Malpractice and Patient Anger

A recent article appearing in Psychology Today (July, 1979, p. 88), "Why Some People Seek Revenge Against Doctors" by Louise Lander, provides an interesting insight into the malpractice problem. She notes that the vast majority of difficulties encountered in the practice of medicine, so-called "unusual incidents," do not result in malpractice suits. Lander cites data collected by a hospital association risk-management program: over a twenty-year period, there were 700,000 unusual incidents reported, and only 15,000 malpractice claims; 85% of the latter involved incidents which had not been previously reported. Lander believes there is good evidence to support the contention that the key element in malpractice suits is not the presence of injury but patient anger with the physician or other health professional. She quotes the executive director of a federal commission investigating the problem of malpractice: "In this whole field of malpractice litigation there is a strong get-even, or revenge factor. I have heard plaintiffs' attorneys say that their clients did not really want to sue for money. What they really wanted was a chance to be alone in the room with the defendant for about 15 minutes." (pp. 92-94.)

Lander believes that much of the problem can be traced to the impact of technology on the practice of medicine, an impact that in many ways is indirect. It is true that new procedures and machines increase the risk and seriousness of mishap, but they also serve to increase the psychological distance between the physician and his patients. It is this distance that contributes significantly to patient feelings of isolation, helplessness, frustration, and anger. The introduction of myriad new drugs into the physician's array of treatments serves to compound the problem; writing a prescription can become an easy substitute for establishing a sound and understanding doctor/patient relationship.

Almost 60% of all malpractice claims result from surgical mishaps. This is, of course, partly explained by the nature of the procedures themselves: they are particularly serious matters and more likely to evoke anger if results are not satisfactory to the patient. Nevertheless, Lander believes this tells only part of the story: the risk inherent in surgical intervention is exacerbated by the surgeon's common failure to deal with the psychological strains associated with undergoing surgery. The surgeon is in a position that enables him "to minimize both psychic and somatic problems by providing the patient with explanations, concern, and reassurance before surgery, and warmth and interest afterward." But it all too frequently happens that the surgeon...

...regards the essentials of his work as taking place only when he is assuming an active, decisive stance above a supine, totally passive body, largely concealed by surgical draping—a person reduced to a thing. When that body regains consciousness and begins attempting to function as an active human being, the surgeon will probably continue to concern himself only with its thingness, attending to the state of the wound but hardly noticing the state of the person. If the state of the wound is not all that it should be, the state of the person—who might tolerate being treated like a thing if that guaranteed recovery—will predictably...

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The basis for the Church's teaching is quite simple and was expressed by Pope Pius earlier in his address: it is the will of God that children should come into being within the union formed by the faithful and indissoluble love of husband and wife and through the act that fosters and expresses that love. The Church is thoroughly consistent (indeed, systematic) here. This principle excludes, in addition to in vitro fertilization, the use of donor sperm or donor ovum and the use of the husband's sperm if the technique employed is not that of assisted intercourse.

Children come from the one-flesh unity of man and wife, and procreation must not be divorced from the act of union. The Church's teaching here is the converse of her teaching on artificial contraception and sterilization: if the procreative aspect must not be separated from the unitive, neither may the unitive be separated from the procreative. Artificial contraception and in vitro fertilization appear to form a package: if one may have sex without babies, why not babies without sex? Once the connection is sundered between procreation and the physically embodied love of the spouses, how could one oppose the following uses of technology: sperm or ova donated by a third (or fourth) party, embryo selection, surrogate or "host" mothers who would bear a child conceived in vitro and then at birth return the child to its biological parents, artificial insemination of single women, cloning of single men together with use of host mothers. If the physical embodiment of our procreative power is rejected as unnecessary so that in vitro fertilization might thereby be found justifiable, there appears to be little firm basis upon which the above-mentioned possibilities could be rejected. What the Church finds reason to fear about artificial contraception and what is maybe more easily seen in the case of in vitro fertilization is the danger of the terribly dehumanizing power implicit in the artificial manipulation of the generative process, a danger which is no less real because the manipulation is accomplished for beneficent motives.

