Advocates' Immunity

Dr Joseph Lizzio, a general surgeon for 20 years, has a practice in general and colo-rectal surgery in the Sutherland Shire. He graduated from the University of Sydney in 1974 and became a fellow of the Royal Australasian College of Surgeons in 1981. He continued his surgical training in the United Kingdom, returning to Australia in 1985. In 2004, Dr Lizzio was appointed a part-time medical adviser and claims manager at United Medical Protection. He graduated in law from the University of New South Wales in 2006. His talk relates particularly to problems confronting him in the operating theatre, problems aggravated by his lack of immunity from civil litigation.

Why don't I have immunity from civil suit? In particular, why I don't have it in the middle of the night? My colleagues can't understand why barristers are immune from suit. They see it as some sort of insider influence.

The background to a crisis

What sort of things might confront me in the middle of the night? This is a typical example of a patient I have to manage. Because my registrar has been in theatre all day, I am not notified about her until about eight o'clock that night.

She is 59, has had three days of abdominal pain, her bowels haven't opened for a while, she has had the occasional vomit, and her abdomen is distended. The registrar, concerned about her, says, quite rightly, that she should be admitted and should have a computerised tomography (CT) scan.

The CT scan

A CT scan, the best of all investigations, will show if there is any distention of the bowel, whether or not it is obstructed and will show the circulation — the crucial factor. Fortunately, he has ordered the scan, but, unfortunately, being fairly junior, he hasn't pushed to have it done promptly. It will be done some time during the evening or in the middle of the night. He will ring with the results. Meanwhile, he has organised a few blood tests.

At about 11 o'clock, he tells me that the scan shows a mass in the left lower abdomen, with a very distended large bowel. The caecum is distended to a diameter of 10 or 12 centimetres.

The clinical situation

The problem with a distended caecum is that it might block the flow from the small bowel into the large bowel, a communication which can work in only one direction. Once the colon is obstructed, the caecum will gradually distend, the outer surface will start to tear, and if nothing is done, the caecum will rupture. If the caecum is about 10 to 12 centimetres distended, something is clearly happening.

Of great importance to me, as a surgeon, is what the patient looks like: is she comfortable, is she tall or short, fat or thin? She is 59, is just over five foot tall, weighs 120 kilos, and is a little uncomfortable. The CT scan shows distention of the caecum, with a mass on the left of the abdomen — probably diverticulitis (inflammation, with infection, of small pockets ballooning out from the large bowel). The CT scan shows nothing else.

My dilemma

What is likely to happen? My concerns are that, if nothing is done, the caecum *will* rupture, and that, if something is done, the caecum *might* rupture. I will be thinking about the sort of operation I might need to do. I also need to resolve what will happen to her *after* the operation, because if I embark on this sort of thing in the middle of the

night in a person of that size, it is highly unlikely that she is going to breathe spontaneously after the operation; she will have to go to the intensive care unit. I will need to know whether or not there is a bed, and whether the anaesthetist is going to be happy to do this.

Which operation?

The procedures I need to consider are those which will decompress the bowel. If not, the caecum will rupture and she will not live very long. The possible procedures are:

- opening the abdomen (laparotomy) and bringing the colon out to open onto the surface into a temporary colostomy bag;
- cutting out the whole of the recto-sigmoid colon and bringing the end of the colon out to open onto the surface in a temporary 'end' colostomy (Hartmann's procedure);
- cutting out the blocked portion of the colon (resection) and re-joining the cut ends (primary anastomosis).

Some form of colostomy is the simplest to do. I have to open the abdomen and bring out part of the large intestine to decompress it so that the caecum doesn't rupture. If possible, I would like to remove the offending diseased colon from the left lower abdomen. The CT scan suggested it might be diverticulitis, but it could be a frank or lurking cancer; removal of the disease would really be good. I mention the last option, because some people might talk about it, but clearly this is not a patient for whom you could remove the disease and re-join the bowel. It is the most dangerous of the procedures and would probably rupture the caecum.

