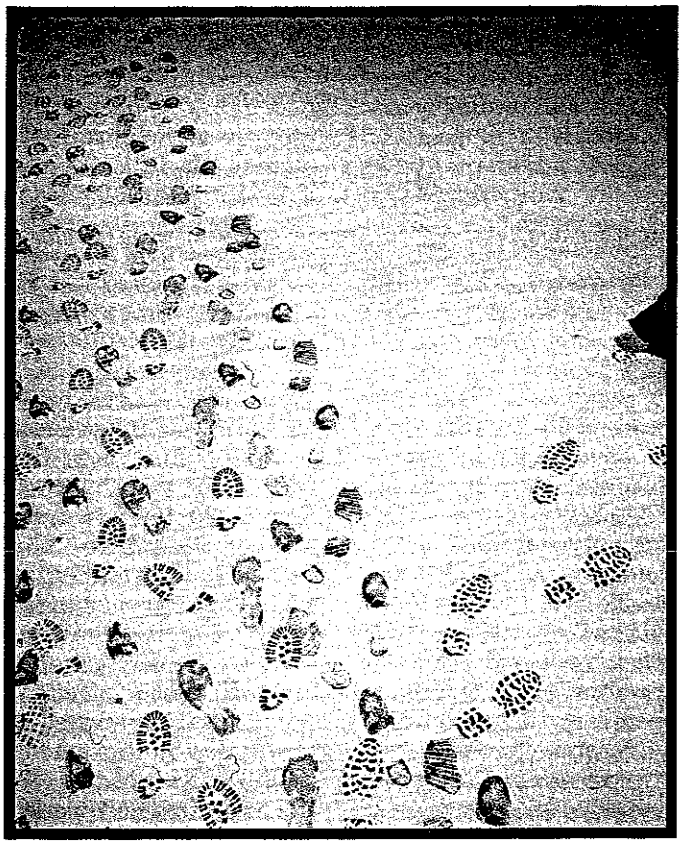
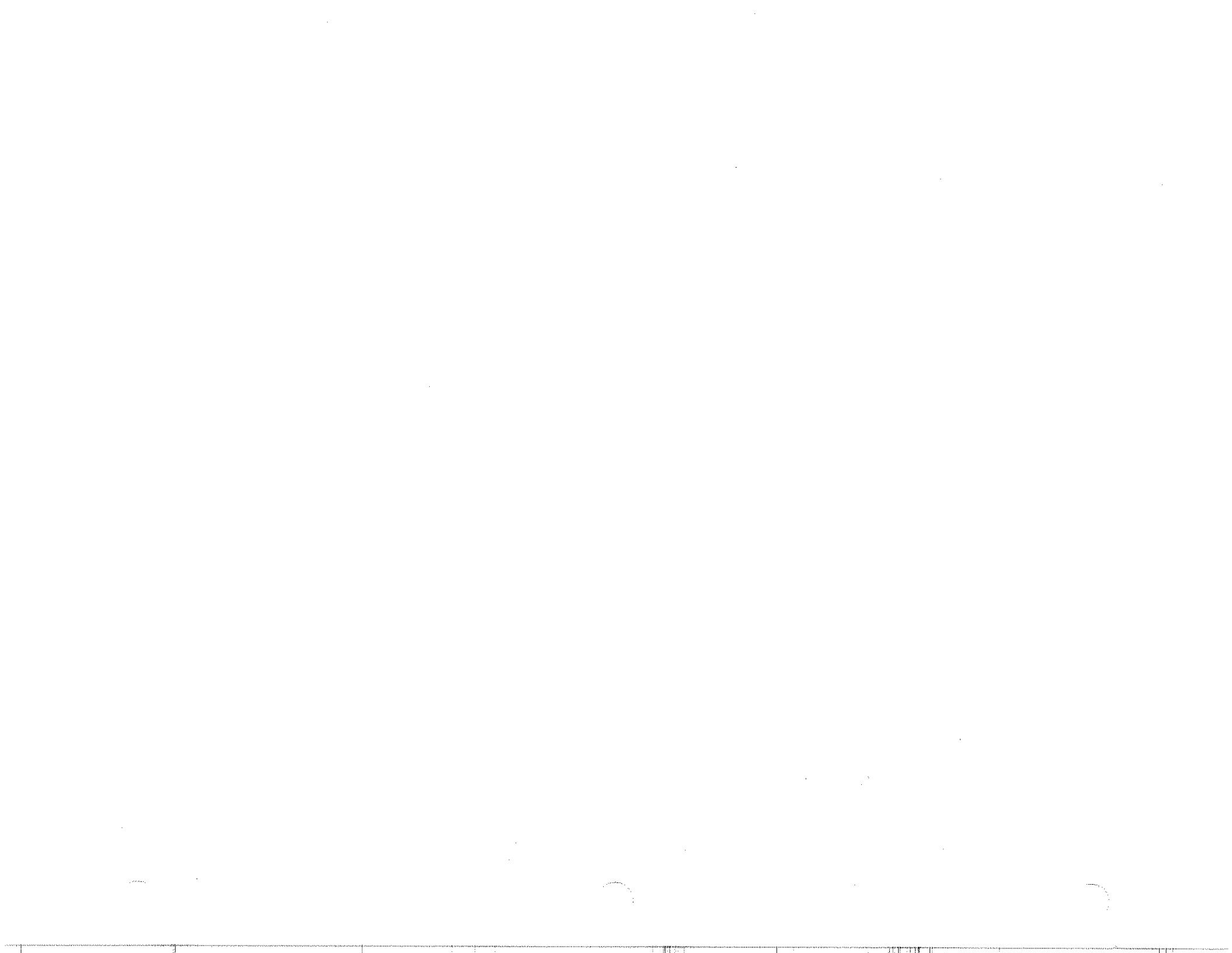
1996

With liberty and justice for all

by Anna M. Ledgerwood, MD, FACS, Detroit, MI





It is hard to imagine that a young girl growing up on a tenant farm in the southeast corner of the state of Washington would be presenting the Scudder Oration. My deepest gratitude to the Committee on Trauma and the American College of Surgeons for the privilege of giving this oration.

