Emphasis on Professional Liability

News

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Q and A session on professional liability popular at meeting

SESAP draws 14,000; sequel ready this fall

A total of 1,786 surgeons registered for and attended the second annual Spring Meeting of the American College of Surgeons March 25–28 in Houston. Total attendance for the meeting was 2,617.

One of the more popular segments was the 7:15 am-beginning Fellowship Breakfast: "Professional Liability–What's New?". While 370 tickets had been sold in advance of the breakfast, nearly 500 persons showed up. All were accommodated.

Following brief presentations of formal remarks by several members of the panel, the majority of the meeting was devoted to questions from the audience and answers from the panelists (see pages 15–20).

C. Rollins Hanlon, MD, FACS, director of the College, served as moderator. Panelists included: Dexter T. Ball, MD, FACS, who spoke briefly on "The Current California Situation"; William V.

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SESAP, the Surgical Education and Self-Assessment Program of the American College of Surgeons, is completing its three-year enrollment period as an unqualified success, according to Harold A. Zintel, ACS assistant director, who had staff responsibility for the program.

When the College introduced the program in the fall of 1971, it was anticipated that 15,000 surgeons would take advantage of this unique method to assess their knowledge. As of March 1974, more than 14,000 surgeons have participated in SESAP.

The popularity of SESAP did not remain confined to the boundaries of the continental United States and Canada. A Spanish translation of SESAP is being prepared for distribution in Spain and Central and South America. The translation will be available through the joint efforts of *Tribuna Medica* (the South American version of *Medical Tribune*) and the Pan American Federation of Associations of Medical Schools (PAFAMS). A German translation also is being readied under the auspices of the German Surgical Society.

While SESAP is entering its wind-up period, work on SESAP II is nearing completion. An entirely new program developed during the past three years by ten specially selected committees, SESAP II will also comprise 750 items and cover nine areas of knowledge essential to a surgeon's daily practice. A detailed brochure explaining SESAP II will be sent to all surgeons in June. Moreover, physicians attending the 60th annual Clinical Congress in Miami Beach in October will have an opportunity to

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ON A RECENT VISIT to the Philippines, J. Englebert Dunphy, immediate past chairman of the ACS Board of Regents, (*left*) met with Ferdinand E. Marcos, President of the Republic of the Philippines (*right*). During his visit, Dr. Dunphy also visited the GSIS General Hospital, where Jose P. Caedo, Jr., MD, FACS, (*center*) is director. Dr. Caedo is also president of the Philippine chapter of the American College of Surgeons.

Registration pack for '74 Congress mailed to FACS

Miami Beach, Florida, for the first time, will be host to the Clinical Congress of the American College of Surgeons, acknowledged to be the largest and most instructive surgical meeting in existence.

Virtually all of the panels, postgraduate courses, and other segments of the Clinical Congress as well as the hundreds of exhibits will be in one location convenient to all hotels, the recently expanded Miami Beach Convention Center.

An advance brochure announcing the Congress was mailed to all Fellows of the College, to the 1974 Initiates, and to all members of the ACS Candidate Group early this month. Other doctors of medicine interested in attending the Congress may use the coupon on page 33 of this issue of the BULLETIN; or may write to:

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Surgical colleges reorganize president's functions; move secretary's office to Scotland

Representatives of 33 surgical colleges or societies attended the biennial meeting of the International Federation of Surgical Colleges (IFSC) in Barcelona, Spain, September 1973. Dr. Walter C. MacKenzie, IFSC president 1972–1975, of Edmonton, presided; representing the American College of Surgeons were Dr. Jonathan E. Rhoads, vice-president of IFSC, and Dr. J. Englebert Dunphy, IFSC past president.

Professor E. A. Elebute, West Africa, was reelected to the executive committee for a second term, and Dr. J. P. van Elk, Netherlands, was elected for his first term.

Among numerous actions taken by the IFSC was a vote to invite an observer from the Chinese Surgical Society to attend the IFSC council meeting in Montreal in January, (none was able to be present).

The federation agreed to send the president and others to attend the meeting of the West African College of Surgeons in Lagos in January 1974, and determined that the next biennial meeting will be held in Edinburgh in September 1975.

A proposal to reorganize the office of the IFSC to involve the president more directly in correspondence on policy matters and to move the office of the honorable secretary from the Royal College of Surgeons in London was made at the biennial meeting and accomplished by the Council at its meeting in January, when Mr. John Cook (FRCS, Ed), Royal College of Surgeons in Edinburgh, was elected honorary

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Young surgeons meeting attracts 57 chapter reps

Fifty-seven younger Fellows of the American College of Surgeons, representing a like number of U.S. and Canadian chapters of the College, attended a day-long meeting concerned with social and economic factors at College headquarters March 15.

A summary of the meeting, including reports from five workshops, will be carried in a future issue of the BULLETIN.

Topics for the workshops were: Progress in Quality Assurance of

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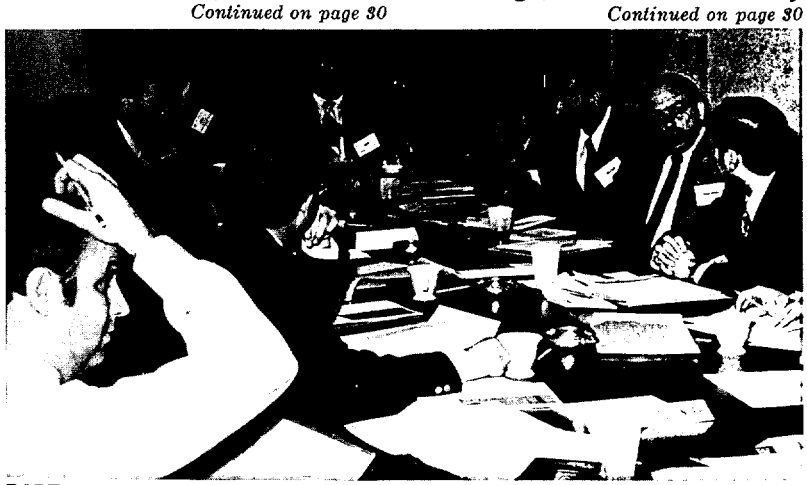

PARTICIPANTS at one of the five workshops held in conjuction with the March 15 Meeting of Young Surgeons seem to agree that, indeed, the topic under discussion raises some very interesting questions.

Trauma society keeps growth; forms state arms

Seventeen hundred individuals, including 1,450 physicians, have become founding members of the American Trauma Society (ATS) since its incorporation in 1971.

Founded for the purpose of preventing accidental injuries and improving the care of the injured, the society is patterned after the American Cancer Society and the American Heart Association, both of which attempt to foster cooperation between members of the medical profession and a large number of lay persons to create programs in all spheres of scientific, clinical, and community endeavor.

As of early February 1974, ATS has incorporated state divisions in California, Georgia, Illinois, Maryland, New York, Ohio, Pennsylvania, Texas, and Utah; while North Carolina, South Carolina, Oklahoma, Michigan, among

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Surgical manpower: *a correction*

In the article, "A summary of the symposium on graduate education in surgery—surgical manpower", in the February 1974 BULLETIN, one of the participants was inadvertently misquoted. In the fourth paragraph on page 17, Dr. William G. Anlyan was reported as having said, "Only in the United Kingdom . . . has the problem of geographic distribution been solved".

Dr. Anlyan has stated that he feels it is important to correct that portion to read, " . . . has the problem of *specialty* distribution been solved."

A similar correction should be made in the next, and final, sentence in the same paragraph.

We regret the error.

17 postgrad courses designed for 1974 Clinical Congress

Seventeen postgraduate courses, ranging in length from six to 12 hours each and all accredited for Category I credit toward the AMA Physician's Recognition Award, will be offered during the 60th Clinical Congress of the American College of Surgeons, October 21-25 in Miami Beach.

The courses, their moderators, and their lengths are: [1] Pre- and Postoperative Care, *Robert Zeppa, 12 hours;* [2] Gastrointestinal Disease, *Ward O. Griffen, Jr., 12 hours;* [3] Diseases of the Liver, Biliary Tract, and Pancreas, *Marion C. Anderson, 12 hours;* [4] Cardiovascular Surgery, *Denton A. Cooley and Edwin J. Wylie, 12 hours.*

[5] Multiple Systems Injury, *A. Campbell Derby, 12 hours;* [6] Gynecology and Obstetrics—Diseases of the Vulva, *Herman L. Gardner, six hours;* [7] Injuries in Athletes—Prevention and Treatment, *James A. Nicholas, six hours;* [8] Thoracic Surgery, *Gilbert S. Campbell, 12 hours.*

[9] Pediatric Surgery, *William K. Sieber, six hours;* [10] Multidisciplinary Approach to the Treatment of Cancer (Area Approach), *Isidore Cohn, Jr., 12 hours;* [11] Urology, *Joseph J. Kaufman, six hours;* [12] Proctology, *Eugene S. Sullivan, six hours;* [13] Plastic Surgery—Neoplasms of the Skin and Soft Tissue, *Robert F. Ryan, six hours.*

[14] Otorhinolaryngology—Reconstructive Surgery for Head and Neck Cancers, *George A. Sisson, six hours;* [15] Ophthalmic Surgery—Glaucoma: Medical and Surgical Management, *Irving H. Leopold, nine hours;* [16] Basic Science Problems in Surgery—Physiology of the Liver, *Dean Warren, six hours;* and [17] Neurological Surgery—Pain: Causes and Methods of Relief, *George Ehni, six hours.*

Limbacher receives trauma award

Accepting the 1974 Meritorious Achievement Award of the ACS Committee on Trauma is Henry P. Limbacher, Tucson (above, center), Chief for section IX, for his outstanding service in the regional committee organization. The award presentation highlighted the Trauma Banquet held in conjunction with the 52nd Annual Meeting of the Committee on Trauma, January 24-26 at Tucson. Presenting the award are out-going COT chairman Curtis P. Artz, Charleston (left) and Robert W. Gillespie, Lincoln, Neb. (right), incoming chairman of the committee.

18 surgeons named Ciné Clinic authors

Eighteen distinguished surgeons have been selected to author this year's Ciné Clinic films, which will be shown, with two exceptions, for the first time during the 1974 Clinical Congress, October 21-25 in Miami Beach.

Film production crews from Davis & Geck, sponsor of this popular program, will travel to four nations and to the Commonwealth of Puerto Rico later this spring and during the summer to film the procedures, which have been selected by the ACS Committee on Medical Motion Pictures, under the chairmanship of Robert E. Condon.

The films will be available for rental approximately six months after their Clinical Congress showing, through the ACS/Davis & Geck Surgical Film Library.

The surgeons, all Fellows of the College, are: Jose H. Amadeo, *San Juan;* Edward J. Beattie, Jr., *New York City;* John L. Bell, *Chicago;* Alexander H. Bill, Jr., *Seattle;* Marion S. DeWeese, *Columbia, Missouri;* and Charles M. Evarts, *Cleveland.*

Also, William J. Fry, *Ann Arbor;* Willard E. Goodwin, *Los Angeles;* W. Hardy Hendren III, *Boston;* John E. Jesseph, *Indianapolis;* George L. Jordan, Jr., *Houston;* and James F. Lind, *Hamilton, Ontario.*

Also John S. Najarian, *Minneapolis;* Carlos A. Peschiera, *Lima, Peru;* David B. Skinner, *Chicago;* Alan G. Thompson, *Montreal;* and Richard Turner-Warwick, *London, England.*

GUIDELINES FOR SCREENING

A number of modifications or corrections to the twelve proposed General Surgical Guidelines for Screening, which were published in the March issue of the ACS BULLETIN, have been received by the College. These are being collated, and will be published in a future issue.

The College would welcome additional comments.

