

Negligence
An Information Paper
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Medical malpractice is almost entirely a state law matter. Through the efforts of state chapters and individual members, some state laws have been changed, gaining significant relief from the threat of malpractice liability. These changes include legislated caps on noneconomic damages and changes in the category of negligence that courts apply to emergency medicine litigation. The ACEP Board of Directors requested that the Medical-Legal Committee create an information paper on negligence, primarily to aid state chapters who are interested in tort reform within their state.

American civil law, which governs liability suits, descends from English Common Law. In fact, the bulk of our tort law, which addresses wrongs and harms, is Common Law. Basically, Common Law is ‘judge-made’ law. Its beauty and effectiveness flows from its creation through real cases, involving real parties, bound by previous decisions in similar cases, and with some attention to the future application of any decision. Post-revolutionary America continued to apply English precedents in our new nation’s courts (with the exception of Louisiana), and we built our own case law history over time.

Alternative legal systems are based in codes. Continental European laws, for example, are said to grow out of Roman law, and their cores are Napoleonic codes, initially imposed by him on conquered countries. A decision in a lawsuit claiming negligence starts with the judge’s announcement of which code section applies to the case at hand.

Our Common Law suits can also involve statutory, legislature-made law, but usually in an adjunctive role, eg, where a statutory violation like running a stoplight is used to prove negligence without any necessity to consider reasonableness. But legislatures can also superimpose rules and standards onto the Common Law courts, which if constitutional, must be followed. Thus, both precedent and statute govern lawsuits over claims of negligence.

Malpractice is a form of negligence, and is basically the failure to act within the standard of care. As Common Law developed over centuries of judicial decisions, disputes were categorized and required to have elements of proof. In the simplest possible terms, a malpractice plaintiff must prove duty, breach, causation, and damages. Each element has its own degree of required certainty. For example, lack of duty is not a defense for emergency physicians; we hold ourselves, or are held out to the public, as offering help, and if anyone takes us up on that offer, the duty attaches. To prove causation, again oversimplifying, the harm must have been foreseeable. Breach of duty, the negligent act or omission, by the common law precedents, need only be shown by the preponderance of the evidence. The hoary analogy presented by plaintiffs’ lawyers is often that of a balance scale tipped by the weight of a feather.

But this scale, and the level of certainty required to call an act or omission negligent, can be weighted by legislative fiat. The balance may be set with “strict liability” laws, such as those making dog owners responsible for an animal bite, regardless of the dog’s history or reasonableness.

We are here concerned with legislated rebalancing in the other direction: requiring “elevated” degrees of negligence be proven before a defendant can be held liable.

Good Samaritan statutes are well-understood and common examples; they require that the plaintiff prove “gross” negligence when suing a volunteer, uncompensated defendant who never had a duty to become involved. In addition to being the best known example of the degree of negligence legislation, they also

serve as examples of how we may argue for legislated relief for emergency physicians and emergency departments. Support for Good Samaritan laws, in part, flows from policy and incentive arguments. We want people to rescue each other, and think it unfair that simple negligence in the volunteer's act can attach liability. Other policy considerations in attaching degree of negligence laws include the inherent risks of a socially beneficial activity. However, Good Samaritan protection does not protect against willful and wanton actions.

There are many different names and degrees of indifference or intent given to negligence. Most often the most colorful ones appear in criminal law: "with a wanton and malignant heart," "reckless indifference," etc. In civil liability and medical malpractice, aggravated degrees of negligence most discussed are gross, willful, wanton, and reckless.

Standards of Proof

These definitions vary by state, and the conduct that courts consider as falling under those definitions depends on the facts of each case.

Burden of proof is the burden of one party in a trial to produce the evidence that will shift the conclusion away from the default position to their own position. There is a burden to produce the evidence and a burden to persuade the court to accept your evidence. The burden of proof usually lies on the person filing the case. The defendant is then responsible to file a response that denies the allegations and sets forth any defenses they may have.

There are different types of burden of proof.

1. Preponderance of the Evidence

To meet the burden of preponderance of the evidence, the evidence presented must be **more likely to be true than not true**. The standard is fulfilled if there is a greater than 50% chance that the evidence is true.

2. Clear and Convincing Evidence

For clear and convincing proof, the evidence presented by the party during the trial has to be **highly and substantially more probable to be true than not true**. This is a high standard. Clear and convincing evidence is a higher burden than preponderance of the evidence. The higher burden makes it more difficult for patients to win in medical malpractice cases.

Standards of Negligence

1. Negligence

Failure to exercise 'reasonable care' is considered to be negligence. Basic negligent conduct is conduct that violates what a reasonable doctor in the same position would have done. Commonly, it is considered to be a breach of the standard of care (which is generally established by expert testimony).

2. Willful and Wanton

Willful and wanton conduct is conduct that is intentional or committed under circumstances exhibiting a **reckless disregard** for the ordinary well-being of others. In this situation, the defendant is aware of his conduct and is aware from his experience that his conduct will probably result in an injury. Other legal definitions include "utter indifference to or conscious disregard for... the safety or property of others."¹ It is actual or deliberate intent to harm someone. It is more difficult to prove willful and wanton misconduct as it requires that the physician actually has the knowledge that an injury will result from the act.²

3. Gross Negligence

Gross negligence also involves a reckless disregard for the safety of others, but it is not intentional. Common definitions include “failure to exercise slight care or diligence,”³ or “conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results.”⁴ The higher standards of gross negligence and willful and wanton negligence are harder to prove.

4. Intentional Act

Intentional acts are when the outcome of the act is known and the physician wants the outcome to occur. One of the more egregious examples of this in recent history was the obstetrician who carved his initials into the patient’s abdomen after delivering her baby.⁵

Examples of Cases with High Negligence Standards

[*Christus Health South East Texas v. Licatino*](#): Court found there was no willful and wanton negligence when the hospital did not follow proper protocol for a patient with chest pain who was discharged home and later died of cardiac arrest.

[*Gardner v. Children’s Med. Ctr. of Dallas*](#): Court held that there was no willful and wanton negligence when a patient suffered permanent brain damage due to deprivation of oxygen because of improper placement of an endotracheal tube.

Medical Liability Reform

Some states have been modifying and reforming their malpractice laws. North Carolina, Arizona and Utah have increased their burden of proof to clear and convincing evidence. In Florida there must be proof that the care was in ‘reckless disregard for the consequences so as to affect the life or health.’⁶ Georgia has increased its burden of proof to clear and convincing evidence of gross negligence.⁷ South Carolina has increased its negligence standard to require gross negligence rather than simple negligence. Texas has increased its negligence standard to require willful and wanton conduct with a preponderance of evidence burden.

References

1. [*Pfister v Shusta*, 657 N.E.2d 1013](#) (1995)
2. [*Infant C v Boy Scouts of America, Inc.*, 391 S.E.2d 322](#) (Va. 1990)
3. M.L.C. § 600.2945(d)
4. [*Draney v Bachman*, 138 N.J. Super. 503](#) (1976)
5. [Doctor carved his initials into patient, lawsuit says](#). *The New York Times*. January 22, 2000.
6. [Fla. Stat. § 768.13\(2\)\(b\)1](#) (2000)
7. O.C.G.A. § 51-1-29.5