Consultant membership - factsheet

The bare bones of orthopaedic claims

This analysis of orthopaedic claims gives a fascinating insight into non-spinal claims settled by the MDU on behalf of trauma and orthopaedic surgeons. Knee arthroscopy, knee replacement and hip replacement seem to be responsible for many claims. The volume of such cases and changing technology may play a part in this, but we may be, on occasion, too keen to try something new. It is important to ensure we always operate within our competence.

Management of patient expectations is essential. It is now established that knee surgery may be less than optimal in outcome in the patient's eyes. Such discussion should be part of the consent process, though specific mention and recording of a complication in the consent form does not automatically protect the surgeon from liability.

Lastly, I would hope to see wrong side, wrong site surgery eradicated from any further report. Systems should allow for marking patients before surgery and I add a plea to allow staff to follow the WHO initiative in this regard.

Stephen R Cannon FRCS
Consultant orthopaedic surgeon

Dr Gemma Taylor and Andy Norman, senior claims handlers analyse clinical negligence claims against orthopaedic surgeons and offer advice on managing risk in this specialty.

A claim for clinical negligence can be brought at any time, often without warning and sometimes many years after the incident occurred.

This review is focused on a cohort of over 400 claims notified to the MDU in a recent five year period by members working in independent orthopaedic practice. The MDU also helps its orthopaedic members with many hundreds of issues not relating to claims each year ranging from regulatory investigations, service complaints, performance concerns, inquests/FAIs and tricky medico-legal or ethical scenarios. This analysis, however, focuses specifically on what lies behind clinical negligence claims brought against our orthopaedic members.

Compensation costs

The first point to note from the review is that the MDU successfully defends the majority of clinical negligence claims pursued against its members. In 78% of the cases in this review, the claims were successfully defended without paying compensation to the patient.

Nevertheless, it can be very distressing to find out a patient is bringing a claim against you. However, be assured that the MDU's expert claims handlers and medico-legal advisers understand how stressful this is and the importance of mounting a robust defence of your position.

Of the cases which had to be settled, compensation payments ranged from £4,000 to £2.4 million with the majority settling for under £50,000. The wide variation in damages paid when a claim is settled reflects partly the variety of different types of cases orthopaedic surgeons can be involved in, and also the wide range of complications that can occur.

Compensation is awarded with the aim of returning the patient to the position that they would have been in had the negligence not occurred. If the injury suffered is such that the person can no longer work and requires a significant level of care, then considerable damages will be paid. The size of damages does not reflect the magnitude of the clinical error, but the injury to the patient.

In this analysis, some of the highest awards were for nerve injury following surgery, failed procedures requiring repeated surgery or acceleration of joint replacement, and severe post-operative infections. Whereas damages at the lower end of the range were for injuries such as minor burns sustained during surgery and medication errors which didn't result in significant harm.

While orthopaedic claim numbers have not increased in recent years, the cost of claims has spiralled. This is not due to clinical standards but to a deteriorating legal environment which the MDU is campaigning to reform. You can see more at *themdu.com/faircomp*

Legal costs

When a claim is settled, the MDU also pays the claimant's legal costs, which can be considerable. The highest legal costs (excluding compensation paid to the patient) on a single claim were £650,000. In total over £3 million of claimant legal costs were paid. In a number of cases the claimant's costs significantly exceeded the damages paid to the claimant.

