The Journal of Laryngology & Otology (2015), ***129***, *244–249*.

doi:10.1017/S0022215115000286

MAIN ARTICLE

Litigation in English rhinology

A S HARRIS, S J EDWARDS, L POPE

Department of Otorhinolaryngology, Abertawe Bro Morgannwg University Health Board, Swansea, Wales, UK

Abstract

Objective: Litigation is a rising financial burden on the National Health Service. This study aims to show if litigation is increasing in rhinology and which procedures lead to the most claims.

Methods: Ten years of data were obtained from the National Health Service Litigation Authority. Rhinology claims were examined for cost, injury, diagnosis and operation type.

Results: Of the 123 rhinology claims identified, 52 per cent were successful. There was a 56 per cent increase in the average annual number of claims between the first half of the study period and the second ($p = 0.0451$). The commonest reasons for a claim were poor cosmesis (15.6 per cent) and lack of informed consent (14 per cent).

Conclusion: The number of claims in rhinology increased over the study period. Most claims resulted from poor cosmetic outcome, lack of consent or recognised complications. It is suggested that enhanced communication and management of patient expectations could reduce litigation and improve patient satisfaction.

Key words: Litigation; Medicolegal Aspects; Malpractice; Negligence; Informed Consent; Nasal Surgical Procedures; Otolaryngology

Introduction

In the 2011–2012 financial year, the National Health Service (NHS) in England paid more than one billion pounds for legal fees and damages relating to clinical negligence claims.[1] It has been suggested that litigation in the NHS will continue to rise; this has been attributed to the growth of the 'no win, no fee' market, which removes the financial risk to the claimant, and to the rise of consumerism in healthcare.[2] Pursuing clinical negligence claims is a lucrative business in the UK, with solicitors charging as much as £800 per hour for successful cases.[3] The cost to the NHS is compounded as under UK law the legal fees for both parties are payable by the losing party.[1] In a time of budget cuts and austerity, this is a bill the NHS will struggle to afford. The blame cannot be completely attributed to the legal system however, as this bill is being paid to compensate for mistakes that are often being repeated.[4]

The NHS Litigation Authority is an NHS organisation that manages clinical negligence claims on behalf of the respective NHS trusts and has overseen all claims since 2002.[5] The NHS Litigation Authority prospectively compiles data on the type and amount of claims they deal with, and this information is available for research under the Freedom of Information Act 2000.

The NHS Litigation Authority data have been studied extensively for certain ENT topics, such as otology and tonsil disease, and for other specialties.[6,7] There are also papers examining litigation in other countries.[8–10] However, there are no recent publications looking at litigation in rhinology in the UK. Rhinology as a subspecialty may be vulnerable to litigation, as complications can potentially result in high morbidity (given the vicinity of vital structures such as the orbit and cranium), and many operations are performed for subjective or cosmetic complaints.

Learning from reflection and experience is integral to modern medical practice. Although the monetary cost of claims is a heavy burden in an increasingly budget-conscious NHS, lessons should be learned from litigation in order to drive progress and improve patient care. Armed with the knowledge of situations in which errors have occurred, the rhinologist can strive not to duplicate them.

This paper aimed to determine whether the level of litigation is changing in rhinology and to identify which procedures lead to the most claims. The results are presented and discussed with the aim of informing clinicians, to improve practice and reduce litigation.

Materials and methods

A request was made to the NHS Litigation Authority for all data relating to claims concerning ENT patients processed from 2000 to the present. These data are available under the Freedom of Information Act 2000.

Presented at the ENT Wales Academic Meeting, 11 October 2013, Cardiff, Wales, UK.
Accepted for publication 26 August 2014

Claims from April 2002 to March 2012 were analysed. (In April 2002, there were changes in the level of claims trusts managed internally and what came to be referred to as the NHS Litigation Authority.) The NHS Litigation Authority data were provided in a Microsoft® Excel spreadsheet. The spreadsheet contained a brief description of the events leading to the claim, the injury sustained and the costs paid by the NHS broken down into damages, defence costs and claimant legal costs.

