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OPINIONS & LETTERS

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Letters to the Editor: Laparoscopic Cholecystectomy Litigation

Editor's Note: *The following letters represent a small selection of those received in response to the opinion article "Five Steps To Avoid Litigation from Lap Cholecystectomy" by Arnold Seid, MD (March 2009, page 1). Several more letters debating the validity of Dr. Seid's recommendations will be published in the June issue.*

The editors of General Surgery News *would like to make it clear that Dr. Seid's opinion article was just that—his opinion. Although Dr. Seid is an experienced surgeon and some surgeons may find his recommendations instructive or helpful, no part of his article should be interpreted as the standard of care for performing laparoscopic cholecystectomy for any community in the United States. The same applies for any article published in* General Surgery News*—no opinion or statement quoted, or otherwise published, in this newspaper should be used to define or determine surgical or medical standard of care.*

As always, we welcome your feedback. Send your comments and letters to khorty@mcmahonmed.com.

To the Editor:

Dr. Arnold Seid, who portrays himself a colossal guru on laparoscopic cholecystectomy (LC), comes up with "five rules" to avoid litigations due to bile duct injury (BDI). A few of his "rules" include principles that are well known to any general surgeon and are considered standard of care—some, unfortunately, do not make sense at all.

Rule 1: "Never perform a LC without a skilled surgeon as your assistant," Dr. Seid lectures. Already, he "can hear howls of indignation from surgeons across the country, particularly in smaller communities, who do not accept rule 1." But this "rule" is not only impractical in my own rural practice (I am the only surgeon in the county) but also around the country. What about teaching hospitals where residents, assisted by surgeons, perform most LCs? Are the second-year residents' eyeballs as perceptive as those of a skilled surgeon? Or perhaps Dr. Seid wants two "skilled surgeons" to assist the resident?

Beyond the issue of manpower (where do we find "skilled surgeons" to assist in each of the 750,000 LCs performed yearly in this country?) and reimbursement (who will pay those "skilled" assistants?) the fact of the matter is that Dr. Seid does not provide us with any evidence to support his "rule." He claims "60% of the legal cases that I have reviewed were performed by only one surgeon"; but this is intuitive and self-explanatory: If most LCs in this country are performed by one general surgeon, with or without a resident, then surely most BDIs and related litigation would concern a single surgeon. I agree with him that "four eyeballs on the monitor are better than two." I use a "surgical tech" (a lumberjack in his second job) who over the years assisted in thousands of LCs. Like a hawk, he observes and comments on any misstep I may take. One does not have to be a fellow of the American College of Surgeons to correctly identify the structures at the triangle of Callot on the monitor.

Rule 2: "Slow down." Yes, most weathered surgeons would agree with Dr. Seid that "speed kills, take

your time." We would all concur that the cystic duct junction with the gallbladder has to be meticulously dissected out and cleared before applying the clips, but the author's insistence on following the "structure" (i.e., cystic duct) *away* from the gallbladder to "assure yourself that it is entering the common bile duct" is potentially dangerous, especially in "difficult cases," where the motto should be "stay *near* the gallbladder—do not scratch around, looking for troubles."

Rule 3. "Knowledge is power." (I wish Dr. Seid's rules were a little more specific.) Any expert would agree (aren't we all experts on LCs?) that failure to convert to an open procedure is a cardinal error in judgment leading to many of the CBI and associated litigation. All of us would concur with the author that "a difficult LC will not be an easy open procedure," but it is impossible to support his recommendation that tube cholecystectomy is the preferred option when the open cholecystectomy proves to be difficult. I am astonished that a mega-cholecystectomist like Dr. Seid is not aware of a better option, that of subtotal or partial cholecystectomy. Many generations of surgeons used—still do—this marvelous procedure, that allows them to stay away from trouble while avoiding gallbladder tubes and unnecessary subsequent operations.