Nearly 50 years ago I stood each morning along with my nine first grade classmates and recited this oath:

> I pledge allegiance to the flag of the United States of America and to the republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

Those words meant little to me then, but were part of the daily ritual. My love for science and medicine evolved during grade school, and by the tenth grade I was convinced I wanted to be a doctor. This conviction created great anxiety, as I knew of no women doctors.

My farm background helped me secure full-time employment the summer following high school graduation as the only dietitian, cook, and dishwasher on the afternoon shift at the local 15-bed hospital. Unfortunately, my farm background didn't help me with vocabulary words, and I did so poorly on the MCAT test that I was rejected on my first application to medical school. Eventually, I was accepted as one of three women in a class of 100 at Marquette University, now the Medical College of Wisconsin. This perceived novel event was captured in a photo noting, "Something new has been added at the medical school." The classes were difficult as there was too much to learn and too little time, but my classmates were supportive both academically and socially. My clinical rotations were rewarding, but surgery more so than the others. I had now met women physicians, but no women surgeons. Applications for a rotating internship were mailed to three university programs with busy emergency rooms. I was matched to Detroit General Hospital, selected sight unseen.

Surgery was my field

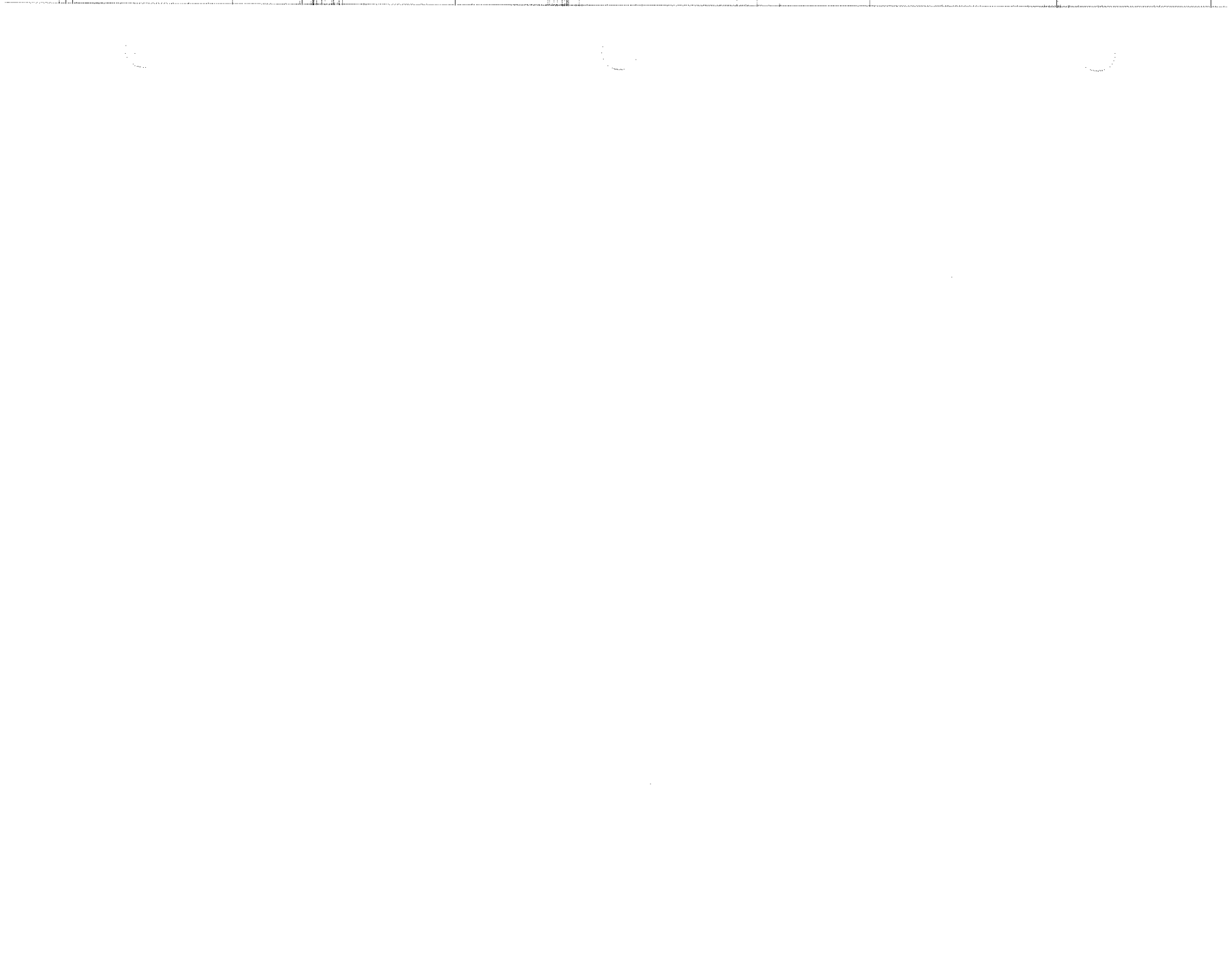
Three weeks into my internship in 1967, disaster, in the form of rioting, struck. The city burned by day and was a war zone by night. My work in the pediatric emergency room suddenly ground to a halt as there were no patients. Only the surgeons were busy. I now saw a new breed of surgeons: the all-knowing, hardest working, all-powerful, cream-of-the-crop surgeons—the trauma surgeons.

