Americans still struggling with malpractice

“What degree of perfection should we expect from our medical community?” asks rhetorically the final report on medical malpractice of the United States General Accounting Office to the Congressional Requesters.1 The insurance costs for doctors and hospitals in the United States rose from $2.5 billion in 1983 to $4.7 billion in 1985; they accounted for 8% of doctors’ average gross business expenses in 1983 and 10% in 1985. More than two fifths (43%) of the claims in 1984 were settled by a payment, and 80% of the injuries on which they were based occurred in hospitals. The average settlement was around $81000.

The report asks who or what is responsible for medical malpractice problems: “Is it physicians who are negligent? Is it insurance companies trying to get higher profits? Is it lawyers bringing suits to increase their income? Is it patients who have unreasonable expectations of medical procedures and health care providers? Is it the system for resolving claims?” Unsurprisingly, the report offers no clear answer and could suggest no specific action to guarantee that insurance rates would not continue to increase. It does, however, suggest some measures that might be taken to reduce the overall cost of insurance. They include increasing the accountability of doctors to their peers; developing alternatives to the tort system of law; and educating the public on what it may reasonably expect from the health care system.

The Association of Trial Lawyers of America believes that the main cause of increasing insurance costs is medical carelessness. The National Insurance Consumer Organisation believes that the profits of the insurers are excessive. Both support tightening up the disciplinary controls over doctors and both oppose any change in the tort law system because it would infringe the right of the patient to recover damages. But the insurers would like to see the law changed to reduce uncertainty, which would enable insurance to be more accurately priced. The major interest groups disagree over the nature of the problem, its solution, and the part that should be played by government in resolving it. The report is sure of at least one thing—that the debate “has been based more on rhetoric, speculation and misconception, than on factual quantitative data.”

The state boards that license doctors come in for special criticism: the report says that they “are much more concerned with faults in prescribing and alcohol or drug abuse by doctors, than with unacceptable standards of care.” This criticism has also been levelled at the United Kingdom’s General Medical Council, and the reason for these authorities seeming to have the wrong priorities is that unacceptable standards of care are much more difficult to prove. About 42% of doctors in the United States in receipt of malpractice claims have had previous claims filed against them. As 43% of the claims are settled by payment out of court and 80% occur in hospitals the report believes that peer review in hospitals is especially relevant. It also urges developing risk management programmes targeted at special groups. More than a third (37%) of doctors may expect to have at least one claim filed against them, but some specialties are more at risk: 65% of obstetricians and gynaecologists and half of surgeons have had at least one claim made against them. Six states already require their hospitals to introduce risk management programmes, and the report recommends that participation in such a scheme should be made a condition of licensing doctors to practise.

Public education, the report says, must emphasise the fact that “in many circumstances medicine is still a young and uncertain science with varying outcomes.” One orthopaedic surgeon testified that the advances in orthopaedic surgery over the past 15-20 years had been so rapid that higher complication rates and more uncertain outcomes were to be expected. He claimed that 5% of orthopaedic procedures will have disastrous results and emphasised that there was some reticence about informing patients about this in advance.

The report’s findings on changes in legal procedures are not so relevant to Britain, where procedures are very different. But the study carried out on the time limit within which an action must be brought is interesting: reducing the time within which a plaintiff had to make his claim from 10 years to nine years meant that over the next 10 years claims were reduced by 8% and settlements by 6-7%. Surprisingly, the report concludes that the contingency fee system, long blamed for the extent of the problem in the US and outlawed as unethical in Britain, “serves a useful purpose in many cases, enabling injured parties without resources to obtain access to the legal system, and providing incentives to lawyers to get the best possible award or settlement.” One eminent lawyer is quoted, however, as having said that most lawyers would not accept a case unless damages of at least $50000 are expected. Periodic payments of damages (over the plaintiff’s lifetime) are preferred to lump sum.
Is the tube in the trachea?

Every day endotracheal intubation is carried out many thousands of times in anaesthetic rooms throughout the country, but in a few cases the tube will be placed in the oesophagus rather than the trachea. If this mistake is not recognised and remedied then the patient will probably become hypoxic and develop brain damage or even die. One of the earliest lessons that every anaesthetist has to learn is, therefore, to recognise when the tube has not been placed in the trachea.

The most reliable clinical sign used to verify tracheal intubation is too see that the tube has passed through the vocal cords at laryngoscopy. Other, and less dependable, signs are that both sides of the chest expand immediately and simultaneously when the reservoir bag is compressed and that the bag refills smoothly and rapidly during expiration while the chest deflates. Even less reliance should be placed on movement of the bag in time with respiration during spontaneous ventilation and on hearing vesicular breath sounds easily in both axillae.

Clinical signs of oesophageal intubation are generally less specific but if cyanosis appears after intubation the primary diagnosis must be malposition of the tube. Nevertheless, cyanosis may take over five minutes to appear if the patient has been preoxygenated.1 Other signs of oesophageal intubation are that gas does not flow freely back into the reservoir bag during expiration and that air can be heard passing into the stomach. After oesophageal intubation a “gurgle” may be heard when the reservoir bag is compressed, breath sounds may be absent or distant and “moist,” and chest expansion may be poor or delayed.

Failures have been recorded for each of these clinical criteria,2 3 so the doctor cannot be completely sure about the position of the tube using them alone, and unrecognised oesophageal intubation still occurs.1 In studies of anaesthetic morbidity and mortality, however, this complication of intubation is classified as an “avoidable factor,” so how may the incidence be reduced further?

Some have implied that measuring the carbon dioxide concentration in the expired gas is an infallible method of locating the tube and recommended that the technique should be used routinely.4 The latter would entail having a capnograph in every anaesthetic room, and logically in every emergency intubation kit as well. The argument that adding monitoring devices will increase the chances of detection is persuasive, but we lack adequate data and there are practical considerations such as the risk of distracting the intubator, the need to educate both clinicians and technicians, and the need for finance to buy and maintain these machines. In addition, the case for capnography is not fully proved because its use to detect tube position appears to have been described so far in only 10 dogs5 and 20 patients.6 Moreover, in two of the patients over 4% carbon dioxide was detected in gas expired from the stomach, which suggests that it will be necessary to display the capnogram waveform rather than just to measure the concentration of the gas.

Until the cost-benefit relation for capnography becomes clearer, therefore, anyone who undertakes endotracheal intubation must realise that all the clinical signs of tube placement can be misleading. Be suspicious after every intubation, therefore, and, if in any doubt, take it out. (After Gray.)7

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1 Howells TH. A hazard of pre-oxygenation. Anaesthesia 1983;38:86.