With a few exceptions, Seid's rule 4 ("Do not repair a bile duct injury") makes sense, and no one would dispute the banal rule 5 ("Don't ignore postoperative complaints"). I would like, however, to recommend yet another rule to Dr. Seid, a rule that has nothing to do with LC: "Support your rules with reliable data."

Yes, *General Surgery News* is not a peer-reviewed scientific journal, but general surgeons are not suckers and do not like to be fed with *lockshen*—they want *evidence*. Any general surgeon who started doing LC during the 1990s has by now been involved with more than a thousand such procedures. And we know that, irrespective of how many eyeballs are watching, bile duct complications do occasionally develop. Thus, I would expect anyone who comes up with "new rules" to back them with data.

Searching Google and performing a PubMed search did not reveal that Dr. Seid has ever bothered documenting his impressive LC series. Therefore, I wish to ask him: Were there any bile duct complications in the 2,500 LCs that he "did together with another skilled surgeon"? How many procedures were converted to open? How many had tube cholecystectomies? How many of the latter needed subsequent cholecystectomy? How many died? And, is he sure that in each of the 2,500 LCs there was another qualified surgeon present?

Dr. Seid wrote: "Most importantly, it is my 15 years of acting as an expert witness in LC malpractice cases that gives me a unique perspective and prompted me to write this article." But, unfortunately, such experience is not "unique"; there are not a few well-documented published series dealing with the legal aspects of LCs complications. To be informative, Dr. Seid should have provided more fine points: in how many such cases he was involved; on which side (plaintiff vs. defendant); and what was the outcome of these cases? A detailed table would have helped.

Professor Bill Heald, FRCS, said: "Rules are for fools." And the legendary surgeon Oliver Wendell Holmes of Boston (1809-1894) wrote: "The young man knows the rules, but the old man knows the exceptions …." So, let us avoid coining "rules" hastily and pompously—and please let us try not to be bombastic.

Moshe Schein, MD, FACS
Ladysmith, Wis.

To the Editor:

I thoroughly enjoyed the opinion piece by Dr. Seid describing five steps to avoid litigation from lap cholecystectomy. While I do not agree with everything he wrote, I do agree with a large portion of it. But, regardless of any disagreement, the article brings forward an incredibly important and often ignored aspect of patient safety. Dr. Seid's five steps can be viewed as the "gold standard" of safety for LC. In other words, this is the most you could do to support a good outcome. I do not believe it is truly the standard of care, especially since the standard of care is a moving target created by the expert witness being deposed, or testifying in court. But these steps should be considered during

every LC, and should be stressed to our trainees repeatedly.

The overlooked concept of patient safety brought forward in the article is: If you deviate from the "safest" steps in carrying out a process, you need a good reason. Five cases that day, a meeting at noon or hunger pangs are not good reasons to take a less safe route. Also, our educational mission in academic centers is not a good reason to bypass these steps. When I started my academic practice, LC was the case that gave me the most heartburn. It is the one case where a resident can destroy the remainder of the patient's life, and your own mental health and well-being with one squeeze of the clip applier or one cut of the shears. This is why it is so essential when taking residents through the case that you tell the resident what you want them to do, make sure they understand what you want them to do, and then watch them do what you want them to do.

Every step in a teaching LC should be planned and executed with a worst case in mind. "How do we know that's not the CBD before we clip it?" "How can you possibly continue the dissection when I cannot identify the planes?" Hunches and heuristics should not be part of the process. If you're not certain, open the patient.

I believe Dr. Seid has set forward some broad concepts that are instructive for all surgeons: Once you know the safest way to do something, that's what you should do. If you don't, the complication is on you. You can often get away with less safe processes, but that doesn't mean it's safe; it just means that you got away with it.

Jeffrey Young, MD
Professor of Surgery
University of Virginia Health System
Charlottesville, Va.