Data were analysed in Microsoft Excel. The cases were categorised into rhinology, otology, laryngology, and head and neck oncology by analysing the condition being treated and/or the operation the patient had undergone. The rhinology cases were then analysed for costs, reason for claim, and condition or operation relevant to the case. 'Total costs', where detailed, refers to the total amount paid by the NHS, including damages, claimant legal costs and defence legal costs. Costs are stated in British pound sterling. Where more than one injury led to a claim, the primary reason for the claim was used in the analysis (this is clearly stated in the NHS Litigation Authority database).

Results

A total of 641 claims for ENT patients were referred to the NHS Litigation Authority during the study period. We identified 123 rhinology claims, representing 19 per cent of all ENT claims. The total cost for ENT claims amounted to £29 070 543, of which rhinology claims made up £2 835 268 (9.8 per cent). The average total cost of an ENT claim was £46 167.78.

Sixty-four rhinology claims (52 per cent) were successful and resulted in the claimant being paid damages. Amongst these claimants, the average amount paid in damages was £21 783.30 and the average total cost was £43 309. Table I shows the average total cost broken down by reason for claim.

Figure 1 is a graph of the number of claims for each financial year, which shows an increasing trend. A significant increase of 56 per cent is seen between the average annual number of claims in the first half of the study period (average of 9.6 claims) compared to the second half (average of 15 claims; $p = 0.0451$). However, no trend was found in the total cost per year over the study period, which peaked in the 2007–2008 financial year with total costs of £771 526.03 for that year.

The most common reasons for making a claim related to poor cosmetic outcome (15.6 per cent) and lack of informed consent (14 per cent). However, these did not lead to the biggest costs (on average £38 054 and £26 581 respectively); the biggest total costs were associated with a cerebrospinal fluid leak and delayed diagnosis, both of which incurred average costs in excess of £100 000. With regards to the four claims for delayed diagnosis, two large costs elevate the average: one claim was for a delay in diagnosing a benign tumour (necessitating a larger operation) and the second was for failing to recognise the severity of epistaxis, resulting in delayed treatment and an intensive care admission.

TABLE I
AVERAGE TOTAL COST PER PRIMARY REASON FOR CLAIM

Primary reason for claim	Claims (n (%))*	Average total cost (£)
Cosmetic	10 (15.6)	38 053.78
Consent	9 (14.0)	26 581.33
Change in vision	7 (10.9)	85 946.15
Retained splints or packs	7 (10.9)	6485.22
Septal perforation	6 (9.4)	25 129.55
Delayed diagnosis	4 (6.3)	104 032.03
Failure to improve symptoms	4 (6.3)	23 996.11
Incorrect operation or site	3 (4.7)	11 757.35
CSF leak	2 (3.1)	254 814.11
Post-op bleeding	2 (3.1)	4965.96
Dental damage	2 (3.1)	2158.84
Meningitis	1 (1.6)	81 601.38
Allergy	1 (1.6)	73 756.71
Damage to lamina papyracea	1 (1.6)	50 170.50
Death	1 (1.6)	35 746.50
Wound infection	1 (1.6)	20 465.85
Oronasal fistula	1 (1.6)	15 847.99
Transfer injury	1 (1.6)	10 500.00
Error in post-op prescribing	1 (1.6)	3741.14

*Total $n = 64$. CSF = cerebrospinal fluid; post-op = post-operation

The findings revealed that 10.9 per cent of claims were for visual change, and this resulted in large total costs (average of £85 946; range, £22 066–£190 596); these claims were for double vision, except for one patient who lost sight in one eye. In addition, 10.9 per cent of patients claimed after packs or splints were found intranasally several weeks after the operation (leading to pain, bleeding and infection).

