When might an operative complication be regarded as acceptable? Part 2: Judicial factors that influence the finding of fault during surgical litigation

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ABSTRACT

In cases where surgeons face litigation over operative misadventure, the result of a trial is uncertain. In order to identify factors in cases of surgical litigation that have influenced the final decision of the courts, we have previously reviewed reported cases where the outcome turned on actions taken by surgeons. We now turn our attention to judicial attitudes to evidence that play a role in the determination of the case.

KEYWORDS

Litigation – Surgery – Standard of care – Bolam – Bolitho – Reasonable standard – Misadventure

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This paper is the second of a two-part legal review of cases where surgeons face litigation over operative complications. It follows on from a review of reported cases where the outcome turned on actions taken by surgeons.¹

Most surgeons will be aware of the aftermath of an operative misadventure but it is the legal process that provides the definitive determination of the reasonable acceptable standard of care and consequently the threshold of an unacceptable misadventure. One sign of a settled judicial view relating to a particular operative accident is the cessation of litigation in court; no case involving a lost swab has been brought to court in England since 1961,² a sign that claimants achieve their aims without resorting to the courts and that defendants tend to capitulate early when faced with this indefensible suit, if only to minimise costs.

However, the legal viewpoint on aspects of evidence is evolving, not settled, so in the cases that follow, the outcome of litigation was by definition uncertain. This second part of our analysis of recent court reports identifies some common themes, which may indicate how an operative accident might be viewed by a judge.

The judicial perspective on a surgeon's general conduct

Since trusting that the doctor will behave properly is of fundamental importance to the patient, it is unsurprising that courts take a dim view of perceived breaches of trust. During the suturing of an episiotomy in 1960, the

obstetrician's needle broke in the perineum and the needle tip remained in the patient's tissues.³ This fact only emerged 34 years later, during investigations for osteoarthritis of her hip. The woman had not been told of the loss of the needle's tip but had suffered dyspareunia and a persistent ache in her perineum throughout the subsequent decades.

During the course of litigation, the court acknowledged that it would never be known whether the obstetrician knew the needle fragment had been retained but the judge noted that: 'I should certainly be loath to conclude that he actually knew. That would involve a finding of the gravest possible misconduct on his part.' At the time of the hearing, in 1999, such a lack of candour was clearly viewed as egregious behaviour by the court although one wonders how many needle tips were lost during this era, unbeknownst to their hosts.

That this judicial comment may have seemed unrealistic to a surgeon in 1960 simply reflects the unusually long time it took the case to come before the courts. Modern surgeons will recognise the importance of ensuring that following surgery, all events that occurred during the operation about which the reasonable patient would want to know must be disclosed to the patient.

Surgical braggadocio, although perhaps imprudent, may be ignored by the court. In the case of a woman who was advised to have a 'well done' operation rather than an alternative procedure that had been recommended by another specialist, the court found that such words did not

place on the surgeon a duty to perform at a higher standard of care than that of any other surgeon experienced in the field.⁴

Records and consistency of evidence

In the case of *Bentley*, a 65-year-old woman who underwent a total hip replacement in 1981,⁵ the patient awoke following the surgery to find that she could not move her ipsilateral foot. It became clear that she had suffered a traumatic paralysis of her sciatic nerve and the court found that this was due to intraoperative traction on the nerve during hip dislocation. The court considered whether other explanations for the injury, such as direct pressure or a vascular injury, could have been responsible but these it rejected. One may speculate that the dislocation must have been unusually troublesome; oral evidence indicated that the operation had been reportedly 'difficult' but the surgeon was unable to elaborate on this because so many years had passed between operation and litigation.

The judgement hints that a clearer contemporaneous appraisal of the surgical difficulties should have occurred although does not go so far as to assert that this would have altered the outcome of litigation. However, if a detailed review of the injury had been performed at the time, it is possible that a credible alternative non-negligent cause for the injury might have emerged. Such a plausible alternative might have either dissuaded the claimant from commencing litigation or convinced a court that the non-negligent cause identified by a review performed while the facts were fresh was persuasive.

In a more recent case, a 37-year-old woman had a laparotomy for the division of gynaecological adhesions.⁶ The operating note recorded the difficult dissection required to separate the sigmoid colon and the adnexa; later statements revealed that the dissected colon was then 're-peritonised'. Three days later, faecal peritonitis from a 2mm hole in the apex of the sigmoid colon necessitated a colostomy.