Finally, I did a rotation in emergency surgery. That first morning, the chief surgical resident presented the new team with the patients in the recovery room who had been operated on the previous evening, all awaiting bed assignments. There were six patients, including one with a gunshot wound to the kidney, liver, superior mesenteric artery, small bowel, and colon; one with a gunshot wound to the heart and lung; one with a stab of the heart; and one with a gunshot wound to the neck with carotid artery and internal jugular vein injury. In addition, there were two other patients, including one who had undergone appendectomy and another who had undergone lysis of adhesions for a small bowel obstruction. All six patients were doing well. This rotation convinced me that surgery was my field.

During the month of June, as the interns were completing the year and posed for a photograph, Robert Wilson, MD, FACS, stopped me in the hall and told me that if I wanted to do surgery I had to see the chairman, Alexander J. Walt, MD, FACS. I made an appointment, we chatted for 10 minutes, and he welcomed me into the residency program. The next four years passed rapidly.

My favorite rotations were trauma and emergency surgery. Charles Lucas, MD, FACS, asked me to assist in making a movie to teach our increasing number of medical students the essentials of trauma. This project trapped me so that when Dr. Walt invited me to stay and help out on the emergency surgery service I readily agreed, as I wanted to see the outcome of this educational product. This decision began a 25-year practice relationship with my partner, Dr. Lucas.

Vivid memory exists of my first operative case as an attending surgeon. This 16-year-old presented at 8:00 pm with pain and swelling of both knees after being struck by a taxicab. The PGY-II surgical resident, rotating from another hospital for his trauma experience, noted deformity of both knees and ordered X rays, which showed bilateral supracondylar femur fractures. The pa-



tient was referred to orthopaedics. If the status of the pulses were noted initially they were not recorded.

The consulting orthopaedic resident noted absent pulses in the right foot three hours later and left a message for the chief surgical resident, who was busy in the operating room with another patient. The chief resident performed a femoral arteriogram six hours after admission, which showed an occluded popliteal artery.

The patient was taken to surgery and the artery was repaired with a saphenous vein graft followed by four-compartment fasciotomy. Although pedal pulses were restored, the calf muscles looked ischemic. Five days later, I saw the patient for the first time and performed a dressing change that revealed necrotic calf muscles; an above-knee amputation was performed the following day.

Eighteen months later, I received a summons and complaint stating I had committed malpractice by failing to timely diagnose and treat a popliteal artery injury leading to amputation. There were nine other parties named in the suit including Dr. Lucas, the orthopaedic surgeon, six surgical residents, and the hospital. My insurance company selected an attorney to defend me and a long questionnaire termed "interrogatories" was completed. Two years later I was called for a discovery deposition, which was attended by myself, my attorney, and three attorneys representing the other defendant parties. When I testified that an arteriogram was essential for assessing popliteal artery injury, the plaintiff attorney based his case on the fact that no arteriogram was done. This possibility seemed inconceivable since a slide of this arteriogram was part of my teaching file. Unfortunately, there was no documentation in the patient's record by the resident as to the results of the arteriogram or by the nurses that one was performed.

Dr. Lucas, distressed by this patient's management, took the arteriogram from the operating room to have photographs made for teaching purposes, precluding an official dictation by the radiology department. Once the arteriogram was produced, the plaintiff's case deteriorated. All the physicians were dismissed and a jury verdict of $20,000 was rendered against the hospital.

This delay in management was most likely due to physician ignorance, oversight at the point of triage, multiple patients needing simultaneous treatment, and obtaining X rays prior to complete physical examination. Furthermore, absence of support services and inadequate emergency room nurse staffing required surgical residents to perform procedures and administer treatment with little time for documentation. This case does not represent "justice for all." There was little justice for the patient who lost an extremity and no justice for this young attending surgeon, as I was completing a residency in another hospital on the day this patient was initially treated. Unfortunately, my interactions with the legal community were just beginning.

I was devastated

Approximately one year later, a 29-year-old male presented with a gunshot wound that entered over the right pubis with the bullet lodged in the right buttock. He was stable, in no distress, and had a normal neurovascular examination. A single-shot arteriogram performed by the surgical resident revealed extravasation from an injury of the deep femoral artery. At exploration, the deep femoral artery was of generous size and an end-to-end anastomosis was easily performed; the transected adjacent vein was ligated. An arteriogram obtained postoperatively was normal.

One year later, he developed a gluteal abscess that spontaneously drained with evacuation of a bullet. A lawsuit was filed against myself and the hospital for failure to remove the bullet. The medical evaluation obtained by the plaintiff's attorney indicated the patient had a metallic taste in his mouth for the past year. This lawsuit, which was dropped 18 months later, most likely resulted from my failure to explain to the patient, both before and after, that operation was to repair damages caused by the bullet and not to remove the bullet. This case taught me that you can and will be sued even when you have excellent results.