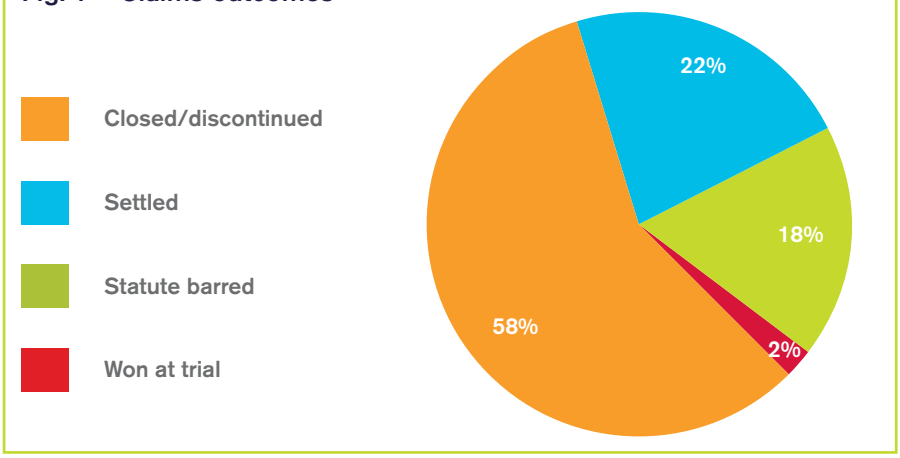
Even in claims that are successfully defended, the MDU can incur significant expenditure, particularly if court proceedings commence. These costs include getting expert advice, which for complex claims can involve multiple specialists, and legal expenditure.

The MDU always investigates claims thoroughly, in order to advise and help members most effectively. Overall, 59% of claims were resolved by an MDU claims handler without the need to instruct a solicitor.

Claims outcomes

Claims that were not settled with a payment by the MDU were either won, discontinued by the claimant, settled by another party or statute barred. A claim becomes statute barred if the claimant fails to issue formal proceedings within three years from the date of the incident or the date they became aware of the alleged harm. This restriction does not apply to children with capacity, for whom the limitation period begins at 18 (16 in Scotland). There is no time limit for patients who lack capacity to conduct their own affairs. Some claims were initially investigated by the MDU but successfully argued to not involve an MDU member.

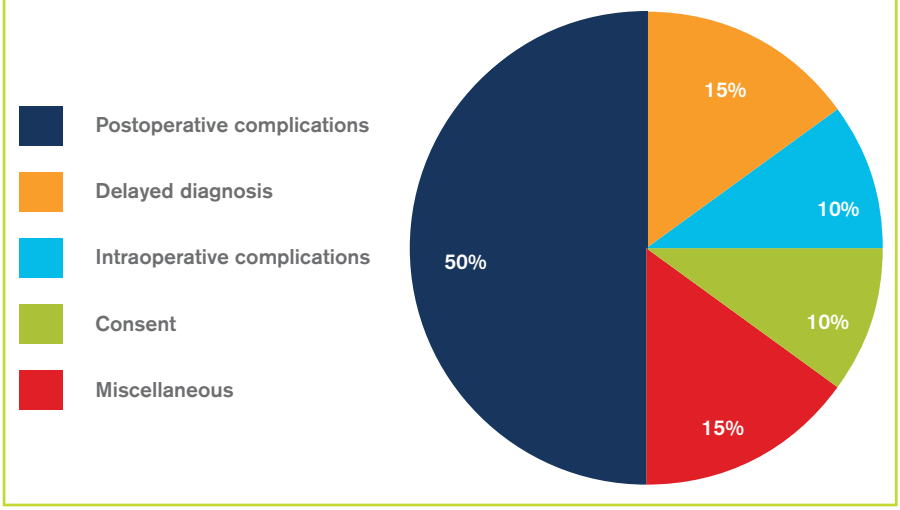
Fig. 1 – Claims outcomes



Reasons for claims

The reasons for orthopaedic claims are varied, but usually arise from the patient having an unsatisfactory outcome. This can range from postoperative pain and infection to permanent nerve damage, amputation, and in some cases the patient's death. There are some key overriding themes however, which we explain below.

Fig. 2 – Reasons for claims



Postoperative complications

Postoperative complications featured in 50% of the claims examined. Allegations included:

- Long-term pain.
- Poor healing and wound infection.
- Radial nerve damage and significant loss of function due to inadequate nerve protection during surgical fixation of the humerus.