Eight types of procedure triggered more than one different complaint each and made up 83 per cent of the successful rhinology claims. The types of procedure which occur more than once in the data set are shown in Table II, including the type of complaints they received. The most common procedures to trigger a claim were septoplasty, functional endoscopic sinus surgery (FESS) and rhinoplasty, together accounting for 59 per cent of the rhinology claims.

Several of the less common complaints also deserve detailing. One patient claimed that he was not monitored effectively post-operatively and suffered alar necrosis due to pressure from a Foley catheter. Another patient who had been expecting a sinus washout received a rhinoplasty which was the treatment intended for another patient. It is unclear from the data set what events led to the single fatality; this patient underwent a septoplasty and submucosal diathermy of turbinates for nasal obstruction and died post-operatively during the recovery period.

https://doi.org/10.1017/S0022215115000286 Published online by Cambridge University Press

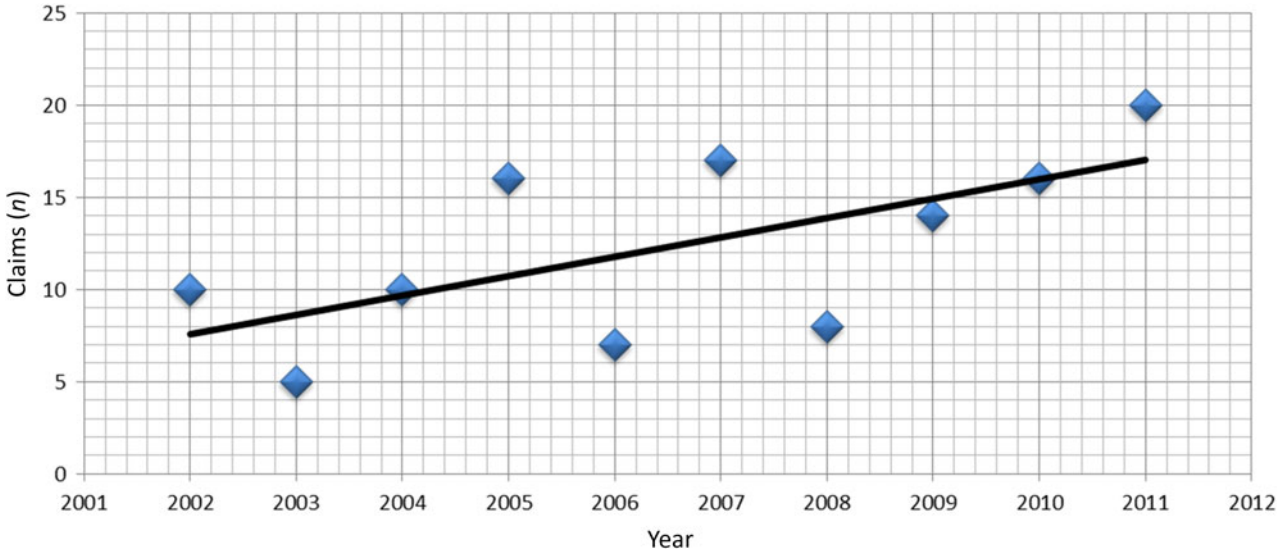

FIG. 1
Graph showing number of claims for each financial year.

Discussion

General outcomes

Rhinology accounts for a proportionately lower number and lower total cost of claims compared to other ENT subspecialties, accounting for 19 per cent of ENT claims and 9.8 per cent of the total amount paid by the NHS for ENT. This contrasts the proportions found in US practice, where rhinology claims may make up to two-thirds of the total indemnity paid for ENT malpractice claims.[10] The average total cost to the NHS of a closed claim was £43 309 for rhinology cases, which is lower than the average ENT claim in this series of £46 167. This is also lower than the average total cost for otology cases found in the study by Mathew *et al.* (£62 700), although this was a different study period and the figures may have subsequently changed.[6] This may be attributable to the only moderate success rate of rhinology claimants; 52 per cent of rhinology litigation claims were successful and resulted in damages being paid, compared to 84 per cent of otology claims and 73 per cent of anaesthesia claims in Mathew *et al.*[6]

However, an increase was seen in the average number of claims from the first half of the study compared with the second half, which follows the upward trend of litigation described in other specialties and for medical claims in general.[2,11,12] The absence of a trend in the average total cost may be attributable to the wide range in the total cost per claim. For instance, a large proportion of the total costs in the peak 2007–2008 year was made up of one claim of £441 446.51.

