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Historical Overview

Malpractice: new under the sun?

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In a quotation which opens the very first section of Kenneth Allen de Ville's magnificent work "*Medical Malpractice in Nineteenth-Century America*" [1], the author cites J.R. Weist's 1884 observation on the malpractice law suits of the time, that the "remedy of these evils in the profession involves many and grave problems in sociology which I cannot now stop to consider" [2]. He might well have added that the problems were not only sociological but medical, educational and legal as well, and that they were ever increasing in number and complexity; the trend, with ups and downs, was to continue for more than a century after he wrote.

At the time of Weist's paper, malpractice proceedings had been a significant phenomenon in the law and medicine of the United States for rather more than forty years. Why they came so markedly to the fore in nineteenth century America is a question which, with De Ville's assistance, is well worth considering; for both their number and the extreme nature of the charges which were brought against physicians (and more particularly against surgeons) provide a wealth of illustrative material, much of which by analogy remains relevant in understanding malpractice litigation at the present day.

Early precedents

Prior to 1840, two contrasting incidents illustrate the range of issues with which the courts were confronted at an early stage. The Connecticut case of *Landon v. Humphrey* in 1832 [3] confronted juries with such disparate matters as standards of skill, contractual relationships, professional delegation, the competence of medical students, the role of the patient, discrepancies in expert testimony, and assessment of damages. In that particular case, the board of health of the town of Salisbury Conn. had hired Dr Asabel Humphrey and other physicians to carry out public vaccinations against smallpox. Because of illness, Dr Humphrey delegated a part of his task to a medical student, one Rollin Sprague. When Mr Sprague came to vaccinate twenty-year-old Miss Harriet Landon, she refused "from real or affected modesty" to raise her sleeve. He vaccinated her all the same as best he could, but the consequence was that the vaccination was made, as the court was told "in an

improper, unusual, and dangerous place”; as a result she experienced great pain and for several weeks was unable to use her lower arm, which was temporarily paralysed. After considering conflicting medical and legal views, the court passed judgement against Dr Humphrey to the sum of \$1000 including costs; his appeal for a new trial was unsuccessful. Essential elements in the case were that the plaintiff succeeded despite the relative nature of her complication, the lack of a direct contractual relationship with the doctor, and the fact that she had perhaps herself played some part in the causation of her injury. Subsequent medical comment on the judgement was however more inclined to reflect concern at the fact that a patient had obtained damages at all for an adverse complication of treatment. The case, declared a writer in the *Boston Medical and Surgical Journal*, predecessor of the *New England Journal of Medicine*, “should excite the astonishment of every medical man” [4].

Medical men tended to be less astonished by and more tolerant of the type of case which reflected gross medical negligence and incompetence, but here the lawyers sometimes felt themselves obliged to face the realities of a large and developing country. Such was the case of *Lowell v. Hawks and Faxon* in 1823 [5]. Charles Lowell had been thrown from his horse near the village of Lubec in rural Maine, and then been trapped beneath the falling animal, after which he was unable to rise. A certain Dr John Faxon (“not a thoroughbred physician”) of Lubec was called in attendance, and having diagnosed a dislocated hip made unsuccessful efforts to correct it. He in turn summoned a Dr Hawks from the village of Eastport, who despite his professed lack of faith in Dr Faxon, undertook with him and (with the aid of several muscular men) some brief but extremely painful efforts to force the limb back into its socket; the patient was thereafter immobilized for fourteen days, after which he found himself quite unable to walk without crutches, with one limb shortened by three inches and in constant pain. Transported to Boston some months later, he was there found by the eminent John Collins Warren to indeed have suffered a simple dislocation, which by reason of improper treatment had now become irremediable. Much against his will, Warren was persuaded nevertheless to attempt correction, but between one and two hours of violent treatment with a pulley device only confirmed the irreversibility of the condition.

The case which Charles Lowell brought against the two village doctors was notable for several things including the acrimony of the medical argumentation (with the defence lawyers dismissing the physicians of Boston as a “bunch of old grannies”), the fact that two other trials were to follow and the judge’s classic ruling to the jury in the third of these that:

“...it is not to be expected of a Surgeon or a Physician in a country or obscure village, that he will possess the skill of a surgeon in the city of London, or any large city – this would be unreasonable to expect...all that is required is ordinary skill according to the state of medical science in the section of the country in which he lives.” [6].