- Femoral nerve damage following knee surgery leading to reduced mobility.
- Non-union of fractures due to surgical technique, for example, mal-positioning.
- The use of wrong sized implants and the failure of surgical components post-surgery.
- Inadequate postoperative wound management. For example, an above knee amputation following total knee replacement.
- Postoperative wound infection. In some cases, this led to the failure of joint replacements leading to revision surgery.

Delayed diagnosis or referral

Allegations of delayed diagnosis or referral were common, and featured in 15% of cases.

The diagnoses allegedly missed or delayed included:

- Tendon ruptures.
- Sarcoma.
- Meningitis.
- Vascular necrosis.
- Ligament/cartilage tears.
- Spinal and other fractures.
- Osteomyelitis.
- Dislocations.
- Nerve damage.
- Perthes disease.
- Post-operative infection/haematomas.
- Post-operative fistulae.

Intraoperative issues

There were many cases of alleged poor operative technique, for example, incorrect sized components, mal-positioning of the limb during surgery and surgery undertaken on the wrong side or body part.

In one case, a patient died following a tear to the inferior vena cava during an elective discectomy. It was alleged this was due to the excessive level of force used.

In 10% of claims problems were alleged to have arisen during the course of the procedure. These included:

- Equipment or other foreign body left in the patient after surgery.
- Chemical or diathermy burns, scarring or nerve damage.
- Incorrect equipment used or the lack of available equipment resulting in surgical procedures being abandoned, delayed treatment and additional procedures required.
- Severe bleeding due to perforation or puncture injury.
- Nerve damage due to poor operative technique, for example, damage to the sciatic nerve during a total hip replacement, resulting in foot drop.
- Intraoperative fractures, such as a femoral neck fracture during hip resurfacing surgery.

Consent

Consent issues feature in many cases but 10% of cases involved allegations centred on inadequate consent.

The consent process is paramount in managing the patient's realistic expectations. Failure to either manage those expectations or adequately explain the risks and benefits of the procedure was a common theme across the cohort of claims. In a number of cases, it was alleged the risk of a worse outcome or long term damage, including nerve damage, wasn't properly explained.

In other cases, patients alleged they consented to unnecessary procedures where symptoms were likely to resolve with conservative management rather than surgical intervention.

Consent cases are often difficult to defend, and it is vital to be aware of the impact of recent judgments such as *Montgomery v Lanarkshire Health Board* (2015) and the updated guidance on *Decision Making and Consent* from the GMC. There is more information about the judgment and GMC guidance at *themdu.com*

Note keeping is vital. Without a thorough contemporaneous record of the detailed discussion with the patient about potential risks and benefits, a surgeon can find it difficult to defend allegations of consent, even where their usual practice is to discuss such issues.

Nerve damage featured in a number of claims alleging inadequate consent. In one case, a patient underwent a total hip replacement. The patient alleged that the surgery was negligent as the surgeon failed to protect and damaged the sciatic nerve during surgery, and failed to discuss or get the patient's consent regarding the risk of nerve damage.

Post operatively the patient suffered foot drop and neuralgia, leading to further surgery to attempt to repair the nerve. No admissions were made regarding inadequate consent, but experts stated that neural damage was a rare but well recognised complication of this surgical procedure. It was admitted the surgery itself was performed negligently and the claim settled for more than £270,000 in compensation and legal costs.

Joint replacement procedures

Looking at the types of procedures leading to claims, joint replacements, are among the most common. Unlike other surgical disciplines, where dissatisfaction may arise from the cosmetic outcome, joint replacements, particularly of the hip or knee, can result in significant functional difficulties. This can accelerate the need for revision surgery or osteoarthritic changes.

Numerous claims arise from failed joint replacements requiring revision surgery.

