Chapter 45
Liability of Otolaryngologists

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Every medical specialty has its own unique set of medical malpractice issues that, more often than not, correspond with the complications associated with procedures or treatments commonly performed by that particular specialist. The field of otorhinolaryngology/head and neck surgery (or ear, nose, and throat medicine and surgery) is no different. As in other medical specialties, it is not uncommon to see otorhinolaryngology-related lawsuits that result from a mere difference of expectations, the patient's expectations of surgical outcome typically being more optimistic or at least "different" than the physician's expectations. Often, the differences in expectations between the two parties can be resolved by obtaining true informed consent.

Three factors unique to otorhinolaryngology must be taken into consideration when litigating a medical malpractice suit (Box 45-1).

The purpose of this chapter is to educate the reader about some of the medical malpractice issues in otorhinolaryngology. Please note that the terms "otorhinolaryngology," "otolaryngology," and "ENT" will be used interchangeably throughout this chapter. The chapter has been divided into malpractice issues dealing with otology, rhinology, and laryngology, respectively. There are so many different types of surgical and medical treatments in this specialty that this chapter is by no means comprehensive. However, actual court cases have been selected to help illustrate some of the more common malpractice issues seen in otolaryngology.

OTOLOGY

Although not all otologic liability or complications are due to surgery, a majority of the medical malpractice suits seen by this author result from surgical complications. Generally, a postoperative complication is defined as a postoperative state that does not meet the expected goal of the surgical procedure, particularly with regard to healing, anatomy, or function. From a purely objective academic standpoint, the difficulty with evaluating trends in postoperative otologic surgical complications is the fact that analyses from one physician to another or one institution to another are not always consistent. For example, some ear surgeries are staged and require multiple procedures. Each procedure is technically a separate surgical case, although complications resulting from these procedures may all be lumped into one general complication.

In contrast, the difficulty with evaluating trends in lawsuits stemming from otologic complications is the fact that the chances of a lawsuit being filed or settled—despite the severity of the otologic complication—are often influenced by numerous subjective medical and legal factors: (1) from the medical perspective, some important subjective factors include hearing sensitivity, vertigo, patient attitudes, and physician rapport with the patient; and (2) from the legal perspective, some critical factors include credibility of the parties and witnesses, adequacy of medical documentation, and extent of the damages (both actual and perceived). For this reason, it is crucial for the otolaryngologist to document not only the objective time lapses between surgery and the development of complications, but also the subjective complaints, findings, and apparent patient "attitudes" that accompany the stages of the procedure or procedures all the way to full recovery. In addition, the attorney representing the otolaryngologist should be mindful of the factors that affect the strength of each case.

Unfortunately, many postoperative complications are unavoidable or the result of surgical intervention. For example, some of the more common causes of otologic complications associated with middle ear surgery are illustrated in Table 45-1.

For an attorney defending an otolaryngologist being sued for medical negligence after an otologic procedure, the lawyer must be cognizant of the numerous possible reasons for the complication that are not necessarily the result of negligence or malpractice. For the otologic surgeon, preoperative patient counseling (i.e., truly informed consent), preoperative patient evaluation (e.g., audiogram, auditory brainstem response testing), and preoperative planning are just as critical to the successful outcome of the procedure as the surgeon's technical skill, experience, and awareness of possible subtle variations in patient anatomy.

The otologist must be aware of some of the more common technical errors and complications that lead to medical malpractice suits. These are listed in Table 45-2.

Another common complication in otologic surgery is associated with recurrent pathology of the ear. Not surprisingly, medical malpractice cases related in some way to recurrent pathology are typically associated with a "negligent informed consent" issue. The following case example, which resulted in a defense verdict, illustrates this point.[1]

The plaintiff brought a medical malpractice action against the defendant otolaryngologist, alleging that the

Box 45-1. Medical-Legal Pearl

Otorhinolaryngologic treatment has the potential to affect one's ability to experience and interact with the environment through one's ability to hear, smell, speak, or swallow. Therefore, any event that adversely affects these abilities may have a dramatic impact upon one's quality of life.

Otorhinolaryngology typically involves the face, the part of the body that most people associate with one's identity. Therefore, any disfigurement or impairment inflicted upon the face may have potentially devastating psychological consequences

Otorhinolaryngology is a specialty that is constantly evolving with new instruments, techniques, and modifications to instruments and/or techniques. Therefore, the definition of "standard of care" is also constantly evolving.

defendant negligently damaged his ear while performing surgery to correct an inner ear problem allegedly caused by the plaintiff's repeated exposure to ocean water. The plaintiff additionally asserted that the defendant physician failed to obtain his informed consent prior to surgery.

The plaintiff, an avid surfer, was diagnosed with exostosis of the inner ear, associated with the formation of bony growths along the ear canal. The diagnosis was made in September 1998, and the condition was causing the plaintiff discomfort, hearing impairment, recurring ear infections, and other problems. The defendant otolaryngologist recommended surgical removal of the growths.