Five of six lecturers selected for 1974 Clinical Congress

Five distinguished surgeons, including a Nobel laureate, will deliver five of the six major lectures during the 60th Clinical Congress in Miami Beach October 21–25. Selection of, and acceptance by, the sixth lecturer, who will deliver the Martin Memorial Lecture October 24, has not been completed at press time.

Abel J. Leader, MD, FACS, clinical professor of urology at Baylor College of Medicine, will deliver the American Urological Association lecture Monday morning, October 21. The tentative title of his lecture is "Elbows, Stomachs, and the Future of Man".

The fourth John H. Gibbon lecturer will be David C. Sabiston, Jr., MD, FACS, professor and chairman, Department of Surgery, Duke University Medical Center, who will speak Monday afternoon.

On Tuesday afternoon, Jack Wickstrom, MD, FACS, professor and chairman, Division of Orthopaedic Surgery, Tulane University School of Medicine, will deliver the Scudder Oration on Trauma.

Charles B. Huggins, MD, FACS (Hon), Nobel laureate and William B. Ogden distinguished professor, Ben May Laboratory for Cancer Research, University of Chicago, will deliver the I.S. Ravdin Lecture in the Basic Sciences on Wednesday afternoon, October 23. The tentative title of Dr. Huggins' lecture is "Transformation of Fibroblasts".

Charles W. McLaughlin, MD, FACS, current president-elect of the American College of Surgeons, will deliver his presidential address Thursday evening, October 24, during the convocation ceremonies.

Registration pack . . .

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Mr. Frank Arado, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

Enclosed with the advance brochure, which features a preliminary, abbreviated program for the Congress, are *(1)* an application for hotel accommodations, *(2)* an advance registration form for the Congress and for the 17 postgraduate courses (at which attendance will be limited, see page 5), *(3)* an application for the Fifth Annual Course in Scientific Communication (limited to 100 registrants), and *(4)* an outline of activities for the ladies' program.

Programmed carefully so that general surgeons and members of each surgical specialty may attend the maximum number of events without conflict are nearly 100 hours of panel discussions or symposia in general surgery and the surgical specialties; the aforementioned 17 postgraduate courses; numerous live telecasts of surgical procedures; 19 films made expressly for this Congress, and over 100 other outstanding medical motion pictures; more than 260 papers, each reporting on a different research project; plus more than 150 scientific exhibits and over 200 industrial exhibits. In addition, an impressive roster of distinguished speakers will deliver the six major lectures.

Q & A session . . .

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Nick, MD, FACS, JD, "Informed Consent", (see pages 12–14); and David E. Willet, San Francisco attorney, who spoke on "PSRO and Professional Liability" (see pages 7–11). Frank E. Stinchfield, MD, FACS, Chairman of the ACS Board of Regents and Robert C. Hickey, Chairman of the Board of Governors also participated.

CPHA develops list for grouping 349 diagnoses

The Commission on Professional and Hospital Activities, with assistance from the American College of Surgeons and five medical specialty societies, has developed a grouping of diagnoses for purposes of review and evaluation of inpatient care. Titled *"CPHA List A: Hospital Diagnosis Groups"*, the listing consists of 349 diagnosis groups. According to CPHA, any of the major diagnosis classifications can be accommodated by the groupings.

A copy of the list is available to interested hospitals free on request from *CPHA, 1968 Green Road, Ann Arbor, Michigan 48105.* PAS hospitals will automatically receive a copy.

Fifth Gastroenterology Congress in Mexico October 13–21, 1974

The Fifth World Congress of Gastroenterology, to be held consecutively with the Third International Congress of Gastrointestinal Endoscopy, will be in Mexico City, October 13–21, 1974.

For further information, contact: *Dr. Francisco Puente Pereda, vice president of information, V Congreso Mundial de Gastroenterologia, Av. Veracruz 93, Mexico 11, D.F., Mexico.*

OR techs to meet

The Association of Operating Room Technicians will hold its Sixth Annual Conference in Washington, DC, June 6–9, 1974. For further information, contact: *Conference Coordinator, AORT, 1100 W. Littleton Blvd., Littleton, Colo., 80120.*

Malpractice claims—
will they increase or decrease with PSROs?

DAVID E. WILLETT, Esq., *San Francisco*

The topic assigned to me is phrased as a question: "Malpractice claims—will they increase or decrease with PSROs?" If my remarks are to be based on what I know, I should probably say "yes" and sit down. My comments, therefore, can only be educated guesses and, as you know, the difference between an educated guess and a lawyer's opinion is that the latter is based on the law; statutory law enacted by Congress or by state legislators, regulations of administrative agencies, and cases decided by the courts.

The topic I am to discuss involves two distinct areas of law. The first is malpractice, and there is no dearth of authority in this field. The second is the law of PSRO, and in this area, not only is there no body of law, but one may question whether the skeleton is yet complete.

The professional standards review portion of Public Law 92-603 is skeletal at best. I've tried to be diligent in following the subject, even before the law was passed, and have acquired a wagon-load of material dealing with the subject. Nonetheless, I still haven't a clear idea of how PSROs are actually going to function, and my impression is that I am not alone. Dr. Henry E. Simmons, deputy assistant secretary for health in HEW, pointed out earlier in this conference that the method by which PSROs will review claims "hasn't been decided" and "is undetermined at present". While I, and certainly you, know how PSROs might function, the variations are nearly endless, and we can only speculate as to how the job will actually be done.

I mention this only because it must be clearly understood at the outset that the influence of PSROs on malpractice litigation will be determined in large part by the regulations adopted by the secretary of HEW, and so far, no regulations have been adopted, or even proposed, by the secretary.

My personal feeling is that malpractice claims will increase with the advent of PSROs, in spite of the strictest precautions contained in the eventual regulations. I say this only because it seems to me that the PSRO, in some instances, must necessarily interfere with the physician-patient relationship to some extent. I think it is the common observation of both physicians and lawyers who have studied malpractice, that a breakdown in the physician-patient relationship, whether caused by the physician himself or by third party interference, is the root cause of many malpractice claims.

We can identify specific provisions in the PSRO law on which problems of malpractice will pivot. The law's numerous references to "professional norms" are paramount. Other sections which deserve our attention deal with confidentiality, punitive action against physicians, and with limitation of liability or immunity from suit.

The first section of the law states that its purpose is to insure that services for which payment may be made under the legislation will conform to "appropriate professional standards". That section goes on to say that payment should be made only when services are "medically necessary, as determined in the exercise of reasonable limits of professional discretion".

In the section defining the duties and functions of PSROs, it is stated that the PSRO shall determine whether services were "medically necessary" and whether the quality of such services (again) meets "professionally recognized standards". The law does not state that services must conform to "norms".

Continued

In brief . . .

Malpractice claims will probably increase, in the personal opinion of this attorney, mainly because Professional Standards Review Organizations must necessarily interfere with the physician-patient relationship, and it is the common observation of all who have studied the problem of malpractice that any breakdown in this relationship, whether caused by the physician or by third party interference, is the root cause of many malpractice claims. But it should be emphasized, the author points out, that the basic PSRO purposes of assurance of quality and cost reduction require minimization of the malpractice risk.

Mr. Willett, a partner in the San Francisco law firm of Hassard, Bonnington, Rogers and Huber, delivered this address during the American Medical Association's Medical Services Conference December 1, 1973 in Anaheim, California.

The law does require that each PSRO apply "*professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice . . . as principal points of evaluation and review*", (emphasis added). The point to be made is that "a norm" is not synonymous with the standard of good medical practice. A norm is a statistical average; it cannot take into account the circumstances under which a specific service was provided. In merely applying a norm, one cannot consider individual variations found in patients, in their circumstances, or in conditions of practice. It is important to note that the norm referred to is a regional norm, developed by a high authority and handed down to the PSRO. I was somewhat surprised when Dr. Simmons indicated at this conference that PSROs will be permitted and encouraged to develop and use local norms. I assume that such a provision will be contained in the regulations. While such a regulation seems somewhat in conflict with the law itself, certainly the secretary has rather wide discretion, and we have to be pleased if administrative discretion is stretched in medicine's direction. We've certainly seen instances, such as in the definition of customary and prevailing fees, where it has been stretched in the other direction. In any event, it remains the PSRO's responsibility to determine independently whether a specific service was medically necessary, and whether that service meets not norms, but recognized standards of good medical practice.

In other words, the physician who departs from norms is *not* "guilty until he proves himself innocent". The PSRO is obligated to utilize a norm in its initial evaluation, but the obligation of the PSRO is to provide comprehensive professional review that goes beyond the application of norms.

Although limitation of liability will be discussed later, it should be mentioned in this context. There is a section in the PSR legislation that begins by saying, in substance, that no physician shall be held civilly liable on account of any action taken by him in compliance with these norms. If that section stopped there, norms might be regarded as the standard of practice, although one might question congress's right to pass such a sweeping law. However, the section does not stop there. It goes on to provide that such immunity shall be available only if the physician has exercised "due care in all professional conduct taken or directed by him". This is, of course, simply another way of saying that the physician must meet recognized standards of good medical practice, and by this proviso, Congress has again recognized that norms do not establish such standards.

I have dwelled at length on the issue of norms because I feel strongly that the procedures devised for their use may be the single most important factor in determining whether, or how much, malpractice claims will increase under PSROs. We must remember that PSROs, while they are ostensibly only to be concerned with quality of care, will inevitably determine whether payment will be made for specific services. The PSRO and the carrier will be inseparably linked. When the carrier refuses payment, the patient will become involved. In spite of all the discussion I have heard about the operating aspects of PSROs, I continue to feel that insufficient attention is being given to the personal involvement of the patient. The PSRO is not a closed circuit linking only provider, carrier, and the public treasury. The patient is personally involved, and he will be very much personally involved when a PSRO concludes that the physician has fallen short in his obligation to the patient.

It is a serious matter to charge a physician with malpractice. When a PSRO concludes that a service is not of acceptable quality, that conclusion is tantamount to a finding of malpractice. When a PSRO concludes that a physician has provided unnecessary services, the inference is that the physician has abused his responsibility to the patient. As you no doubt are aware, there is recent judicial precedent holding a physician liable for such abuse. In the past, when a carrier has disallowed a portion of a physician's billing on the grounds that his fee exceeds customary or prevailing levels, we have seen violent response from both patients and physicians, because of the inference that the physician had overcharged the patient. As serious as this problem has been, it pales in comparison to the problem we will have if the patient is told that the quality of his care is in issue. Medicine has a responsibility to protect patients against substandard performance, and I do not suggest that this finding must be concealed from the patient if the physician has, in fact, been derelict. However, I would suggest that the most stringent precautions must be taken against the communication of unsubstantiated findings or inferences. The charge must first be proved, and it is the PSRO's responsibility to do so. It is not the physician's obligation to

prove himself innocent, particularly in front of his patient. Such interference with the physician-patient relationship is not in the best interests of patients or physicians.

Let us now consider the issue of confidentiality. When I use the term 'confidential' you may have in mind only the medical records of the patients themselves. Certainly, confidentiality of patient records must be maintained; PSRO legislation says so specifically. Also, there is an exception to the Freedom of Information Act that expressly protects medical records from public disclosure. However, the issue of confidentiality has much broader scope. PSROs will have possession of a mass of data and information that does not pertain to identifiable patients, including physician profiles, coded patient profiles, records of PSRO deliberations, and, if names of patients are deleted, actions with respect to particular physicians. Norms themselves might fall into this category.