Consent and patient expectations

A large proportion of claims can be attributed to consent either directly or indirectly. It was found that 14 per cent of claims were directly caused by a perceived lack of informed consent (the second highest reason to claim). Poor cosmetic outcome was the most common reason for a claim, with half of these claimants having received surgery for cosmetic reasons. Dissatisfaction with appearance after a cosmetic procedure can be partly attributed to a failure in managing patients' expectations effectively, and this is also a part of informed consent.[12–15] Poorly managed expectations may also be a factor in the 6.3 per cent of patients who claimed because of a failure to improve their symptoms. Ensuring the patient has a realistic understanding of the impact a procedure can have on their symptoms or appearance, in both the best and worst case scenario, is vital. Many patients expect dramatic results from cosmetic operations and are seeking 'perfection'.[12,14,15] It is useful to realise that the patient's perception of a positive outcome may differ hugely to the surgeon's.[15] It is also suggested that if the surgeon does not feel that the patient has realistic expectations of the outcomes of cosmetic surgery, then surgery should not be offered.[15]

Consent and expectations can also play a role when patients claim as a result of recognised complications. The ENT-UK has published information for patients on some of the more common ENT procedures, including septoplasty, FESS and rhinoplasty (which, as mentioned above, account for over half of claims in this study); 47 per cent of claims for these three procedures were for complications that are stated in the ENT-UK patient information material.[16–18] If the patient is fully aware of the common or serious complications of their procedure pre-operatively, they may be more accepting and less likely to litigate if these complications arise. This conclusion is reflected in other studies of malpractice litigation, in the UK and the USA, including those looking at iatrogenic orbital injury and plastic surgery.[6,7,13,19,20]

Improving the quality of consent is a priority for medical indemnity insurers. The Medical Protection

https://doi.org/10.1017/S0022215115000286 Published online by Cambridge University Press

TABLE II
PROCEDURES OCCURRING MORE THAN ONCE IN THE DATA SET AND THE TYPE OF COMPLAINTS FOR EACH

Primary reason for claim	Procedure (*n*)								Total (*n*)
	Septoplasty	FESS	Rhinoplasty	Septorhinoplasty	Polypectomy	Epistaxis cautery	Manipulation of nasal fracture	Biopsy	
Consent	3	0	2	1	0	1	1	1	9
Cosmetic	3	0	1	2	0	0	1	0	7
Change in vision	1	4	1	0	1	0	0	0	7
Septal perforation	3	0	1	0	1	1	0	0	6
Retained splints or packs	2	0	2	0	2	0	0	0	6
Failure to improve symptoms	4	0	0	0	0	0	0	0	4
Post-op bleeding	1	1	0	0	0	0	0	0	2
Dental damage	0	2	0	0	0	0	0	0	2
Meningitis	0	2	0	0	0	0	0	0	2
Incorrect operation or site	0	0	1	0	0	0	0	1	2
Delayed diagnosis	0	0	0	0	0	1	1	0	2
Wound infection	0	0	1	0	0	0	0	0	1
Death	1	0	0	0	0	0	0	0	1
CSF leak	0	1	0	0	0	0	0	0	1
Transfer injury	0	1	0	0	0	0	0	0	1
Total	18	11	9	3	4	3	3	2	53

FESS = functional endoscopic sinus surgery; post-op = post-operation; CSF = cerebrospinal fluid

