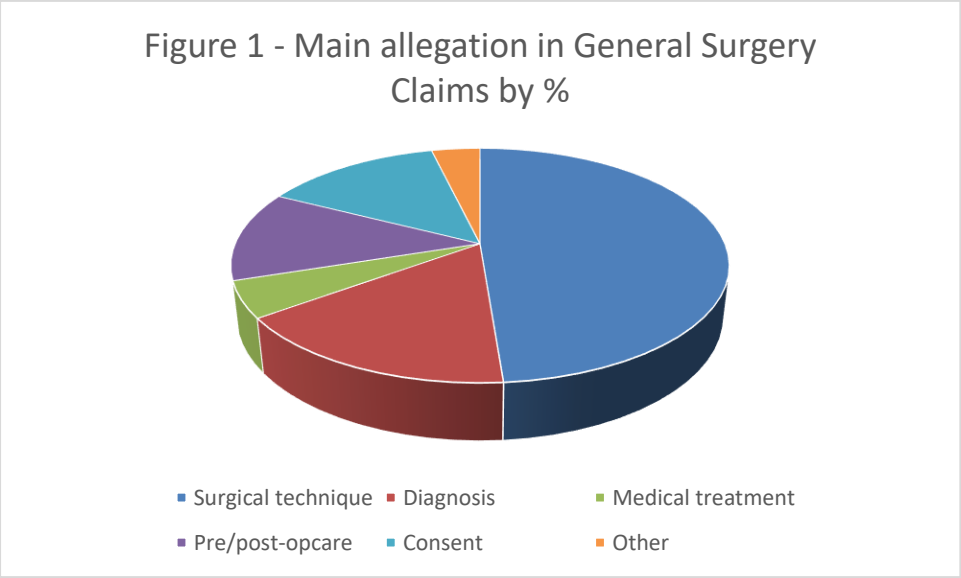
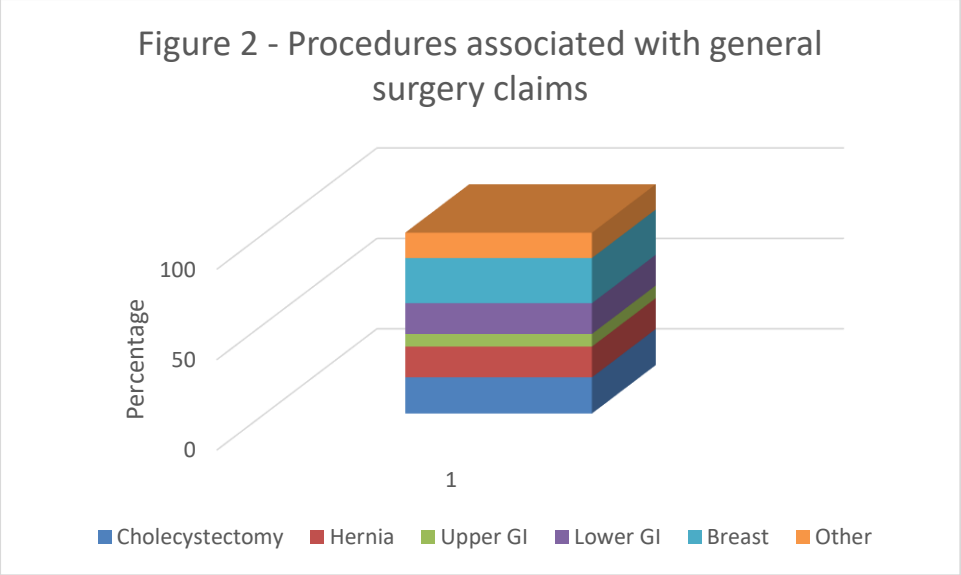
General surgery - learnings from litigation

Dr Sarah Townley, Deputy Medical Director at Medical Protection, shares learnings from Medical Protection's general surgery private practice claims.

At Medical Protection, our medicolegal teams support private practitioners with a range of potential issues arising from professional practice – from complaints through to inquests and of course clinical negligence claims. However, our preferred approach is to proactively assist members in helping them to reduce their risk whilst undertaking their day-to-day roles, and as part of this we regularly review and share themes and learnings from a range of past claims.

In this article we are specifically looking into clinical negligence claims experienced by general surgery consultants working in private practice in the UK over a 10-year period (2010-2020), excluding any bariatric procedures. These several hundred claims vary enormously in their complexity, but also in terms of cost with some claims being valued at over £1million. Most claims have a variety of underlying allegations including surgical technique, diagnosis, pre/post-operative care, consent and medical treatment (Figure 1). Although surgical technique appears as the dominant allegation, most claims involve a mix of many of the themes, and consent in particular can often be a crucial factor in the decision whether to defend or settle a claim.





Surgical technique

The commonest outcomes due to alleged inadequate surgical technique were bowel perforation, bile leak, nerve injury and poor cosmetic outcome. Often cited as a contribution to these injuries was an alleged failure to correctly identify the relevant anatomical structures, particularly in laparoscopic cholecystectomies. After these injuries, concerns were often raised that the injury was not identified during the operation and hence a significant delay in treatment occurred. In addition, the choice of operation/approach was also questioned in several claims particularly when more conservative options were available.