The plaintiff's expert otolaryngologist opined that the defendant deviated from the standard of care by opting to enter the ear canal through an approach that failed to provide the defendant with optimal visibility of the affected structures of the external auditory canal. The plaintiff's expert contended that the defendant's technique traumatized and injured the ear canal. The plaintiff maintained that as a result of the defendant's alleged negligence, he suffers from permanent diminished hearing in the left ear, tinnitus (ringing in the ears), and chronic ear infections.

The defendant denied negligence and maintained that surgery was properly performed. In addition, the defendant contended that the plaintiff was fully advised of the risks and alternatives to surgery. The defendant contended that the patient was noncompliant with regard to postoperative care and specifically failed to follow the physician's instructions regarding water-related activities. The jury also found for the defendant.

This case deals with exostosis in the external auditory canal. Nodular bony outgrowths from the osseus meatus, usually sessile, multiple, and bilateral, are common incidental findings on otoscopic examination. The term "exostoses" typically refers to discreet nodules, whereas the term "hyperostoses" is typically applied to more diffuse bony elevations of the wall of the osseus meatus. Van Gilse first described exostoses of the meatus, related to swimming in cold water.[2] So close is the relationship between cold-water exposure and exostoses of the inner end of the osseus meatus that the otologist is seldom mistaken in concluding that the patient has been an ardent swimmer in relatively

Residual bone disease	Some complications of new bone formation include: (1) osteoma and eburnated mastoid, (2) ossicular ankylosis (usually of the stapes and the head of the malleus), and (3) obliteration of the oval window secondary to residual otosclerosis, tympanosclerosis, or osteitis. Chronic or persistent osteitis may cause further lysis or necrosis of the ossicles or even of the preserved posterior wall or a portion of it. Residual osteitis can appear anywhere in the middle ear, and sometimes may be responsible for progressive damage of the osseous labyrinth. Another possibility is the risk of long-term suppuration when bone dust is left in an infected area.
Residual cholesteatoma	Often related to the care and skill given to the removal of the matrix or any "unsafe" tissue, which includes ossicular remnants. For this reason, many otologists advocate the taking of a second look in a staged procedure.
Residual tubal dysfunction	Often dependent upon the preoperative care and treatment of the rhinopharynx. An endoscopic preoperative examination of the eustachian tube is performed by some otolaryngologists, and idiopathic tubal dysfunction is also a known disorder. Incomplete removal of disease in this area (such as polyps, cholesteatoma, or scarred occlusive folds) occurs relatively frequently when the anterior remnant of the tympanic membrane has been left in place.
Residual mucosal disease	Involves the mucosal lining of the middle ear cleft. Frequently dependent upon the immune status of the patient. The proportion of normal to diseased tissue remaining in the middle ear often directly affects the risk of residual disease evolution. One commonly sees persistent or nonspecific infections wherein the immune system probably has an underlying critical role. Examples: fibrous inflammatory hypertrophy of the basal mucosal lining, absence of self-cleaning activity secondary to the disappearance of ciliary cell activity, increase of secretory and mucous glandular cell population, mucosal degeneration, granulomatous metaplasia, residual cholesterol granulomas, and fibrosis of aeriform spaces of the middle ear cleft when a large area of mucosa is removed. Syndromes or disorders such as Wegener's granulomatosis, and nonspecific inflammatory granulomas (such as histiocytosis X, eosinophilic granuloma, or xanthogranuloma) should be considered.

Table 45-1 Common causes of otologic complications with middle ear surgery

Acoustic trauma	Labyrinthine injury may be caused by extremely high sound energy. This occurrence can happen with any kind of bur; perhaps more prevalent with cutting burs that may make contact with ossicles that are still connected with the inner ear. Heavy suction applied to the stapes or to the oval window may also be hazardous.
Exposed bony areas	A poorly replaced skin flap or meatal skin graft may cause exposed bony areas on the external auditory canal; may result in complications such as obliteration of the lateral space of the hypotympanum leading to a concave, scarred, and nonfunctioning tympanic membrane.
Graft defect	Careful selection and evaluation of the implanted material is critical; perforations or small dehiscences in an implanted tympanic membrane may lead to early postoperative perforation.
Lateral displacement of an implanted tympanic membrane	May occur when a fascia graft is applied using an underlay technique when the fibrous annulus has not been correctly replaced or in an overlay technique when the fibrous annulus has been removed and the graft fails to make good contact. Choice of anesthesia may have an effect on the outcome: a partial gas pressure of nitrous oxide or even pure oxygen may have consequences for the tympanic membranes.
Postoperative care complications	Ear packing is probably associated with the most common postoperative care complications. Lateral displacement of the inferior part of the external meatal skin secondary to bleeding under the replaced meatal skin leading to overgrowth of epithelium and fibrous obliteration of the inferior sulcus. A stenotic ring may result from removing the packing too early or poor replacement of external skin on top of the graft. Patient education is key. For example, patient should be advised not to insert any blunt instruments (such as a Q-tip) in the ear and should avoid the intrusion of water or other liquid into the ear canal.
Audiologic complications	Decreased hearing sensitivity or deafness following surgery. The ultimate postoperative vestibular and auditory function is of critical importance in successful ear surgery and of more critical importance in avoiding malpractice liability. Documentation of the postoperative audiometric and vestibular outcomes is crucial. Outcomes are typically assessed by measuring hearing level by air and bone conduction and measurement of air–bone gap, as well as speech discrimination tests and tympanometry.

