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Medical malpractice and hernia repair: An analysis of case law

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ABSTRACT

Background: Litigation analysis and clinician education are essential to reduce the number and cost of malpractice claims. This study evaluates the clinical characteristics and legal outcomes of medical malpractice litigation initiated by patients having undergone a hernia repair operation.

Materials and methods: Published civil suits were obtained from a legal database for state and federal decisions constituting case law. The published material includes information on defendants, plaintiffs, allegations, outcomes, and a variety of legal issues. A retrospective review of 44 published cases from 25 states was performed.

Results: Complications were present in 20 of 44 (45%) suits, four (9%) of which were because of infection. Death occurred in five (11%) cases, and failure to obtain informed consent was alleged in seven (16%) of the suits. Retained foreign bodies were present in 7 of the 44 (16%) suits. Other allegations included incorrect surgical technique, insufficient need for surgery, and emotional distress. Most (64%) patients initiating malpractice litigation were male, and inguinal, hiatal, and ventral hernia repairs account for 39%, 27%, and 14% of cases, respectively. Most suits (40%) were initiated in Southern states. Surgical mesh was indicated in 5 of 44 (11%) suits but four of five were unrelated to the suit. One patient initiated litigation because of the fact that the surgeon did not use mesh during surgery, which was discussed preoperatively during the informed consent. The court ruled in favor of the plaintiff in 12 of 44 (27%) suits, with compensation ranging from roughly $19,000 to $8,000,000. Louisiana and New York had six and seven suits each, which appears disproportionate given their respective populations.

Conclusion: Complications and death resulting from alleged clinical negligence play a significant role in both the initiation and the outcome of malpractice litigation. Retained foreign bodies and lack of informed consent account for roughly one-third of malpractice litigation associated with hernia repairs. Many of these suits may be avoided with proper patient education and documentation of such along with standard operative preventative measures.

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1. Introduction

Hernia repairs represent one of the most common General Surgical procedures, with at least 700,000 cases of inguinal hernia repairs and 200,000 cases of ventral hernia repairs performed annually in the United States alone [1,2]. Most patients have a short inhospital stay, short recuperation time, and return to their regular activities without suffering long-term complications [3]. However, similar to most surgical procedures, these procedures are not free of complications; there is a potential for the patient to experience chronic pain, wound complications, infection, visceral or vascular injuries, and so forth and, as a result, short- or long-term morbidity that impacts their quality of life [4–6].

The relentless debate over medical malpractice litigation continues in both the United States and abroad [7,8]. Advocates of tort reform protest the burden of frivolous malpractice lawsuits and thereby branding them as a major impetus for rising health care costs [9]. Lawsuits involving malpractice, even ones that are later dropped, are costing medical community exponentially more than compared with just a few short years ago [10]. Unfortunately, with 75% of physicians in low-risk specialties and 99% of medical professionals in high-risk practices being sued for a malpractice incident before the age of 65, litigation is nearly unavoidable for most surgeons regardless of competency and technical skill [11]. In addition to being unavoidable, malpractice litigation is tremendously expensive and costs the surgical community over $250 million annually in indemnity payments alone [12]. Even when successfully litigated, malpractice litigation costs for defendants average more than $50,000, according to a recent study of approximately 1,500 malpractice insurance claims [13]. Furthermore, the mental toll of malpractice litigation can have devastating and lasting effects, especially for surgeons, who have a 10% greater chance of developing depression and a 7% higher rate of burnout [14].

Despite the massive scale of this problem, malpractice reform has yet to occur, which underscores the importance of litigation analysis and clinician education. Various topics in medical malpractice involving General Surgery have been studied, but little is known about litigation as it relates to operative hernia repairs in the United States. This study aims to evaluate the clinical characteristics and legal outcomes of medical malpractice litigation initiated by patients having undergone a hernia repair operation.

2. Methods and materials

A collection of U.S. civil suits that involved malpractice in patients having undergone hernia repair was retrieved from an online legal database (LoisLaw, Wolters Kluwer, New York, NY). This database includes published case law related to civil suits on the federal and state levels. Case law is a set of reported judicial decisions of both trial and appellate courts, which make new interpretations of the law and can be cited as precedents. All federal and state cases were reviewed, and published reports were obtained. Forty-four reports of cases involving nonjailed individuals from 1975 to 2005 were analyzed. Data were extracted from the reports and entered into Excel (Microsoft Corp, Redmond, WA). Data included the patient's gender, type of hernia repair, use of mesh, surgical complications, and mortality. Information related directly to the trial, including reasons for the suit, trial state and year, legal outcomes, and indemnity payments, also was obtained.

3. Results

Complications were present in 20 of 44 (45%) suits, four (9%) of which were because of infection. Surgical mesh was indicated in 5 of 44 (%) suits but four of five were unrelated to the suit. Other complications included postoperative pain, perforated bowel or esophagus, nerve damage, severed arteries, severed vas deferens, and anoxic and traumatic brain injuries. In 5 of the 44 (11%) suits, the hernia repair resulted in death. Causes of death included pulmonary embolism, oxygen deprivation, severed hepatic vein, hemorrhage, and sepsis. Retained foreign bodies were present in 7 of 44 (16%) suits, which included surgical sponges (five), sutures (one), and metal clamp (one). Failure to obtain informed consent was alleged in seven (16%) suits, with the most common alleged reason being that the physicians performed procedures not discussed within the informed consent for the operation. One patient alleged that she was not informed of alternative options to surgery. Additional details regarding cases involving consent failures can be found in Table 1. Other allegations included incorrect surgical technique, insufficient need for surgery, and emotional distress.

Inguinal hernia repairs accounted for 17 of 44 (39%) of suits, with one of these surgeries resulting in death and one resulting in postoperative infection (Table 2). Hiatal and ventral/incisional hernias accounted for 12 (27%) and 6 (14%) of 44 suits, respectively. Death occurred in two of the hiatal hernia suits and one of the ventral/incisional hernia suits. Postoperative infection occurred in two of the hiatal hernia suits and in one of the ventral/incisional hernia suits. There was one suit that involved a spigelian hernia repair and two

Table 1 – Malpractice case details for consent failures.

Case year	Hernia type	Allegation/reason
1978	Not indicated	Surgeon performed ileostomy without prior informed consent.
1983	Inguinal	Patient was not informed of nonsurgical alternatives.
1987	Hiatal	Surgeon used an Angelchik ring without prior informed consent.
1989	Hiatal	Surgeon performed vagotomy and pylorplasty without prior informed consent.
1996	Inguinal	Surgeon did not use mesh even though the consent indicated so.
2000	Umbilical	Patient's navel was removed as a result of the surgery and was not informed of this potential complication.