To the Editor:

While I am sure Dr. Seid has the best of intentions, his ideas are far from the standard, and have no bearing whatsoever to the modern practice of surgery. I am happy for him if he has found a unique way to be personally successful with the operation, if not a bizarre one. I feel badly for him that insecurity with his knowledge of anatomy requires two surgeons for every operation, and I feel badly for his patients who obviously are being subjected to a high frequency of open cholecystectomy and to prolonged anesthesia.

There is a legal tenet in North Carolina called the "standard of care." It should be stated strongly and clearly that his ideas do not represent the standard of care. If this is the standard in California (and I very much doubt it), then it is little wonder that the state finds itself at the forefront of the health care access and economic crisis.

I am sure you rationalized publishing this article, believing that you would stir some controversy or increase your circulation or "keep physicians informed" about the dangers they face. This is a disservice to the community of thoughtful surgeons who practice safe, efficient laparoscopic cholecystectomy daily in the operating room rather than the courtroom. I assume next month there will be equal time for real surgeons to state the standard of care for the operation as it is really performed. But maybe that isn't quite as interesting as the fringe.

"We have met the enemy and he is us!" [Walt Kelly]

Ellis A. Tinsley Jr., MD, FACS
Past President, North Carolina Chapter
American College of Surgeons

To the Editor:

I am thankful that the above piece contained the heading of "Opinion," because this is exactly what it was. Unfortunately, Dr. Seid speaks with more authority than what should be afforded to him. None of what he claims has been adequately supported with data from adequately-powered trials.

If Dr. Seid would like to dispute this comment of mine by bringing up some retrospective article supporting any one of his notions (for example, his implication that intraoperative cholangiography should be done routinely), then I can counter with numerous articles showing the opposite conclusion. It is not my intention to negate Dr. Seid's five rules, but they should be taken for what they are—opinions. I find the tone of this opinion piece offensive because the author tries to convince the reader that his opinions are foregone conclusions.

Anecdotal, retrospective experience is still experience, and nothing more. Dr. Seid's personal experience in this area is impressive, but conclusions based on such experience are opinions, not rules. These conclusions do not stand up to scientific scrutiny.

I expect that this article will put the medicolegal issues surrounding ductal injury into further disarray, because plaintiff lawyers will latch on to Dr. Seid's article, and pursue this tort with renewed fervor. Incidentally, I also would expect that Dr. Seid's expert witness referrals will increase as a result of this opinion piece.

Mark A. Carlson, MD, FACS
Associate Professor of Surgery
University of Nebraska Medical Center Omaha, Neb.

To the Editor:

I read Dr. Seid's opinion "Five Steps To Avoid Litigation From Lap Cholecystectomy" and have mixed feelings. It bothers me a little that his title calls these "steps," yet in the body of the article he calls them "rules." There is a big difference, especially in the eyes of a litigator.

I would certainly strongly agree with step 3 (opening can be salvation …) and step 5 (early and aggressive workup of any patient that does not seem to be doing perfectly after a LC.) Step 4 (do not repair a bile duct injury), is debatable. Obviously, an injury that is not recognized until postoperatively should be immediately referred to a hepatobiliary surgeon. However, intraoperative recognition of simple injury such as one cut duct where there is no loss of length of the duct can be handled easily by most skilled surgeons. Where there is loss of duct length, I would agree with a referral depending on the surgeon's experience.

Step 1 of always having a skilled surgeon as a first assistant is unnecessary. My practice does not always allow a partner to be available, yet I am quick to call for assistance if it is indeed a difficult gallbladder case in which the anatomy is unsure. If another surgeon is not available, opening is maybe the next best option.

Dr. Seid is setting a bad precedent if he is suggesting, as in step 2, that a LC should never be done in less than an hour. I would say that most elective outpatient LCs are done in less than an hour for many, if not most surgeons and done very safely. Malpractice lawyers would love to have him on their side when he can make a statement about an operation being done too quickly and, therefore, unsafely, with no science to back it up. Is Dr. Seid an expert witness for plaintiffs? Because that is the kind of attitude encountered when dealing with "experts" who can make a blanket statement like that and call it a "rule" when it's just an opinion and nothing more.