Table 45-2 Common technical errors and otologic complications that lead to medical malpractice suits

cold water. Multiple exostoses are almost always bilateral and appear as hard, smooth, rounded, whitish nodules that lie close to the sulcus tympanicus, resulting in a greater or lesser narrowing of the osseus meatus. This rarely causes the occlusion of the ear canal. When exostoses cause sufficient narrowing of the bony ear canal (osseus meatus) to produce retention of epidermal debris and conductive hearing impairment, surgery should be performed. Patient compliance after surgical treatment is key to avoiding recurrence.

In this case, the otolaryngologist was sued based upon allegations that ear damage occurred following surgery and because the physician allegedly failed to obtain informed consent prior to surgery. Despite the plaintiff's expert's contentions, the key to defending this case rested upon proper documentation of informed consent as well as documentation of the patient's noncompliance in the postoperative period.

A more recent otology-related case, decided on June 22, 2005, is a prisoner's medical malpractice claim for negligent ear cleaning.[3] In *Gary Griffen v. The State of New York*, the plaintiff claimed that rough ear cleaning caused hearing loss. On March 25, 1996, claimant Gary Griffen, an inmate in the New York State Department of Correctional Services, underwent a routine physical examination at Woodbourne (N.Y.) Correctional Facility. The doctor informed him that he had wax in his ears. The wax was to be removed at a later appointment, and Griffen was given eardrops. Several days later, the doctor used an instrument to clean the inside of Griffen's ears. Griffen claimed that the procedure was extremely painful and that he suffers residual hearing loss.

Griffen sued the State of New York, alleging that the physician improperly used the cleaning instrument and that his actions constituted negligence and medical malpractice. Griffen complained of extreme pain and hearing loss after the doctor used the instrument. The doctor informed him that his hearing would return. However, Griffen claimed that he had no hearing for the three days during which he took an antibiotic. He repeatedly returned to the facility to complain of hearing loss and to request outside testing. He testified that an otolaryngologist diagnosed hearing loss and requested retesting. In December 1997, Griffen had an appointment with an audiologist (or hearing specialist). His hearing loss in one ear continues, and he needs a hearing aid. The judge ruled that for Griffen to prevail, he would have had to have presented expert testimony of a variation from accepted medical standards. He concluded that Griffen had not presented such testimony. Thus, the claim was dismissed.

RHINOLOGY

Rhinology involves the treatment of diseases involving the nose. In the field of otolaryngology, this includes treatment of the sinuses. In this author's experience, it is rare to find rhinologic malpractice cases asserting solely damages of anosmia (inability to smell) or ageusia (lack or impairment of taste). Although epistaxis (nosebleed) is one of the most common rhinologic problems seen emergently by the otolaryngologist, the majority of lawsuits associated with rhinology are related to cerebrospinal fluid (CSF) rhinorrhea (CSF leaking from the nose) following nasal or

endoscopic sinus surgery (ESS). In addition, lawsuits secondary to complications from ESS, such as infection leading to meningitis, are common. Perhaps the most frequently reported type of rhinology-related malpractice suit is associated with a CSF-leak complication of ESS.

CSF rhinorrhea may result from trauma, congenital abnormalities, septal surgery, or sinus surgery. Leakage may become apparent immediately following surgery after dural injury, or the leak may reveal itself many days later after tissue swelling has subsided. During nasal septal surgery, the anterior skull base is at risk if care is not taken to protect the cribriform plate from direct trauma. During ESS with septal surgery, the perpendicular plate of the ethmoid and the attachment of the middle turbinate are often manipulated, which also places the skull base at risk. Certainly, the risk of intraoperative skull base damage and/or dural damage is diminished by using only sharp instruments to divide the perpendicular plate of the ethmoid or the middle turbinate before removing these structures. This precaution decreases the chance of applying unnecessary torque to the cribriform plate when these structures are being manipulated.

CSF rhinorrhea may first become evident after the patient experiences an episode of acute meningitis, chronic headache, or some other acute intracranial pathologic process. Some related clinical findings may include hoarseness, chronic cough, positional cephalgia, or altered taste sensations (such as a salty or sweet taste in the mouth). CSF rhinorrhea typically tends to be intermittent and position-dependent. Often, it is difficult to localize the source of leakage.