My third lawsuit involved a 65-year-old diabetic male who was admitted with a close-range shotgun wound to his left chest and axilla with multiple rib fractures, flail chest, and a large soft tissue defect in the left axilla. His respiratory failure required tracheostomy for ventilatory

support. After weaning from the ventilator, the tracheostomy was left in place to facilitate anesthesia for patient comfort during dressing changes. By the 19th post-injury day, the wound had a healthy granulating base with significant contraction and the last dressing change to be done under anesthesia had just been completed when he suffered a cardiac arrest. He was resuscitated, taken to the recovery room, and placed on a ventilator for treatment of a suspected MI or pulmonary embolus. Shortly thereafter, the certified registered nurse anesthetist (CRNA) informed the chief surgical resident, in private, that the student anesthetist had committed a technical error. The very frustrated chief surgical resident loudly announced to the attending staff, "Do you know what she did? She turned off the oxygen and turned up the nitrous oxide!" The patient remained comatose and died 75 days later. A lawsuit was filed six months later naming myself, the surgical residents, the CRNA, the student anesthetist, and the hospital. The hospital settled for $50,000, and all other parties were dismissed. All student-teacher relationships require supervision by the teacher and progressive responsibility for the student while maintaining patient safety. This patient's anesthetic was brief and uncomplicated: an ideal case for increased student responsibility. Unfortunately, the patient died and the student was dismissed. How ironic that the anesthesia used for patient comfort led to his death.

Human error by any member of the team may be lethal. Monitoring devices, such as pulse oximetry, available today decrease the incidence of this lethal complication. Personal distractions that interfere with the necessary attention to details required in the operating room should be eliminated. Complications should be discussed in private, as was done by the CRNA but not by the surgical team. I am saddened that I lacked the maturity to communicate with the family regarding this patient's unfortunate event. Perhaps, if I had met with the family and explained the circumstances, the patient's hospital stay and the family's turmoil would have been shortened and this suit might not have been filed.

This third lawsuit over a short span of three years nearly ended my career as I received notice that my malpractice insurance was being canceled. I was devastated to think that I could no longer care for injured patients and even fearful that I would not be able to do breast biopsies. Dr. Walt, always receptive, supportive, and philosophical, stated: "Don't worry, there will be a way." A physician-sponsored insurance fund was developed and allowed me to continue as a trauma surgeon, but it didn't stop the lawsuits.

> "There was little justice for the patient who lost an extremity and no justice for this young attending surgeon..."

My fourth summons and complaint resulted from the treatment of a 32-year-old male who was crushed between a truck and a brick wall. He was initially seen in an industrial clinic for hematuria; the hematocrit was 25 percent. He was given one transfusion and transferred one hour later. He arrived hypotensive with massive swelling of his scrotum, a tender pelvis, and absent movement, sensation, and pulse in the right lower extremity. After stabilization with eight transfusions and intravenous fluid, an aortogram revealed occlusion of the right external iliac artery. The contused and thrombosed external iliac artery was resected and repaired with a saphenous vein graft. Unfortunately, there was massive oozing from the retroperitoneum that failed to respond to intraabdominal packing and massive transfusions, and he expired in 24

hours. The lawsuit claimed that I failed to take and record a proper history and physical examination and delayed performing a necessary surgical procedure.

There was no further activity in this lawsuit against either myself or the hospital, and I never investigated the reasons. Most likely, a large settlement was obtained from the patient's place of employment and there was no need for anyone to testify regarding the activities at the workplace or the industrial clinic. In retrospect, I consider this a preventable death while attempting to salvage the limb. An extra-anatomical bypass to restore blood flow to the extremity would have avoided entering the contained retroperitoneal hematoma.

My fifth lawsuit involved a 21-year-old unrestrained male who hit a pole while driving a stolen car at 75 miles per hour during a police chase. He was found in the back seat with facial lacerations and bilateral lower extremity fractures. After a 45-minute extraction, he arrived yelling and swearing, with a blood pressure of 90/50 and a pulse of 108. He was stabilized with fluids and was sent to X ray 40 minutes later. He arrested in X ray. The chest X ray taken just prior to the arrest showed only minimal haziness in the left chest. During resuscitation, however, massive hemoptysis was noted in the endotracheal tube. The etiology of this hemoptysis was unclear, and initially I was concerned that the patient had aspirated blood from his oral lacerations, which had not been sutured. I openly criticized the surgical resident in front of the nursing staff for failure to suture these lacerations prior to X ray. The hemoptysis continued and a left thoracotomy was performed, which revealed a huge hematoma involving the left lung. Shortly thereafter, a second cardiac arrest occurred and he expired. Autopsy demonstrated a torn right pulmonary vein and lung injury as the source of the massive hemoptysis.

The lawsuit filed seven months later named myself, the emergency department staff, and the hospital for failure to monitor vital signs and timely diagnose and treat a right pulmonary vein injury. The patient's mother deposed that the suit was filed because "a nurse told me something was not done correctly and I should contact a lawyer." The defendant expert concluded that no malpractice occurred. The single report of survival following repair of a blunt tear of a pulmonary vein was in a patient who was undergoing thoracotomy for other injuries. The physicians were dismissed but the hospital settled for $80,000.

This suit clearly resulted from my open and inappropriate criticism of a surgical resident in front of others, suggesting that something was wrong with the treatment. Even if the resident had done something wrong, constructive criticism should have taken place behind closed doors when emotions had waned. An added factor in the hospital's decision to settle was the family's perception that the care of their loved one was taken lightly. I later learned that emergency department personnel were overheard by the family while they were laughing and joking over pizza in the early morning hours when activity had slowed.

These unfortunate experiences in a surgeon's life are not discussed in open meetings and are never published. Being served with a summons and complaint is considered such a curse that it cannot even be discussed with one's closest colleagues. I have learned that the injustice I suffered is not unique, as I have had the opportunity to review malpractice suits against my colleagues. I've selected three of these incidents to share with you, with their permission.

