Closed Claim Review: Juries Get Good Medicine

By Stephanie Deupree, JD, BSN

Martha Mae Randolph, an active 74-year-old female with a history of esophageal stricture, GERD, and hiatal hernia presented to the office of general surgeon, Dr. Cameron Smith.[1] Approximately one year earlier, Dr. Smith had performed a robotic Nissen fundoplication with hiatal hernia repair. Although Mrs. Randolph initially reported relief from her symptoms related to GERD and the hiatal hernia after her surgery, over the last few months the symptoms had returned and, more recently, worsened.

Specifically, Mrs. Randolph had developed dysphagia, regurgitation, and odynophagia. These symptoms were increasing in frequency and severity. Eating had become very difficult. When she was able to eat, Mrs. Randolph experienced early satiety and nausea. All these issues led to unwanted and unneeded weight loss of 25 pounds within three months.

Dr. Smith ordered a battery of tests, including a barium swallow and endoscopy. The tests revealed esophagitis and a large recurrent paraesophageal hernia. Following the tests, Mrs. Randolph returned to see Dr. Smith. At that visit, Dr. Smith explained to Mrs. Randolph that she needed a revision surgery. Dr. Smith advised that he only performed this type of revision surgery with an open approach. Mrs. Randolph did not want an open procedure and expressed her desire for minimally invasive surgery. Due to Mrs. Randolph's strong preference for minimally invasive surgery, Dr. Smith referred her to Dr. David Cowen, a board-certified thoracic surgeon at a large metropolitan medical center known for his expertise with laparoscopic and robotic surgery.

Within a few weeks Mrs. Randolph had an appointment with Dr. Cowen. During the appointment with Mrs. Randolph, Dr. Cowen reviewed her symptoms along with the available diagnostic testing results. Dr. Cowen concluded that the patient needed surgery, but before scheduling revision surgery, he ordered a gastric emptying study and cardiac clearance.

Once these items were satisfactorily completed and revealed no problems, Mrs. Randolph, accompanied by her husband, returned to see Dr. Cowen. During the visit, Dr. Cowen explained to Mrs. Randolph that she was a candidate for laparoscopic revision surgery. He explained to Mrs. Randolph and her husband the difficulty of revision surgery, illustrating the anatomy and how he hoped to repair it. In addition, he gave handouts pertaining to hernias and the laparoscopic procedure. They had a lengthy discussion about the risks, benefits, and alternatives to surgery. Dr. Cowen advised the Randolphs of potential complications including damage to other organs, prolonged disability, and the risk of death. Nonetheless, Mrs. Randolph wanted to proceed with surgery. Dr. Cowen documented the informed consent process in great detail, and Mrs. Randolph was scheduled for surgery in one week.

The morning of surgery Dr. Cowen saw and examined Mrs. Randolph once again. She was given the opportunity to ask questions but declined. After the examination and discussion, Mrs. Randolph signed a detailed consent form for the surgery which outlined the significant risks and potential complications of the procedure including organ damage and death.

During the surgery, Dr. Cowen encountered significant scarring and severe fibrosis. While carefully dissecting to the esophagus, he faced significant fibrosis and unusually distorted anatomy all the way. When he reached the esophagus just under the pericardium, Dr. Cowen saw brisk bleeding coming from the hiatus. Believing there was a posterior heart injury, he immediately called for a stat cardiac surgery consultation.

Dr. Cowen did a quick laparotomy and placed his hand in the hiatus. Resuscitation efforts were initiated, blood products were administered, and the cardiac surgeon arrived within a few minutes. Upon arrival, the cardiac surgeon performed a median sternotomy which revealed an injury to the left atrium and pericardial tamponade. Despite the cardiac surgeon's efforts to repair the cardiac injury and the resuscitation efforts of the entire surgical team, Mrs. Randolph expired on the operating table. Dr. Cowen met with the Randolph family immediately after the surgery to explain what had happened and to offer his condolences.

Following Mrs. Randolph's death, her family decided to sue Dr. Cowen and his practice group. Years of litigation eventually led to a four-day jury trial. At trial, the Randolphs were able to paint a very sympathetic picture of a lady much loved by her family and community. Prior to her death Mrs. Randolph was still working part-time and was very involved in the lives of her children and grandchildren. Dr. Cowen's defense team never disputed any of this or maligned Mrs. Randolph in any way. In fact, the defense agreed that Mrs. Randolph was a lovely person by all accounts, and her death was a sad, unfortunate event.

As there was no question as to the cause of Mrs. Randolph's injury and death, when it was time for the defense team to present their proof, they focused on the standard of care. First, Dr. Cowen testified in his own defense, going through his informed consent discussion and process. He also testified about the surgery with the use of anatomical exhibits to help the jury understand what he saw and did. Dr. Cowen's testimony showed him to be a caring and conscientious physician who had grieved the unfortunate loss of his patient, whom he had been trying to help.

Second, two fully supportive medical experts testified at trial that Dr. Cowen complied with the standard of care throughout his treatment. The experts were able to explain to the jury the complexity of the surgery and how the injury could occur in the absence of any negligence. Their ability to walk the jury through the science and evidence was markedly different from the plaintiff's expert, who struggled to articulate his opinions in a clear and concise manner.

At the conclusion of the trial, the medical proof as presented by Dr. Cowen and the defense experts, along with Dr. Cowen's well-documented informed consent process, carried the day. The jury returned a defense verdict despite the very sympathetic nature of the case. Taking the time to document every step of the way through treatment ultimately helped Dr. Cowen prevail. The defense was able to show the jury all of Dr. Cowen's documentation, including office notes, history and physical note, operative report, and consent form. These documents showed not only that Mrs. Randolph had been fully

apprised of the significant risks associated with the surgery, but also that she understood and willingly chose to proceed with the surgery knowing the possible outcomes. Certainly, Dr. Cowen and everyone else involved would have preferred a very different outcome. This case illustrates the importance of providing and documenting thorough informed consent, especially in the event of a bad outcome.

[1] The names of all involved parties have been changed.