One of the questions for the court to determine was whether a reasonable surgeon would have seen a hole if one had been made during the dissection of the bowel from the adnexa. The operating surgeon's original witness statement that the area over which the affected bowel wall had been thinned by the necessary dissection had been interpreted initially by the court as indicating an area less than 0.5cm in diameter. Subsequent oral evidence at trial, however, led to the surgeon adopting a 4–5cm estimate of an affected area, equating to the final estimate of the extent of adhesions between the contiguous structures.

The court found the trust liable, on the basis that a reasonable gynaecologist would have either inspected the bowel and found the hole or, being unable properly to inspect the bowel, called a general surgeon. The tenor of the judge's words, noting that the surgeon was not clear what inspection had been performed or why the inspection had been performed, may have been set at least to some extent by the late change in evidence, which will affect the court's assessment of the witness' reliability. In keeping

with *Bentley*,⁵ the court in *Tagg* also found it extraordinary that a detailed analysis of the complication had not occurred at the time of the injury.⁶

The effect of precedent

Courts make their findings based on the facts before them; similar facts may not produce the same findings. Owing to the well known risk of damage to the ureter during hysterectomy, the standard of care espoused by generations of experts is that the ureter must, if at all possible, be identified and protected before any clamps or sutures are applied to tissues in the vulnerable anatomical area. Despite this, in a case where there was heavy capillary oozing after the bulkier part of a fibroid laden uterus had been removed, the court found that that the resultant bleeding could and should have been dealt with before the clamp (that probably caught the ureter) was applied.⁷

In the same year, there was unanimity among claimant and defendant experts that if a ureter was obstructed during a hysterectomy by an encircling suture or the application of a clamp, then substandard surgery had been performed.⁸ However, if the ureter had been kinked by a suture, then liability was at issue. During review of the original evidence at appeal, it was found possible in a straightforward case reasonably to insert a suture in the uterine arterial pedicle in the vicinity of the ureter without realising its proximity and that this possibility had not been tested in the original hearing. For this reason, the claim failed. If the original trial judge had made it clear that on the balance of probability, he had found that the arterial suture was placed too close to the ureter, the claimant would have succeeded.

In a very recent Scottish case of a woman whose ureter was damaged during a hysterectomy by the application of a clamp to the infundibulopelvic ligament, the judge found expert evidence from both sides to be persuasive.⁹ The court found that the operating surgeons were confident (but not certain) that the ureter was safe. The claimant experts propounded the need for certainty of positive identification of the ureter but the court equally found ample logical support for the defendant experts' practice of proceeding on the basis of confidence, balancing the risk of damaging the ureter when *uncertain* of its location against the risk of damaging it by the dissection required to achieve certainty. Accordingly, the case was defended successfully.

Precedent is not necessarily as reliable a guide to the outcome of future actions as one might think.

Res ipsa loquitur

Notwithstanding *Thomas*¹⁰ (see Part 1 of this legal review for more information),¹ the doctrine of *res ipsa loquitur* is frequently employed by claimants although its applicability to surgical liability is unresolved. Translated from Latin, the phrase means 'the thing speaks for itself' and, originally, the 'thing' referred to the occurrence of an accident rather than to the injury that resulted from it although these days, such a distinction is less clear. When the claimant pleads that the facts of the case support the contention

that care has been substandard and that harm has been caused, the defendant must show a plausible alternative non-negligent explanation to rebut the claimant's case and escape liability. The doctrine may be helpful to claimants who know that they have been harmed but who cannot identify how the harm has occurred (for example, when they have been anaesthetised).

A recent case involved a man who awoke from a five-minute anaesthetic (for a cystoscopy) with excruciating shoulder pain.¹¹ He asserted that this was caused by the occurrence of some unknown perioperative event that had damaged his shoulder and that this by itself was indicative of substandard care since such an event should not occur during a reasonably performed cystoscopy. The hospital led evidence that no untoward events had occurred during Mr Hussain's operation but additionally rebutted the claimant's assertion of *res ipsa loquitur*. Subsequent investigation of the patient's shoulder had provided a radiographic and endoscopic diagnosis of acute impingement syndrome in the subacromial joint, which showed evidence of chronic degenerative change.

The court found that there was a realignment of the joint's muscular support during the anaesthetic and that the patient's pre-existing degenerative joint disease predisposed him to the impingement that commenced during the anaesthesia. The defendants therefore successfully rebutted the claimant's case, which was dismissed.