Giving "wish list" care

A 64-year-old woman in southwest Michigan was plowing her field when she fell under her large tractor and was run over by the rear tire. She was transported at 4:05 pm to the local hospital with a normal Glasgow Coma Scale, pulse, and blood pressure. Her respiratory rate was 30 and she complained that it "hurt to breathe." She was obese and had large abrasions, with pain and tenderness over the right side of her body. She could move all limbs and distal pulses were present. Routine laboratory studies and electrocardiogram were normal. Standard X rays showed fractures of the right fourth, fifth, sixth, and seventh ribs and a possible fracture of the right pubic ramus. The lateral C-spine was incomplete. The emergency physician called for a general surgeon but none was available.

The patient was transported via helicopter with a C-collar and oxygen to a trauma center, where she arrived at 5:55 pm. She had marked tenderness over the right chest and abdomen and severe right lower extremity ecchymosis. A repeat chest X ray showed right pleural reaction. An abdominal CAT scan was normal. Repeat laboratory studies showed a rise in LDH and CPK. She was admitted to the SICU and treated by the trauma service for severe soft tissue injury and possible myocardial contusion. The following day, right chest pain persisted and CPK levels had doubled. The C-spine was cleared and the collar was removed. On the second postinjury day, the echocardiogram was reported as normal. She was transferred to the acute care ward, given a bedside commode, and a full liquid diet.

The following day, she was afebrile but had decreased breath sounds over the right lung and a 90 percent oxygen saturation on two liters of nasal oxygen. That evening, she suddenly fell while ambulating in her room, was incontinent of stool, rolled her eyes back, and became unresponsive. She expired despite CPR.

An autopsy performed by a family practitioner serving as the coroner in the patient's small community included the statement "hospital record shows no use of TED hose or other antithrombotic prophylaxis." The autopsy report identified large thrombi in the right ventricle and in both pulmonary arteries. This family practitioner dissected the right leg veins from six inches above the knee to the heel and noted thrombi in the posterior tibial and peroneal veins. There was no report of inspection or of any clots in the veins from the vena cava to the knee on either side.

The subsequent summons and complaint stated this wrongful death from pulmonary emboli originating in the right leg veins was due to failure to elevate the legs, encourage ambulation, use TED hose or pneumatic compression stockings, give low-dose heparin and/or aspirin, administer thrombolytic agents, test for clots by Doppler scans and/or venograms, or install a protective filter.

How does one determine if this is malpractice or an unfortunate event? Malpractice is defined as the failure to follow the standard of care which, according to the legal profession, is defined as what a reasonable physician would do when treating the same or similar patient under the same or similar circumstances. Thus, an expert of the same specialty must determine the minimal acceptable level of care. A physician is not required to give the best care, but must give reasonable care. My review concluded a huge clot that filled the pulmonary artery and the ventricle would not have arisen in small leg veins. I further concluded that continuous elevation of the legs impairs deep breathing and coughing. Immediate ambulation is precluded in a patient with possible myocardial contusion, cervical spine injury, and contusion of the leg muscles. Low-dose heparin does not prevent deep venous thrombosis in injured patients and is dangerous in patients with possible cord injury or severe ecchymosis. This patient met no one's criteria for a prophylactic filter. In my opinion, this patient was treated appropriately. Had I been this patient's surgeon, I might have "wished" in retrospect that I had used a compression stocking on the normal leg, not because I believe it helps, but because the plaintiff experts promote such treatment.

Unfortunately, some physicians and surgeons, including my academic colleagues, testify that such a "wish list" is the standard of care. University professors must remember that an unfortunate result is not always malpractice. I recommended an aggressive defense of this suit, but the surgeons, tired of the aggravation, permitted a settlement for slightly less than $30,000. Justice would have been better served by an accurate autopsy interpretation.

An unfortunate event

The next patient was a 56-year-old belted female passenger in a motor vehicle crash. The patient's 16-year-old daughter attempted to stop at a red light in a rainstorm; the car slid into the intersection and was struck by another vehicle on the passenger side. The patient appeared to have a seizure at the scene and was transported to the local hospital, where vital signs showed a blood pressure of 90/60, pulse of 104, and respirations of 20. The patient was anxious and complaining of pelvic pain. Intravenous lines were started by the emergency physician, laboratory

studies were sent, the general surgeon and neurosurgeon were called, and the Foley catheter revealed bloody urine. Lateral C-spine and chest X ray were normal. An abdominal film showed fracture of the right transverse processes of L2, L3, and L4. The general surgeon arrived 15 minutes later, noted abdominal guarding, passed a nasogastric tube, and took the patient to CAT scan. The neurosurgeon saw the patient in the CAT scan room and determined the head CT was normal. An abdominal film was being taken when the patient became hypotensive and anxious; blood transfusions were begun.

Following completion of the scan, which showed extravasation of dye from the bladder, the general surgeon called for a urologist and scheduled the patient for a laparotomy. Upon return to the emergency department, the patient had a cardiac arrest. Central lines were placed, CPR was instituted, and the patient was in the operating room 65 minutes after arrival in the hospital. At laparotomy, there was massive hemoperitoneum and the patient expired. Autopsy showed a rupture of the abdominal aorta. A lawsuit was filed against the surgeon, emergency physician, and the hospital indicating that they should have performed a diagnostic peritoneal lavage on arrival so that the patient would have been in the operating room at the time the aorta ruptured.

Clearly, this was an unfortunate event rather than malpractice. The pelvic fracture explained the blood loss and hypotension while in the X ray suite. The CAT scan showed the aorta to be intact with no retroperitoneal hematoma. The plaintiff attorney spent many hours interviewing every individual in the hospital who had any contact with this patient, hoping to capitalize on subtle differences in recollections. Eventually, this case went to trial and seven years later the jury rendered a no cause verdict.