The laboratory examination for CSF leak should be more involved than just a dipstick test for glucose because this method gives many false positive results secondary to the normal glucose content of nasal secretions. A CSF sample should be sent to the lab for quantification of glucose. A glucose level equal to or greater than 50 mg per 100 ml is typically diagnostic.[4] Beta- or tau-transferrin testing is most specific for CSF rhinorrhea. Localization of the CSF leak may be clinically difficult to determine, and radiologic studies may be indicated. Studies using metrizamide, a radiographic contrast medium, as well as high-resolution CT scanning may assist with localization.

Statistically, about 70% of postoperative CSF leaks resolve spontaneously.[5] Conservative treatment includes elevation of the head and avoidance of straining or sneezing. This may be combined with lumbar punctures or subarachnoid lumbar drain placement. If spontaneous closure does not occur, surgical intervention is indicated. If the site of an anterior cranial skull base leak is localized, then extracranial modes of closure are usually preferred. On the other hand, if the leak is persistent and cannot be well localized, then an intracranial approach is indicated. The following case illustrates a common ESS complication scenario.[6]

The male plaintiff, who suffered from chronic sinusitis, came under the care of the defendant otolaryngologist, who recommended an endoscopic ethmoidectomy. The plaintiff contended that the defendant doctor inadvertently perforated the thin membrane separating the sinus cavity and the brain. Furthermore, the plaintiff asserted that the tear was negligently repaired, allowing subsequent infection to develop.

The plaintiff was subsequently diagnosed with meningitis and resulting brain damage. Although the plaintiff survived the meningitis, he was left with permanent cognitive deficits such as short-term memory problems, personality changes, and difficulty processing abstract thought. The plaintiff also claimed that he was permanently disabled from returning to work in his previous occupation as a self-employed plumber. The plaintiff claimed a lost earning capacity of $45,000 annually for the remainder of his life expectancy.

The plaintiff's experts were prepared to testify that the sinus cavity is situated adjacent to the cranial cavity, separated by only a thin sheath of tissue, and that tearing or perforation of the sheath or tissue is a recognized risk of surgery that can occur in the absence of negligence on the part of the treating surgeon. In addition, the experts were prepared to testify that the defendant deviated from the standard of care, not in tearing the tissue, but in failing to properly repair the injury. The plaintiff's experts would testify that the subsequent infection was caused by the alleged negligent repair undertaken by the surgeon.

The defendant otolaryngologist denied liability and maintained that his care and treatment of the plaintiff comported with the standard in all aspects of the procedure. Nevertheless, this case from Cuyahoga County, Ohio, resulted in a $2,600,000 settlement prior to trial.

Although this case probably had extenuating circumstances that led to the large settlement, one thing is sure: the propensity for lawsuits associated with ESS is such that any otolaryngologist should be extremely vigilant in every aspect of patient care when this surgery is contemplated. Very critical to the defense of these types of cases is the medical documentation in the preoperative, intraoperative, and postoperative periods. The following case also depicts CSF rhinorrhea.[7]

A female plaintiff brought this action against the defendant otolaryngologist to whom she presented with complaints of recurring ear infections. The plaintiff claimed that the defendant negligently failed to attempt less invasive alternative treatments to surgery and negligently failed to perform all the necessary diagnostic studies prior to proceeding with surgery on the plaintiff's sinuses. The surgery left the plaintiff with a continual "runny nose." Ultimately, it was determined to be CSF rhinorrhea resulting as a complication of the surgery. The plaintiff underwent surgical repair of the leakage, but was left with permanent neurologic damage as noted above.

The plaintiff contended that the defendant otolaryngologist ordered a CT scan at the time of her initial presentation, during which time she also complained of recurrent earaches (otalgia). She claimed that after receiving the CT scan results, the defendant advised her that she would require surgery to her sinuses as a first step to alleviating her recurrent otalgia. According to the plaintiff, the defendant offered no alternative course of treatment at the time.

The plaintiff further alleged that the surgery was scheduled for November of 1996, but that she decided to postpone the surgery.

The plaintiff testified that she contacted the defendant again approximately 9 months later complaining of worsening ear complaints. The sinus surgery was rescheduled for July 1997. The surgery proceeded as scheduled, but sometime shortly thereafter, the plaintiff began experiencing drainage of clear fluid emanating from her left nostril. Leakage continued from her nose even after she returned home. The plaintiff contended that the otolaryngologist failed to address her new symptoms of fluid drainage from the nose.

Upon presenting to her family physician, the clear drainage from the plaintiff's nose was tested, and was determined to be cerebrospinal fluid, suggesting that the defendant otolaryngologist had perforated the ethmoid sinus intraoperatively. The plaintiff's condition necessitated surgical repair, but she was left with permanent neurologic damage resulting from trauma to the olfactory nerve thought to have occurred during the course of the repair surgery. In addition, the surgery resulted in loss of taste and smell as well as partial facial paralysis.