This doctrine, later to become known as the locality rule, and which in this particular case ultimately defeated Lowell’s efforts to secure any damages at all,

was for a great part of the nineteenth century to play a role in judging the standards by which medicine could and should have been practised in any particular instance of alleged injury. It was to remain in vogue, both in the United States and in certain other countries, so long as one was dealing with a large and empty country with vast distances, relatively poor communications, and a shortage of proper medical education. Once those problems receded, as they did thanks as much to the expansion of the Universities as to the building of the railways, so should the locality rule have fallen into disuse. Remarkably, it did not. Although the eminent physician Stephen Smith [7] could argue cogently in 1860 that it was now “manifestly dangerous” to employ the rule, and although plaintiffs had become accustomed to summoning medical witnesses from the cities to support their cases against local practitioners, the rule was to grow once more in stature during the last third of the century.

The flood and its sources

The extraordinary publicity attracted to the Lowell case reflected in part the relative rarity of medical litigation during the first third of the century. By 1840, as De Ville shows, all that was changing. A veritable deluge of litigation burst loose, with cases ranging from the trivial to the deeply tragic. In 1853 the *Boston Medical and Surgical Journal* was warning its readers that every surgeon in the country was liable to a lawsuit for damages, and expressing concern that juries appeared to be siding with plaintiffs rather than with the profession [8]. It seemed that New York was in the van; Frank Hamilton told the 1843 graduating class of Geneva Medical College that he knew of over twenty malpractice prosecutions against “respectable and eminent” New York state surgeons in the preceding two years alone [9] and a medical witness in Buffalo in 1848 testified that, while he himself had never been sued, the frequency of malpractice prosecutions in the state had driven him from practice. The *Buffalo Medical Journal*, reporting his statement, noted that “in this city there are but a few surgeons of years or reputation in the profession, who have not been latterly crowned with the accompanying honors of a public prosecution for malpractice” [10]. Thereafter the rage spread rapidly north and west; in Ohio, where the first malpractice case was heard in 1850, 1855 saw four cases being heard in a single week [11]. The range of incidents giving rise to action was also widening; earlier instances had related most commonly to mechanical faults and failures, notably severe deformity through inexpert treatment of fractures and dislocations, or bad management in obstetrics, soon followed by vaccination injury; by mid-century one found cases relating to the use of violent purgatives, to misdiagnosis and to haemorrhage.

A conclusion still familiar today is that the increasing vogue for medical litigation even in cases of relatively modest injury reflected in part greater expectations inspired by advances in medicine and technology. If a new treatment for a malady was known to have emerged, the belief was rapidly seeded that it would be universally applicable, successful and free of harm.

Contemporaries interpreted the rising tide of litigation variously as evidence that the status of the profession was deteriorating, that it had become the whipping boy of its non-orthodox competitors, that it was the victim of its own technical shortcomings and internal conflicts, or that it had been seized upon as a scapegoat by a basically hostile public [12].

All of these explanations seem to have held good to some degree, although the one may merely have been a consequence of the other. What seems clear is that what Dr Alexander Garnett in 1854 called “defective medical acquirements” comprised an essential part of the phenomenon; the profession of the day was neither uniformly skilled nor uniformly conscientious. Commonly, medicine was simply not as good as it could have been. Educational shortcomings were one reason for the defects: as De Ville puts it: “Poor, uneven, and disorganized medical education left physicians ill prepared to deal with the complexities of the human body” [13]. The manner in which the practitioner in the field comported himself was, however, at least as relevant. However much one might fulminate against the excesses of the self-styled alternative schools, the American medicine of the day itself offered a home to numerous curious, unproven and sometimes highly injurious practices, blessed only by the fact that they had been developed by a registered practitioner. The “heroic” treatments of Dr Benjamin Rush were among those held in great esteem, despite the fact that they involved nothing better than the intensified application of centuries-old techniques of dubious repute. Patients were bled until they fainted [14]; leeches were applied to every part of the body; cathartics and emetics were administered in overwhelming quantities. Calomel was dosed until the gums bled, and the hair and teeth fell out. If in the face of such measures the public turned away to the homeopaths and osteopaths it was in part because their measures at least did no harm. As one physician wrote in 1835, the injudicious employment of heroic treatments:

“... has produced, does continue, and will perpetuate (unless obviated), the fear, jealousy, and suspicion that exists between... the community, and the profession at large” [15].

