MEDICO-LEGAL ASPECTS OF SURGICAL PRACTICE

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I would like to discuss briefly a few medico-legal points of major interest to a surgeon.

One of the most common problems we have to face is to decide whether bodily harm in any particular patient is grievous or slight. It is grievous if:

A. It can give rise to the danger of: i) loss of life; ii) permanent debility of health or permanent functional debility of any organ of the body; iii) any permanent defect in any part of the physical structure of the body; iv) any permanent mental infirmity.

B. It actually causes deformity or disfigurement in the face, neck or either of the hands.

C. It is caused by any wound which penetrates one of the body cavities without causing permanent debility of organs or to the physical or mental health.

D. It causes mental or physical infirmity lasting for a period of 30 days or more, or if it prevents the

injured person from attending to his normal occupation for an equal period.

E. It induces premature delivery of a pregnant woman.

A few comments on these sections will not be amiss. An injury which can give rise to the danger of loss of life is a grievous one. Hence, the mere possibility of loss of life supervening on an injury is enough to make it grievous, even though the patient may never have actually been in any such danger.

With regard to the term 'permanent' as applied to debility of the health or functional debility of any organ, or defect in any part of the physical structure of the body, difficulty may arise in ascertaining the degree of permanence of the effects of bodily harm. It is important to remember in this connection, that if there is a probability of such permanence, then the bodily harm is grievous. If a ruptured kidney has had to be removed, then there is no doubt of the permanent defect in the body structure. On the other hand, a ruptured kidney that did not need removal may or may not develop permanent functional debility. It may be difficult to decide on the probability of the permanence of such damage in this case. The lawyer will press the surgeon for a decision which may be no more than a well-informed intelligent guess. After all, medicine is not an exact science.

To take another example, injury to the brain may leave no obvious permanent after-effects in a patient who has completely recovered soon after the injury. On the other hand, it may produce a number of sequelae which gradually subside or improve to such an extent that after a time the patient is considered medically cured. Months of careful observation and testing may be necessary before a final decision can be reached. Though a surgeon would be the last person who would wish to prolong the law's delays, enough time should be allowed him before he can give a final opinion on the case. This is particularly important, now more than ever before, when such decisions have a great bearing on the evaluation of damages and the amount of compensation which could be awarded to the claimant.

Deformity involving the exposed parts of the body, namely the face, neck and hands, is a more serious form of bodily harm than if these parts are disfigured, although in both instances the harm is classified as grievous. It should be noted here that the qualification 'permanent' is not used in this section, so that the permanence or otherwise of the disfigurement has no relevance here. It is obvious that the alteration in the appearances of these exposed parts is not so much a medical matter as much as a loss in aesthetic or cosmetic value. Hence it should not require an expert medical opinion nor should it be based on a medical decision. It is certainly a matter which the presiding judge and the jury, or the magistrate could very well determine directly. It is felt that perhaps it is high time that this section of the law were brought up-to-date, particularly also because quite a few years have passed since it has become customary to expose to public gaze other parts of the body besides the face, neck and hands.

The next section relating to wounds that penetrate the body cavities is of great importance. With regard to the cranial cavity, cases of penetration will practically always require surgical exploration as part of the management, so that penetration can thus actually be proved at operation. With regard to the thoracic cavity, it is quite often unnecessary to explore the wound from a surgical point of view. Fortunately, it is also usually unnecessary to explore the wound from the legal point of view, because penetration can be deduced or excluded by clinical and radiological examination. The situation is rather different in the case of the abdominal cavity, and as the wording of the section seems to imply, penetration must be excluded, and here the only means available in most cases is surgical exploration. This is almost forcing the surgeon's hand when it is well recorded that from the surgical treatment point of view this may be unnecessary for the patient. This is because simple penetration, even without producing damage to intra-abdominal organs, is enough to amount to grievous bodily harm in the legal sense. The

medical members of the audience would have noted that I have referred to the abdominal rather then the peritoneal cavity advisedly. The kidneys are outside the peritoneal cavity but are surely placed within the abdominal cavity.

As I have said earlier on, an injury which produces bodily harm that causes an infirmity lasting for 30 days or more, or if it prevents the injured person from carrying on his usual work for an equal period, is considered to be grievous. Two important considerations should be made here. One is that the 30-day limit should be kept in mind by the surgeon attending the patient so that the most efficient treatment necessary to cure the patient is carried out expeditiously. In this way, if the patient is not cured and is not back at work by this time, no blame could be imputed to the surgeon. The second consideration is that of over treatment. We all have come across the patient who has hurt his back in an accident and who appears cured in a week or two. But then he or she continues to complain and a prolonged peregrination starts. The patient goes from doctor to doctor, from specialist, to specialist, and is still doing the rounds long after the 30 days have elapsed. It often happens that each doctor visited, prescribes treatment, and even major surgical operations have been resorted to in some cases occurring abroad. All this continues to foster in the patient the belief that he is ill and so the cost of his treatment continues to rise. I am not suggesting that such patients are malingerers, but they are often neurotics who can go to inordinate lengths in their demand for treatment of usually minor sequelae to bodily harm. Many such patients after appropriate examination to exclude organic disease require only firm though sympathetic handling.

