Post-Op Complications and Their Impact on Medical Defense

By Grace Gilliland, J.D.

Medically-assisted weight-loss has taken center stage in recent years for patients with high body mass indexes, increased risk of diabetes, and other co-morbidities. While use of prescription weight-loss drugs is on the rise, bariatric surgeries have been a weight-loss solution for decades. These surgeries can be difficult for some patients and may present post-operative complications.

Complications from bariatric surgery became a reality for a patient in his mid-fifties with a history of morbid obesity and hypertension. In 2017, the patient sought treatment from Bariatric Surgeon Dr. Galinda Alani[1] for gastric lap-band surgery. During the surgery, the patient had no noted complications, nor did he voice complaints during several routine follow-up visits. However, sometime later, the patient developed several complications, all of which he attributed to Dr. Alani's surgery.

The patient's first ER visit in September 2017 indicated a possible lap-band slip. He went to the ER complaining of abdominal pain, nausea, and vomiting. His esophagram showed that the band orientation appeared proper, but that a small portion of the stomach had

slipped through the band. His treatment included prescription medication, and he was discharged to follow up with Dr. Alani. His symptoms resolved a few days later, and he was tolerating liquids without issue. He continued to see Dr. Alani every two weeks with no issues. Throughout the following year, the patient underwent several band adjustment procedures with Dr. Alani, all of which were completed without complications.

Approximately a year and a half after the initial surgery the patient went to the ER again, this time with a small bowel obstruction. A CT scan showed that the lap-band was appropriately positioned, there was no free air, and there was dilation of the proximal small bowel, duodenum, and stomach. The patient had a perforation, which the ER providers noted was likely due to essential closed-loop obstruction between the band and small bowel transition. The on-call surgeon, Dr. Suki Bee,[2] performed an exploratory laparotomy, removal of the laparoscopic adjustable gastric band, repair of a gastric perforation, and lysis of adhesions with release of a small-bowel obstruction. Following the surgery, the patient began exhibiting signs of respiratory failure. He remained at the admitting hospital for approximately two weeks, until he was discharged to a nursing and rehab facility.

The patient filed a lawsuit against Dr. Alani and her group shortly after his discharge from the nursing facility. Some of the allegations included failure to obtain informed consent of the risks associated with the placement of the lap-band, including slippage and erosion of the stomach wall; failure to perform additional testing to determine the extent of slippage; and failure to perform testing to determine if there was erosion of the stomach wall. These allegations were heavily analyzed during the discovery process, and the parties learned that the patient had several previous abdominal surgeries before his gastric lap-band surgery. Furthermore, his psychological evaluation prior to surgery raised some concern about his level of functioning and awareness of the risks and complications of the surgery. Although the patient completed all pre-surgery educational requirements, was warned of potential risks, and signed the seventeen-page consent form, his mental status was still in question.

In the litigation, the patient asserted an issue regarding his ability to consent to the surgery along with his expert proof on the standard of care and causation. The patient argued that he did not give informed consent for the 2017 surgery. He claimed that he was not advised of the risks associated with the procedure or alternative treatments, despite completing the pre-surgery educational requirements and signing the lengthy consent form The trial judge was not persuaded by his argument, and instead entered an order finding that the patient did consent to surgery. However, the judge agreed to pause the case while the patient pursued an interim appeal. Ultimately, the appellate court determined that informed consent for the surgery was obtained. The case proceeded, but the court dismissed the patient's claim regarding his consent to the surgery. The patient proceeded with his expert proof as to the standard of care and causation of his injuries. He presented an expert who asserted that once a slip was seen on the imaging, Dr. Alani should have performed surgery to reposition the band or ordered a swallow test one month after the slip was diagnosed to determine if the slip fixed itself. Surprisingly, the expert testified on multiple

occasions that the lap band did not cause the small bowel obstruction. Instead, it was more likely that prior abdominal surgeries and adhesions caused the obstruction.

Dr. Alani presented a thorough and formidable defense of her care. She explained during her deposition that most bariatric patients have psychological issues, including anxiety and depression, which is one reason for frequent follow-up. She also explained that the bowel obstruction was likely a result of scar tissue that occurred from previous abdominal procedures. Dr. Alani's position was well-supported by expert testimony. The defense expert testified that Dr. Alani met the standard of care during the initial surgery and post-surgically. The defense expert was supportive of the position that the lap band did not cause the bowel obstruction, and it was likely the adhesions from prior abdominal surgeries caused the obstruction.

This case went to trial and Dr. Alani prevailed. Although this was a situation that involved many post-operative complications for this patient, the evidence showed that such complications were known to the patient, that he consented to the procedure, and that the care he received during surgery and post-operation was appropriate. Ultimately, the majority of jurors[3] found that Dr. Alani used the degree of care and skill that a reasonably prudent and competent physician would under similar circumstances, based in no small part on her well-prepared testimony at trial, strong expert support, and the thorough documentation of the informed consent discussion.

[1] Names have been changed to protect the identity of parties involved.

[2] Names have been changed to protect the identity of parties involved.

[3] This case was tried in a jurisdiction that does not require unanimous jury verdicts. The requirement for a unanimous verdict is a question of law, specific to the type of case filed.
