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Medical negligence

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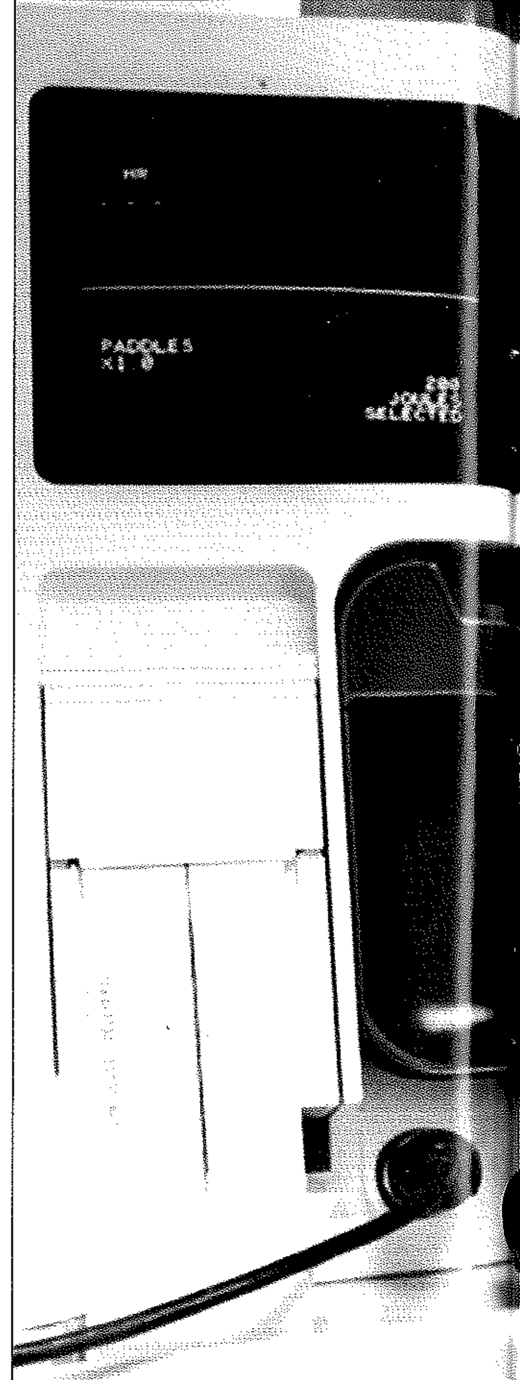
Liability for postsurgical infection

Surgical wounds are prone to infections. Good medical care requires doctors and hospitals to adequately warn patients and to diagnose and treat infections properly when they occur.

JIM LEVENTHAL AND ANTHONY VIORST



Consider this common scenario: A patient enters the hospital for routine surgery, assured by her surgeon that she will be home again and feeling better in a few days. After the operation, the doctor reports that the procedure went well and that she will recover quickly.

As time passes, the patient is feverish and weak. Her incision is not healing. She calls the surgeon several times and is readmitted. Her doctor diagnoses an infection and prescribes antibiotics, but the patient dies.

Most patients understand that surgery carries inherent risks, but many don't realize that one of the most serious is the risk of postoperative infection. Failure to diagnose and properly treat infections is one of the most common claims for negligent postsurgical care.

Courts have firmly established that any doctor who performs postsurgical follow-up care has a duty to do so competently. Plaintiffs have prevailed in a range of cases in which they have alleged negligence on the part of a doctor following surgery—for example, one defendant failed to recommend radiation treatment after cancer surgery;[1] another didn't reveal his suspicion that he had left a surgical sponge inside the plaintiff's wound.[2]

In a more common case, a patient's postsurgical infection causes significant medical complications or death. Courts have found doctors and hospitals liable for mismanaging such infections and for the complications that result.[3]

Although negligence claims related to follow-up care are subject to the same proof requirements as surgical claims—including, for example, the need for expert testimony[4]—attorneys need to be aware of the factual and legal issues that are particular to this kind of medical malpractice case.

Doctor and hospital liability

Postoperative negligence on the part of a physician can come in many forms. In one case, a doctor performed an appendectomy on an 11-year-old girl who had been brought to the emergency room complaining of abdominal pain. The patient developed an infection of the surgical wound, which the doctor drained and treated with an antiseptic medication. On the same day she

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was discharged, the patient later was admitted to another hospital, again complaining of abdominal pain. The same doctor continued to treat her until she was discharged a week later.