James C. Sherman, MD, FACS
Augusta, Ga.

P.S. I agree that we should throw the Veress needles in the trash.

To the Editor:

I enjoyed Dr. Arnold Seid's article, and I agree with his specific recommendations to avoid litigation and to avoid harm to patients. But it strikes me that under these circumstances, surgeons who perform lap cholecystectomy have got to be fools.

Dr. Seid is obviously a master surgeon who is unlikely to cut a bile duct. On the other hand, think of

an average surgeon such as me. My bile duct injury rate must be average, that is one out of 200 LCs. (I have been lucky so far, I guess.) But my luck will probably run out, and I will drift to the average. Now, if I perform 200 LCs at the New York Medicare fee of $753.20, I would be paid $150,640. Oh, I forgot the cholangiogram. Add $17.72 each, for a total of $3,544. The grand total income for my efforts would be $154,184. But wait, on average I would have caused one bile duct injury. Of course, I have very good rapport with my patients, so they are only 50% likely to sue and win. (If you believe that, I have a bridge in Brooklyn you might be interested in buying.)

The average litigation/settlement award costs for a life-changing injury in New York state are about $300,000. So my malpractice cost for doing the 200 LCs is 50% of $300,000, or $150,000. This sum must be paid into the malpractice system. Payments for surgical "misadventures" are completely paid for by surgeons paying premiums for insurance. Therefore, on average, I would earn $154,184 for performing surgery, and on average, I would pay $150,000 into the malpractice system for bile duct injuries. Doing the subtraction leaves me with $4,184 for 200 procedures, or $20.92 each.

If it's a bad deal for me as the surgeon, think about the poor assistant. Dr. Seid makes him or her a full partner in the enterprise, since four eyes are better than two. Therefore, he must bear 50% of the malpractice exposure. Still working on Long Island, N.Y., the assistant is paid 16% of the surgeon's fee, or $123.35 at Medicare rates, or $24,670 for 200 assists. If his malpractice premiums are increased by 50% of $150,000, or $75,000, the assistant is so far in the hole they'll have to pipe daylight in for him.

In actuality, an attending surgeon will need to be an assistant in order to get a skilled assistant when one is needed. Therefore, he will spend about as much time assisting as being the primary surgeon.

Far better it is to do open cholecystectomy, for more than $1,000 per procedure, with essentially no additional malpractice exposure from common duct injury.

Why have surgeons embraced this inherently risky procedure for no additional benefit? Why has it become the "standard of care" in less than 20 years? Are we all risk takers? If I posted Dr. Seid's article in my office, would any of my patients agree to laparoscopic cholecystectomy? Or have we all got to be fools?

Jonathan V. Goldstein, MD
Rockville Centre, N.Y.

To the Editor:

I take issue with a number of statements in Dr. Seid's article. Of these statements, rule 1, "Never perform a laparoscopic cholecystectomy without a skilled surgeon as your assistant," seemed particularly inflammatory and generally out of touch to me.

I am the only general surgeon in my small rural Kansas community. Our hospital serves a nine-county area with a population of approximately 60,000. Since I cannot have a skilled surgeon assist me with laparoscopic cholecystectomy, I guess that I should just give up the 20% of my practice that comes from gallbladder surgery. I don't see that rural communities will have much use for or confidence in a surgeon that cannot skillfully perform this common procedure. One could question whether a surgeon without the competence or confidence to perform solo laparoscopic cholecystectomy should be engaging in laparoscopic anything, let alone open major abdominal surgery, without an assistant. Without surgery, my rural hospital would struggle to exist. General surgery is not just a "big city" specialty. There is real need for competent surgeons in rural areas.