Society have recently published two case reports relating to consent, one of which describes a case of diplopia following FESS.[21,22] They concluded that litigation could have been avoided if the implications of the possible complications were more extensively explained, stating that non-surgical options must be explicitly described.[22] The Medical Defence Union have published an analysis of their plastic surgery claims, 10 per cent of which followed rhinoplasty and 20 per cent related to consent.[12]

Having established that consent is an issue at the root of many claims, the question of how to improve it is a difficult one to answer. The importance of consent is taught in medical school and throughout post-graduate surgical training. The General Medical Council and Department of Health publish general principles of providing informed consent, but by necessity there is huge scope for interpretation by clinicians.[23,24] Recently, there has been a shift in focus from providing the level of information another reasonable doctor would provide to what a reasonable patient would expect.[25]

There is conflicting evidence in the literature regarding who undertakes the written consent procedure, and where most education should be focused. Studies performed in 2002 and 2005 showed that in various ENT departments, more than 80 per cent of Senior House Officers (SHOs) reported being routinely responsible for consenting patients.[26] Of note, the two procedures with a significant drop in SHO involvement in the consent process were septoplasty and FESS. This is in direct contrast to the study performed by Goodyear *et al*. which showed that SHOs accounted for only 18 per cent of those responsible for completed consent forms.[27] This study showed that while consultants would omit 48 per cent of expected complications from documentation, SHOs omit only 18 per cent. The consensus is that SHOs will be expected to perform consent because of the limited availability of senior staff; therefore, discussion of the specific risks of procedures should form part of an ENT departmental induction.

The provision of written information leaflets may contribute to patient understanding, and reduce claims relating to a lack of information and poor communication skills.[26] Written information is not without its limitations however, and has been shown to vary widely in terms of quality and in evidence base.[28–30] A Cochrane review of the use of decision aids, including leaflets but also multimedia options (such as video and online interactive tools), found that they were effective in informing patients of realistic outcomes and complications; however, the review found no studies on the effect of decision aids on litigation.[31] In the UK, there are initiatives to improve shared decision making. These include the 'MAGIC' (Making Good Decisions in Collaboration) programme, currently being developed in Cardiff, which uses option grids with patients considering tonsillectomy and treatment for head and neck cancer.[32]

https://doi.org/10.1017/S0022215115000286 Published online by Cambridge University Press

Packs and splints

A significant proportion (10.9 per cent) of patients complained after packs or splints were found intranasally, several weeks after the operation. The limitations of the data mean that direct causes cannot be identified. It is not clear if these were meant to remain in the patient for a period post-operatively. Rigid attention to protocol in the operating theatre, and emphasis on verbal or written communication to the post-operative team, may prevent this complication and ensure that packs are removed when they are meant to be. This should be seen as a basic, foreseeable error; with good communication, this should be easily avoidable, with an even lower occurrence.

Why patients claim

It is apparent that the reasons why patients make a complaint or a claim for compensation are complex and not related to the clinical incident alone. If all patients who suffered the complications listed in Table I made a legal claim, then the numbers in this paper would be a lot higher. Studies looking at patients' motivation for complaining have found that the majority of complaints are routed in ineffective communication as well as a negative incident; the need for redress and to prevent similar incidents recurring is also a common finding.[33–35] These studies suggest that the manner in which the patient is dealt with by the clinical team immediately after a negative incident is a crucial deciding factor in triggering a complaint or a claim. Patients desire to be more involved in decisions, to be managed with empathy and sympathy, and to receive an apology.