The secretary of HEW is going to have to decide at the outset whether he will permit confidentiality of information solely to avoid PSRO involvement in malpractice litigation. Although the mere suggestion that the secretary should do so will provoke violent and outraged response from the plaintiffs' bar and groups that claim to speak for the consumer. They will contend that the PSRO law is intended to benefit patients, not physicians, and that if PSROs have the capability to advance the interests of patients who might bring malpractice action, they should do so. My response is that this assertion represents a narrow, short-sided view, which, in fact, is inconsistent with the true purposes of professional standards review. Moreover, I can point to ample precedent for doing just what I suggest the secretary should do: insulate PSROs from malpractice litigation.

Simply put, the secretary is going to have to decide whether he wants earnest, impartial, let-the-chips-fall-where-they-may peer review, or whether he will impose a nervous compromise, with the PSRO viewing every claim reviewed as an incipient malpractice suit. In PL 92-603 there is already one provision that favors unencumbered peer review; section 1167 provides immunity against either civil or criminal liability for any person who either furnishes information to a PSRO, or who actively participates in PSRO activities, so long as that person acts neither fraudulently or maliciously. This provision, particularly the portion providing immunity for the PSRO participant, is lifted from a statute that was enacted in California more than a decade ago, and has since, according to my best information, been adopted in 30 states. The reason these legislatures were willing to grant this special immunity was to encourage fearless peer review.

Similarly, California has enacted, and I suspect that by now other states have also enacted, a law that provides that the records of hospital staff committees and medical society review committees having responsibility for quality of care are not disclosable; with very limited exceptions, they cannot be obtained or utilized as evidence in litigation. Again, this law was adopted when our legislature became convinced that the profession could better police itself if its sole concern is thorough investigation and determination. If such a committee must recognize that a plaintiff's attorney can seize its files at will, it will be overly cautious about the content of those files. It will carefully avoid including any speculation, rumor, or unsubstantiated data. Such restraint is appropriate in a judicial proceeding, but this extraneous concern will hamper the initial efforts at fact finding and investigation. PSROs are composed of physicians. They cannot fairly be expected to forget entirely about the effect malpractice litigation is having upon the practice of medicine. This is not a narrow or selfish concern. Many persons who hold no brief for the medical profession are now coming to the conclusion that the cost of malpractice litigation and the impact of such litigation upon the actual provision of care is not in the public interest. I would urge that the secretary permit PSROs to focus their attention on quality of care exclusively, minimizing concern that such a positive effort may be overweighed by contributions to an already oppressive malpractice liability problem.

The law permits such confidentiality. In fact, the law states that "any data or information acquired by any professional standards review organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except to the extent that may be necessary to carry out the purposes of (the law) or, in such cases and under such circumstances as the secretary shall by regulations provide, to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care". Since the secretary has these very broad discretionary powers, and since quality of care

Continued

Informed Consent—the new decisions

William V. Nick, JD, MD, FACS, *Columbus, Ohio*

Both the common law and the first amendment to the Constitution provide the origin for the patient's right to determine what treatment he shall accept. A classic expression of the common law theory of liability where surgeons undertake operations without, or in excess of, the consent of patients was stated by Justice Benjamin Cardozo in an historical decision in 1914.[4] "Every human being of adult years and sound mind has a right to determine what shall be done with his own body and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained."

The first amendment's inviolability of a person's privacy was noted by Mr. Justice Brandeis in 1928:[5] "The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred the right to be let alone—the most comprehensive of rights and the right most valued by civilized man".

In brief . . .

The intensity of litigation from health care provided the consumer in the past decade has made more than an actuarial impact. Three landmark decisions from high courts in California[1], the District of Columbia[2], and Rhode Island[3] reflect changing social policy and the resurgence of patients' rights in American judicial thought. These cases have made informed consent the most troubling day-to-day problem on the medico-legal horizon, the author points out.

It is worth re-emphasizing, he states, that the new decisions will have their greatest influence in elective surgery and cases in which more than one mode of treatment is practical, such as breast cancer.

Dr. Nick is editor of Legal Medicine Press, *of Columbus, Ohio.* Legal Medicine Press *compiles and constantly updates the literature index of published information on malpractice. It reports on relevant legislation in the 50 states and the District of Columbia, and on current cases reported in all jurisdictions. Dr. Nick is also an associate professor of surgery at the Ohio State University School of Medicine.*

The changing community standard rule

The established standard for informed consent is the community rule in most American jurisdictions: "whether or not a surgeon is under a duty to warn a patient of the possibility of a specific adverse result of a proposed treatment depends upon the circumstances of the particular case and upon the general practice followed by the medical profession in the locality; and the custom of the medical profession to warn must be established by expert testimony".[6]

But the California Supreme Court in Cobb vs. Grant states: "despite . . . the prevailing rule, it has never been unequivocally adopted by an authoritative (?) source. Therefore, we probe anew into the rationale which purportedly justifies, in accordance with medical rather than legal standards, the withholding of information from a patient". The community rule, the court concluded, "appears so nebulous that doctors become, in effect, vested with virtual absolute discretion". The community standard concept was thus discarded, eliminating a substantial obstacle, that an expert witness establish a medical standard for informed consent. In the Canterbury case, from the District of Columbia, the court also substituted a legal standard which the jury will use to measure the physician's conduct rather than measuring disclosure by what medical custom in the community would demand.

The "reasonable man" standard

The Supreme Court of Rhode Island[7] used a similar premise: "the patient is entitled to receive material information upon which he can base an informed consent. The decision as to what is or is not material is a human judgment, in our opinion, which does not necessarily require the assistance of the medical profession. The patient's right to make up his mind should not be delegated to a local medical group—many of whom have no idea as to his information needs. . . . The jury can decide if the doctor has disclosed enough information to enable the patient to make an intelligent choice without the necessity of the plaintiff's expert".

The court said that a reasonable-man standard must be applied as a professedly objective criterion of whether a risk is material. It stated: "materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position,

would attach to the disclosed risk or risks in deciding whether to submit to surgery or treatment". The same test of reasonableness was adopted by the District of Columbia Court in Canterbury.

What to tell the patient

All three landmark cases are similar in postulating basic premises for physicians to explain those facts necessary for the patient to make an "informed" judgment regarding his consent to treatment. They are: (*1*) patients are generally unlearned in medical sciences, (*2*) yet the patient has the right to exercise control over his body, (*3*) so the consent to treatment, to be legally effective, must be an informed consent and finally, (*4*) the patient has dependence upon and trust in his physician for the information upon which he relies in making his decision creating what in law is a fiduciary relationship,[8] wherein the physician is liable for misrepresentations, whether by affirmative statement or nondisclosure. The responsibility to inform the patient clearly rests with the physician, not his nurse or an admitting clerk.

It is essential that surgeons know how extensively they must inform the patient. As in the Canterbury case, the court in Cobbs said the scope of what to tell the patient is what he needs to know to make up his mind whether to have the procedure performed and that need is "whatever information is material to the decision". There is a duty "of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each." This court recognizes that the use of phrases like "full disclosure" does "obscure common practicalities," and provided two qualifications. "A minicourse in science is not required; the patient is concerned with the risk of death or bodily harm and problems of recuperation . . . When there is a common procedure a doctor must . . . make such inquiries as are required to determine if for the particular patient the treatment under consideration is contraindicated . . . but no warning beyond such inquiries is required as to the remote possibility of death or serious bodily harm . . . There is no physician's duty to discuss the relatively minor risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence." The court cited a blood count as an example. There are obviously grey zones for procedures that defy simple categorization.

"When there is a more complicated procedure (which) inherently involves a known risk of death or serious bodily harm, a medical doctor has a duty to disclose to his patient the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur."[9] This would certainly apply to any type of elective major surgery.

The strongest language is in the Canterbury decision: " . . . it is normally impossible to obtain a consent worthy of its name unless the physician first elucidates the options and perils for the patient's edification . . . The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are . . . the incidence and the degree of harm threatened . . . In sum, the patient's right of self-decision is the measure of a physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an 'intelligent choice'."[10]

As in Canterbury, the court in Wilkinson said a "very small" chance of death or serious disability may well be significant. Further, a potential disability that greatly outweighs the potential benefits of treatment or the detriments of the patient's existing condition may require disclosure.[11]

The exceptions to disclosure

All three courts recognize that the duty of disclosure is not absolute. Beyond the previously mentioned qualifications, the California court in Cobbs said: "a medical doctor need not make disclosure of risks when the patient requests that he not be so informed . . . A disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote. . . A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence he relied upon facts which would demonstrate to a reasonable man the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment". The Canterbury court continues to elucidate the exceptions: there is no obligation to communicate commonly known dangers of which persons of average sophistication are aware, for discussing hazards the patient has already discovered or those having no apparent materiality to the patient's decision on therapy. What is material, however, will be a question for the jury. In emergency situations in which the patient is incapable of consenting "the physician should, as current law requires, attempt to secure a relative's consent if possible". In many

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emergencies there is a consent to treat implied by law. And, "if the patient is a minor, or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative".[12]

The California court stated the most important defense of all, the prudent patient test. Permitting recovery would be unjust if the patient would have accepted treatment even if he had known of the risk of the particular complication which occurred. A plaintiff-patient naturally contends that he would have withheld consent. But once the physician's information has been disclosed, his expert function has been performed. The weighing of risks against the patient's subjective fears and hopes is not an expert skill. That decision is a non-medical judgment reserved for the patient. The court solves this problem by substituting an objective test for a subjective test: the jury must determine what "a prudent person in the patient's position (would) have decided if adequately informed of all significant perils".

Under this test a patient is not going to make a convincing case if he testifies that he would not have consented if he had known certain facts. The court requires that the patient prove that a "reasonable man" would have refused treatment if the essential information had been provided.

Forms and progress notes

The recent decisions clearly indicate that a physician is in a hazardous defense position when he relies solely on conversations with the patient, without preserving written evidence of the conversation. Current consent forms are virtually useless as to the materiality of the information given to the patient. The typical standard form does not contain an actual explanation of the treatment, alternatives or risks, so it conveys none of the essential information. There are several measures that are quite effective. Informative notes on charts are easy to make. The subjects discussed with the patient can be carefully documented prior to surgery, emphasizing the threat of death, serious bodily harm and the problems of recovery and convalescence. It may be helpful to record the patient's reactions in the medical chart. Detailed explanations in lay language can be prepared for procedures the surgeon repeatedly performs. The patient can be asked to read these explanations in advance of the opportunity for discussion with the surgeon before consent is requested.

It has been suggested that it may be practical to tape record the explanations for the patient, or that short summations of standard operating procedures may be pre-recorded on video tape. The tapes are then available to be introduced as direct evidence of what was actually said.

Some defense attorneys state that it is inadvisable to list all the risks, particularly if a complication develops that was omitted from the conversation. Others feel that detailed statements prepared by specialty groups should be presented to the patient and initialed by him as evidence of his receipt of the requisite information.

Guarantee of medical results

A further dilemma in conversations with patients arises when the surgeon helps the patient approach operations by instilling confidence and helping to allay his fears. The Supreme Court of Michigan[13] has recently held that the effect of words used for therapeutic reassurances may be construed as a contract or promise to cure. Continuing the concept of a legal rather than medical standard, the court ruled that it is for the jury to determine whether a physician's statements were merely therapeutic reassurances or a guarantee of medical results; that is, whether a contract existed.

If the courts held spoken encouragement to be a guarantee, an additional burden is placed on the surgeon to include in his forms and written documentation a disclaimer that he does not guarantee a favorable outcome.

The dissenting opinion rationally examined the flaws in the majority's argument and emotionally stated that this was an: "unwarned, unprecedented, wholly gratuitous and destructively witless war of contract liability" upon a brother profession which, by the manifold harrassment of malpractice actions, has been forced already to undertake what is professionally known as "defensive medicine".