At trial, the patient's mother claimed that the doctor's negligence had resulted in a longer recovery time from the infection and had left her daughter with a much larger and more unattractive scar than she would have had if she had received proper care. Specifically, the plaintiff alleged failure to administer preoperative antibiotics, improper choice of postoperative antibiotic, failure to culture the wound to determine the proper antibiotic to administer, and improper discharge of a patient with a draining wound.[5]

Because consent forms commonly refer to postsurgical infections, a defendant doctor may try to present a consent or assumption-of-risk defense. However, a patient's consent to the possibility of a postsurgical infection is not a consent to its mismanagement. This was articulated in *Vedros v. Massiha*:

> Plaintiffs concede that they were fully informed by Dr. Massiha of the risks of the initial surgery and that one of the risks they were informed about was the risk of infection. In fact, plaintiffs were informed of the high risk of infection involved in the particular surgical procedure which they wanted him to perform. However, once the infection manifested itself, plaintiffs argue that they were not thereafter fully informed of further risks involved in the treatment of the infection. . . .[6]

In several cases, courts have upheld the general principle that when a patient signs a consent form, he or she has not consented to any subsequent negli-

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JIM LEVENTHAL *is a partner with Leventhal, Brown & Puga in Denver.* ANTHONY VIORST *is an associate with Lapin & Associates, also in Denver.*

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gence by the defendant. A patient's consent to the potential risk inherent in a procedure does not absolve a doctor of responsibility for subsequent care, including for postsurgical infection.

For example, in *Waller v. Aggarwal*, the plaintiff claimed that as a result of negligence during laparoscopic surgery, the defendant twice perforated her bladder. In denying the allegations, the defendant used several affirmative defenses, including that the plaintiff was fully informed of the risks associated with the medical procedure.

An appeals court, however, determined that the admission of a consent form was reversible error because

> the fact that appellee informed appellant that injury to the bladder was a possible risk of the procedure could not be a defense to the claim of negligence brought by appellant... [and] the admission of evidence pertaining to that issue, and references made to that issue, carried great potential for the confusion of the jury.[7]

Admission of a patient's informed consent—even in a strong medical negligence case—carries a substantial risk that the jury will confuse it with a release of liability such as, for example, one customers sign to rent ski gear.

Regardless of consent or lack thereof for the surgery itself, claims should be considered when a postsurgical infection is mismanaged. A doctor may have failed to administer an antibiotic preoperatively, chosen an inappropriate postoperative antibiotic that had severe side effects, or discontinued the appropriate antibiotic without informing the patient. *Hutchinson v. United States*, although it did not involve postsurgical negligence, provides a good example.

The Ninth Circuit held that the trial court erred in granting judgment in favor of a U.S. Public Health Service hospital on the plaintiff's informed consent claim. The appeals court found that the evidence showed the plaintiff's asthma had responded favorably to conservative, low-risk drug treatment in the hospital's emergency room. However, after admitting the patient, the doctor discontinued the medication and substituted a drug carrying the risk of crippling side effects, which the plaintiff

developed a year later. The court reinstated the case.[8]

A hospital, acting through its nurses or other agents, may also be held liable for the damages arising from postsurgical infections. While a hospital is "not a guarantor against infection,"[9] it opens itself up to a negligence action if, for example, it fails to take adequate steps to avoid or minimize an infection, or fails to recognize signs or symptoms of an infectious process.[10]

This liability is well established. In cases dating back more than 60 years, courts have found hospitals liable for placing a patient in contact with infected people,[11] using an unsterile hypodermic needle,[12] and conducting an unsterile manual examination.[13] In suits where it is clearly evident that an infection would not have occurred had the accepted medical standard been followed, a plaintiff may be entitled to a res ipsa loquitur instruction.[14]

Apportionment of liability

Under common law, the original tortfeasor is liable for all foreseeable consequences of his or her negligence. This includes subsequent acts of medical malpractice.[15] According to the *Restatement (Second) of Torts,*

> If the negligent actor is liable for another's bodily injury, he is also subject to liability for any additional harm resulting from normal efforts of third persons in rendering aid which the other's injury reasonably requires, irrespective of whether such acts are done in a proper or a negligent manner.[16]

The same principles may apply when the original tortfeasor is a physician whose negligence led to subsequent care that was also negligent. Accordingly, a surgeon may be held liable for all damage resulting from negligent care of a postsurgical infection. If the infection results from the surgeon's negligence (as when a sponge is left inside the patient), he or she will be deemed the original tortfeasor and can be held responsible for any subsequent negligence by doctors who treat the infection.