Injury is sudden

Some of you will say, "This is precisely why I don't take trauma call or accept trauma patients." This perceived increase in liability is due to multiple differences in care of injured patients compared to those undergoing an elective surgical procedure. Injury is sudden and does not allow for preparation by the patient, family, or surgeon. The patient and family have no freedom to select a hospital or a surgeon, so that when an adverse outcome occurs the anger is directed toward those they view responsible. The patient may be mentally compromised from drugs or alcohol, which prohibits any meaningful discussion of the injuries and the options for management. This mentally compromised state frustrates the trauma team members, who then cannot obtain accurate information and certainly not an informed consent. Being called to treat injured patients requires one's entire effort at the patient's bedside and leaves no time to have a discussion with family members. For these reasons, trauma surgeons have difficulty establishing rapport with either the patient or the family.

All too often, trauma surgeons must inform distraught families of an adverse outcome or death. These family members are hysterical and do not comprehend why their loved one died. Few surgeons contact the family after the autopsy to explain the cause of death in a less emotional setting. Thus, the family seeks legal input to determine if care was appropriate. In Detroit, the patient's family is provided a 1-800-Law-Suit number on park benches and on the back of city buses. The injury lawyers are more than willing to obtain autopsy reports and hospital records. There are also physicians, even surgeons, who are willing to render an opinion that the standard of care was not met—as long as the price is right. All these factors lead surgeons to refuse trauma patients for fear of increased liability. Erwin Thal, MD, FACS, in his Scudder Oration of 1992, emphasized that there is no data to support the fear that caring for trauma patients increases malpractice risks. Although this lawsuit afforded neither justice to the family nor the physicians, I am happy to say the involved surgeon continues to treat injured patients in his hospital.

Being an "expert"

The third incident involved a 24-year-old male who was brought by his cousin to the local hospital at midnight with a stab wound to the left upper chest. The patient was talking but appeared pale and diaphoretic. Blood pressure was

70/56 and pulse was 110. Although there was no trauma system in this hospital, the patient was promptly seen by the emergency physician and the surgical house officer. Intravenous fluids were started and a large chest tube was placed, which immediately drained 900 ml of blood. Blood pressure improved to 110 systolic. Chest X rays showed the blood to be evacuated with a small apical pneumothorax. Vital signs remained stable and he arrived in the SICU at 3:00 am. Thirty minutes later, there was a drop in blood pressure and a sudden increase in the chest tube output. The surgery resident was called and arrangements were made to take the patient to the operating room. On arrival in the operating room at 4:50 am, the patient was hypotensive with a blood pressure of 76/40 and a pulse of 120. As the left thoracotomy was being performed, the patient had a cardiac arrest. The pericardium was quickly opened, clot evacuated, and a hole in the left atrium sutured. There was a left ventricular laceration just below the aortic arch with transection of the left anterior descending coronary artery. This was sutured and bleeding was controlled. The heart beat well for the next five minutes and then a large ecchymotic area developed over the apex of the left ventricle. Shortly thereafter, the heart fibrillated and the patient could not be resuscitated.

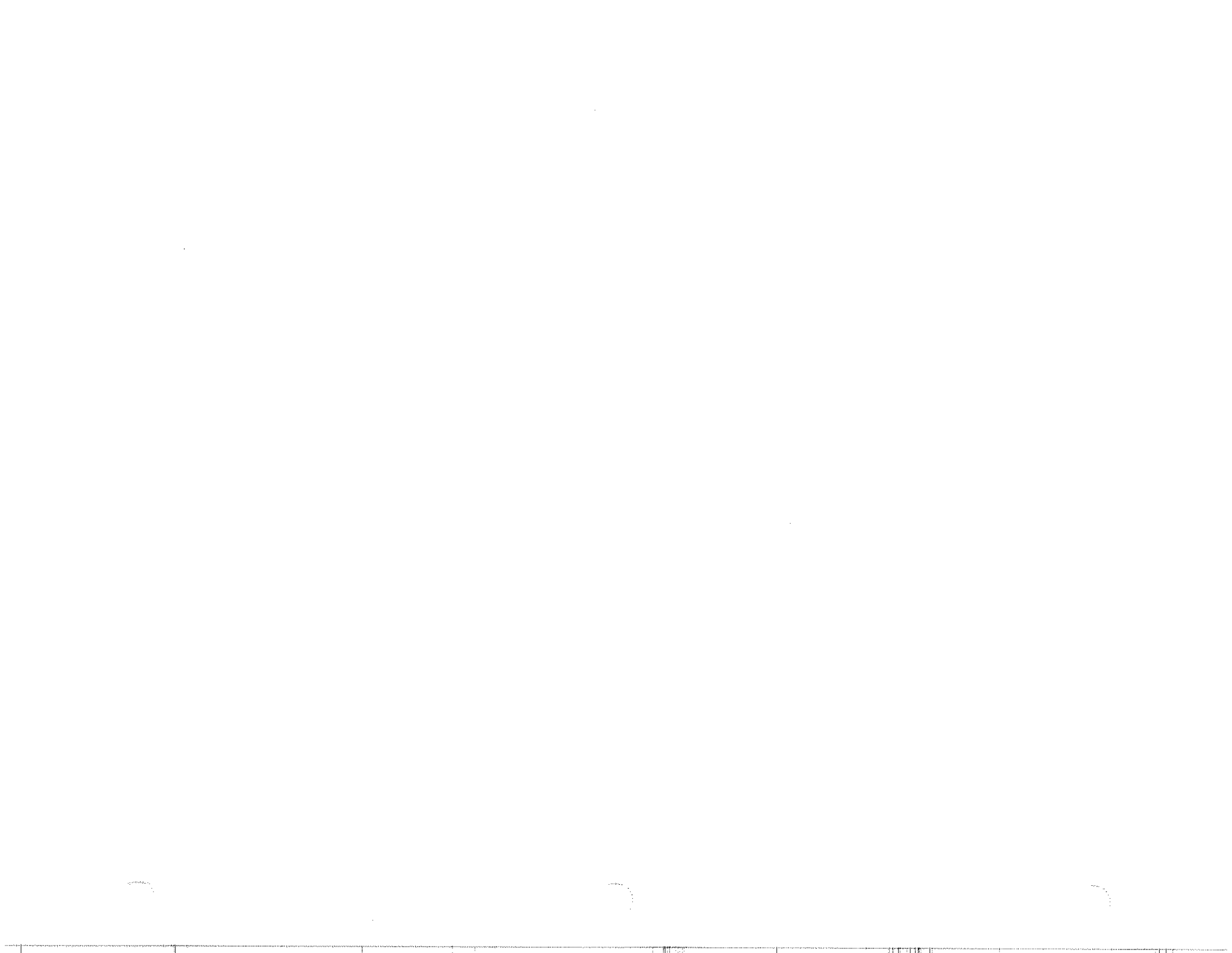
A lawsuit was filed claiming wrongful death due to failure to perform central venous pressure monitoring, an EKG, a pericardiocentesis, and failure to diagnose and treat a stab to the heart. In addition, the lawsuit indicated that the resident did not see the patient for one hour after the SICU nurse had called him. From my review of this case, I concluded there was no proximate cause. In other words, the stab wound severed the left anterior descending coronary artery. It was ligated to control bleeding, which led to ischemia and arrhythmia. Central venous pressure is not a standard of care and is not required in every patient with a stab wound to the chest. Lastly, progress notes are usually timed when written, which is often after treatment has been provided.

