

MEDICINE AND THE LAW

Postoperative care: From a legal point of view, whose responsibility is it?

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An ear, nose and throat surgeon recently asked if anyone else would be responsible postoperatively for removing a patient's throat pack that had been negligently left in place by the anaesthetist. Generally, members of the operating or treatment team such as anaesthetists, surgeons and circulating nurses are not legally liable for one another's negligent acts or omissions in theatre or postoperatively. However, in situations where one or both of the other members of the team could have directly intervened to prevent harm to a patient and failed to do so, such team members could have legal liability imposed on them as joint wrongdoers, e.g. where a throat pack is negligently left in a patient by an anaesthetist.

S Afr Med J 2016;106(9):874-876. DOI:10.7196/SAMJ.2016.v106i9.11082

At a recent medical ethics seminar, an ear, nose and throat surgeon asked if anyone else would be responsible for removing a patient's throat pack that had been negligently left in place by the anaesthetist.^[1] Is it solely the duty of the anaesthetist, or is there a duty on the surgeon or the circulating nurse to check that it has been removed while the patient is in theatre or when the patient is in the recovery room? To answer this question, it is necessary to consider: (i) what is meant by postoperative care; (ii) what standard of care is required by law regarding postoperative care; and (iii) in the throat-pack scenario, who is responsible for the insertion of the throat pack and its removal postoperatively.

What is meant by postoperative care?

In general terms, in the hospital environment postoperative care refers to the period from the completion of the surgical procedure until the patient (as inpatient) is discharged from the hospital.^[2] However, postoperative care may also continue when the patient is an outpatient. The degree of postoperative care required will depend on the patient's preoperative condition and the nature and consequences of the operation. Postoperative care includes the time when the patient is in theatre, in the recovery room, in a high-care unit, in an intensive care unit, in a surgical ward or in any other ward, and may even continue after the patient has been discharged from hospital.

In the recovery room, the patient's condition should be monitored by the nursing staff under the general supervision of the anaesthetist until the patient has recovered from the effects of the anaesthetic.^[3] From the recovery room the patient may be discharged by the anaesthetist and recovery nurse to a high-care ward, intensive care unit or general surgical ward or other ward, depending on their condition, where their condition is monitored by the nursing staff.^[2] The nursing staff are responsible for the postoperative care of the patient, but should remain in contact with the surgeon regarding the patient's condition until the postoperative care has been completed and the patient is discharged from hospital.

What standard of care does the law require for postoperative care?

Medical practitioners^[4] and nurses^[5] are expected to exercise the degree of care that a reasonably competent doctor or nurse in their field of practice would have exercised. This means that an

anaesthetist will be judged by the standard of a reasonably competent anaesthetist,^[6] a surgeon by the standard of a reasonably competent surgeon in his or her particular field of expertise,^[7] and a nurse by the standard of a reasonably competent nurse in that field of expertise.^[5] If a reasonably competent anaesthetist, surgeon or nurse in their position would have foreseen the likelihood of harm and would have taken steps to guard against it, and if he or she fails to take such steps, the anaesthetist, surgeon or nurse will be liable for negligence.^[8]

The standard of care in surgical cases covers the preoperative procedures, the procedure during the operation and the postoperative care procedures. The courts have dealt with postoperative situations such as failure to detect a broken needle^[9] or a swab^[4] in theatre or the recovery room, and a patient sustaining severe burns while still under the influence of an anaesthetic.^[10] In a paediatric high-care unit, failure of a nurse to replace a tracheotomy tube that had moved in a neonate rendered the hospital liable for damages.^[5]

In surgical and other wards, failures in postoperative care have included cases where a patient fell out of a cot and fractured her leg because the sides of the cot had not been raised by the nurses,^[11] where babies were 'swapped' in a maternity ward,^[12] where bedsores were allowed to develop,^[13] and where negligent nursing caused further injury to a patient.^[14] There have also been cases of postoperative care failures resulting from the premature discharge of a patient from hospital,^[15] not following up on a patient who had been discharged,^[16] failing to warn a patient that a tight plaster cast on an injured limb could cause a Volkmann's contracture,^[17] and loss of a specimen after an operation, causing a second operation that would otherwise not have been necessary.^[18]

During the postoperative stage, particular care must be taken to prevent infection, e.g. breast infection from plastic surgery,^[7] or any other form of hospital-acquired infection.^[19] Care must also be exercised to make sure that patients who are compelled to lie in a prone position for hours do not suffer from blood clots or circulation problems.^[14] Special care must be taken to ensure that the condition of patients in intensive and high-care units is properly and regularly monitored, e.g. checking that tracheotomy tubes have not moved.^[5] Should any other complications emerge as a result of negligence on the part of the practitioners required to monitor them, such practitioners may be liable for damages.