The Pope John Center hopes in the future to be able to publish a study on the moral and social implications of reproductive technologies.
**Hyperalimentation as Extraordinary Means of Preserving Life**

FACT: For patients who are unable to take food and liquids by mouth, the technique of permanent, home hyperalimentation is becoming increasingly common. The technique is one that patients are capable of performing on their own. While they sleep at night, patients “feed” themselves by receiving three liters of a nutrient solution through a thirty-inch-long subclavian catheter. When the patients are awake and active, they seal the tip of the catheter with a rubber cap and tape the coiled tubing to their stomachs. Patients learn how to use fresh tubing and filters and to clean the catheter site with anti-fungal cream (Medical World News, March 20, 1976, p. 55.)

COMMENTARY: The report notes that at first the patients are “overwhelmed and anxious about whether they can care for their own ‘life lines’ at home” but that many are capable of making a good emotional adjustment to the fact that they will never eat in the normal way again but must use the feeding apparatus for the rest of their lives. One of the key factors in making this adjustment seems to be the kind of support they receive from their doctors and families. Nevertheless, a serious moral question arises concerning the responsibilities of those patients who, for whatever reason, are unable to adjust to this new way of living.

Food, as we know, is more than simply a means of sustaining life. The eating of food can be important in relieving a person of boredom, anger, frustration. It possesses an important aesthetic quality in addition to the pleasures of taste, and it is employed as a powerful symbol expressing and fostering community and personal relationships. Indeed, many of the patients using hyperalimentation are reported to continue joining their families at meals; they sip and chew, but they spit the foods and liquids out. Even though the use of hyperalimentation is capable of preserving the life of the patient, his dependence on the technique and knowledge that the benefits of eating may be irretrievably lost can constitute an overwhelming burden for a particular patient. The question arises of whether he may rightfully request discontinuance of the use or even decline it in the first place.

The teaching of Pope Pius XII on the use of life-sustaining means is relevant here:

“But normally one is held to use only ordinary means—according to circumstances of persons, places, times and culture—that is to say, means that do not involve any grave burden for oneself or another.” (Address to the International Congress of Anesthesiologists, November 24, 1957.)

The phrase “ordinary means” is often taken to refer to those means that are customarily employed for the preservation of life: e.g., food and liquids by mouth, the manner in which the vast majority of human beings take in nutrients. Nevertheless, for a patient incapable of employing such means for the preservation of life, hyperalimentation becomes the customary (because only) means of life preservation. But Pope Pius’ teaching makes clear that what he means in this context does not refer to what is customary or expected or normal but, rather, to what is not excessively burdensome.

The case here of permanent hyperalimentation is somewhat similar to that of chronic hemodialysis: many patients are capable of making a reasonable adjustment to their new regimen, but some are not. As Pope Pius emphasizes, what constitutes an ordinary means must be seen as relative to the patient himself; so that for those patients who find a technique of no great burden, its use might be obligatory, whereas its use would not be required for other patients who find the same technique gravely burdensome for them.

Therefore, with regard to the moral requirements of the situation, a patient should consider the degree of burden imposed by the use of a particular technique, being careful to weigh this burden against the seriousness of his responsibilities to others. But if, after careful consultation and discussion with those whose welfare is most immediately involved, and after a suitable lapse of time, the patient should conclude that the use of permanent hyperalimentation imposes an unduly grave burden, his request for discontinuance of hyperalimentation should be honored. Furthermore, unless he has seriously misrepresented the nature of the burden and of his responsibilities, his decision should be seen as a morally correct one.

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**progress from anxiety to resentment to outright anger.** (p. 92.)

Lander believes that the primary cause of the difficulty is the surgeon’s concentration, one shared by the medical profession as a whole, on the technological aspects of the medical profession at the expense of its human features. The physician “feels much more comfortable maneuvering the hardware of the modern medical scientist; as one internist said about putting his patients in a coronary-care unit, ‘With all those monitors and other gadgets, we get a sense of control.’” (p. 92.)

When something goes wrong, whether in a single operation or in a general system of medical care, it is always easy to point the finger of blame at someone else. Certainly it would be unreasonable to suggest that the medical profession is uniquely responsible for the difficulties in which the present system finds itself. Nevertheless, Lander has focused on an important dimension of the problem: a commonly encountered attitude among physicians, fostered during the educational process and encouraged in medical practice, to emphasize the technological at the expense of the human aspects of care. Rather than attempting to shift the blame elsewhere, the medical profession should use the problem of malpractice as an opportunity to examine its own fundamental assumptions and values as they are expressed in ordinary practice.