Diagnosis

Many claims centered around an alleged delay in diagnosis, particularly in relation to cancer diagnoses. Often this was due to a perceived delay in undertaking appropriate imaging, failure to consider alternative diagnoses or failure to involve a multi-disciplinary team or appropriate specialists. In some very high value claims the critical error originated from a simple administrative omission such as failing to organize a follow-up appointment, with potentially life changing results.

Pre- and post-operative care

Criticism of pre-operative care mainly arose from the alleged failure of the clinician to consider the risks and implications of the patient's previous medical history, and commonly their risk of thromboembolism. These failures often led to further allegations involving the failure to discuss alternative treatment options or delaying treatment. For post-operative care allegations often involved the failure to identify deterioration in the patient condition (e.g. deteriorating renal function, increased analgesia use, signs of sepsis) resulting in delay in further imaging and subsequent treatment. Failure to diagnose post-operative DVT/PE also featured prominently.

Consent

As we see in many clinical negligence claims, consent allegations centred around two themes: risks and alternative treatment options. Many of the claims related to alleged failure to advise of specific risks such as bowel injury, nerve injury and inadequate cosmetic outcome. Increasingly however, allegations in relation to consent are extending to failure to advise of alternative treatment options, particularly a conservative/non-surgical approach.

The recent case of McCulloch v Forth Valley Health Board (2023) brought this area into focus and clarified that a doctor should inform a patient about reasonable alternative treatment options by applying the Bolam professional practice test. A doctor should not simply inform a patient about the treatment option that the doctor themselves prefers.

Checklist to minimise your risk of a claim:

1. Review your consent discussion and documentation. Ensure that a patient is aware of the risks, benefits and complications of the procedure, but also any alternative or subsequent treatment option. Consider how the consent process may need to be tailored to that individual depending on any comorbidities, medical or social history, and allow sufficient time for the patient to consider their options. Ensure you are up to date on the latest GMC guidance regarding consent.
2. Consider the use of supporting information such as patient information leaflets or online guides to ensure full patient understanding at a time that is convenient to them. Use of these should also be documented in the records, and regularly reviewed to ensure they are still fit for purpose.
3. Be alert to the possibility of adjacent organ injury peri-operatively and have a low threshold for early review or to involve specialist colleagues at an early juncture.
4. You may be a very experienced surgeon, but it is always beneficial to continually evaluate your procedural skills or competency, perhaps through data or observation by a colleague. Alternatively, you may want to consider observing other colleagues to refresh your skills and knowledge or consider alternative techniques.
5. Ensure you undertake a thorough, consistent and documented pre-assessment of the patient, involving any specialist colleagues as needed to support your clinical reasoning.
6. Document a clear post-operative plan of when and how you should be contacted should any complications arise, how often observations should be undertaken, when other specialties should be involved if required and have a clear procedure for ensuring all test results are reviewed.

Case Study

Patient A was referred by their GP to Mr B, a consultant general surgeon, with recurrent abdominal pain. Patient A was a 50-year-old obese female who had experienced recurrent bouts of biliary colic and acute cholecystitis. Recent ultrasound demonstrated a dilated gallbladder containing multiple large mobile calculi.

Mr B saw Patient A in his clinic at the private hospital and explained the findings of the recent ultrasound. He discussed the possibility of undertaking a laparoscopic cholecystectomy and drew diagrams to explain the procedure and anatomy involved. A week later Patient A was admitted to hospital for her procedure. Pre-operatively Mr B visited the patient, discussed the risks again and Patient A signed the consent form. The consent form outlined that the procedure was a laparoscopic cholecystectomy with a 5% possibility of conversion to an open procedure. The form also referenced diagrams that were drawn in clinic to explain the risks but didn't specifically list the risks apart from bleeding and infection.

The operation was carried out the following day without any apparent difficulties. Mr B documented that the 'critical view' was obtained following initial dissection, and the cystic duct and artery were clearly identified. The gallbladder was removed and because the operative field appeared dry no drain was required.

Post-operatively Patient A was reviewed on several occasions by Mr B and discharged two days later following satisfactory observations. Histology confirmed a gallbladder containing numerous stones and an appearance consistent with cholecystitis.

Unfortunately, Patient A was readmitted two days later with jaundice and dark urine. Her abdomen was soft and non-tender; however, her liver function tests were abnormal. Following 24 hours observation Mr B made a provisional diagnosis of gravel in the common bile duct and elected to undertake an ultrasound the following day.

The next day, the ultrasound demonstrated two calculi in the proximal common duct and dilated intra hepatic ducts. On this basis Mr B felt the most likely cause of the jaundice was obstruction of the common duct by stones. Mr B referred Patient A for an ERCP which occurred five days later. At the ERCP the patient was found by Mr B's colleague to have a normal bile duct up to a specific level where four clips were found to completely occlude the duct. It was found impossible to pass contrast or a guide wire past the obstruction. The following day Patient A was taken for a laparotomy by Mr B to explore the common bile duct obstruction, remove the clip and repair the bile duct. Patient A made a slow and steady recovery and was discharged home eight days later.

A claim was brought against Mr B for failure to clearly outline the risks of a bile leak and increased risks of a surgical procedure in a patient with obesity, failure to correctly identify the critical anatomy during the operation and failure to refer to a specialist hepatobiliary surgeon for the bile duct repair.

Following the involvement of a clinical expert to assess the merits of the allegations the claim was settled on Mr B's behalf. Mr B reflected following the process and acknowledged that he would now have a lower threshold for converting to an open procedure if struggling to identify critical anatomy and would ensure more detailed documentation of the consent process in future.