Changing patterns of practice

It is worth re-emphasizing that the new decisions will have their greatest influence in elective surgery and cases in which more than one mode of treatment is practical, such as breast cancer. Most surgeons accept the responsibility to discuss alternatives to treatment and risks. The legal implications now associated with imparting this information will frequently be regarded as unfair. Recognizing that the legal community will continue to set the standards for disclosure, the surgeon will understand that the best legal protection flows from obtaining consent himself and documenting what he does in the patient's record. One response that may

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Professional liability—what's new?

Questions and answers from the Fellowship Breakfast

held during the Spring Meeting of the American College of Surgeons

In brief . . .

Over 500 surgeons, out of a total professional registration of 1,786, attended the Fellowship Breakfast Wednesday morning, March 27, during the recent second annual Spring Meeting of the American College of Surgeons.

Following brief introductory remarks by several of the panelists, questions were collected from the audience and presented by the moderator to one or more of the panelists serving as resource persons.

The panelists were: Dexter T. Ball, chairman of the ACS Board of Governors' Committee on Professional Liability; William V. Nick, JD, MD, FACS, editor of Legal Medicine Press, *Columbus, Ohio; and David E. Willett, LLB, a partner in the San Francisco law firm of Hassard, Bonnington, Rogers and Huber which, for the last two decades, has represented physicians in malpractice litigation. Frank E. Stinchfield, chairman of the ACS Board of Regents, and Robert C. Hickey, chairman of the Board of Governors, also participated. C. Rollins Hanlon, director of the College, served as moderator.*

Following are the questions presented by members of the audience, and the answers from one or more members of the panel. In some instances, related questions have been combined. The material has been slightly edited, using as a source transcripts made from a tape recording of the entire session.

Regarding informed consent, how much time should an oral explanation take, and how much detail should be explained? Is it sufficient to state in the patient's record, for example, "The risks of appendectomy have been explained"?

DR. NICK: To simply state, "I have explained these things [risks] to the patient", without documenting what risks were enumerated, is probably the ordinary practice in documenting consent. However, in several jurisdictions including Rhode Island, the District of Columbia, and California, recent court decisions now demand more. It would be more proper to detail what was told the patient, specifically, in the progress notes. As to how long it takes to explain these things to a patient, I find that I am doing it more and more, and it takes me about half an hour.

MR. WILLETT: There may be some difference of opinion here. Nobody is going to know what the answer is until the courts have grappled with this a bit more. Based on the work that has been done in California, we finally concluded that the physician need only make a note that says, in effect, I have explained the risks and alternatives of this procedure to the patient, contemporaneous with the interview and in the usual fashion. He need not go into further detail unless he wants to. Our basic supposition here is that juries do not regard physicians as liars, they believe that physicians tend to tell the truth. When there is an argument and the patient says the doctor didn't tell me, and the doctor says, "yes I did, I always explain these risks when I discuss this procedure with a patient", we think the jury is going to believe the physician.

Why doesn't the American College of Surgeons prepare informed consent forms for standard surgical procedures so that the individual physician could use copies of these in his practice?

DR. NICK: There are 51 jurisdictions in the United States, therefore it would be impossible to develop a consent form that is applicable to each and every jurisdiction. This would, in effect, force a particular jurisdiction to change its standards to a higher or lower standard. If you follow the guide set out in the case of Canterbury vs. Spence in the District of Columbia, a physician would have to explain all of the obligations and talk about them in terms of peril, for example, involving percentages of risk as low as .0004. If you want to raise the standards in all of the jurisdictions, then a national consent form could be developed. I believe, rather, that consent ought to be on the basis of what is the law in your particular state. Most states still follow the community rule of what is the prevailing practice in the local community, which has nothing to do with locality rule in malpractice actions based upon a more national scope.

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Is the surgeon still responsible for errors of negligence by anesthesiologists or nurse anesthetists; in other words, does the "captain of the ship" doctrine still apply? And, a related question, is it the surgeon's responsibility to explain general anesthesia, is it the duty of the anesthesiologist, or is there an overlap?

MR. WILLETT: The "captain of the ship" doctrine does still apply. That is, responsibility rests with the senior individual present or involved. However, it is recognized that the anesthesiologist is a specialist with his own competence and his own responsibility, and one need not assume because the anesthesiologist makes a mistake that the surgeon will be held responsible. I think it depends on the facts of the individual case.

DR. STINCHFIELD: I am becoming more sympathetic to the complaint of the anesthesiologist regarding consent. I don't think it is fair or beneficial to the patient for the anesthesiologist to come to the patient's room the night before surgery just to secure informed consent. While I think one is naturally reluctant to do the other person's work, really the surgeon should assume more of the burden and responsibility. The difficulty might be in assuring the anesthesiologist that the surgeon has in fact done some of the things he should do properly. This is a problem that requires further discussion between the two specialties.

DR. NICK: I don't personally see why a surgeon has to get full informed consent for an anesthesiologist, that is the responsibility of the anesthesiologist. It does, I agree, put the anesthesiologist in a somewhat precarious position, 7 o'clock at night is a hard time to explain the adverse effects of different drugs or procedures. I think a proper understanding, compromise if you will, might be for the surgeon to lead up to what type of anesthesia is going to be used, then tell him that someone will be coming to talk to him about it.

There are situations, in Pennsylvania and in the federal courts, where a surgeon is still responsible for the nurse anesthetist and anesthesiologist in case something should go wrong, but in most other instances it has been recognized that anesthesiology is an independent profession, and that their activities are not imputed to those of the surgeon.

Can nurses obtain the signature for informed consent? And, if a medical history is taken by paramedical personnel and reviewed by the physician, will it stand up in court?

DR. NICK: Yes, a nurse can, but I think the person who is going to provide the procedure or do the operation ought to obtain the signature. As regards the second question, screening, computerized profiles, and histories taken by paramedical personnel are evidence that a history was taken. As to whether the person who took that history was competent to elucidate, for example, allergy in the case of a drug reaction, or whether the physician ought to have supervised the history more carefully, becomes an issue of great magnitude. It is the obligation of the physician to assure that the history is accurate and that all the facts are properly documented. As supervisor, he is responsible for the acts of persons working for him.

Suppose you are operating on a patient for an esophageal stricture, and find that he has cancer in the lower esophagus. How does one handle this? Would you be liable, in other words, for changing gears in the middle of the procedure, and does that constitute a battery if the permit, or consent, is for one thing, and you go on in the midst of an operation and do something further?

DR. BALL: I will defer to one of the attorneys for expert legal advice on this, but I believe we still have the obligation, in spite of recent emphasis on informed consent, to do what we think is best for the patient under the circumstances.

MR. WILLETT: Well, there is a lot of difference, for example, between a muscle splinting operation and a radical esophagectomy, and I think the patient is not consenting to unknown surgical problems. You cannot extend your operation to include undiscovered diseases unless you create your own emergency at the time of surgery. Where it involves the same organ, and is a mistake in diagnosis, then I think the surgeon has some latitude in proceeding with the proper operation, and ought to do so without stopping and waking the patient to get his consent. Obviously, this does not extend to simple or radical mastectomy after a breast biopsy, or a total hysterectomy after a D & C shows carcinoma, if the patient has not consented. The proper place to think about this is beforehand, not afterwards.

What about the general problem of psychiatric patients, and whether or not they are competent? And what about aggravating the worry and emotional state of patients by giving detailed analyses to obtain informed consent?

their present legal education programs. *2*) The university and community hospitals approved for internships and residencies will be asked to add to their teaching programs a practical course relating to legal liability. *3*) Medical-legal education programs will be offered at the ACS Spring Meeting and at College chapter meetings.

Is there any insurance available to protect the physician from the $5,000 liability for each patient's hospital bill in cases where it is determined that admission was not justified?

MR. WILLETT: The group program in northern California is looking into it, but there is no need for it yet, because PSRO hasn't geared up. One might argue, but probably not too successfully, that it is covered under many existing policies.

What about no-fault insurance? Would it be of any value in instances where neither the patient nor the physician was responsible and negligence was not a factor, yet redress was desirable?

DR. BALL: The California Medical Association undertook a rather exhaustive study of no fault, but the conclusions thus far have been inconclusive. Perhaps the ultimate answer may be found somewhere as a blend between no fault and some arbitration plan, or even some workmen's compensation type of schedule where a certain type of injury is worth so much. Of course, you will still have to decide whether the injury was the fault of medical care or whether it was just an unfortunate outcome and would have happened anyway.

DR. HANLON: The analogy between no fault auto insurance and no fault professional liability insurance limps because the latter is not considered a serious problem by the general public. There is hardly a person in this room or elsewhere who has not been directly or indirectly involved in a "fender-bender", but there are not many lay persons who can rise instantly with any personal experience when you talk about protecting a doctor or protecting a patient. In the opinion of insurance people, who know where business is, this is not a problem that concerns everyone in the country and attempting to legislate as for automobile no-fault will not hold up. Also, automobile insurance business is currently in the neighborhood of $34 billion worth of premium money, while malpractice premiums now total about a few hundred million, still small potatoes.

Is the chief of surgical service responsible or liable for actions of other surgeons on the service?

MR. WILLETT: He is not liable as the master for the other surgeons because he is not their master. But this is an area of liability which I am sure we are going to have to explore further. He has to be doing his job as the chief, whatever it is the chief is supposed to be doing in overseeing care on the service. He had better be doing it because if it is shown that he has taken the title and not done the job, that's a separate neglect and may be actionable. He may be liable to patients who are injured if it can be shown that the surgeon who caused injury would have been restricted had there been adequate supervision.

DR. NICK: There are cases in which not only the attending physician but the chief of the service have been held responsible under the master-servant rule for the negligent acts of residents and interns.

Where will the average practitioner find available of the various percentages regarding chance of complications of a given procedure? Is there such a thing as a ready risk guide to chances of trouble?

MR. WILLETT: I'm not sure you want that. If you get all kinds of numbers and if your numbers are not the other surgeon's numbers, you may end up having to explain the discrepancy. You may do better using terms such as very seldom, once in a while, and the like. While these terms are indefinite, so are the court decisions. As long as you give a fair idea of what to expect, you may be better off than by using numbers.

What will protect members of the doctor's committees from suit if they accuse someone of malpractice? And what will be the effect of national health insurance on professional liability, insurance rates, and malpractice awards?

MR. WILLETT: Members of the Professional Standards Review Committee are protected from suit by the statute itself. As to what lies ahead, heaven knows. There was a proposal in the original Kennedy bill which would provide malpractice insurance to physicians,

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but the hooker was you only had that insurance as long as your performance was satisfactory to the administrating agency. If they didn't like what you were doing, you lost your insurance. Certainly, national health insurance is going to have some impact, simply because here again will be opportunity at least for interference with the physician-patient relationship, and more opportunity to challenge the judgment or action of the physician. But beyond that is sheer speculation.

Would you comment further on the question of the graduated contingency fee?

DR. BALL: I don't quite know how New Jersey passed this, but it is a graduated fee schedule such that over a certain, fairly high award to the plaintiff, the attorneys are permitted to take only a much lower amount than they are in many other states where they may take as much as one-third or one-half. All I can say is that every time our state medical society meets, the first thing it wants is for us to have the state legislature abolish contingency fees. As I am sure you all know, most legislators are attorneys, and they are not about to do this.

MR. WILLET: There is no question but that the contingency fee is one of the most irritating factors of the malpractice situation as far as doctors are concerned, but it may not be as big a factor in the scheme of things as some of the other things. I think eventually the courts will accept some limitations, even in states such as California.

In what percentage of malpractice actions were Fellows of the College involved?

DR. NICK: We really can give no estimate. In our 1971 survey, we had over 15,000 responses documenting 7,000 claims or trials, ranging from a low of 23 percent in the southeastern United States to a high of 70 percent in California. This represents a ten-year span of time. However, since we queried only Fellows of the College, we have no way of determining whether they do better or worse than the generality of surgeons and physicians, which I assume is implied in that question.

