Res ipsa amputated: Plaintiffs turn to circumstantial evidence

At both the federal and state levels, the latest medical malpractice reform campaign seems to have fallen short of its mark. Despite the relentless efforts of the insurance and medical lobbies, statutory medical malpractice reform at the federal and state level will have to wait for another day.

Here in North Carolina, however, the Court of Appeals is delivering the prize that has eluded lobbyists for years. The statutory "same or similar communities" standard, which has morphed into a standard governing the admissibility of expert witness testimony, has been so badly mauled by the courts that even the most well-credentialed and meticulously prepared experts confront the prospect of being stricken in a given case. As a result, dismissal of meritorious claims for want of expert witnesses has become commonplace in medical malpractice cases.

And now, the Court of Appeals appears to be slamming the door on what may be the most common type of malpractice claim, the surgical malpractice case.

In the first phase of this assault, the Court of Appeals all but eliminated the application of res ipsa loquitur to medical malpractice cases. As a consequence, plaintiffs must now staff even the most clear-cut surgical malpractice case (think amputating the wrong leg) with a phalanx of experts. In a typical operating room case, an injured patient is forced to hire multiple standard-of-care and causation experts to review and synthesize the evidence, re-create what occurred during surgery to cause the plaintiff's injuries, re-create the acts and omissions committed by the various defendants, and then render opinions as to whether the conduct of the defendants complied with the applicable standards of care. In other words, instead of pursuing a res ipsa case, plaintiffs now have to go the more complex (and more expensive) route of proving a circumstantial evidence case.

With the recent case of Kenyon v. Gehrig, 2007 N.C. App. Lexis 1104 (June 5, 2007), in the books, surgical cases based on circumstantial evidence are now threatened with extinction as well. In Kenyon, the court blithely ignored the testimony of three physicians, all of whom testified that negligence in the operating room caused the plaintiff's injuries, on the basis that the experts presumed negligence purely from the fact of the injury itself. The opinions at issue in Kenyon were unremarkable and were characteristic of the circumstantial evidence testimony that plaintiffs have been presenting in operating room cases for decades. More worrisome still, Kenyon is so poorly reasoned and susceptible to capricious misinterpretation that its likely legacy will be the filing of summary judgment motions in all operating room cases.

In Part One of this series we will view the traditional application of res ipsa loquitur in medical malpractice cases and the systematic narrowing of this doctrine to the vanishing point by the Court of Appeals. In Part Two, we will address attempts by plaintiffs to prove surgical malpractice cases through the use of expert testimony and circumstantial evidence. We will conclude with an analysis of the Kenyon opinion, its rationale, and its implications for injured patients.

Epidemic of surgical errors

Limiting a patient's ability to recover for operating room malpractice is especially alarming in that surgical mistakes are likely the most common form of medical malpractice. The Institute of Medicine has estimated that nearly 100,000 deaths occur each year as the result of medical errors.1 Recent research suggests that a large percentage of these deaths and other adverse events are surgery-related.

A recent analysis of 15,000 hospital discharges revealed that 66 percent of the reported adverse events were surgery-related and that surgery-related errors accounted for 12 percent of all hospital deaths.2 Examining 1277 patient-days for 192 general surgery patients, Canadian researchers reported that 39 percent of those patients suffered a total of 144 complications. Seventy-eight percent of the errors occurred during or after surgery.3 According to statistics from the National Patient Safety Benchmarking Center, adverse events in surgery are the most frequent and costly type of medical error occurring in hospitals. In the December 2001 issue of its Sentinel Event Alert, JCAHO reported that the number of wrong-site, wrong-person or wrong-procedure surgeries had grown tenfold since 1998.

Reasonable minds can differ on the issue of tort reform. No one, however, can credibly deny the fact that thousands of operating room patients are being injured and killed every year by preventable surgical errors.

Evidentiary hurdles in surgical malpractice cases

Because surgical patients are rarely witnesses to the negligence that injures them, the North Carolina courts were traditionally indulgent in allowing application of the res ipsa loquitur doctrine in medical malpractice cases.

In clear-liability cases, one would expect to find some suggestion of error in the surgical report, anesthesia record or PACU documents. Think again. We frequently see cases where clients are butchered in the operating room but have medical records that read like a surgical textbook.

Depositions offer even less prospect of success. In most operating room cases, the testimony of one becomes the testimony of all. This is not to suggest collusion or choreography. It is a simple fact, based upon years of observation. I have yet to hear even the most culpable surgeon or CRNA admit to fault during a deposition.

Discovering the truth is further hampered by the impenetrable shroud of peer review. Following a sentinel event, surgeons, anesthesia personnel and operating room staff typically huddle at a medical review meeting. Presumably, the participants discuss the case, assess potential causes for the adverse outcome, and implement strategies for improving care in the future. Unfortunately, these proceedings and findings never see the light of day due to North Carolina's broad peer review privilege.

Given this combination of factors, the surgical malpractice case is very much an exercise in puzzle-solving and is frequently replete with mysteries, conspiracies, sub-plots and intrigue. The pieces are all on the table, but it is up to counsel, well-armed with a nose for mystery and a cohort of expensive experts, to assemble those pieces into a coherent whole.

Res ipsa loquitur

Mindful of the evidentiary difficulties confronting surgical malpractice plaintiffs, the North Carolina courts were traditionally generous in permitting application of the doctrine in operating room negligence cases. For example, North Carolina courts applied the doctrine when foreign objects, such as surgical sponges4 and drainage tubes were left in patients during surgery. The doctrine was also applied when patients suffered an unusual injury to an area that was physically remote from the body area that

was targeted for treatment. For example, res ipsa was applied when a patient emerged from major gynecological surgery with ulnar nerve damage.