This occurrence again seemed like an unfortunate event and not malpractice. Unfortunately, depositions were taken of the trauma team members. The emergency physician testified that the hospital lost his original dictation and he had to redictate his note six weeks following the incident. He added that he ordered a "trauma panel" that included CPK and MB fractions, which are available within one to two hours. He further testified that the "gold standard" for diagnosing a cardiac injury is an angiogram or direct observation. This emergency physician, under oath, not only criticized his hospital but committed the cardinal sin of being an expert in an area he knew nothing about.

> "Our current system gives us liberty—liberty to claim injustice or file suit against another."

The discovery deposition of the surgical resident indicated that he saw the patient and was working with him during the one hour from the time he was called until his note was written. He criticized his hospital by stating he had trouble getting the nursing personnel to help him get the patient to the operating room when the patient was crashing.

The attending surgeon testified several months later without reviewing the record. He forgot that he had closed the hole in the left ventricle and ligated the coronary artery. He thought that a central venous pressure catheter had been placed and was constantly monitored and testified that it was the standard of care. He



also thought there were two chest wounds instead of one.

When the patient's attorney asked the attending surgeon what the value was of an elevated CPK MB fraction in a patient with a stab to the heart, the frustrated and angry attending surgeon responded, "It's as useless as tits on a bullfrog." This experienced and gifted surgeon who was covering for trauma at his community hospital was distressed by the legal system that had trapped him in this case. He was ill prepared by his own attorney. Unfortunately, all information obtained in a discovery deposition can be reread at trial. Even if the physician prepares for trial, the patient's attorney can present the information obtained in a discovery deposition. Contradictory information leads the jury to believe that the physicians are either ignorant, incompetent, or lying. Although I concluded that no malpractice occurred, I recommended that a settlement be reached because of the multiple problems with the depositions. The hospital paid $225,000.

Liberty

Our current system gives us liberty—liberty to claim injustice or file suit against another. Surgeons may be and are sued even when they do nothing wrong. Although no pain equals that of a surgeon losing a patient, receiving a summons and complaint announces the beginning of a more frustrating journey. The sequence of interrogatories, chart reviews, meetings with attorneys, and discovery depositions of all involved parties seems endless. One must not get angry at the patient, the family, other doctors, or the attorneys. One should not criticize others or claim to be an expert in areas one is not.

Prepare carefully for depositions, remain calm, and answer questions truthfully without contributing anything extra. Trial preparation requires extensive review of one's prior discovery deposition; altered verbs and adverbs meaning nothing to a patient's treatment are seized on by the plaintiff attorney, who is intent on manipulating the interpretation of words to best fit his or her position.

The trial bears no resemblance to a surgical procedure that begins promptly at 7:30 am and proceeds without interruption until the bandage is placed. The trial is scheduled for 9:00 am, always starts late, and is filled with multiple, unrelated interruptions. Successful defense requires the constant presence of a well-prepared surgeon who assists the attorney. Both the surgeon and the attorney are best served when the surgeon leaves his or her ego at the hospital.

Prophylaxis is essential

Most suits emanate from patient frustrations rather than surgical error. Thus, prophylaxis is essential. Lessons learned from these experiences include the need for a thorough history and physical examination prior to diagnostic testing. Uncooperative patients with head injury or under the influence of drugs, alcohol, or hypoxia should be treated as compromised. Documentation should include who, what, where, and when. The patient should be informed both before and after the operation regarding the findings and treatment. The attending staff should promptly respond and be polite when called by nurses and surgical residents. Surgeons in training should be allowed progressive responsibility, but the attending staff should be close enough to see when supervising. Complications should be discussed in private. The surgeon must not only be available but be willing to call for help when too busy.