Allegations about the causes of failed surgery include:

- Incorrect sizing or choice of implant.
- Poor pre-operative preparation.
- Poor operative technique.
- Postoperative infection that was difficult to eradicate.
- Defective parts/components.
- Incorrect initial diagnosis or contraindicated surgery.

Manage the risk

Claims involving orthopaedic surgeons are made for a wide variety of reasons, but there are some common risk factors, which if managed appropriately, can help to reduce risks. These include:

- Providing patients with detailed information on all treatment options verbally and in writing and making sure they have appropriate time to make a decision.
- Considering more conservative treatment options, and whether all avenues have been exhausted before recommending invasive procedures to patients – particularly in spinal or joint replacement surgery.
- Seeing the patient 'as a whole' not just the isolated issue at hand. This includes consideration of comorbidities and psychological factors.
- Giving appropriate safety netting advice so the patient knows in what circumstances to return for further advice.
- Keeping detailed records of your discussions with patients including any phone calls by you or your administrative team. Record discussions with other clinicians (GPs, out of hours clinicians and other consultants involved in the care process). Many claims are brought a considerable time after events in question so records can be vital.
- Making sure that the full range of equipment and necessary components are available when operating in the private setting. Consider an urgent referral to an NHS hospital if necessary.
- Being aware of the increased difficulties when operating on morbidly obese patients – have a lower threshold for closer post-operative follow-up and early investigation of possible complications, and considering whether it is more appropriate for these patients to be treated in an NHS setting with high-dependency care available if needed.
- Making sure you have robust post-operative arrangements for patients in the private setting – remember that you must be contactable or provide appropriate cover, and must arrange for prompt assessment of the patient in the event of any issues.
- Considering your professional duty of candour. If something goes wrong, apologise and notify the patient and any necessary parties as soon as possible.

Case study

Complication from hip surgery not due to negligence

This is a fictitious example, based on the type of claims notified by MDU members.

An elderly patient underwent a left total hip arthroplasty after an x-ray showed a significantly arthritic hip. The patient complained of significant hip pain and a restricted range of movement.

Ahead of the procedure, the patient and orthopaedic surgeon, who was an MDU member, discussed the options. The surgeon recommended arthroplasty and the patient signed a consent form which included a number of potential benefits such as pain relief, as well as serious or frequently occurring risks including deep vein thrombosis, pulmonary embolism, infection and fracture.

At the end of the surgery, during closure, the surgeon inadvertently put a stitch through the outer fibres of the sciatic nerve. Post-operatively, the patient suffered foot-drop and underwent two further procedures to repair the nerve, which were unsuccessful. The patient was left with pronounced foot-drop and required an orthopaedic brace and crutches in order to walk. The surgeon apologised to the patient for the mobility problems he was experiencing following the procedure, explaining that this complication was extremely rare.

The surgeon contacted the MDU after receiving a letter of claim in which the patient alleged he was not informed during the consent process of the risk of nerve damage and, had he been, he would not have undergone surgery that day and would have sought a second opinion.

The patient alleged that sciatic nerve injury was a recognised complication of total hip arthroplasty, despite the risk of this complication being less than 1%.

Orthopaedic expert evidence was obtained by the MDU and, in the expert's opinion, the decision to offer the surgery was entirely appropriate. The surgery was performed to a reasonable standard, but, unfortunately, the patient suffered a non-negligent complication of surgery. The expert confirmed that the risk of sciatic nerve damage was very rare, occurring in less than 1% of cases, and the specific risk of putting a stitch through the sciatic nerve was much smaller.

The MDU member approved a letter of response in which it was accepted that the risk of damage to the sciatic nerve had not been discussed during the consent process. The letter asked for proof that given the severe hip pain and restriction of mobility that the claimant had experienced pre-operatively, he would not have undergone surgery had he been warned of this risk.

The claim was not pursued further.

For individual medico-legal advice:

24-hour advisory helpline

T ***0800 716 646***

E ***advisory@themdu.com***

W ***themdu.com***

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