Successful Defense of Surgical Judgment

By Dan Himmelberg, JD

Mr. Gamgee1 was a 70 year-old male who was a smoker and slightly overweight. He had a history of back pain and of a skin cancer removed 20 years before. His hypertension had been treated over many years with various medications but was not well controlled. He presented to the Emergency Department early Thursday evening with right lower quadrant abdominal pain (which he reported as a 10 out of 10 on a pain scale), stating he had been experiencing this pain for a day. Mr. Gamgee complained of nausea, vomiting and insomnia the night before. He had a BP of 174/89, temperature of 98.9, pulse of 64 and respirations of 20. CBC test results showed his white blood count slightly elevated at 13.5. Blood chemistry labs showed an elevated BUN at 23 and elevated creatinine at 1.8. X-ray imaging showed a calcified aortic shadow suggesting an infrarenal aortic aneurysm which warranted follow-up evaluation. Mr. Gamgee was admitted for surgical evaluation.

Morphine helped the patient's pain, and a CT scan was performed. The surgeon, Dr. Whyte, reviewed the CT imaging himself and identified a large aortic aneurysm below the renal artery but saw no evidence of leakage of blood from the aneurysm. A radiology report the next day agreed with this interpretation. Dr. Whyte interpreted the CT imaging as not confirming an abnormality of the appendix but not ruling it out. The later radiology report did not mention the appendix. When Dr. Whyte evaluated Mr. Gamgee, his right lower quadrant was very tender at McBurney's point. There was little abdominal distension. He was able to palpate the aneurysm, and the patient did not report tenderness. Mr. Gamgee was not tachycardic.

Dr. Whyte recognized the surgical dilemma. The clinical symptoms were strongly suggestive of appendicitis, but the CT imaging did not show appendicitis. The CT imaging was thought to be up to 95% accurate in diagnosing appendicitis. Alternatively, the symptoms were not typical, but Dr. Whyte could not rule out that the aneurysm was causing them. Additionally, the patient was at increased surgical risk due to his high blood pressure and kidney concerns.

Dr. Whyte decided the best course was to perform a diagnostic laparoscopy then let his findings guide the surgical course. If it showed any evidence of blood tinged fluid then he would proceed with emergency repair of the aneurysm. If it did not, then he would evaluate the appendix and otherwise try to optimize the patient for later surgical repair of the aneurysm. Mrs. Gamgee signed the surgical consent for her husband. In the surgery, Dr.

Whyte saw no evidence of leakage from the aneurysm. He described the appendix as appearing “a little inflamed”. Because it did not appear completely normal and Mr. Gamgee had strong clinical symptoms, Dr. Whyte removed the appendix.

After surgery, Mr. Gamgee was admitted to the ICU to try to improve his blood pressure and kidney function. Dr. Whyte’s plan was for an arteriogram to take place the following Monday to further assess the aneurysm. The next day, Friday, cardiologist Dr. Took assessed the patient as high risk for further surgery and recommended proceeding with caution. Mr. Gamgee was in no distress and no longer had nausea or vomiting.

Dr. Whyte briefed his partner, Dr. Brandybuck, who was covering for him over the weekend. Mr. Gamgee appeared to improve on Saturday. Dr. Brandybuck and a radiologist reviewed the CT scan from Friday and agreed that it did not show any signs of leakage from the aneurysm. A preliminary pathology report stated the appendix appeared to be normal. Mr. Gamgee appeared stable and improved through the day on Sunday. At 22:40 Sunday evening, he complained of some right flank pain. At 22:43 Mr. Gamgee complained of intense sharp back pain, his eyes rolled back, and he arrested. Resuscitative efforts were not successful, and Mr. Gamgee was pronounced dead at 23:05. The record of death noted the immediate cause of death as “cardiopulmonary arrest” and did not reference a ruptured aneurysm. No autopsy was conducted. Dr. Whyte prepared the death certificate and listed “ruptured abdominal aneurysm” as the cause of death.

Ten months after the death, Mrs. Gamgee filed suit against Dr. Whyte. The litigation advanced, and her experts opined that Dr. Whyte should have ruled out appendicitis. They stated that the CT results showed no problems with the appendix and given Mr. Gamgee’s pain complaint of 10 out of 10, there should have been a high level of suspicion that the appendix was not the cause. These experts testified that the aneurysm was the true concern that should have been dealt with urgently. They conceded that the patient’s blood pressure and kidney function needed to be dealt with but they alleged that this could have been done within a day. They noted how well the patient was doing the day after the appendectomy. The plaintiff’s experts opined that the aneurysm could have been dealt with that day if Dr. Whyte had not imprudently performed the appendectomy. If the aneurysm had been treated (either by stenting or with a bypass) then the rupture and death would have been avoided.

Dr. Whyte defended his care and had supportive experts. Fortunately, Dr. Whyte’s surgical decision-making was outlined in the records which aided his defense significantly – especially when trying to convey what he was thinking at the time he was treating the patient (without the benefit of 20/20 hindsight). Dr. Whyte’s testimony, in his deposition and a trial, needed to be credible and convincing in order to fully explain his actions and thought process. Even though Dr. Whyte had served as a testifying expert witness in the defense of other surgeons and was generally familiar with the process, he took the extra step of working with a witness preparation consultant prior to his trial testimony. Explaining his care as a defendant required a different mind-set and perspective than he had needed

an expert witness. He had to show his care and concern for Mr. Gamgee as much as his actual surgical expertise and decision-making based on the information he had at the time. Fortunately, the jury found that Dr. Whyte used reasonable surgical judgment and returned a defense verdict on his behalf. The Court entered a Judgment for Dr. Whyte and dismissed the lawsuit. This case was likely won at trial due to Dr. Whyte's thorough documentation in the patient's record at the time of treatment and then his time and effort in working with his defense team after the suit was filed.

[1]The names of the patient and physicians have been changed.
