services as one who expects to receive compensation therefor.

"It is elementary to say that a physician does not warrant a cure, and if the practitioner has exercised the degree of skill and care with which he is chargeable under the law, he is under no liability to the patient, even though an unsatisfactory and unfortunate result be attained.

"Quite apart from the question of the degree of technical skill required of a physician or surgeon, as the case may be, is the question of lack of care involved in non-attendance to a patient. If a physician answers a call there is an implied contract that he will give the patient that attention which is necessary until such time as the same be no longer necessary or the physician be discharged from attendance. One who leaves a patient at a critical stage of a disease without reason or sufficient notice to enable him to procure another medical attendant, to the patient's damage, is guilty of an actionable wrong. The physician is bound to use not only the ordinary care and skill exacted of men in his class, but is bound to exercise a discriminating judgment as to when his visits may be safely discontinued.

"The foregoing comments apply to practitioners generally without undertaking to differentiate between general practitioners and specialists. The degree of care and skill with which a general practitioner is chargeable is, however, different from that standard to which the law holds a specialist.

"A general practitioner is said to be 'bound to bestow such reasonable ordinary care, skill and diligence as physicians in the same neighborhood in the same general line of practice ordinarily have and exercise in like cases.' He must keep himself informed of the general advancement in matters pertaining to his profession and is chargeable with negligence if he fails to conform to the requirements of advances in science which are generally understood and followed. He is chargeable with a reasonable degree of skill as distinct from the very highest degree of skill and with ordinary care as distinct from a very high degree of care, but for the absence of such ordinary skill or the failure to exercise such ordinary care, resulting in damage, the physician is liable at law.

"The standard of skill and the degree of care to which a specialist is required to conform is much higher than that required of a general practitioner. One who holds himself out as a specialist impliedly warrants that he possesses a degree of skill and knowledge higher than that possessed by a general practitioner and furthermore that he is the possessor of that degree of skill and knowledge which specialists in his particular department who keep pace with the advancement in such specialty, possess. It has been held in Missouri in an adjudicated case that a specialist will be held to that degree of skill which he holds himself out to possess and that by professing to be a specialist he holds himself out to possess 'a degree of skill and diligence * * * as high as that possessed by other good surgeons of the specialty to which defendant belonged.' (McMurdock vs. Kimberlin, 23 Missouri Appeals 1, c. 531.)

"It will thus be seen that the specialist is chargeable with bringing to the aid of his patient a degree of skill and knowledge such as is possessed by physicians who give special study to the specialty, having regard to the state of scientific knowledge at the time of the treatment.

" 'The physician is not to be judged by the mere result obtained or for mere errors of judgment. His negligence is to be determined by recourse to the pertinent facts existing at the time of his examination and treatment, of which he knew, or, in the exercise of due care, should have known. It may consist of a failure to apply appropriate remedy upon a correct determination of existing physicial conditions, or it may precede that and result from a failure properly to inform himself of these conditions.' (Rand vs. Twitchell, 71 Atlantic, 1045, Vt.)

"The general practitioner in many instances, confessing that he has reached the end of his resources, refers the patient to a specialist. This well illustrates the difference in the degree of skill which may properly be exacted of the one and of the other. The general practitioner adopts the remedies and treatment most appropriate under the circumstances in the light of his general practice, but is not liable for negligence in failing to obtain desired results and upon realizing this situation refers the patient to a specialist who is properly expected

to possess a higher degree of skill and care and, by the fact of holding himself out as a specialist, to warrant that he possesses the same."

How Much Should We Promise Our Patients?

What will be the immediate result of the operation—will the patient pass safely through it? What will be the remote results of the operation—will the disability and the troublesome symptoms be relieved?

These are questions of vital importance to the patient. She asks, and she has a right to ask, for specific information on these points, and the surgeon is in duty bound to answer the questions intelligently and conscientiously. It is not an easy task. There is considerable uncertainty in any case and the probabilities of complete relief are surrounded by possibilities of quite a different character. There are two ways of dealing with this phase of operative work, one way being better for some patients and the other way better for others.

1. The most common method, and the preferable one in the majority of cases, is to avoid the prognosis almost entirely. The results hoped for, and which usually follow the operation in question, are pointed out, but the patient understands that owing to the uncertainties always present the results cannot be definitely promised in any case. The operator is to do the work in a careful and thorough manner, and if no unusual condition develops the intended results may be expected. With most patients this general understanding without specific discussion is satisfactory. In many cases detailed discussion of the pros and cons of the various untoward results that might come, would increase the patient's worry and distress without any corresponding benefit.

2. In certain exceptional cases specific discussion of the probabilities in regard to immediate and remote results is called for. This may be (a) because the patient evinces misunderstanding in regard to the matter or (b) because the patient is undecided as to whether the probability of benefit is sufficient to justify the trouble and expense of operation, and wishes to carefully weigh all features of the subject. In such a case the facts available should be placed before the patient as extensively as she desires. The responsibility of decision rests with her and she depends on the surgeon to put before her the facts on each side of the question.

An important point is to avoid persuading the patient toward operation. After the information and advice are given, the patient should be left undisturbed to deliberate on the subject and to make her choice freely. The author is careful to avoid operating for a patient who is undecided as to whether or not she really wishes the operation. When a patient comes for operation in that state of mind she is advised to wait. The matter should be settled definitely in her own mind, either by personal consideration of the various facts or by deciding to be guided by the surgeon's advice. The responsibilities which the surgeon must assume are numerous enough without adding any unnecessary ones.

The subject of promises to patients is very well summed up in the following remarks by Howard A. Kelly in a discussion before the American Gynecological Society (Transactions, 1896):

"I think to protect ourselves as specialists certain rules ought to be adopted which I follow in my own case. We ought to keep a written record of the history of cases and of the subsequent visits made. We ought to note carefully the examination, and under the head of examination I think it is always important to put down what the patient says, in her own language, of her present condition. There is often a wide discrepancy, when she comes back and says she is not improved by the operation, between her statements at the first visit and afterward. You can call her attention to the fact that certain things have disappeared, and she is often ready to acknowledge it when she recollects them. I think it is important to note, the first time you get a clear idea of the case, what line of treatment it is proposed to follow and what is promised as a result of that treatment. I am also very careful never to promise absolutely to effect more than a mechanical result in a surgical operation. The patient comes to us, as a rule, for pain, and we look to another thing—the mechanical result which the surgical operation is going to effect—and we are sometimes working at cross-purposes. We get the mechanical result, but the patient may keep the pain and be dissatisfied for that reason. So I promise the patient to remove the disease or correct the deformity but I promise nothing more, absolutely. I always state to the patient that while the chances are in favor of recovery and relief, the relief is not promised as absolutely certain."

OPERATIVE GYNECOLOGY

BY

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