An anaesthetic nightmare

While this is going on, I alert the anaesthetist, who needs to see the patient. She might be a smoker, have diabetes, and be hypertensive. She probably has sleep apnoea. The anaesthetist will be really happy to know that she has just had a few dental crowns put in, has a short neck, and had a difficult incubation the last time she had an anaesthetic! All these things will really worry him or her. I am sitting there thinking that if I don't do anything, she is not going to survive the night. So something will need to be done.

Pre-operative preparation

The next stage is for her to be taken to the operating theatre. The anaesthetist will want to have everything ready before the operation begins: a central line directly in a vein of the neck, an arterial line, and a catheter in the bladder.

Which procedure?

I now have to resolve whether to remove (resect) the diseased bowel or just do a colostomy. Both have advantages and disadvantages. If I resect the diseased bowel, the distending process will have been removed, probably allowing the colon to decompress itself. Unfortunately, just to get into the abdomen, I will have to delve down through a ten or twelve centimetre layer of subcutaneous fat in a such very short person who weighs 120 kilos. This is not going to be easy. Just handling the abdominal contents is enough to rupture the caecum.

I have recently had both types of patient: in one I was able to do a resection, but in the other, even though I had made an enormous incision, there was no way I could. It was just too difficult and too worrying to actually handle the bowel; so I had to abandon the resection and do a colostomy.

What else can go wrong?

The assistant I need an assistant, usually the registrar, who is not only junior but has been working all day and night. By the time the operation is done, it is close to midnight, possibly later. The theatre sister is not likely to be someone I normally operate with, and therefore is not familiar with my technique.

The procedure might be going along quite nicely. Half-way through the operation, the accident and emergency department rings to say that they have an emergency. Does the registrar stay with me or does he go down there? After we discuss what is happening in the emergency department, I will say, "You'd better go down and see what is going on", but then I am left without an assistant. I summon the ward intern, who will take some time to arrive.

The nurses Unusual events can happen during the operation. A typical example is that the theatre sister suddenly decides that she is missing a needle. She'll find it sooner or later, but if you have had anything to do with a theatre sister, you would understand that it completely changes her mindset. She will be completely distracted trying to work out where that needle could be. She doesn't want to spend the rest of the night trying to find it. She knows that, if we haven't found it by the end of the procedure, we will have to organise an x-ray. So she won't let me close the abdomen until she has found it. We will spend much time searching around, looking inside and outside the patient's body.

The nursing staff and the scout would have passed me sponges and swabs. They would be counted during the procedure. The swabs might have been put into little packs. These will be have to be unpacked for all the swabs to be counted again while checking for the needle.

The scout nurse may know the system or might have been called in at the last minute, with absolutely no idea where anything is. The modern approach to theatres is not to have any spare equipment, not have any spare sutures, in the theatre itself. So if you ask for a suture that is not there, she will have to go to the sterile stores and will probably never find it. The surgeon knows this and will be too scared to ask for anything. She might disappear and never return.

After the operation

After we have done the procedure, we will be confronted with a person who requires ventilation and some time in intensive care.

Between the devil and the deep blue sea

During this entire process, if I make a 'wrong' decision, for example, deciding not to do a resection but a colostomy instead, and then the patient is waiting to be have her colon put back together and to have the colostomy closed, we may or may not ever find out what the disease process was until it is eventually removed.

If, at a later date, there is some delay in proceeding, I have no immunity if I have chosen to do the 'wrong' procedure.

If I have done a resection and the patient suffers complications, it is easy for people to say, "You did the wrong operation. You shouldn't have done a resection in the middle of the night. It was obviously too dangerous. You should just have done a colostomy."

So I might be legally vulnerable irrespective of what I chose to do. While I hope I have made the right choice, I don't have any immunity. Why not?