DR. BALL: At least in our part of the country, it has been shown that the specialist, or the surgeon who is the most competent, is as likely to be sued as is the less competent practitioner. Surgeons who take on horrendous cases are most often the best surgeons in the area, and I believe statistics I have seen show that they actually are sued more, and at higher rates, than some of the people who stick to the more common and less complicated cases. I would assume that the former surgeons in many cases are Fellows of the College. Therefore, one could say, based on this reasoning, that Fellows would be more involved in claims than other physicians.

MR. WILLETT: I agree with Doctor Ball. Also, I think that the surgeon who is not competent quite often can point to the fact that he has never been sued. When he is brought before the medical society quite often on charges, his principal defense, whether or not it is related to the charge, is that his patients have never sued him. The PSRO may uncover this person, or it may not.

DR. HANLON: It is a sad fact that there is a negative correlation between competence and the likelihood of being sued, mainly for reasons that have been brought out. The comment of the plaintiff's lawyers that what they are doing is suing to raise the standard of care and smoke out the incompetents falls of its own weight, since a large number of the suits are leveled against practitioners of the highest quality.

If lay people are on boards of directors of PSROs they are, in fact, practicing medicine. Should they have this duty without a license?

MR. WILLETT: The PSRO law says that the PSRO medical review must be performed exclusively by physicians. Also, for the next two years, PSROs can be comprised only of physicians. Consumerism is not presently an element of the PSRO law.

As additional governmental involvement in medicine occurs, and especially if, or when, national health insurance occurs, what is likely to happen to the confidentiality of medical records?

MR. WILLETT: This is, and has been, a great concern of medicine, and I think medicine is properly being given some of the credit for its efforts to protect confidentiality of medical records. However, once information is put into some large computer or data bank, there is no assurance that this information will remain confidential. But I don't think things are as bleak in this department as in some others.

DR. NICK: The physician has a therapeutic privilege to withhold an explanation of risks where he thinks it will unduly disturb the patient, and he documents this. This may lead to the situation where a consultant is brought in for the patient solely for the purpose of verifying the consent. This is also true for the psychiatric patient, although there is a difference between a patient who has been declared incompetent or insane, versus a person who, on his medical record, may indicate some history of nervous or mental disease that is poorly elucidated or is undocumented. These latter patients may give their valid consent unless they are fully declared insane or incompetent, and I think this is where the use of a consultant comes in very handy. If one documents on the progress notes what the state of mind of the patient is, what the urgency of the situation is, and what the physician did about it, and then proceeds to provide the appropriate therapy, I think that is all that is necessary. If one documents the basis for his therapy he should not lose a court case in the circumstances mentioned.

If you tape record the explanation of risks, will it hold up in court? Do you need a witness regarding your discussions?

DR. NICK: Video tapes or cassettes are helpful for demonstrating evidence to document what the physician did tell the patient if they are properly introduced at the time of the trial. I think they can be helpful in the states where you have to go a long way in explaining, such as the District of Columbia and Rhode Island. I believe Mr. Willett answered the second question earlier when he stated that most juries, as does the general population according to recent polls, tend to believe physicians are telling the truth.

Can definitive treatment be given to a minor in the emergency room, in the absence of parents or a responsible person; not just first aid, but definitive care?

DR. NICK: I think the answer is yes. You have an emergency situation, and have the right to go ahead and treat. In some states, Louisiana for instance, the minor has been deemed to have given consent to open fracture therapy as young as the age of seven in the absence of parental consent.

DR. STINCHFIELD: I think you run the risk of a suit if you do anything more, or less. Do the reduction, do a debridement, and immobilize it, and I don't think you would be criticized in any way if the parents were not there. A lot of internal fixation, however, may be on the other side of the fence.

What recourse is there if the patient conceals information intentionally, during the history for example? Does he invalidate his claim for malpractice because deceit has been practiced by his withholding information?

MR. WILLETT: The patient never invalidates his claim for negligence. However, if he conceals facts which would induce the physician to offer a different form of therapy he may invalidate his consent.

In cases where a resident is going to perform the operation, who would be responsible for obtaining informed consent?

DR. NICK: I think it is clear that when the resident operates, the patient has to know about it. In cases where the resident delivers care in excess of that anticipated by the patient, we have a fundamental problem which may produce a lawsuit because it does indeed lack the consent of the patient. Generally, it is the responsibility of the attending surgeon with participation by the resident.

Will it be feasible and advisable to have a universal state-wide surgical consent form approved by the state medical society and the state bar that you can hand out to every one?

MR. WILLETT: No. There has been a piece of "boiler plate" terminology in every hospital for years, a standard operative consent form in the hospital chart that has been proved useless if we are talking about informed consent. In California, when Cobbs vs. Grant was announced, we tried setting up a committee on informed consent, and spent an awful lot of time and money on the venture before coming to a conclusion which, in retrospect, was probably an inevitable one: that this is the wrong way to go. First of all, there was no way that this committee, in its corporate wisdom, could do what the physician has to do in considering the circumstances of the individual patient and the individual case, and we could not provide him with what he needed in every case. Secondly, by promulgating a committee standard form we were

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promulgating a standard and if the physician deviated, he was going to have to explain himself. We have also seen efforts by hospitals to impose a standard form, which every surgeon has to furnish to the hospital signed by the patient before the patient is admitted. And the same vices are present there.

Is there any difference in the type of liability insurance an incorporated or an unincorporated physician should carry? Also, if the surgeon is incorporated, then drops his malpractice insurance, is the corporation (or the surgeon) liable in a lost case?

MR. WILLETT: Simply by incorporating or forming a professional group, one does not relieve himself of his liability for negligent acts. You cannot hide behind a corporate veil and get immunity from suit. As to the type of liability insurance, the corporation is an additional entity, and should have its own insurance. This is most often determined under state law.

Why was the recently highly publicized case in California, where a physician is alleged to have performed incorrect and unnecessary surgery for several years, not picked up sooner by the medical community, and what can we do in our community to prevent this?

MR. WILLETT: The reference is, of course, to the Nork cases, and I don't know that it is useful to discuss the facts of those cases here because the facts are still very much in dispute. I think it is useful to say that the Nork cases have sparked a greater insistence on self regulation. There may be more suits against medical staffs for failure to police themselves, and there are going to be efforts at legislation which will require more self discipline. I also think that, because of the Nork and similar cases, legislation will be introduced in California that will permit free communication of information between medical societies, medical staffs, and medical schools. There will be no liability for anything you say in furnishing information for the purpose of evaluating professional competency unless you knowingly misrepresent the facts. This may seem like a small thing to ask for, but we couldn't get it in previous years. As a result of the presumed liability in the past, one medical staff was reluctant to write a letter to another for fear the person they were writing about might sue them.

What about my rights in blatant incidences of harassment, why can I not take a lawyer or his client to court for violating my civil rights?

MR. WILLETT: Nuisance suits are problems. They increase the defense costs, they are highly irritating to physicians, and they waste a lot of time. A law requiring posting of bond when punitive damages were sought was actually passed in California, but the Court of Appeals threw it out. Nuisance suits, however, are a less important problem than some of the other issues we have to face. After all, we do win (a vast majority of) the nuisance suits; but this is not to suggest that we should not try to curb them.

What efforts, if any, are being made by bar associations to control activities of plaintiff lawyers in seeking cases for suit?

MR. WILLETT: The bar associations are not doing much. Negotiations between the American Medical Association and the American Bar Association are continuing, in hopes of finding a new system, but so far nothing has developed.

I'd like to digress for a moment and mention that I believe you are making a mistake in attacking the lawyers when you discuss malpractice. I think you would make more mileage when you discuss the impact of malpractice suites on your patients and on the public, including the cost of care and your ability to care for your patients. You will have to mention lawyers once in a while, but if you set them up and make the lawyers the problem, you really are misleading the people you are trying to convince.

What about educating the medical profession?

DR. HANLON: Dr. Franklin L. Shively, Jr. answered this question to some extent in his report of the Governors' Committee on Professional Liability in the March 1974 issue of the Bulletin, since one of the committee's major activities has to do with education of the profession and the public. As detailed in Dr. Shively's report, a three-part malpractice education program will be primarily directed to medical students, interns and residents, and medical graduates. This proposed program is expected to reduce the malpractice insurance premium as well as minimize malpractice suits. In summary: *1*) Medical schools will be encouraged to establish medical jurisprudence activity if none is already in existence, or they will be asked to up-date

The law of informed consent

An analysis of the law of informed consent prepared by the Medical Liability Commission as it varies from state to state and as it has been applied to varying factual situations*

An analysis of the court decisions indicates significant differences among the requirements of the various states. This index sets forth the general categories of requirements of the various states, indicating the legally required scope of disclosure that physicians must take. The decisions are tabulated under these categories.

The decisions are also tabulated on the basis of the medical or surgical procedure involved, out of which the issue of informed consent arose. They are likewise tabulated on the basis of the fact or risk involved about which it was alleged that there was no advance disclosure or an inadequate disclosure. In a few decisions, the degree of risk, in terms of percentages or ratios, is disclosed. These are also tabulated separately.

The interpretation and application of the doctrine of informed consent varies so much from one jurisdiction to another and are changing so rapidly that attorneys advising physicians locally should base their advice on the existing law and discernible trends as they appear in the particular jurisdiction. Of primary concern, of course, will be appellate decisions in their own jurisdictions. Decisions from other jurisdictions, however, may be of lesser but still important concern. The citations listed include all reported appellate court decisions in which the question of informed consent was discussed up to July 31, 1973.

The absence of an appellate court decision in a particular state on the issue of informed consent should not be considered as assurance that the doctrine has not been applied in that state at the trial court level. It is not possible to predict whether or when the doctrine of informed consent may be applied in these states: (as of July 31, 1973) Alabama, Arkansas, Connecticut, Idaho, Indiana, Kentucky, Maine, Nebraska, Nevada, New Hampshire, North Dakota, Puerto Rico, South Carolina, Utah, Vermont, Virginia, Virgin Islands, and West Virginia. There have been reported federal trial court decisions in Alabama, Idaho, and Virginia, which are included in the tabulations.