The plaintiff's medical expert testified that the defendant deviated from the standard of care by proceeding with the surgery based upon one clinical exam, one CT scan study, and without first attempting less invasive means of treatment of the plaintiff's ear complaints, including a trial by antibiotic therapy alone or in conjunction with other medications. The plaintiff's expert emphasized the serious risks associated with the surgical procedure, as evidenced by the plaintiff's unfortunate outcome. The plaintiff's expert supported the contention that less invasive treatment measures should have been attempted prior to subjecting the patient to such surgery.

Meanwhile, the defendant otolaryngologist contended that the surgery was indicated based upon the extensive history provided by the plaintiff's medical record, combined with the results of the CT scan study and clinical examination. The jury found for the plaintiff and returned a verdict of $1,900,000.

In this medical malpractice case, the sinus surgery may or may not have been indicated. It is also unclear from the report as to the actual cause of the facial hemiparesis. Regardless of whether or not surgery in this case was indicated—even if a CSF leak had occurred—the jury outcome may have been different if there was evidence that the physician had carefully followed the procedures listed in Box 45-2.

It is highly unlikely that all of the events in Box 45-2 occurred in this case, and it is quite likely that the jury was aware of this fact. Again, many medical malpractice lawsuits can be avoided just by educating the patient about the specific pathologic processes occurring in their body. Indeed, patient education should be a fundamental component to obtaining informed consent for any surgical procedure or medical treatment.

In another more recent rhinology case, a 19-day medical malpractice trial in California resulted in a defense verdict on May 16, 2005.[8] In this matter, the plaintiff had sinus and allergy problems, which led to a loss of his sense of taste (ageusia) and smell (anosmia). Defendant #1, a primary care physician, was treating the plaintiff for general care and referred him to an otolaryngologist, defendant #2. The otolaryngologist performed an intranasal polypectomy. The pathology report revealed a malignant tumor, which was also surgically removed. Although the plaintiff was instructed to continue close follow-up with the otolaryngologist, the plaintiff stopped seeing defendant #2 in August 2000.

Box 45-2. Medical-Legal Pearl

... explained to the patient the differential diagnosis for conditions that cause her clinical symptoms;
... explained to the patient the possible medical and surgical treatments that follow based upon the otolaryngologist's shared consideration of the differential diagnosis;
... presented the patient with a list of potential viable treatment options and alternatives (both medical and surgical) that would logically treat the conditions contemplated in the differential diagnosis;
... explained to the patient the potential risks, benefits, and complications associated with each viable treatment option;
... documented all of the above, and demonstrated that the treatment chosen resulted from truly informed consent from the patient.

In March 2003, plaintiff saw defendant #1 for sore throat and right otalgia he had been having for the past month. During that visit, plaintiff informed defendant #1 for the first time that he was no longer being treated by defendant #2 and had not seen any ENT for the past two years. Defendant #1 immediately referred plaintiff to a new ENT, who determined that plaintiff's nasal polyps had returned and his tumor had recurred. As a result, plaintiff received extensive treatment at UCLA, which included a cranial resection and removal of his right eye. Plaintiff underwent extensive radiation and chemotherapy treatments due to the recurrence.

Plaintiff alleged that defendants #1 and #2 failed to properly assess and treat his tumor. Specifically, he contended that defendant #1 failed to appropriately and timely refer him to another ENT in the early months of 2002 and 2003, when he allegedly was showing signs of severe sinus problems. He further alleged that defendant #1 failed to ensure that plaintiff's tumor was being properly treated by checking to make sure that plaintiff was following up with defendant #2 on a regular basis.

The damages claimed by plaintiff included: (a) $131,353 past medical; (b) $107,744 per year future medical; (c) $31,660 past lost income; (d) $453,725 future lost earnings; (e) $250,000 general damages; and (f) $350,000 outstanding Medi-Cal lien. Reportedly, the initial demand during settlement discussions was for $595,000 However, defendant #1 offered nothing, but defendant #2 settled with plaintiff just prior to trial.

LARYNGOLOGY

The larynx is the musculocartilaginous structure situated at the top of the trachea and below the base of the tongue

and the hyoid bone. It is the essential air passageway that guards the entrance into the trachea, and functions secondarily as the organ of voice. Not surprisingly, most medical malpractice lawsuits associated with the larynx include cases involving acute airway emergencies or cases involving some type of voice impairment. Anytime an otolaryngologist is emergently consulted, it is usually because of an acute airway situation or some type of acute bleeding. The following case illustrates an airway issue.[9]

Mr. M, complaining of difficulty in breathing, went to the emergency room at approximately 3:00 A.M. He was placed under the care of Dr. VH, the emergency room physician on duty. Dr. VH's physical examination of M revealed swollen lymph nodes, inflammation of the pharynx, enlarged, swollen tonsils covered with pus-like exudate, and a muffled, hoarse voice. M also had stridor. After examining M, Dr. VH asked the nurse to telephone the on-call otolaryngologist.