For example, in *Holleman v. Gibbons*, the plaintiff alleged that the defendant doctor's negligence following an osteotomy delayed the healing of her bone and required prolonged treatment, including the application and removal of several casts.[17] The defendant claimed that a hospital technician negligently applied the last of the casts, resulting in peroneal nerve palsy in her foot.

The trial court found insufficient evidence to show that the doctor's treatment of the plaintiff until the final cast was applied, even if negligent, was the proximate cause of her palsy. The appeals court disagreed, finding that the lower court wrongly instructed the jury to limit its consideration of negligence to the doctor's treatment of the plaintiff after the last cast was applied.

Courts have upheld the general principle that when a patient signs a consent form, he or she has not consented to any subsequent negligence by the defendant.

Some states, however, have enacted statutes that allow the original tortfeasor to seek an apportionment of liability. Under Colorado law, for example,

> any provision of the law to the contrary notwithstanding, the finder of fact in a civil action may consider the degree or percentage of negligence or fault of a person not a party to the action . . . in determining the degree or percentage of negligence or fault of those persons who are parties to such action.[18]

Therefore, it is usually in the plaintiff's best interest to name all potentially negligent parties as defendants. Practitioners must be mindful of such legislative provisions before relying on the common law rules holding the original tortfeasor liable for the conduct of subsequent actors.

Negligence during postoperative care is sometimes overlooked as a viable claim, but it can constitute a basis for liability in a medical malpractice case. Plaintiff lawyers should investigate the potential for such a claim before filing a complaint. Those who fail to do so risk presenting only a partial picture of the plaintiff's injuries. ■

Notes

1. Esfandiari v. United States, 810 F. Supp. 1 (D.D.C. 1992).
2. Dietze v. King, 184 F. Supp. 944 (E.D. Va. 1960).
3. *See, e.g.,* McKowan v. Bentley, 773 So. 2d 990, 997 (Ala. 1999); Searle v. Bryant, 713 S.W.2d 62 (Tenn. 1986); Porter v. Henry Ford Hosp., 450 N.W.2d 37 (Mich. Ct. App. 1989); J. Kraut, Annotation, *Hospital's Liability for Exposing Patient to Extraneous Infection or Contagion,* 96 A.L.R.2d 1205 (1964).
4. *See, e.g.,* Cox v. Jones, 470 N.W.2d 23, 26 (Iowa 1991).
5. *See Searle,* 713 S.W.2d 62, 63.
6. 646 So. 2d 1120, 1123-24 (La. Ct. App. 1994).
7. 688 N.E.2d 274, 275 (Ohio Ct. App. 1996). *See also* Yonce v. SmithKline Beecham Clinical Lab., Inc., 680 A.2d 569, 584 (Md. Ct. App. 1996).
8. 915 F.2d 560 (9th Cir. 1990).
9. Criss v. Angelus Hosp. Ass'n, 56 P.2d 1274, 1278 (Cal. Ct. App. 1936).
10. *See Porter,* 450 N.W.2d 37, 39.
11. *See, e.g.,* Kapuschinsky v. United States, 248 F. Supp. 732 (D.S.C. 1966); Taaje v. St. Olaf Hosp., 271 N.W. 109 (Minn. 1937).
12. *See, e.g.,* Kalmus v. Cedars of Lebanon Hosp., 281 P.2d 872 (Cal. Ct. App. 1955); Peck v. Charles B. Towns Hosp., Inc., 89 N.Y.S.2d 190 (App. Div. 1949).
13. *See, e.g.,* Helman v. Sacred Heart Hosp., 381 P.2d 605 (Wash. 1963).
14. *See, e.g.,* S. Fla. Sanitarium & Hosp., Inc. v. Hodge, 215 So. 2d 753 (Fla. Ct. App. 1968).
15. *See, e.g.,* Powell v. Brady, 496 P.2d 328, 331 (Colo. Ct. App. 1972).
16. RESTATEMENT (SECOND) OF TORTS §457 (1965).
17. 541 N.E.2d 345 (Mass. App. Ct. 1989).
18. COLO. REV. STAT. §13-21-111.5(3)(a) (2003).