My early malpractice experiences interfered with my ability to discuss complications critically and to teach others to do the same. Complications presented at my weekly morbidity and mortality conference were rationalized as the patient's fault, the nurses' fault, the resident's fault, or an act of God. My attitude changed after I had the opportunity 12 years ago, along with David Root, MD, FACS, to visit trauma centers in the Denver area. During that visit, we met Henry Cleveland, MD, FACS, who was serving as a trauma director at St. Anthony's Hospital with his dedicated group of private practicing surgeons committed to the care of injured patients, all without extra compensation. For the first time, I saw what a quality assurance program entailed. These surgeons would critically review their own care, identify their mistakes, institute corrective action, and document the results.

ACS program

During the past 10 years, I have been privileged to participate in the American College of Surgeons Committee on Trauma Consultation and Verification Program. The most rewarding aspect of site visits to other institutions has been the opportunity to witness the impact of a mature quality improvement program on patient care. Such a program requires a respected, dedicated trauma director who is able and willing to tackle difficult issues and who has the authority to correct problems. A cast of trauma surgeons and specialists provide support with their attendance and discussion. All deaths are reviewed by a peer and by the attending surgeon; constructive self-criticism helps in determining whether the death was preventable. The presence of the medical examiner at the peer review meeting allows proper interpretation of the autopsy findings in light of the patient's clinical course.

Unfortunately, there have been some programs where the surgeons have been reluctant to discuss deaths and complications in a peer review format for fear of malpractice. This fear is not based on fact. The Health Care Quality Improvement Act of 1986, Public Law 99-660, protects hospitals and physicians engaged in peer review from being sued by doctors who are disciplined because of the review process. Representative Wyden, who initiated this congressional action, stated that most doctors are honest, hard-working, competitive professionals. He further stated that physicians were in the best position to identify and correct incompetence. This same law established the National Practitioner Data Bank, which requires that any entity or individual making payment of greater than $30,000 on behalf of a licensed health care practitioner report this information to a data bank and to the appropriate state licensing board.

Plaintiffs' attorneys currently obtain information regarding patient care by subpoena of the medical records. Peer review documents, however, are not discoverable for malpractice suits even upon issuance of a subpoena. Controversy centers on what exactly is a peer review document. Defendant attorneys recommend that the hospital trauma peer review committee be attended only by peers, with the minutes identified as a quality assurance product, kept confidential, and never circulated. All papers and documents provided at the peer review committee meeting should be collected at the end of the meeting and shredded. Failure to comply with these recommendations in my hospital led to minutes of the meeting being obtained by the local newspaper. Once published, they became public information and were freely discoverable. Even trauma systems, such as the outstanding San Diego County system, have implemented a peer review of their system without documents becoming discoverable.

Although quality improvement programs have made great strides, chart reviews at my own and at other hospitals have indicated that problems that contribute to malpractice suits still exist. One major problem is the failure to communicate with family members during the early phases of evaluation and resuscitation. This problem can be solved with the addition of a social worker or chaplain to the trauma team. This person can interface with family members, assist in alleviating fear and anxiety, and prepare the family for catastrophic news.

Another problem is the tendency for the trauma surgeon to quickly transfer care to a subspecialist. The trauma surgeon needs to coordinate all aspects of care like a conductor of a symphony orchestra. He or she should continue to be the "captain of the ship," supervise patient care, and communicate with family members. In turn, this requires each specialist to communicate his or her findings and plan of management to the trauma surgeon and log it in the medical record.

We need better communication with family members following adverse outcomes. A description of injuries, hospital course, autopsy results, and the cause of death as determined by the peer review meeting could be provided in a letter sent by the surgeon. An offer to meet with the family to discuss adverse outcomes will prevent them from needing to call the 1-800-Law-Suit number to obtain information.

The road less traveled

What will be done when a serious complication or a preventable death is identified? I am re-

minded of another pledge I took some 21 years ago. The Fellowship pledge of the American College of Surgeons includes the promise, "I will deal with each patient as I would wish to be dealt with if I were in the patient's position." I propose today that when a serious preventable complication or preventable death is identified the case be referred to a new committee. This quality improvement/risk management committee would determine what percent of the responsibility belongs to the hospital for system failure or to the surgeon for poor practice. A financial award would be recommended, and the patient or family would be notified. A meeting would be held with family, trauma team, hospital risk management, and legal representatives. The hospital and surgeon's insurance companies would be requested to make appropriate compensation. Ideally, the hospital's and physician's fees would be waived as part of the patient's compensation. This system would provide justice for the patient, who would be compensated according to established criteria. The plaintiff and defense attorneys would be circumvented.

Many of you will say, "She has gone too far." Perhaps, but this is how I would want to be treated if I were the injured patient. Furthermore, full payment of malpractice insurance fees would go to the patient rather than the plaintiff and defense attorneys, thus reducing premiums. This action would provide justice for the surgeons, as it would hopefully prevent unnecessary lawsuits.

Clearly, we are talking about new ground that has not been plowed before. Trauma surgeons, however, are in a unique position to again lead the way in defining the mechanism for patient compensation just as they paved the road for quality improvement. This newly traveled road would certainly satisfy our pledge as Fellows of the American College of Surgeons to deal with each patient as we would wish to be dealt with if we were in the patient's position. As Robert Frost concludes in his poem, *The Road Not Taken*:

> Two roads diverged in a wood, and I—
> I took the one less traveled by,
> And that has made all the difference.

Trauma surgeons today have the liberty to take the road less traveled. Yes, we have the liberty, the liberty to ensure justice for all—and that will make all the difference. Ω

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