Supported, in part, by the American College of Surgeons. Compiled by Joseph E. Simonaitis, Legal Research Department, American Medical Association, February 1974

Informed consent decisions tabulated by applicable legal rules

1. A physician must disclose that which a reasonable medical practitioner would have disclosed under like or similar circumstances.
   - ARIZONA—*Shetter v. Rochelle*, 409 P.2d 74 (1965)
   - COLORADO—*Stauffer v. Karabin*, 492 P.2d 862 (1971)
   - DELAWARE—*DiFilippo v. Preston*, 173 A.2d 333 (1961)
   - FLORIDA—*Ditlow v. Kaplan*, 181 So.2d 226 (1966)
   - HAWAII—*Nishi v. Hartwell*, 473 P.2d 116 (1970)
   - ILLINOIS—*Green v. Hussey*, 262 N.E.2d 156 (1970)
   - IOWA—*Grossjean v. Spencer*, 140 N.W.2d 139 (1966)
   - KANSAS—*Tatro v. Lueken*, 512 P.2d 529 (1973)
   - LOUISIANA—*George v. Travelers Insurance Company*, 215 F.Supp. 340 (1963)
   - MASSACHUSETTS—*Haggerty v. McCarthy*, 181 N.E. 2d 562 (1962)
   - MICHIGAN—*Roberts v. Young*, 119 N.W.2d 627 (1963)
   - MISSISSIPPI—*Ross v. Hodges*, 234 So.2d 905 (1970)
   - MISSOURI—*Aiken v. Clary*, 396 S.W.2d 668 (1965)
   - MONTANA—*Negaard v. Estate of Feda*, 446 P.2d 436 (1968)
   - NEW JERSEY—*Kaplan v. Haines*, 232 A.2d 840 (1967)
   - NEW YORK—*Petterson v. Lynch*, 299 N.Y.S.2d 244 (1969)
   - TEXAS—*Wilson v. Scott*, 412 S.W.2d 299 (1967)
   - VIRGINIA—*Dietze v. King*, 184 F.Supp. 944 (1960)
   - WASHINGTON—*ZeBarth v. Swedish Hospital Medical Center*, 499 P.2d 1 (1972)
   - WYOMING—*Govin v. Hunter*, 374 P.2d 421 (1962)
2. Because a full disclosure may have a very detrimental effect on some patients, physicians may tailor the extent of their disclosure to patients.
   - ALABAMA—*Roberts v. Wood*, 206 F.Supp. 579 (1962)
   - ALASKA—*Patrick v. Sedwick*, 391 P.2d 453 (1964)
   - CALIFORNIA—*Cobbs v. Grant*, 502 P.2d 1 (1972)
   - DISTRICT OF COLUMBIA—*Canterbury v. Spence*, 464 F.2d 772 (1972)
   - HAWAII—*Nishi v. Hartwell*, 473 P.2d 116 (1970)
   - IOWA—*Grossjean v. Spencer*, 140 N.W.2d 139 (1966)
   - KANSAS—*Tatro v. Lueken*, 512 P.2d 529 (1973)

RHODE ISLAND—*Wilkinson v. Vesey*, 295 A.2d 676 (1972)
TENNESSEE—*Ball v. Mallinkrodt Chemical Works*, 381 S.W.2d 563 (1964)

3. A physician has an obligation to make a reasonable explanation and disclosure to his patient.
IOWA—*Grossjean v. Spencer*, 140 N.W.2d 139 (1966)
KANSAS—*Collins v. Meeker*, 424 P.2d 488 (1967)
NEW YORK—*DiRosse v. Wein*, 261 N.Y.S.2d 623 (1965)
NORTH CAROLINA—*Watson v. Clutts*, 136 S.E.2d 617 (1964)
TEXAS—*Wilson v. Scott*, 412 S.W.2d 299 (1967)
VIRGINIA—*Dietze v. King*, 184 F.Supp. 944 (1960)

4. A physician must warn his patient of any substantial risk incident to the procedure or treatment.
CALIFORNIA—*Cobbs v. Grant*, 502 P.2d 1 (1972)
COLORADO—*Mallett v. Pirkey*, 466 P.2d 466 (1970)
DISTRICT OF COLUMBIA—*Canterbury v. Spence*, 464 F.2d 772 (1972)
IDAHO—*Riedinger v. Colburn*, 361 F.Supp. 1073 (1973)
NORTH CAROLINA—*Starnes v. Taylor*, 158 S.E.2d 339 (1968)
RHODE ISLAND—*Wilkinson v. Vesey*, 295 A.2d 676 (1972)
WASHINGTON—*ZeBarth v. Swedish Hospital Medical Center*, 499 P.2d 1 (1972)

5. In certain circumstances, a physician has a duty to reveal any serious risks.
MISSISSIPPI—*Ross v. Hodges*, 234 So.2d 905 (1970)
TENNESSEE—*Ball v. Mallinkrodt Chemical Works*, 381 S.W.2d 563 (1964)
WYOMING—*Govin v. Hunter*, 374 P.2d 421 (1962)

6. A physician must disclose all relevant material facts and expert medical testimony is unnecessary to establish the required standard of disclosure.
CALIFORNIA—*Cobbs v. Grant*, 502 P.2d 1 (1972)
DISTRICT OF COLUMBIA—*Canterbury v. Spence*, 464 F.2d 772 (1972)
NEW YORK—*Fogal v. Genesee Hospital*, 344 N.Y.S. 2d 552 (1973)
PENNSYLVANIA—*Cooper v. Roberts*, 286 A.2d 647 (1971)
RHODE ISLAND—*Wilkinson v. Vesey*, 295 A.2d 676 (1972)
WASHINGTON—*Hunter v. Brown*, 484 P.2d 1162 (1971)
WISCONSIN—*Trogun v. Fruchtman*, 207 N.W. 2d 297 (1973)

7. Expert medical testimony is required to establish one or more of the elements necessary to support the claim.
COLORADO—*Stauffer v. Karabin*, 492 P.2d 862 (1971)
DISTRICT OF COLUMBIA—*Canterbury v. Spence*, 464 F.2d 772 (1972)
FLORIDA—*Ditlow v. Kaplan*, 181 So.2d 226 (1966)
ILLINOIS—*Green v. Hussey*, 262 N.E.2d 156 (1970)
IOWA—*Grossjean v. Spencer*, 140 N.W.2d 139 (1966)
KANSAS—*Collins v. Meeker*, 424 P.2d 488 (1967)
LOUISIANA—*George v. Travelers Insurance Co.*, 215 F.Supp. 340 (1963)
MASSACHUSETTS—*Haggerty v. McCarthy*, 181 N.E. 2d 562 (1962)
MICHIGAN—*Miles v. VanGelder*, 137 N.W.2d 292 (1962)
MISSOURI—*Aiken v. Clary*, 396 S.W.2d 668 (1965)
NEW YORK—*Petterson v. Lynch*, 299 N.Y.S.2d 244 (1969)
OREGON—*Getchell v. Mansfield*, 489 P.2d 953 (1971)
RHODE ISLAND—*Wilkinson v. Vesey*, 295 A.2d 676 (1972)
TEXAS—*Anderson v. Hooker*, 420 S.W.2d 235 (1967)
WASHINGTON—*ZeBarth v. Swedish Hospital Medical Center*, 499 P.2d 1 (1972)
WYOMING—*Stundon v. Stadnick*, 469 P.2d 16 (1970)

8. Expert medical testimony is not necessary to establish the required standard of disclosure.
CALIFORNIA—*Cobbs v. Grant*, 502 P.2d 1 (1972)
DISTRICT OF COLUMBIA—*Canterbury v. Spence*, 464 F.2d 772 (1972)
PENNSYLVANIA—*Cooper v. Roberts*, 286 A.2d 647 (1971)
RHODE ISLAND—*Wilkinson v. Vesey*, 295 A.2d 676 (1972)
WISCONSIN—*Trogun v. Fruchtman*, 207 N.W.2d 297 (1973)

9. No expert testimony is required if the necessity of disclosure is so obvious that it can be recognized by laymen.
WASHINGTON—*Hunter v. Brown*, 502 P.2d 1194 (1972)

10. Where expert testimony has established that a risk is material, that alternatives are feasible, and that disclosure of the risk will not be detrimental to the patient, expert testimony is not required to establish a duty to disclose such risks.
OREGON—*Getchell v. Mansfield*, 489 P.2d 953 (1971)

11. A physician must make a full disclosure of the known dangers inherent in the treatment or procedure.
NEW JERSEY—*Lopez v. Swyer*, 279 A.2d 116 (1971)
SOUTH DAKOTA—*Block v. McVay*, 126 N.W.2d 808 (1964)

12. A physician does not owe a duty of disclosure to the patient's spouse or other member of the patient's family.
HAWAII—*Nishi v. Hartwell*, 473 P.2d 116 (1970)

13. No disclosure need be made if the patient requests that he not be informed.
CALIFORNIA—*Cobbs v. Grant*, 502 P.2d 1 (1972)

14. A physician has no duty to inform a patient of the hazards of an improper performance of a procedure.
COLORADO—*Mallett v. Perkey*, 466 P.2d 466 (1970)
GEORGIA—*Mull v. Emory University*, 150 S.E.2d 27 (1966)

15. If a procedure is novel and unorthodox, a physician must so inform his patient.
NEW YORK—*Fiorentino v. Wenger*, 272 N.Y.S.2d 557 (1966)

16. The jury must determine what a prudent person in the patient's position would have decided if adequately informed.
CALIFORNIA—*Cobbs v. Grant*, 502 P.2d 1 (1972)
DISTRICT OF COLUMBIA—*Canterbury v. Spence*, 464 F.2d 772 (1972)
NEW YORK—*Fogal v. Genesee Hospital*, 344 N.Y.S.2d 552 (1973)
PENNSYLVANIA—*Cooper v. Roberts*, 286 A.2d 647 (1971)

17. In a complicated procedure which inherently involves a known risk of death or serious bodily harm, a physician must disclose these risks.
CALIFORNIA—*Cobbs v. Grant*, 502 P.2d 1 (1972)

18. Other reported decisions which merely reiterate the rules indicated above, which have been superseded by the above decisions, or which involve other aspects of the doctrine of informed consent.

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CALIFORNIA
Carmichael v. Reitz, 95 Cal.Rptr. 385 (1971)
Rainer v. Buena Community Memorial Hospital, 95 Cal.Rptr. 901 (1971)
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Tangora v. Matanky, 42 Cal.Rptr. 348 (1964)
Salgo v. Leland Stanford, Jr. University Board of Trustees, 317 P.2d 170 (1957)

DELAWARE
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Fischer v. Wilmington General Hospital, 149 A.2d 749 (1959)

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FLORIDA
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Visingarde v. Tirone, 178 So.2d 135 (1965)
Russell v. Harwick, 166 So.2d 904 (1964)
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GEORGIA
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Yeats v. Harms, 393 P.2d 982 (1964)
Williams v. Menehan, 379 P.2d 292 (1963)
Natanson v. Kline, 354 P.2d 670 (1960)

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Zachary v. St. Paul Fire & Marine Insurance Company, 249 So.2d 273 (1971)
Carroll v. Chapman, 139 So.2d 61 (1962)
Lester v. Aetna Casualty & Surety Company, 240 F.2d 676 (1957)
Hall v. United States, 136 F.Supp. 187 (1955)

MARYLAND
Kruszewski v. Holz, 290 A.2d 534 (1972)

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MINNESOTA
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Bang v. Charles T. Miller Hospital, 88 N.W.2d 186 (1958)

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Woods v. Brumlop, 377 P.2d 520 (1962)

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Darrah v. Kite, 301 N.Y.S.2d 286 (1969)
Stewart v. Long Island College Hospital, 296 N.Y.S.2d 41 (1968)
McDermott v. Manhattan Eye, Ear & Throat Hospital, 228 N.Y.S.2d 143 (1962)
Ferrara v. Galluchio, 152 N.E.2d 249 (1958)

NORTH CAROLINA
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Sharpe v. Pugh, 155 S.E.2d 108 (1967)
Hunt v. Bradshaw, 88 S.E.2d 762 (1955)

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Belcher v. Carter, 234 N.E.2d 311 (1967)

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Gray v. Grunnagle, 223 A.2d 663 (1966)

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Weiser v. Hampton, 445 S.W.2d 224 (1969)
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Gravis v. Physicians & Surgeons Hospital of Alice, 415 S.W.2d 674 (1967)
Bell v. Umstattd, 401 S.W.2d 306 (1966)

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Watkins v. Parpala, 469 P.2d 974 (1970)
Woods v. Pommerang, 271 P.2d 705 (1954)