I have performed 375 solo laparoscopic cholecystectomies since graduating from my residency program two and a half years ago without a single CBD injury. My average operating time is 20 to 25 minutes. I do not cut corners and perform a careful dissection in each case in addition to routine cholangiography. I agree that if the anatomy is unclear, or if cholangiography shows an abnormal result, the procedure should be converted to open. I do not, however, agree that surgeons should abandon the procedure if they cannot have a skilled surgeon as an assistant. This is simply impractical in an area where recruiting is next to impossible and a partner is something nice to

dream about. If rural surgeons followed Dr. Seid's rule 1, then rural surgery would simply cease to exist.

Jake Breeding, MD
Pratt, Kan.

To the Editor:

Thanks to Dr. Seid for a well-written opinion on laparoscopic cholecystectomy litigation.

I practice in a rural hospital in Wisconsin where I don't have the opportunity to have another surgeon with me. My BDI rate at the operating table is one out of 1,000. The one time I injured a common duct was early in my career as an attending surgeon. I did transect a common duct, but having worked in liver transplant intensively in my residency, I repaired the injury and the patient continues to do fine over a decade later. Interestingly, I did a primary re-anastomosis over a t-tube. During a liver transplant we reconnected ducts regularly. I was fresh out of my program so I did it without any difficulty; if it happened today, I would transfer care to a biliary surgeon.

I haven't had a single bile duct injury in more than 12 years. I operate without another surgeon. I watched my attendings in residency as they carelessly injured a duct on occasion. This was eye-opening. The lesson learned was simply that the injuries can occur in experienced hands even when there are two surgeons with experience doing the procedure.

Cholangiograms are not without complications of injuring the common duct. This is an old argument and I've never bought it. I use them selectively and will continue to do so—without ego.

I tend to agree with everything else Dr. Seid recommended. Well-done article, Dr. Seid.

Adam Dachman, DO
Dodgeville, Wis.

Dr. Seid's Response

I welcome the vigorous and often charged comments that my fellow surgeons contributed to this discussion on laparoscopic cholecystectomy (LC) and I commend the editors for providing a forum in which to address this complicated topic.

There are two points that I want to make in response as unequivocally as I can.

First, it was neither within the scope of my intentions nor my abilities to define the surgical "standard of care" for LC. As the editor points out, statements in this journal do not determine that standard. Indeed, though it varies from state to state, the standard of care can be understood as "the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances." Therefore, if it is common practice in your community to perform this operation without a general surgeon as assistant and/or to complete it in 20 minutes, then you are operating within the standard of care.

However, this leads directly to my second point.

The majority of the 3,000 bile duct injuries (BDIs) that occur annually in the United States are preventable. The injuries generally are a consequence of misidentification of anatomy. The guidelines I set forth have been offered as suggestions in the ongoing quest to lower this complication rate.

There are technologies both presently available and in development that could help further reduce this complication rate. First, laparoscopy does not require an assisting surgeon to be present in the operating room. The image on the monitor can easily be transmitted anywhere in the world in real time. Telementoring and tele-assisting opportunities have been available for years but have been underutilized.

Second, there are tunable diode laser analyzers being developed that may soon be capable of differentiating anatomy. It is possible that in the coming years that our standard monitor in LC will have the common bile duct lit up like a neon sign to guide us as we do this operation.

The above are high-tech aids that may impact the problem. The guidelines I laid out in my editorial were practical aids. In that vein, allow me to suggest a study that might show interesting results. A busy surgical service could tally their historical incidence of BDIs. Then they could prospectively perform all of their LCs with two surgeons, use cholangiography liberally, employ a very low threshold for conversion to open surgery, and perform 10 minutes of further dissection before clipping what was identified as the cystic duct. These measures might show a statistically relevant reduction of the incidence of BDI.

I appreciate Dr. Young's succinct distillation of my analysis and his concurring with my suggestions. I look forward to the ongoing debate in the upcoming June issue.