Even where medicine had good things to offer, it seemed incapable of demonstrating to a public which was heavily reliant on home cures and receptive of charlatans, that it could offer greater benefit or greater safety than could unskilled care. Indeed it succeeded in alienating itself from public sympathy by its sometimes high-handed or inept approaches to important issues. When leading practitioners sought, with much justification, to introduce an adequate licensing system, their initiatives were widely regarded as being no more than a subtle means of suppressing competition.

The role of the lawyers

The rise in litigation in nineteenth century America seems to have owed surprisingly little to any prodding on the part of acquisitive lawyers, a phenomenon

which was to become pronounced only in our own time; physicians indeed commonly professed their high esteem for the legal profession's sympathetic handling of the phenomenon, while plaintiffs not infrequently experienced much difficulty in finding attorneys to act on their behalf [16]. Stephen Smith was among those who were utterly convinced that any right-minded juror and attorney could be convinced of the need to line himself up with the medical profession:

“Could the capable and the conscientious legal adviser clearly understand and be thoroughly impressed with the inherent difficulties in the practice of medicine, he would be slow to counsel prosecutions of medical men; and had the court the same knowledge, we believe that a nonsuit would be the summary termination of many a trial for alleged malpractice” [17].

Attorneys for their part commonly acted for fees normal for their time, though at a very early stage the notion of contingency payments arose and the lawyers then received – as in later years was to become so common – an agreed proportion of any damages awarded [18].

Development of the law

Down to the late eighteenth century, American lawyers had still turned to the commentaries of Blackstone or Coke in English law for guidance, and to the occasional precedents to be found in the London law reports. Only after Judge Nathan Weston propounded the locality rule in setting standards of medical skill and knowledge in 1823 did American malpractice law begin to develop any clear characteristics of its own. As pointed out above many other issues had to be faced early; all the same, when the deluge of litigation against physicians broke loose in the middle of the century, the law was all but overwhelmed by the complexity of the scene; in the sometimes frenzied state of litigation, attorneys of varying hue and merit struggled with a legal system the views of which on the malpractice issue were still muddled and in a state of flux.

Unavoidably, very many matters were handled *ad hoc* and rulings of principle avoided; that was the case where the legal basis of the physician-patient relationship was concerned – provided a physician admitted to treating the plaintiff, as defendants generally did – the court would conclude that a “duty-filled relationship” existed and would proceed to the substantive issues [19].

What had become clear at an early phase is that explicit promises to cure had seldom been made and that courts were almost never prepared to construe them. When in 1833 an Ohio man sought to bring charges against a physician under a writ of *assumpsit* (i.e. breach of promise) for failing to deliver safely the plaintiff's child, the trial judge dismissed the case because “the law does not raise from the fact of employment an implied undertaking to cure” [20].

Almost at the same time the trial court judge in *Lando v. Humphrey* laid down a further basic principle with his instruction to the Connecticut jury that “if there

was either carelessness, or a want of ordinary diligence, care, and skill, then the plaintiff was entitled to recover” [21]. Sixteen years later the Maine Supreme Court declared that a malpractice defendant “is not liable for a want of the highest degree of skill, but for ordinary skill” [22]. By 1860 the principle had reached its almost definitive form with the ruling by the Illinois Supreme Court in *Ritchey v. West*, in which no less an attorney than Abraham Lincoln appeared for the plaintiff, that:

“...when a person assumes the profession of physician and surgeon, he must, in its exercise, by held to employ a reasonable amount of care and skill. For any thing short of that degree of skill in his practice, the law will hold him responsible for any injury that may result from its absence. While he is not required to possess the highest order of qualification, to which some men may attain, still he must possess and exercise that degree of skill which is ordinarily possessed by members of the profession” [23].