The significance of the medical literature

On occasion, defendants have relied on the absence of reported complications to justify their actions. In the case of a child who suffered from neurological injury after being lifted out of the uterus with a forceps during a difficult Caesarean delivery, the court found that excessive force had been used.¹² At issue was whether the surgeon should have opened the uterine wall more widely to reduce the resistance to delivery of the after-coming head. The expert for the defence noted that brain injury had never been reported in these clinical circumstances and gave evidence that he would not have felt uncomfortable about applying more traction than was used ordinarily. The court took this as an 'argument [that] may be used as a licence to use unnecessary force because, so it is said, nothing bad is going to happen'. The court regarded this as a recipe for disaster and rejected the defendant's expert's evidence.

After the percutaneous division of his lateral patella retinaculum (necessitated by evidence of lateral tracking of the patella), a patient suffered a haemarthrosis, requiring cautery of a bleeding branch of the superior geniculate artery.¹³ The claimant asserted that (in 2008) such a procedure should be done under direct vision and discounted as outdated evidence from the 11th edition of *Campbell's Operative Orthopaedics* (2008) that supported both percutaneous and arthroscopic techniques.

Citing other textbooks and personal series, the defence view that both techniques fell within the reasonable standard was entirely accepted by the court. The judge found that it would 'seem to be extraordinary if leading textbooks

would endorse a surgical technique which was out of date and not to be performed'.

Expert evidence

Surgeons providing expert evidence in civil litigation provide a vital public service. Acting as servants of the court, they furnish the claimant or defence with an analysis of the surgical events surrounding the claim and an opinion as to whether the surgeon's actions were reasonable. In our common law adversarial system, it is likely that expert evidence for the parties will differ and it is the court's role to adjudicate between opposing expert evidence in order to establish the facts of the case.

Although both courts and counsel are often experienced in surgical cases, they remain heavily reliant on the expert witness to describe and explain the anatomy, operative procedures, and potential causes of complications and errors. In any particular case, the court is constrained by the evidence; if relevant evidence of abnormal anatomy or a common error is not pleaded, the court may not be aware of its existence. For tactical reasons, neither claimant nor defence are likely to introduce a point that could assist their opponents and for this reason, the case for claimant and defence are heavily dependent on the opinions of their surgical experts.

We must assume that all experts act in good faith, and remember that the readers of law reports see only the expert evidence, and not what the experts have seen and read in formulating their opinion. What can seem self-evident to the casual reader may have been dismissed for good reasons by the expert, once immersed in the detail of the case. Furthermore, in having their decision making painstakingly analysed in court and recorded in law reports, surgical expert witnesses are subject to a quality of scrutiny that few of the rest of us in purely clinical practice have to endure.

Nevertheless, surgical experts are setting the standard for their profession, in terms of what constitutes operative performance that falls below the reasonable standard that the patient is entitled to expect. As can be seen in this review of case law, divergent and sometimes surprising expert opinions are advanced on behalf of both claimants and defendants, and these contribute to the uncertainty of litigation since the court can only find facts on the basis of the expert evidence presented to it. Only surgical specialty organisations are in a position to judge whether expert evidence uttered in court, purportedly representing the standards of their profession, accord with the consensus view of a 'reasonable standard' in their specialty.

Conclusions

It is clear that many factors, derived from surgical conduct, quality of evidence and court process, influence the outcome of litigation over an operative misadventure. Some of these factors remain under the control of the surgeon and attention to these may reduce the uncertainty that accompanies the defence of a claim.

References

1. Wheeler R, Blackburn S, Biggs H. When might an operative complication be regarded as acceptable? Part 1: Surgical factors that influence courts when finding fault during litigation. *Ann R Coll Surg Engl* 2015; **97**: 98–101.
2. Wheeler R, Blackburn S, Biggs H. Seeking responsibility for the lost swab? Search elsewhere. *Ann R Coll Surg Engl* 2014; **96**: 177–180.
3. Fenech v East London and City Health Authority [2000] 1 Med LR 35–40.
4. Dove v Jarvis and Another [2013] 6 Med LR 284–290.
5. Bentley v Bristol and Weston Health Authority [1991] 3 Med LR 1–16.
6. Tagg v Countess of Chester Hospital NHS Foundation Trust [2007] EWHC 509 (QB).
7. Bouchta v Swindon Health Authority [1996] 7 Med LR 62–70.
8. Hooper v Young [1998] Lloyd's Law Reports (Medical) 61–69.
9. Hannigan v Lanarkshire Acute Hospitals NHS Trust [2012] CSOH 152.
10. Thomas v Curley [2013] EWCA Civ 117.
11. Hussain v King Edward VII Hospital [2012] EWHC 3441 (QB).
12. Smith v Sheridan [2005] EWHC 614 (QB).
13. Ecclestone v Medway NHS Foundation Trust [2013] EWHC 790.