Where the harm suffered by a patient has been caused by the negligence of more than one practitioner (e.g. the anaesthetist, surgeon and nurses), the damages can be apportioned between them, with each being liable for their proportion of the harm suffered by the patient in terms of section 1(1)(a) of the Apportionment of Damages Act.^[20] In this instance the courts can hold the parties 'jointly and severally liable', which means that under section 2(13) of the Act any one of them can be made to pay all the compensation, and the person paying may then claim a contribution from the other parties in proportion to their fault.^[20]

Who is legally responsible for the various aspects of postoperative care?

South Africa (SA) does not apply a 'captain of the ship' approach whereby the surgeon is in charge of, and held liable for, everyone who assists him or her with an operation^[21] – including postoperative care. The approach of our courts is that during surgical operations surgeons and anaesthetists are independent contractors and are not responsible for each other's actions, nor do they have to 'second-guess' each other's conduct.^[6] The same applies to theatre sisters^[4] or circulating nurses: 'Each one performs a specific specialised function as part of a team consisting of surgeon, anaesthetist and nursing staff',^[6] and cannot be held jointly liable for one another's mistakes. For instance, the court has held that a surgeon may not be liable for the conduct of a theatre sister when it comes to the counting of swabs.^[4] The individual liability of each practitioner in the operating theatre applies equally to their conduct during the postoperative stage.

The above statement is the general rule, but there may be exceptions, e.g. if a surgeon uses an anaesthetist who he or she knows is not very competent.^[6] Another exception would be where one of the practitioners knows, or ought reasonably to have known, that another practitioner has committed an unlawful act that will harm the patient, and allows that person to proceed without objecting.^[21] Such failure to act by the practitioner concerned will amount to personal negligence – apart from any fault by the practitioner committing the unlawful act – and both practitioners may be held liable for their harmful conduct. This applies to their conduct during the operation in the operating theatre and during the postoperative stage inside or outside the theatre.

A medical practitioner is required to keep treating a patient until the patient is cured or the treatment can be handed over to another qualified healthcare practitioner. Failure to treat a patient until the patient is cured or the treatment is handed over to another qualified healthcare practitioner may constitute abandonment of a patient.^[22] It is submitted that once the anaesthetist is satisfied that the patient has recovered from the anaesthetic in the recovery room, the rest of the treatment becomes the responsibility of the nursing team under the general supervision of the surgeon. The surgeon is entitled to rely on the nurses to deal with the postoperative treatment adequately, but should be briefed by them on the patient's progress. If this is not done, the surgeon should check with the nurses regarding the patient's progress until he or she is discharged from hospital.

The throat-pack scenario: Who is responsible for the insertion and removal of a throat pack?

What procedure should be followed for the insertion and removal of a throat pack?

Throat packs are placed in the mouth and oropharynx to prevent saliva, blood or other surgical debris from tracking down into the pharynx, oesophagus and respiratory tract during ear, nose,

and oral surgical procedures.^[23] In Canada, the suggested guidelines for the management of throat packs during surgical procedures^[23] recommend that the surgeon and anaesthetist should discuss the procedures to prevent the pack being left in the patient's throat. The insertion of the throat pack should then be verbally communicated to the surgical team by the surgeon or anaesthetist responsible for its placement.^[23] The anaesthetist or surgeon who has taken the responsibility to insert the throat pack should ensure that the throat pack is positioned appropriately with one end protruding externally.^[23] The circulating nurse should document the throat pack insertion and removal times on the surgical count record.^[23] At the end of the surgical procedure, the surgeon or anaesthetist should verbally communicate the removal of the throat pack to the surgical team.^[23] These guidelines could be of assistance to the courts in SA for claims involving the failure to remove a throat pack, although the courts are not required to rely on them.^[24]

Who is responsible for removing the throat pack from a patient after an ear, nose and throat procedure?