What that “ordinary” standard of diligence, care and skill should be considered to comprise was nevertheless still subject to the ever-present locality rule, or clouded by the heterogeneity of courts, judges and state procedures.

Charlatanism and irregular schools of medicine

Surprisingly, the litigation epidemic seems to have done relatively little to counter frank charlatanism. With a few spectacular exceptions, irregular practitioners were relatively rarely sued and on some occasions those of some popular standing and repute were even favoured as expert witnesses in supporting actions brought against qualified men, much to the indignation of the profession. One reason for this, as De Ville puts it, was clearly the long American tradition of “self-cure, home remedy and folk healing” [24], carried forward in the highly tolerant approach developed in many states to the recognition of alternative qualifications of varying origin. The Thomsonian school, a form of practice much in vogue throughout the century, derived its very name from one Samuel Thomson of Massachusetts who had found himself on a manslaughter charge following the use of potent emetics and diaphoretics [25]; the movement nevertheless was one of those readily placed upon the same pedestal as orthodoxy so long as patients were ready to accept it. As the chief judge in a case brought in Iowa against a Thomsonian physician in the late 1840’s told the jury:

“...there is no particular system of medicine established or favored by the laws of Iowa... The people are free to select from the various classes of medical men.” [26].

What that principle inevitably meant was that the “ordinary” standards of diligence, skill and care which were being proclaimed so eloquently soon afterwards in courts across the land were in other courts being interpreted to mean only

the standards which might be expected of a healer practising in some obscure school of alternative medicine, however deficient those standards might be.

The courts and the medical profession

By the middle of the century, medical men were prone to complain that the courts were hard on them and that they would have little hope of defending themselves once they found themselves in the courtroom. “The sympathy of a jury of citizens is not generally with the doctor”, declared one writer in 1866, “but rather on the side of the poor, ill-advised, unfortunate victim of incurable injury” [27]. De Ville has provided much evidence that such suspicions of persecution were exaggerated. Although only a fraction of all cases have come down to us in the form of reliable reports, it seems clear that in the bulk of medical malpractice trials reported in the medical literature juries ruled in favour of the defendant physician [28]. In 1859 an Ohio physician indeed suggested that although the tendency to sue physicians continued to increase “this certainly has not originated from the success connected with these prosecutions. In not one instance in twenty as far as my observation extends – have they been successful” [29]. Acquittal rates seem to have been particularly high in the cases of relatively minor injury, and many defendants who lost their cases in the court of first instance won them on retrial or appeal.

The aftermath, and the lessons

De Ville’s *Medical Malpractice in Nineteenth-Century America* carries the story a great deal further than it can be carried here. The events in the U.S.A. in the nineteenth century established a tradition, many elements in which remain, for better or for worse, with us in many western countries today. The physician had clearly been displaced from the pedestal upon which the community had for much of history chosen to place (or at all events to tolerate) him. Henceforth he would have to earn whatever respect he enjoyed, and exert himself to provide the standard of care which his patients deserved, on pain of public examination and sanction. That is the brighter side of the story, and in helping physicians to attain and maintain a higher level of competence both education and legislation have benefited from the hard American lessons of a hundred and fifty years ago. Much of the darker side has persisted too; the threat of undeserved litigation is to many a medical man and woman, particularly in the United States, as great a threat – or greater – today as it was four generations back. Even today, an important segment of public opinion can be seen to be more forgiving to the charlatan who lies and harms than to the physician who tries but errs.

Reading Kenneth Allen de Ville’s masterly account of events in nineteenth century America is an invitation to consider the future as well as the past. It would be naive to believe that history cannot repeat itself. Some would argue that the

current move towards a more tolerant and less authoritarian society, whatever its merits, brings with it a threat to the centralized mechanisms developed over so long a period to assure the community the best in trained medical care. Whether in that situation litigation will provide an additional threat to honest medicine or – quite the opposite – a necessary instrument of self-defence in an unprotected community is a question, the answer to which yet another century will have to deliver.

References

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