- **10 years of rhinology litigation cost the National Health Service (NHS) in England £2 835 268**
- **An average rhinology claim costs the NHS £43 309**
- **The number of claims made per year in rhinology appears to be rising**
- **Septoplasty, functional endoscopic sinus surgery and rhinoplasty result in the most claims**
- **Many claims relate to consent and a failure to manage a patient's expectations**

Evaluation

There are a number of restrictions in utilising the NHS Litigation Authority data set. The data collected are not compiled for research but for internal audit, and the depth of information given is limited. This means that there is limited clinical detail concerning the operative procedure or the underlying condition related to the claim. This makes analysis of individual claims difficult, but the data are adequate for the purposes of looking at trends and themes. The NHS Litigation Authority data are also restricted to NHS patients in England. A number of other organisations were contacted to expand the pool of data to include Scotland, Wales and private practices across the UK. These included the main UK indemnity insurers, the Central Legal Office in Scotland and the Shared Services Partnership in Wales. However, these bodies were unable to supply any data, primarily citing confidentiality issues.

Conclusion

The number of claims made by rhinology patients is increasing. Over half of claims in rhinology are successful and on average pay more than £20 000, with the NHS paying more than double this because of legal fees. A large proportion of claims are a result of recognised complications of the various procedures and lack of informed consent. Understanding and managing patient comprehension and expectations is fundamental to tackling this complex area. Particular attention should be made when consenting patients for cosmetic procedures, septoplasty, FESS and rhinoplasty. Developing good quality decision aids in these areas may be beneficial. In addition to this, a number of claims relate to basic principles such as ensuring the correct procedure is carried out, on the correct patient, in the correct site, and ensuring packs or splints are removed.

Our findings emphasise the importance of focusing on the basics of clinical care and good communication. We suggest this would reduce adverse events, leading to fewer claims and improved patient outcomes.

Acknowledgement

The authors would like to thank the NHS Litigation Authority for supplying the data.

References

1 Dyer C. NHS bill for compensation exceeds £1bn for the first time. *BMJ* 2012;**345**:e4638
2 Eaton L. Clinical negligence claims continue to rise, thanks to "no win no fee" deals. *BMJ* 2010;**341**:c4258
3 Dyer C. Government looks at ways to reduce the cost of NHS negligence claims. *BMJ* 2011;**342**:d1131
4 Dyer C. Suing the NHS: can the £1bn annual compensation bill continue? *BMJ* 2013;**346**:f978
5 NHS Litigation Authority. About us. In: http://www.nhsla.com/AboutUs/Pages/Home.aspx [2 June 2013]
6 Mathew R, Asimacopoulos E, Valentine P. Toward safer practice in otology: a report on 15 years of clinical negligence claims. *Laryngoscope* 2011;**121**:2214–19
7 Mathew R, Asimacopoulos E, Walker D, Gutierrez T, Valentine P, Pitkin L. Analysis of clinical negligence claims following tonsillectomy in England 1995 to 2010. *Ann Otol Rhinol Laryngol* 2012;**121**:337–40
8 Nikoghosyan-Bossen G, Hauberg A, Homøe P. Increased number of ear-nose-throat malpractice complaints in Denmark. *Dan Med J* 2012;**59**:A4321
9 Lynn-Macrae AG, Lynn-Macrae RA, Emani J, Kern RC, Conley DB. Medicolegal analysis of injury during endoscopic sinus surgery. *Laryngoscope* 2004;**114**:1492–5
10 Dawson DE, Kraus EM. Medical malpractice and rhinology. *Am J Rhinol* 2007;**21**:584–90
11 Markides GA, Newman CM. Medical malpractice claims in relation to colorectal malignancy in the NHS. *Colorectal Dis* 2013;**16**:48–56

https://doi.org/10.1017/S0022215115000286 Published online by Cambridge University Press