Either the surgeon or the anaesthetist may be responsible for removing the throat pack.^[23] Whoever removes it should communicate the removal to the circulating nurse for her/his records.^[23] If the anaesthetist has inserted the throat pack and has failed to communicate the removal of the throat pack to the circulating nurse, the surgeon should check with the anaesthetist to make sure that the pack has been removed. This is because although generally legally independent specialist practitioners are not required to 'second-guess' the work of their colleagues,^[6] where there is a danger of harm to a patient as a result of unlawful conduct by a colleague, there is a duty on the first practitioner to take steps to prevent such harm from occurring.^[21] Leaving a throat pack in a patient may be life-threatening because it obstructs the airway, and the surgeon needs to check that this has not happened.^[23]

If the patient suffers harm because a throat pack inserted by the anaesthetist is not removed, the anaesthetist will be liable for failing to remove the throat pack. The surgeon may also be held 'jointly and severally liable' if the surgeon knew, or ought to have known, that the anaesthetist had not told the circulating nurse that the throat pack had been removed, and did not check whether the pack had been removed. If the anaesthetist fails to remove the throat pack and the surgeon negligently fails to check whether the pack has been removed, there may be also a legal duty on the circulating nurse to raise the status of the throat pack with the anaesthetist and the surgeon. This is because although the circulating nurse is an independent contractor, if the nurse knew, or ought to have known, that the throat pack might still be in the patient, there will be a legal duty on the nurse to act to protect the patient from harm.^[4] The circulating nurse should act as the patient's advocate while the patient is under the influence of the anaesthetic.

Conclusion

The general rule is that in theatre the members of the operating or treatment team, such as anaesthetists, surgeons and circulating nurses, are independent contractors and are not legally liable for one another's negligent acts or omissions in theatre or postoperatively. Where a negligent act by one of them may harm a patient, however, and one or both of the other members of the team could have directly intervened to rectify the situation, failure to do so may result in legal liability being imposed on the other team members as joint wrongdoers. This principle will apply where a throat pack is negligently left in a patient by an anaesthetist.

1. McQuoid-Mason DJ. Seminar on Medical Ethics, Human Rights and the Law. Durban: Lancet Foundation, 3 May 2016.
2. Young A, van Niekerk CF, Mogotlane SM, eds. Juta's Manual of Nursing. Vol. 1. Cape Town: Juta & Co, 2003:681-687.
3. Mogotlane SM, Manaka-Mkwanazi, Mokoena JD, Chauke ME, Young A, eds. Juta's Manual of Nursing Practice: Practical Manual. Vol. 2. Cape Town: Juta & Co, 2004:293-294.
4. Van Wyk v Lewis 1924 AD 438.
5. Cf. Collins v Administrator, Cape 1995 (4) SA 73 (C).
6. S v Kramer 1987 (1) SA 877 (W).
7. Castell v De Greef 1994 (4) SA 408 (C).
8. Cf Kruger v Coetzee 1966 (2) SA 428 (A).
9. Cf. Mitchell v Dickson 1914 AD 519.
10. Cf. Lower Umfolozi District War Memorial Hospital v Lowe 1937 NPD 31.
11. St Augustine's Hospital (Pty) Ltd v Le Breton 1975 (2) SA 188 (D).
12. Clinton-Parker v Administrator, Transvaal, Dawkins v Administrator, Transvaal 1996 (2) SA 37 (W).
13. Silver v Premier, Gauteng Provincial Government 1998 (4) SA 569 (W).
14. Cf. Afrox Healthcare Bpk. v Strydom 2002 6) SA 21 (SCA).
15. Carstens P, Pairman D. Foundational Principles of South African Medical Law. Durban: LexisNexis, 2007:663-664.
16. Webb v Isaac 1915 EDL 273.
17. Dube v Administrator, Transvaal 1963 (4) SA 260 (W).
18. Hewatt v Rendel 1925 TPD 679.
19. McQuoid-Mason D. Hospital-acquired infections – when are hospitals legally liable? S Afr Med J 2012;102(6):353-354.
20. Apportionment of Damages Act No. 34 of 1956. www.saflii.org/za/legis/conspl_act/aoda1956246.pdf (accessed 5 May 2016).
21. Claassen NJB, Verschoor T. Medical Negligence in South Africa. Pretoria: Digma, 1992:109-111.
22. McQuoid-Mason DJ. 'Over-servicing', 'underservicing' and 'abandonment': What is the law? S Afr Med J 2015;105(3):181-182. DOI:10.7196/SAMJ.9141
23. Winnipeg Regional Health Authority. Clinical Guideline for the Management of Throat Packs during Surgical Procedures. Winnipeg: Winnipeg Regional Authority, 2014:2-4.
24. Michael v Linksfield Park Clinic (Pty) Ltd 2001 (3) SA 1188 (SCA).

Accepted 30 May 2016.