This practical approach may be best illustrated by the case of Schaffner v. Cumberland County Hospital System, Inc., 77 N.C. App. 689, 336 S.E.2d 116 (1985). In Schaffner, the minor plaintiff woke from ear surgery with a burn on her left hand. The court allowed the case to go to the jury on a res ipsa loquitur instruction, based on the plaintiff's theory that the burn was caused by an electrocautery device used during the procedure.

The court began its analysis by recognizing that "while ordinarily negligence must be proved and cannot be inferred from the fact of an injury … res ipsa applies and allows the finder of fact to draw an inference of negligence from the circumstances surrounding injury" when (1) the injury is of a type that does not ordinarily occur in the absence of some negligent act or omission; (2) direct proof of the cause of the injury is unavailable; and (3) the instrumentality involved in the accident is under the exclusive control of the defendant.

As to the first element, the court held that "[w]hile undoubtedly risks are inherent in the medical treatment patient received, a jury, based on common knowledge and experience, could reasonably conclude that a burn on a portion of her body not involved in the surgery was not among those risks and that, but for the negligence of some person(s) in control of her person and the instrumentalities used in her treatment, she would not have been injured."

Evidence in the case revealed that the device had malfunctioned during surgery and had been problematic in the past. The court held that, "while this [evidence] falls short of establishing the actual causation necessary to prove negligence directly, it identifies a plausible source of plaintiff's injury. Such evidence may be considered in determining whether res ipsa should apply (emphasis added)."

As to the second res ipsa element, that direct proof of the injury be unavailable to the plaintiff, the court held that it had likewise been satisfied. In so holding, the court observed that "[h]ere plaintiff was anesthetized during surgery and can offer no account of her injury. Plaintiff's mother and grandmother can only attest to the fact that her hand was not burned prior to surgery, but was burned immediately afterward." This, the court ruled, was sufficient to satisfy the second prong of the res ipsa test.

The court held that plaintiff had also satisfied the "exclusive control" prong of the res ipsa doctrine. Arguing against this position, defendant argued that plaintiff had failed to identify the specific instrumentality that inflicted the injury, and failed to identify the specific defendant who was in control of that instrumentality. The court disagreed, holding that, "[h]ere plaintiff has identified the [device] as a probable source of her injury and … testimony regarding the defective [device] strengthens the inference of negligence arising from the circumstances surrounding the injury. Further, defendants were admittedly in control of plaintiff's person and of all instruments in the operating room. To require an anesthetized patient to do more than establish the defendants' control of the circumstances causally linked to the patient's injury would artificially limit a doctrine intended to apply when the particular facts surrounding an injury are not known (emphasis added)."

In reaching this conclusion, the court echoed reasoning that had been applied by the North Carolina Supreme Court a half-century earlier in the case of Pendergraft v. Royster, 203 N.C. 384, 166 S.E. 285 (1932). In Pendergraft, the court held that, while "mere proof of a mistake or poor results does not itself

prove malpractice … where the injury is received while the patient is unconscious, [res ipsa] commonly is held to apply because under such circumstances the patient would not be able to testify as to what happened, whereas the physician could."

Since Schaffner, the North Carolina appellate courts have been excruciatingly reluctant to recognize application of the doctrine in medical malpractice cases. For example, the Court of Appeals has held that the appearance of a wound on a patient's cheek following denture surgery did not, standing alone, warrant application of res ipsa loquitur. Citing the complexity of the medical conditions at issue, the Court of Appeals has held that res ipsa was inapplicable to a patient who suffered sciatic nerve damage during a bone marrow harvesting procedure. Similarly, the court recently determined that the inadvertent laceration of an artery during a laminectomy was not sufficient to invoke the doctrine, nor was a patient's adverse reaction to an approved medication.

Indeed, it appears that the North Carolina appellate courts have recognized the application of res ipsa in a malpractice case only once since 1985, and that case involved a sponge that was left inside a patient following surgery.16 To remove any doubt as to the lengths defendants will go to avoid application of the doctrine, the defendants in that case argued against application of res ipsa on the basis that the sponge was left inside the patient to serve a "therapeutic" purpose!

One lesson emerges from these cases. Except for cases involving a retained surgical instrument, there is no such thing as res ipsa loquitur in medical malpractice cases. I would go even further and suggest that, given its current makeup, the Court of Appeals might well reject application of the doctrine to a case involving a retained instrument, as long as defense counsel is able to find an expert who is willing to defend the conduct of his Hippocratic brother. And trust me, this is no tall task, even in the most egregious cases.

The decisions emerging from the Court of Appeals over the past 20 years suggest that res ipsa loquitur will not be recognized in any malpractice case that involves contradictory expert testimony. If a defendant can find an expert to testify that retained surgical sponges serve a therapeutic purpose, you can be certain of one thing: Out there somewhere is an expert who is willing to testify that amputating the wrong leg, while not exemplary care, is within the standard of care.

Conclusion

Attorneys who file malpractice claims relying solely on the doctrine of res ipsa loquitur do so at their peril. The more conservative course is to retain an expert, regardless of how obvious or clearcut the negligence may seem.

Of course, absent an admission of negligence, most surgical malpractice claims still require plaintiffs to base their cases on circumstantial evidence. In Part Two of this series, we will examine the manner in which plaintiffs have accomplished this task, and will address the likely impact of Kenyon will have on future operating room negligence cases.