Obviously, this has a bearing on those cases where damages are awarded. Unwittingly and perhaps not unnaturally, the patient seeks to obtain the highest possible compensation, and the doctor or specialist might be aiding and abetting such endeavours without realising it. It is therefore essential that the attending doctor should be on his guard. A complete history and a careful examination and the application of the most efficient treatment are essential. Once the patient is cured and is fit to resume work, no effort should be spared to ensure that the patient cooperates to the full. Doctors should beware of those patients who have already been under the care of other colleagues for the same complaint. Further treatment in such cases may not only amount to over treatment but may be outright unnecessary or even improper. This is one way of turning a previously normal person into a pitiful wreck who becomes a burden to himself, his family and to society in general.

I would now like to make some remarks on the Death Certificate. It is of course a most important legal document that proves the death and on which so many legal issues are based. The death certificate is also a medical document in so far as it is intended to record the cause of death with the greatest possible scientific accuracy. In its printed form, there is space for the insertion of the primary cause of death as well as for antecedent and contributory causes in conformity with the recommendations of the W.H.O. It is common knowledge that mortality statistics are based on death certification. The accuracy of the statistics and of the deductions made therefrom depend on the accuracy of the cause of death. I wish to submit that in many instances, the listed primary cause of death may be no more than an intelligent guess or simply a less responsible one. Whenever surgeons have operated on a patient they are more likely than the physicians to prove their original diagnosis. Similarly the pathologist at post-mortem can correct a clinician's diagnosis. Indeed, at the clinico-pathological conference, the pathologist is the one who has all the diagnostic answers derived from a thorough post-mortem examination. I do not wish to imply that the post-mortem examination always produces the correct cause of death. At times, even the most thorough examination fails to provide the accurate answer, but it is the best that can be achieved.

I strongly feel, therefore, that in what I might call medico-legal deaths, where the apportioning of guilt or the

assessment of damages and liabilities with consequent compensation is necessary, post-mortem examination is absolutely essential and should in all cases be required by law. This should be so even when the clinician in charge of the case feels that he is certain of the cause of death and is in a position to draw up the death certificate in good faith. In the case of a pedestrian who is knocked down by a car and who dies a few hours later of severe head injuries, only a postmortem examination could reveal that a coronary thrombosis was the cause of his falling in the path of an on-coming car. This may be an exceptional but a true example that illustrates my point.

In Malta, a doctor has a legal obligation (Section 6 Medical and Kindred Professions Ordinance Ch. 51) to inform the police of all deaths where there appear to be signs of poisoning or violence. Similarly, if the cause of death is not known, the police are to be informed. An example of this is where a person is found dead and has not been attended during his last illness by a doctor. In other instances, a doctor may feel free to sign a death certificate for a person who has died of apparently natural causes even though he has not seen that person professionally for some weeks. So far as I know, in Malta, there is no legal limit imposed on the time prior to death that a doctor may have examined a person in order to be able to sign a death certificate. Indeed there is no legal obligation to see the deceased prior to signing the death certificate.

Relatives of deceased patients in hospital are at times enlightened enough to accede to the doctor's request for a post-mortem examination. This request may be made because an investigation in detail of the pathological process and of the effects of treatment may reveal information which will enlarge the sum of medical knowledge for the general benefit — even though the cause of death itself is not in doubt. In other instances however, the request is made in order to establish the cause of death. Strange as it may seem to the uninitiated, a person may spend weeks in hospital, have a battery of investigations, possibly even an operation, and in the end may die without a diagnosis having been reached. This is not very different from the case where in spite of the thoroughness of the police investigation of a crime the culprit is not discovered. Though the consent of the deceased's relatives for a post-mortem examination is not legally necessary, it has become customary to ask for it and it is most welcome to the clinician. When relatives withhold this consent, the surgeon or the physician must either guess at an approximate cause of death, a most unsatisfactory business, or else he will find himself bound to report the case to the police as one where the cause of death is not known. Thus practitioners are faced with the incomprehension of magistrates and the police, who dazzled by the wonders and marvels of science about which they have heard so much, fail to understand how it is possible that a person who has been under care in hospital for weeks dies from undetectable causes which have evaded even the most scrupulous and competent physician. It is also very frustrating to find that in some cases the general practitioner who originally referred the case to hospital is approached by the furious relatives of the deceased, and he mercifully, though not without some degree of irresponsibility, condescends to draw up a death certificate himself. This is, you will probably agree, a pitiful and regrettable state of affairs which demands some legal censure.

It is hoped that these thoughts may help to clarify the doctor's attiude in medico-legal matters, and may have helped to indicate where some improvements are called for.