Pursuant to the emergency room's procedure, its answering service telephoned the defendant, a board-certified otolaryngologist, and left a message. When the defendant returned the telephone call at 3:15 A.M., he spoke to Dr. VH. The defendant had never treated M. The defendant described his telephone conversation with Dr. VH, in part, as follows:

[Dr. VH] told me he had seen a patient, 31-year-old obese male, come in with sore throat .... He had stridor, he had tonsillitis, and he had a positive strep test....

He then asked me how our group treated our patients with tonsillitis. And I replied, "Did you say he had stridor? Did you—is this guy's airway obstructed? Is the patient in acute airway distress?"

He said, "No, the patient's airway is not obstructed, he's not in acute airway distress. In fact, he's walking around and he's talking, and has normal O_2 sats. on pulse oximetry."

I said, "Well, is he having noisy breathing?" He said ["Y]es.["] I then asked him what did he see on his exam. He said he had large, inflamed tonsils that were almost touching. I asked him if one tonsil was larger than the other.... He said ["N]o, they were both symmetrically enlarged and almost touching.["]

And then I said, "Well, you had told me that you had given him a shot of penicillin and that you had ordered a breathing treatment." And he said, "That's correct. I've already given him the penicillin shot."

I said, "Well, what we normally do with our patients is to give them a gram of Rocephin... and give them Dalalone.... "

....

*I said it probably wouldn't hurt to give him the—you know, an additional shot of the other antibiotic, and that I said, "You needed [**sic**] to observe the patient, especially after giving him the shot and the breathing treatment."*

And he asked me how long we observed patients, and I told him that we usually, at least with the shot, have them wait 20 minutes; and with the breathing treatment, it could be 30 minutes to an hour.

....

I then told him that... if anything changed, to call me, let me know. I reminded him that it took me about 25 minutes to get in to the hospital.

....

And then I said, "Why don't you just give me a call after he finishes the breathing treatment and let me know how he's doing." And that was the end of the call. And the next call I received came later that morning sometime before 6:00 [A.M.].

....

Dr. VH said that he was going to refer the patient to me. I said that was fine, to have the patient call me, set up an appointment that morning.

....

He said that—"Would it be all right if I referred the patient to you?" I said that's—that's—that would be fine, to ask the patient to call me in the morning to set up an appointment, to tell him—try to set that appointment up for that—for that morning.

During his deposition, Dr. VH explained some of his reasons for contacting the defendant:

Q: What time did you call defendant?

A: About 3:15 [A.M.].

Q: And that would be after your examination?

A: After the examination.

Q: And when you finished your examination, you just weren't comfortable about what problem Mr. M might have?

A: Yes, I had an understanding of his problem.

Q: But you weren't entirely sure; is that correct?

A: You are never sure about anything.

Q: All right. So you consulted with someone who was a specialist in the area of your concern?

A: That's correct.

Q: And your number one concern was that the fact that you heard stridor?

A: That's correct.

....

Q: And you knew stridor was bad, could be?

A: Could be.

Q: And so you wanted to call an ENT specialist; is that correct?

A: That's correct.

Later that morning, Mr. M stopped breathing and arrested in the emergency room. Dr. VH attempted to intubate him, was unsuccessful, and then performed an emergency tracheotomy. In the interim, the defendant was

called and was asked to come to the hospital to assist Dr. VH. When the defendant arrived, he examined Mr. M for the first time and transferred him to the intensive care unit. A subsequent EEG showed that Mr. M had no brain activity. Three days later, Mr. M died.

Mrs. M sued the otolaryngologist for medical malpractice. The case above ultimately resulted in a defense verdict for the otolaryngologist when the Texas Court of Appeals held that the otolaryngologist did not take an affirmative action to treat Mr. M sufficient to create a physician–patient relationship, and therefore owed no duty to Mr. M. This case should remind the otolaryngologist to be particularly diligent with medical documentation whenever there is a consultation regarding a potential acute airway patient.

Although production of voice is the secondary function of the larynx, it is of critical importance in one's ability to communicate. More importantly, voice-related liability issues are also commonly seen in the courtroom. Here is another case example.[10]

The plaintiff was a 54-year-old college professor. On April 21, 1978, she was referred to otolaryngologist Dr. MT for treatment of a lump in her throat. Dr. MT's diagnosis was a thyroglossal duct cyst, and he continued the plaintiff on antibiotics as prescribed by the referring physician. When the antibiotics failed to effect improvement, Dr. MT recommended removal of the cyst by surgery. The plaintiff signed the appropriate consent form and surgery was performed on May 9, 1978.

After incision the cystic mass was visualized as extending from the cricothyroid membrane to the infrahyoid area. A second mass was identified as either a projection of the thyroid gland or a pyramidal lobe. After removing the second mass, Dr. MT utilized blunt and sharp dissection to retract the thyroglossal duct cyst on its upper end. The lower end of the tract turned 180° superiorly behind the thyroid cartilage. The inferior half of the thyroid cartilage was incised, and the tract visualized as penetrating the underlying membrane for 2–3 mm. The entire tract, including the cyst, was excised in one piece. The edges of the thyroid cartilage were reapproximated with a No. 30 wire. Before concluding the operation Dr. MT performed a laryngoscopic examination that revealed the presence of a possible mucosal laceration, 3–4 mm in length, near the anterior commissure.