12 Armstrong J. The changing face of plastic surgery. *MDU Journal* 2011;**27**:18e20
13 Svider PF, Keeley BR, Zumba O, Mauro AC, Setzen M, Eloy JA. From the operating room to the courtroom: a comprehensive characterization of litigation related to facial plastic surgery procedures. *Laryngoscope* 2013;**123**:1849–53
14 Gorney M. Claims prevention for the aesthetic surgeon: preparing for the less-than-perfect outcome. *Facial Plast Surg* 2002; **18**:135–42
15 Sykes JM. Managing the psychological aspects of plastic surgery patients. *Curr Opin Otolaryngol Head Neck Surg* 2009;**17**:321–5
16 ENT UK. Surgery on the nose - septal surgery. In: https://entuk.org/ent_patients/nose_conditions/septal_surgery [30 September 2013]
17 ENT UK. Functional endoscopic sinus surgery (FESS). In: https://entuk.org/ent_patients/nose_conditions/fess [30 September 2013]
18 ENT UK. Surgery on the nose - rhinoplasty. In: https://entuk.org/ent_patients/nose_conditions/rhinoplasty [30 September 2013]
19 Svider PF, Kovalerchik O, Mauro AC, Baredes S, Eloy JA. Legal liability in iatrogenic orbital injury. *Laryngoscope* 2013; **123**:2099–103
20 Patel AJ, Morrison CM. Opportunities to reduce plastic surgery claims through an analysis of complaints data. *J Plast Reconstr Aesthet Surg* 2013;**66**:455–9
21 Medical Protection Society. Sinus surgery: damaged vision. In: http://www.medicalprotection.org/uk/case-reports-september-2013/sinus-surgery-damaged-vision [21 January 2015]
22 Medical Protection Society. It's all about consent. In: http://www.medicalprotection.org/uk/case-reports-september-2013/it-is-all-about-consent [21 January 2015]
23 General Medical Council. *Consent: Patients and Doctors Making Decisions Together*. London: GMC, 2008
24 Department of Health. *Reference Guide to Consent for Examination or Treatment*. London: Health Sciences and Bioethics Division, 2009
25 Moulton B, Collins PA, Burns-Cox N, Coulter A. From informed consent to informed request: do we need a new gold standard? *J R Soc Med* 2013;**106**:391–4
26 McDonald SE, Chadha NK, Mills RS. Changing practices in the consent process for nose and throat procedures: a three-year study. *J Laryngol Otol* 2008;**122**:1105–8
27 Goodyear PW, Anderson AR, Kelly G. How informed is consent in a modern ENT department. *Eur Arch Otorhinolaryngol* 2008;**265**: 957–61
28 Grewal P. Survey of post-operative instructions after inguinal hernia repair in England in 2012. *Hernia* 2014;**18**: 269–72
29 Askari A, Shergill I. Patient information leaflets for extracorporeal shock wave lithotripsy: questionnaire survey. *JRSM Short Rep* 2012;**3**:35
30 Shergill I, Bahl K, Farjad M, Phipps C, Fowlis G. Patient information leaflets for transrectal ultrasound guided prostate biopsy: results of North Thames deanery survey. *BMC Res Notes* 2010; **3**:27
31 Stacey D, Bennett CL, Barry MJ, Col NF, Eden KB, Holmes-Rovner M *et al*. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2011; (5):CD001431
32 The Health Foundation. MAGIC: Shared decision making 2013. In: http://www.health.org.uk/areas-of-work/programmes/shared-decision-making/sites/ [30 September 2013]
33 Bark P, Vincent C, Jones A, Savory J. Clinical complaints: a means of improving quality of care. *Qual Health Care* 1994;**3**: 123–32
34 Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994; **343**:1609–13
35 Bismark M, Dauer E, Paterson R, Studdert D. Accountability sought by patients following adverse events from medical care: the New Zealand experience. *CMAJ* 2006;**175**:889–94

Address for correspondence:
Mr Andrew S Harris,
Hazeldine,
Hillside,
Prestatyn LL19 9EN,
Wales, UK

E-mail: drewharris@doctors.org.uk

Mr A S Harris takes responsibility for the integrity of the content of the paper
Competing interests: None declared

https://doi.org/10.1017/S0022215115000286 Published online by Cambridge University Press