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Risk Management Review

PATIENT SAFETY & RISK SOLUTIONS

Suboptimal Care in Vulnerable Patient Results in Poor Outcome and Large Malpractice Payment

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Introduction

Some patients who present for medical or surgical treatment are generally in good health, while others have comorbid conditions that may or may not directly relate to the condition for which they are receiving treatment. When suboptimal treatment exacerbates an already existing condition, it can be difficult to determine the amount of harm for which the doctor is responsible, as evident in this interesting case from the Northwest.

Facts

The patient was a 41-year-old female who had a medical history that included hysterectomy, degenerative disc disease, and mental health issues (including depression and panic disorder). In May of Year 1, she presented to Dr. M, a MedPro-insured obstetrician/gynecologist (OB/GYN).

The patient reported rectal pressure and minor fecal incontinence. Dr. M diagnosed her with a posterior rectal prolapse (rectocele) and recommended a surgical repair using mesh.

After being advised of the risks (e.g., mesh erosion and extrusion; infection; bladder, urethral, and bowel injuries; injury to local nerves; and/or residual pain), the patient consented to a posterior colporrhaphy using mesh. Dr. M performed the procedure in June of Year 1. The postoperative diagnosis was a second-degree to third-degree rectocele. Dr. M contended that he performed both a rectal deflection during the procedure and a visual inspection at the end; however, neither was documented in the operative report. The patient was discharged to home just after 12:00 p.m. on the day of surgery.

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At 9:30 p.m. on the same day, the patient presented to the hospital emergency department (ED) reporting pain measuring 10 out of 10 at the operative site, right leg pain, and an inability to void. She was treated in the ED and discharged home with instructions to see Dr. M the following day. Dr. M saw her the following morning and, upon examination, determined everything was normal.

Two days later (the third postoperative day), the patient returned to the ED with reports of increasing pain in the posterior of her right leg, urinary retention, and fecal incontinence. She was again discharged from the ED and saw Dr. M, who reported a normal examination. However, on this occasion, Dr. M ordered a lower back and pelvis MRI, which demonstrated *"bulging to the right at L5-S1, moderate arthropathy at L4-L5,"* and *"an unusual signal in the low pelvis, which may be related to intervention with mesh placement of the patient's rectocele repair."* No evidence suggests that Dr. M acted on this report.

At 12 weeks postsurgery, the patient could not sit for prolonged periods, walk any distance, or have sexual intercourse due to pain and fecal incontinence. Another MRI at that time demonstrated a rectovaginal fistula with inflammation of the sciatic nerve and sacral plexus branches. After this MRI, a colorectal surgeon and an OB/GYN at an academic medical center performed a surgical repair, removing the mesh and placing an ileostomy.

That evening, the patient became hypotensive and was taken back to surgery to repair intra-abdominal hemorrhaging. Unfortunately, during the intubation, she vomited and aspirated. Although the bleeding was successfully treated, the patient developed pneumonia and remained hospitalized for 12 days. The ileostomy was reversed prior to her discharge and she made a complete recovery. However, following her treatment, the patient was diagnosed with posttraumatic stress disorder (PTSD) relating to her hospitalization.

An important note in this case: Sometime after Dr. M treated this patient, a fire occurred at his practice that destroyed many patient records, including this patient's office notes. Therefore, no documentation regarding the office examinations and treatment remained.

The patient sued Dr. M for negligence in the original surgery and his subsequent treatment. She sought past and future medical expenses as well as compensation for pain and suffering, including ongoing PTSD. Her husband

sought damages for loss of consortium. At Dr. M's request, the case was settled with a payment in the high range. Defense costs also were in the high range.

Discussion

An analysis of this case shows that three factors contributed to a settlement in the high range: (1) suboptimal performance of surgery and postsurgical management, (2) the patient's state of mental health, and (3) the loss of important documentary evidence.

First, the surgery Dr. M performed was problematic. Although he insisted that he had done the procedure "by the book," expert review was very comprehensive because the academic medical center videotaped the surgical repair. The defense team was unable to find expert support for Dr. M's surgery. Additionally, a review of the mesh used in the procedure found no defects or contribution to the patient's injuries. All of these factors, in combination with the failure to act on the first MRI, made Dr. M's care of the patient indefensible.

Second, a well-established legal doctrine known as the "eggshell skull rule" applies in this case. This legal principle states that a defendant in a tort case must take full responsibility for any damages to the victim, regardless of whether the victim had an unforeseeable and/or uncommon outcome. Thus, if the injury that the victim suffers is disproportionate because of some particular vulnerability he/she has, the tortfeasor cannot use that vulnerability as a defense.

The patient in this case had a thoroughly documented mental health history that would appear to make her especially vulnerable to the development of PTSD. No one involved in the case disputed that Dr. M did not directly cause the patient's PTSD; after all, she did not develop it following the initial surgery or during the initial postsurgical period.

However, per the eggshell skull rule, the patient can argue that if the original surgery had not been negligently performed, she would not have needed the repair. Therefore, she would not have experienced hemorrhaging, vomiting and aspiration, pneumonia, and — ultimately — PTSD. Further, given that PTSD is subjective, it would be difficult to distinguish the mental health consequences of the second surgical experience from her preexisting mental health issues.

Finally, the issue of the lost health records complicated this case. Although the approach to record-keeping has changed significantly over the years, the importance of the health record in defending a malpractice case has not. Without documentation of the treatment that occurred in the office, Dr. M was without any verifiable evidence to refute the patient's allegations. It simply became his word against her word.

In the end, these three overarching factors led the defense to conclude that a settlement in the high range was the only way to protect Dr. M from an almost certain plaintiff's verdict in an amount that they could not predict.

Summary Suggestions

The following suggestions may be of assistance in providing efficacious postsurgical care:

- When completing an operative report, note all that was done in the course of the procedure, including the details of the procedure and any postsurgical examinations. Failure to provide this specific information can lead to the legal presumption that these details of the procedure did not occur.
- Develop a thorough and reliable test-tracking process to ensure clinically significant study findings (such as MRI results) are received and follow-up occurs. When deciding not to act on clinically significant tests results, be sure to provide documentation of the clinical rationale in the patient's record.
- Regardless of medical specialty, concentrate your practice on procedures for which you have ample training and experience. MedPro data indicate that many surgical malpractice cases involve issues related to technical skill (either in the procedure itself or in the overall management of the case).[1] These issues can involve poor surgical technique and procedural inexperience.
- Communicate clearly and frequently with patients and/or families when complications develop. Doing so can help set realistic expectations for treatment results and reduce predictable anxiety. For communication tips, see MedPro's guideline *Communicating Effectively With Patients to Improve Quality and Safety*.

- Develop appropriate policies and protocols for safeguarding onsite records. When developing contingency plans, consider the possibility of theft, fire, and other environmental hazards. Ideally, protocols should include offsite backup of electronic health records on a daily basis. For more information, see MedPro's article *Weathering the Storm: Electronic Health Records and Disaster Recovery*.

Conclusion

In both surgical and nonsurgical practice, not all cases go according to plan. However, knowledgeable and skillful care, combined with careful attention to overall case management, can help manage the effects of untoward developments in the care process.

[1] MedPro Group. (2020). *General surgery: Claims data snapshot*. Retrieved from www.medpro.com/documents/10502/5086243/General+Surgery.pdf