Postsurgical progress was uneventful; the sutures were removed and the vocal cords moved well. However, when examined on July 12, 1978, the plaintiff complained of hoarseness. Dr. MT found no objective basis for the complaint as the vocal cords appeared normal and moved satisfactorily. Dr. HM, an associate of Dr. MT, noted a slight edema (swelling) of the vocal cords but otherwise movement was good. The plaintiff was given a prescription for Valium and told to consult a speech therapist for problems with articulation and phonics. It was the plaintiff's last visit with Dr. MT.

The plaintiff sought treatment from Dr. LT, an otolaryngologist, on September 27, 1979, for congestion in her ears associated with postnasal drainage and chronic sore throat. She informed Dr. LT of hoarseness and vocal cord dysfunction since the operation of May 9, 1978. Examination revealed a slightly atrophic right vocal cord. Dr. LT intervened surgically on October 16, 1979, using a laser to divide scar tissue, which was believed to be pulling down slightly on the right vocal cord. No improvement was noted. A second diagnostic laryngoscopy revealed a small web of scar tissue involving the right vocal cord and the anterior commissure, and the left vocal cord was atrophic and scarred. A sterile glycerine solution injected into the left vocal cord to increase its bulk effected no demonstrative improvement. A final laryngoscopic exam on April 23, 1980, revealed the posterior commissure rotated to the left. Dr. LT referred the plaintiff to a speech therapist.

From April through June of 1980, the plaintiff was treated by Dr. OV, a psychiatrist, for depression with anxiety secondary to the loss of her normal vocal capabilities. She filed suit on September 25, 1980, claiming the hoarseness and vocal cord dysfunction impacted on her ability to teach and to support herself and her family. The central issues at trial were whether the thyroglossal duct cyst operation was negligently performed and whether, as a proximate result of negligence, the plaintiff suffered injuries that would not otherwise have been incurred.

The proceedings in this case resulted in a classic courtroom "battle of the experts," wherein testimony from multiple plaintiff's experts and defendant's experts was pitted against each other before the judge in order to determine which experts were more credible. The defendant's surgical treatment and management were meticulously scrutinized in this lawsuit, but the defendant prevailed. However, there are two important factors to note in this case: (1) the importance of establishing the standard of care through credible expert witness testimony, and (2) the potentially devastating impact that voice impairment can have upon a patient (or plaintiff).

Otolaryngologists who specialize in voice procedures emphasize the importance of proper preoperative as well as postoperative management of voice patients. Dr. Robert Ossoff, a prominent laryngologist from Vanderbilt University School of Medicine, recommends a preoperative assessment by a speech and language pathologist, a vocal pedagogue, and a gastroenterologist in order to maximize the success of any voice procedure.[11] In addition, Dr. Ossoff recommends a preoperative voice recording as well as a videostroboscopic examination and photograph as the minimum necessary preoperative assessments for patients undergoing vocal surgery or any surgery that may affect one's ability to phonate, particularly if the patient's livelihood is dependent upon their ability to speak or sing.[11] Although this author realizes that these documentation measures and resources may not be readily available to a typical small ENT practice, it is this author's belief that a "high risk" patient or a patient who appears litigious should be referred to a facility that is equipped to perform a complete and adequate preoperative assessment.

Finally, informed consent for voice procedures should include patient education about potential complications such as chipped or broken teeth, bleeding, infection, voice

hoarseness, and voice whisper. The patient should be aware that poor vocal outcomes may occur even if surgery is performed perfectly, and they should be educated that healing after vocal surgery is a *process*, not an *event*. This process may typically take anywhere from 3 to 18 months, depending upon the surgery.[11]

In the United States, the largest otolaryngology-related verdict of 2005 resulted in an award of $4,250,000 in New York.[12] On April 30, 2001, plaintiff RP, age 32, a bus driver, underwent a uvulopalatopharyngoplasty—the surgical removal of excess tissue that occupied the rear portion of his throat. The procedure was performed by Dr. MG, at Long Island Jewish Medical Center, in New Hyde Park. MG was assisted by an anesthesiologist, Dr. KB, and a nurse, KJ.

RP's endotracheal oxygen-providing tube dislodged while he was emerging from the anesthesia that was administered before the surgery. A subsequent examination revealed that RP suffers incapacitating brain damage. RP's sister, SG, claimed that the brain damage occurred because the endotracheal tube was not quickly replaced. SG, acting as RP's guardian *ad litem*, sued the medical center; MG; MG's practice, Otolaryngology & Facial Plastics Center, LLP; KB; and KJ. SG alleged that the defendants failed to adequately monitor her brother and that their failures constituted medical malpractice.