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1. ANESTHESIA, SPINAL
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2. AORTOGRAPHY
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3. APPENDECTOMY
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4. ARTERIOGRAM
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5. BSP TEST
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6. CAESAREAN
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7. CALLUS, REMOVAL OF
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8. CARDIAC CATHETERIZATION
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9. CATARACT SURGERY
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11. CERVICAL FUSION
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12. COLECTOMY AND ILEOSTOMY
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13. CONDYLECTOMY
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14. CORNEAL TRANSPLANT
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15. CRANIOSTENOSIS
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16. CYST, REMOVAL OF
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17. DERMABRASION
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18. DISC, REMOVAL OF
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19. DRUG THERAPY
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20. ECTOPIC PREGNANCY, MANAGEMENT OF
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21. ENDOTRACHEAL INTUBATION
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22. ESOPHAGOSCOPY
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23. EXPLORATORY SURGERY
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24. EYELID, SURGERY ON A DROOPING EYELID
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25. FISTULA, REPAIR OF
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26. FISTULECTOMY
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27. FOREIGN BODY, REMOVAL OF
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28. FRACTURE, REDUCTION OF
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29. GASTROSCOPIC EXAMINATION
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30. GENITAL-URINARY SURGERY
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31. GOLD INJECTIONS
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32. HERNIA, REPAIR OF
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33. HIP SURGERY
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34. HYPOSPADIA, SURGERY FOR
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35. HYPOTHERMIA
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36. HYSTERECTOMY
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38. LAMINECTOMY
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39. LAMINECTOMY AND SPINAL FUSION
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40. MASTECTOMY
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42. MYELOGRAM
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43. NEUROFIBROMA, REMOVAL OF
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44. NOVEL PROCEDURE
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45. PREGNANCY, MANAGEMENT OF
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47. RADIATION THERAPY
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49. SHOCK THERAPY
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51. SKIN GRAFT
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52. SPINAL FUSION
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53. STAPEDECTOMY WITH A VEIN GRAFT
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54. THYROIDECTOMY
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55. TONSILLECTOMY AND ADENOIDECTOMY
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56. TOOTH EXTRACTION
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57. TRANSFUSION
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58. TUMOR SURGERY
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59. ULCER SURGERY
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60. UNIDENTIFIED PROCEDURE
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61. VARICOSE VEIN STRIPPING
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62. VENTRICULOGRAM
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2. ANESTHETIC, TYPE USED
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3. APLASTIC ANEMIA
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5. BIRTH DEFECTS
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7. BLOOD CLOT
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8. BLOOD VESSEL DAMAGE
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9. BONE, REMOVAL OF PORTION OF
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10. BRAIN DAMAGE
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12. CARDIAC ARREST
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16. CRANIAL NERVE DAMAGE
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Gray v. Grunnagle, 223 A.2d 663 (Pa. 1966)
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Starnes v. Taylor, 158 S.E.2d 339 (N.C. 1968)

The new decisions

Continued from page 14

occasionally be necessary is the use of consultation just to clarify the issue of consent.

Courts will recognize that it is difficult to construct and articulate consent rules that require equal disclosure of all risks to all patients. Their continuing impact in physician-patient relationships may be modified by further social engineering such as legislative change of informed consent rules, as in Georgia.[14] If the practical consequence is to stimulate litigation in patients with serious disability where there is no substantial evidence of negligence, these rules may encourage physicians to simplify the legal aspects of their practice by the use of arbitration.

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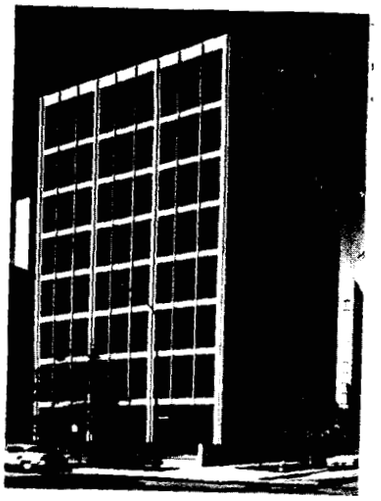
A review . . .

The 2nd annual Spring Meeting

(See related article, page 34)

Photos this page, counter-clockwise, beginning upper right

GEORGE L. JORDAN, JR., MD, FACS, general chairman of the planning committee for the 1974 Spring Meeting during opening ceremonies . . . **ROBERT C. HICKEY,** MD, FACS, chairman of the ACS Board of Governors, chaired the postgraduate course with the longest title: No. 3—Cancer: Surgical Oncology Interscience Symposium with special workshops for Gynecologic; Urologic; Head and Neck; and General, Skeletal, and Thoracic Cancers . . . **SOMETHING NEW** in the industrial exhibit area catches quite a few eyes and ears . . . **SOON AFTER** this picture was taken just a few moments before registration opened, the information and message center pictured in the foreground became a popular place . . . **WORKMEN** hurry to put finishing touches to the industrial exhibit area prior to its opening.



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is sent to you
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ANDREW PATRICK McEWEN FORREST, MD, FRCS(Edin,Eng), leaves the podium after finishing his lecture on "Breast Cancer: Surgery and Curability". William V. Muller, Jr., MD, FACS, leads the applause.

PROFESSIONAL LIABILITY—WHAT'S NEW? was the topic discussed at a well attended Fellowship Breakfast. Panelists, seated left to right: Dexter T. Ball, MD, FACS, chairman of the ACS Board of Governors' Committee on Professional Liability; William V. Nick, JD, MD, FACS, editor of *Legal Medicine Press* of Columbus, Ohio; and David E. Willett, San Francisco attorney. Robert C. Hickey, MD, FACS, chairman of the Board of Governors and Frank E. Stinchfield, MD, FACS, chairman of the Board of Regents also participated. C. Rollins Hanlon, MD, FACS, ACS director, at podium, moderated.

JOHN K. LATTIMER, MD, FACS, (above) lectured on "Prostatic Cancer: A Major Widow-maker".

LEWIS THOMAS, MD, president of the Memorial Sloan-Kettering Cancer Center, (below) spoke on "The Future Impact of Science and Technology on Medicine".

WORLD SERVICE LIFE Insurance Company, the new administrator for the FACS group insurance program (above) set up shop in the exhibit area to explain the program and to answer questions. **MEET THE PRESS** (below): several of the score of scientific writers and reporters who covered the Spring Meeting meet informally with one of the participants, in this instance lecturer John K. Lattimer, to explore his subject in more detail to aid in their interpretations.

Surgical colleges . . .

continued from page 4

secretary, replacing Mr. R. S. Johnson-Gilbert. Also at the January council meeting, Dr. William P. Longmire, Jr., of Los Angeles, was elected honorary treasurer.

A report was received on a meeting with the major national surgical specialty bodies, during which it was explained that the IFSC recognizes the essential role of surgical societies in scientific development in their disciplines, and does not wish to interfere with their sovereignty. Hope was expressed that the various national societies might embrace all surgical specialties. Representatives of the societies recognized the need for multidisciplinary teamwork and for identification of a common core of surgical training. It was agreed that these discussions should continue, and that a working party should prepare a memorandum for the IFSC biennial meeting in 1975.

The meeting received the final report of the working party on research, and the IFSC expressed its hope that the work might continue under the World Health Organization.

The IFSC also received a report of a March 1973 meeting of the European Economic Community (EEC) to explore ways in which surgical qualifications and training might be brought into harmony in the new alignment. The IFSC had offered to help clarify the provisions for free movement of labor, and reciprocal recognition of degrees in the EEC countries. After extensive discussion of the stipulations in the Treaty of Rome, and the circumstances in the countries involved, it was agreed that while registration and accreditation is technically a state responsibility, it actually lies with those who have trained the specialists.

In all EEC countries, minimal periods of specialty training, after six years of undergraduate education, are as follows: *five years*—general surgery, neurological surgery, urology, orthopaedic surgery, plastic surgery, thoracic surgery, and vascular surgery; *four years*—gastroenterology; *three years*—ophthalmology, stomatology, and anesthesiology. Not all specialties are recognized in all countries.

In discussion of the course of medical education leading to basic qualification, it was evident that there is no standard pattern currently, except that it is of six years' duration. The exchange of external examiners was urged to insure maintenance of standards. It is now necessary for each EEC country to accept basic qualifications of persons trained in other countries on good faith, with full harmonization of curricula and qualifications to be accomplished later.

Exploration of specialty training after basic qualification (MB, BCh, or MD) revealed much similarity in form, but differences as to duration of basic surgical education or internship (six months to two years), and as to method of selection of trainees. Some countries choose early after basic qualification, while others allow many to continue training until the very end, with resultant fully-trained persons who cannot be placed as specialists.

It was generally agreed that a period of adaptation would be desirable for any migrant surgeon, but that this could only be voluntary in the present situation.

Delegates from Holland urged collaboration of surgeons and surgical organizations with the offices of the EEC in Brussels, and suggested that a European College of Surgeons should be considered.

The IFSC was urged to begin active promulgation and publication of standards of ideal surgical training, based on information it has been accumulating, to the end that there might be a greater degree of worldwide reciprocal recognition of standards.

Four chosen for Honorary FACS

Four widely recognized surgeons from four nations, South Africa, England, Australia, and Japan, will have Honorary Fellowship in the American College of Surgeons bestowed on them during the 60th annual Clinical Congress in October.

The four are: Professor D. J. Du Plessis, FRCS (Eng), Department of Surgery, University of the Witwatersrand Medical School, *Johannesburg;* Professor J. C. Goligher, FRCS (Eng, Edin), University Department of Surgery, The General Infirmary, *Leeds, England;* Sir Benjamin K. Rank, FRCS (Eng), FRACS, FACS, *Melbourne, Australia;* and Professor Shigeru Sakakibara, MD, Tokyo Women's Medical College, *Tokyo.*

Committee on Trauma names state chairmen

Two new chairmen to head regional committees of the ACS Committee on Trauma have been appointed recently.

Walter F. Pizzi, MD, FACS, New York City, was appointed chairman of the New York—Brooklyn committee, one of COT's six regional committees with state committee status, in February.

The Oklahoma committee's new chairman, by a March appointment, is Gerald W. McCullough, of Norman.

The ACS Board of Regents appointed C. Thomas Thompson, MD, FACS, Boston, to chair the COT's subcommittee on regional committees.

Young surgeons . . .

continued from page 4

Surgical Care and PSROs; The Role of the Chapter in College Activities and the Community; Compensation for the Delivery of Surgical Care; Continuing Education and Recertification; and Production and Distribution of Surgeons in the United States.

Chapter meetings

Western New York Wanakah	May 9
Indiana Evansville	May 9–10
Illinois Springfield	May 10–11
Florida Hollywood	May 11
Northern California San Francisco	May 11
Upstate New York Geneva	May 15–16
North Carolina Chapel Hill	May 16–18
Minnesota Duluth	May 17
New Mexico—El Paso El Paso, Tex.	May 17–18
Rhode Island Bermuda	May 17–18
North Texas Dallas	May 18
Alabama Point Clear	May 23–25
Ohio Akron	May 24–25
San Diego San Diego	June 1–2
Brooklyn and Long Island Jamaica, N.Y.	June 10
Arkansas Heber Springs	June 13–15
Missouri Branson	June 14–15
Washington Harrison, B.C.	June 21–23
Montana-Wyoming Big Sky	August 8–10
Oregon Sun River	September 6–7
Maryland Ocean City	September 14
South Carolina Spartanburg	October 4–5
Eastern Pennsylvania Bethlehem	November 13
Louisiana New Orleans	November 17
Idaho Boise	December 7
Massachusetts Newton	December 7
Manitoba Winnipeg	December 7
New Jersey Morristown	December 7

SESAP draws . . .

continued from page 3

participate in a "mini-SESAP" assessment of their surgical knowledge, and to acquaint themselves with the scope and methods of SESAP II. Under this "mini-SESAP" assessment, a Congress participant will answer a number of selected SESAP II items and receive an on-the-spot, computer-scored evaluation of his performance.

Credit hours in continuing education for participation in SESAP II are recognized by the American Medical Association and many other medical societies and by some organizations with medically related programs. For the AMA Physician's Recognition Award, 22 credit hours are allowed for the assessment, and a maximum of 22 credit hours are allowed for self-learning, (*categories 5A and 5D*). For details, contact the specific organization of your professional interest.

The success of SESAP has been credited to several of the program's key factors, Dr. Zintel pointed out.