SG subsequently discontinued her claims against KJ, MG, and MG's practice. The matter proceeded against KB and the medical center. SG's counsel claimed that RP was administered two doses of epinephrine that spanned a 6-minute-long segment of his postsurgical recovery. They contended that the epinephrine was administered to prevent any heart damage that could have stemmed from the oxygen interruption. As such, they argued that the endotracheal tube's displacement must have lasted more than 5 minutes. They claimed that the intervening oxygen deprivation caused cardiac hypoxia that led to hypoxic ischemic encephalopathy—damage of cells of the central nervous system.

Defense counsel contended that a hospital employee quickly determined that RP's endotracheal tube had been dislodged. He claimed that the tube was replaced within 90 seconds and that RP did not sustain cardiac hypoxia. The defense counsel also claimed that RP's brain damage was a product of intrasurgical electromechanical dissociation (EMD)—cardiac arrest in which the heart produces electrical impulses, but cannot generate the responsive contractions. He claimed that the epinephrine was administered to treat the EMD.

RP is unable to communicate or walk, and he requires constant assistance and supervision. The plaintiff's expert neuropsychologist opined that RP's disability is permanent and that RP can feel pain. MG sought recovery of her brother's future medical expenses, his future care expenses, and damages for his past and future pain and suffering. Defense counsel maintained that RP's brain damage was a product of a cardiac arrest that he sustained during the surgery.

The defense's expert neurologist opined that RP does not feel pain. The defense's life-care-planning experts opined that RP will probably live an additional five years and that, as such, his future care expenses will total $1.8 million.

CONCLUSION

In any medical malpractice lawsuit, negligence is defined by treatment that falls below the so-called "standard of care." Perhaps the most difficult aspect of litigating an otolaryngology-related case is the fact that this specialty is always in a state of evolution with new techniques, new instrumentation, and new "standards" as clinical data are accumulated about the new techniques and new instruments. For example, there are numerous ways to perform a tonsillectomy. Tonsils can be removed by wire snares, electrocautery, laser, and even sharp or blunt dissection. All techniques work, and all are acceptable techniques that are often dependent upon the skill and experience of the operator, as well as the basic health, education, and comprehension ability of the patient.

In the courtroom, however, if the plaintiff's expert testifies that electrocautery is the *only way* that tonsils should be removed and that any other technique falls below the standard of care, then electrocautery becomes the "standard of care" for that courtroom until contrary evidence is produced from the opposing expert witness. Otolaryngologists should be aware that new instruments and new techniques are often fraught with potential "new complications," and that medical documentation is often the physician's best defense in a medical malpractice suit.

For the attorney representing an otolaryngologist in a medical malpractice suit, the lawyer should be aware of otolaryngology's constant evolution, and that proper education of the judge or jury about the current standard of care is critical to each case. One common denominator in many malpractice suits is that of informed consent. The reader should note that standard of care and informed consent issues are addressed in other chapters of this text, and should refer to those chapters for a more in-depth discussion.

Endnotes

1. *Conn v. Purcelli, M.D.* (Case No. SC059122, Mar. 15, 2001), 16(7) National Jury Verdict Review & Analysis 17 (2001).
2. P.H.G. Van Gilse, *Des Observations Ultérieures sur la Genèse des Exostoses du Conduit Externe par l'Irritations d'Eau Froide*, 26 Acta Oto-Laryngol. 343 (1938).
3. *Gary Griffen v. The State of New York*, 2005 WL 3692664 (N.Y0. Ct.Cl.), N.Y. J.V. Rep. 23.
4. J.R. Chandler, *Traumatic Cerebrospinal Fluid Leakage*, 16 Otol. Clin. North Am. 623–632 (1983).
5. D.L. Myers & R.T. Sataloff, *Spinal Fluid Leakage After Skull Base Surgery*, 17 Otol. Clin. North Am. 601–612 (1984).
6. Citation withheld by reporter, 17(1) National Jury Verdict Review & Analysis 18 (2002).
7. *McKibben v. Baldone* (Case No. 98CCV A06-4535 Sept. 2001), 17(8) National Jury Verdict Review & Analysis 16 (2002).

8. *Torres v. Caremore Medical Group*, 2005 WL 2170708 (Cal. Sup.), 35 Trials Digest 8th 6.
9. *El Majzoub v. Appling*, 2002 WL 31521130, Tex. App.-Hous. (1 Dist.).
10. *Pernia v. Trail*, 519 So. 2d 231.
11. Telephone interview with Robert Ossoff, D.M.D., M.D., Aug. 7, 2002.
12. *Sharon Grady as Guardian ad litem for Rubin Person, an incompetent v. Mark Norman Goldstein & the Otolaryngology & Facial Plastics Center, LLP, Kevin Barcohana, Kathy Jaeger & L.I. Jewish Medical Center*, 2005 WL 3618160 (N.Y. Sup.), N.Y. J.V. Rep. 23.