SESAP is a personalized method of continuing education. It is a simple method to help a surgeon evaluate and improve his surgical knowledge. It suggests new information vital to his self-education.

SESAP is up to date. Truly a program of continuing education, SESAP will be revised periodically to offer the surgeon new knowledge as it becomes tested and accepted in surgical practice.

SESAP is designed to aid all surgeons. It covers that body of knowledge which should be possessed by general surgeons and specialists alike. It is available to all doctors of medicine, including residents.

SESAP is individualized. With SESAP, a surgeon can identify those areas in which he may be strong or deficient, design an educational program matching his own needs, and compare his surgical knowledge with the knowledge of his peers.

SESAP is comprehensive. It covers 750 items in all areas essential to a surgeon's practice.

SESAP is oriented toward clinical problems. It stresses patient management, x-ray interpretation, recognition of pathologic conditions, and important physiologic principles underlying the care of the surgical patient.

SESAP is thoroughly referenced. Each item is indexed in an extensive bibliography, including both standard textbooks and the current surgical literature.

SESAP is convenient. A surgeon may complete SESAP at any time, anywhere—in his office or home, while traveling, or while on vacation. Each participant sets his own learning pace.

SESAP is confidential. Only the participant will ever know his performance, and no record is kept of the participant or his performance.

Fellows and facts

Howard Balin has been named professor and chairman of the Department of Obstetrics and Gynecology at Hahnemann Medical College and Hospital of Philadelphia . . . **Lynn R. Callin** is the new president of the Medical Society of the State of New York, while **Ralph S. Emerson** is the new president-elect . . . **William H. Cooper** is the new president-elect of the Medical Society of the District of Columbia . . . **Cecil Couves** has been appointed professor and chairman, Department of Surgery, The Memorial University of Newfoundland . . . **Allan E. Dumont** has been named the first Jules Leonard Whitehill Professor of Surgery at the New York University School of Medicine . . . **Orion H. Stuteville** has been appointed chief of the Department of Plastic and Reconstructive Surgery at the Foster G. McGaw Hospital, Loyola University Medical Center, Maywood, Ill., and head of the Plastic Surgery residency program at Hines VA, St. Francis, St. Joseph's and Cook County hospitals.

Chapter news

The Second Annual Regional Teaching Day, sponsored by the Massachusetts chapter, will be held Friday, June 7, 1974, at Dunfey's Hyannis Resort and Conference Center in Hyannis, Cape Cod, Mass.

The teaching session will be a detailed study program featuring working case presentations. Emphasis will be on infection, shock, and pulmonary insufficiency. A question and answer period will follow each case analysis, and ample time will be allowed for group discussion.

For further information, contact: *Massachusetts Chapter, ACS, Six Beacon Street, Suite 620, Boston, Mass., 02108. Or telephone (617) 227-0760.*

NEW OFFICERS were elected for a one-year term during the annual meeting of the **Mexico** chapter in February. From left are: Drs. Jorge Cervantes, secretary; Marco Antonio Lazcano, president; J. Leonel Villavicencio, governor; and Carlos Walther, vice-president. Not pictured are: Jorge Caraza, pro-secretary; Raul Santos, treasurer; and Carlos Sanchez Basurto, pro-treasurer.

Nearly 100 people, many from the United States, attended the **Guadalajara Chapter** meeting in February, where papers were presented and sessions held in both general and plastic surgery. Simultaneous English translations were given during the general surgical sessions, while 90 percent of the papers on plastic surgery were presented in English.

Bermuda will host the **Rhode Island Chapter** meeting May 17 through 20, which will include five lectures and panel discussions. Among the lectures are Carcinoma of the Breast-The Value of Self Examination, given by Henry J. Robidoux, MD, FACS, and Cultural Aspects of Acupuncture in Asia, given by Michael E. Scala, MD, FACS. An awards presentation will be held and ACS President Claude E. Welch will be the honored guest speaker.

Trauma society . . .

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others, are approaching incorporation, according to the society.

The American College of Surgeons, in addition to a $5,000 contribution to help launch the society, has given the society its full endorsement, and has appointed two representatives to the society's board of directors.

The society has announced it will still accept founding memberships, upon individual contributions of $100 or more. Further information is available by contacting: *Thomas L. Gresham, executive director, American Trauma Society, 15th Street and Upland Avenue, Chester, Pa. 19013.*

ELECTIONS were also held during the annual meeting of the **Colombia** chapter in February. The new officers pictured below, with guests, are: from left, Drs. José F. Patino, councilor; Jorge Suarez, secretary; Alfredo Rebahin, councilor; John Q. Gallagher; Juan DiDomenico, president; Alfonso Latiff, governor; Joseph P. Evans, College Latin American liaison representative; Alfredo Aljure, councilor; Guillermo Umaña, vice-president; Jaime Escobar, councilor; and J. Emilio Restrepo, councilor.

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Director's memo

SPRING MEETINGS

Two recent spring meetings deserve comment. First, during mid-March we held the third meeting of young surgeons. The young surgeons movement is now in its fifth year. It is achieving a gratifying degree of stability and effectiveness as an outcome of the Regents' decision several years ago to encourage a larger role for young surgeons in College activities. The 55 young surgeons meeting in Chicago at College headquarters were selected and subsidized at the meeting by individual College chapters, to which they will return with a report of their day-long plenary sessions and workshops. Representatives are regularly enthusiastic at the opportunity to share views with their colleagues, to question the staff and officers of the College, and to learn more about the workings of the College by on-site inspection. This allows them to bring back to their chapters a fresh view of the basic issues confronting surgery today.

Following the young surgeons meeting by two weeks was the second annual Spring Meeting in Houston, a successor to the initial 1973 Spring Meeting in New York.

The "Spring Meetings" of New York and Houston, with others scheduled for Atlanta, Boston, and Los Angeles in the next three years, are an important facet of the College's long range educational plans. Fundamentally, these meetings are collections of two-day postgraduate courses, featuring plenary sessions for up to 500 people, followed by smaller group meetings with intensive interaction between moderators and groups of 20 to 50 participants. A syllabus is provided for each course, and case material furnishes an opportunity for registrants to test their clinical skills by contrasting their management choices with those of the moderators. Enthusiasm for this meeting format was high on both occasions. In Houston, there were 1,786 surgeons registered, a somewhat smaller number than in New York, as had been anticipated. 1,700 course tickets were sold, with about 450 individuals attending two courses, over the full four day period. Thus, two out of three physicians at the Houston meeting had come for the purpose of taking at least two days of postgraduate study, and nearly a third of them spent four days in such work. These percentages are comparable to the experience with postgraduate course attendance in New York.

It is too early to draw conclusions on trends for the Spring Meetings when we have completed only two of the five definitely scheduled. Professional attendance patterns may be expected to vary depending on population density in the general area of the meeting. Fellows of the College are the largest group attending; non-Fellows and house officers each accounted for about 10 percent of the participants.

It is important to stress that these meetings are not really "substitutes" for the old regional or sectional meetings, which were in essence expanded chapter meetings. Neither are these Spring Meetings at present a place for adjunctive meetings of other societies, alumni gatherings, televised operations, and all the variegated fare which we have come to expect at our Clinical Congress. While the program offers movies, distinguished lecturers, general panel sessions, and other diversions from a strictly postgraduate course format, we are currently continuing to emphasize the basic orientation toward individual and small group instruction, resisting the trend toward a smaller replica of our Clinical Congress.

In subsequent planning, our Program Committee will observe carefully the expressed wishes of the Fellowship for variations in the present scheme of these highly successful Spring Meetings. Moreover, the College's Committee on Continuing Education is exploring new approaches to broadening the activities of the College in maintaining competence of the Fellows by providing increased educational opportunities.

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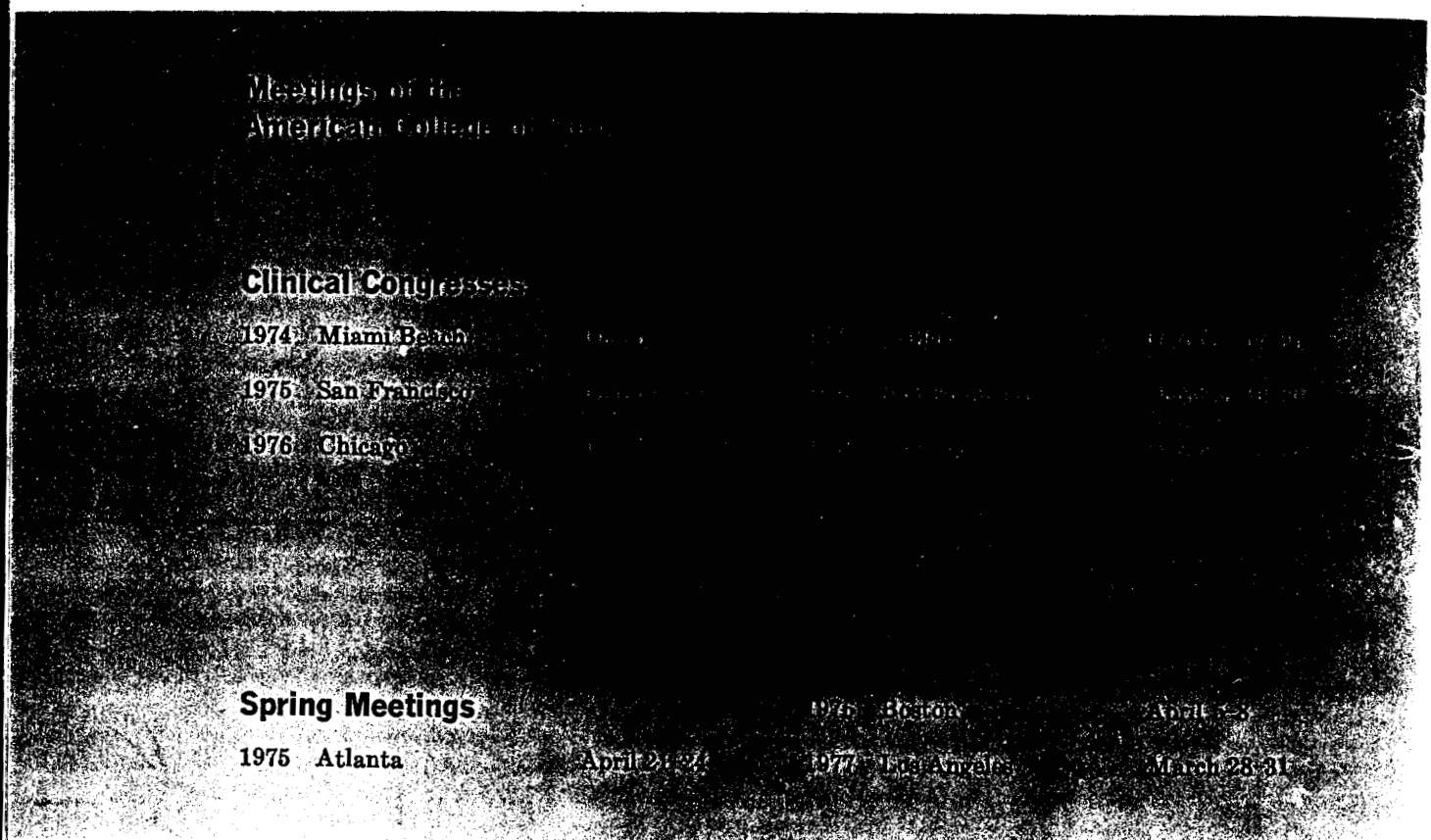
Meetings of the
American College
Clinical Congresses
1974 Miami Beach
1975 San Francisco
1976 Chicago
Spring Meetings
1975 Atlanta
April 21-24
1976 Boston
April 5-8
1977 Los Angeles
March 28-31