MedPro Group
a Berkshire Hathaway company

Risk Management Review

PATIENT SAFETY & RISK SOLUTIONS

Postoperative Patient Not Adequately Treated, Leading to Death; Malpractice Lawsuit Follows

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

Introduction

In the field of healthcare risk management, we have made significant progress in our efforts to identify errors occurring in the healthcare delivery system, and in many cases we have developed effective strategies to minimize the likelihood of treatment-related patient injuries. One of the more difficult circumstances is when multiple mishaps occur at various stages (what we call the "Swiss cheese effect"), resulting in a suboptimal outcome. That situation occurred in this interesting case from the Midwest.

Facts

The patient was a 62-year-old Caucasian female with several pre-existing medical conditions, including chronic epigastric pain, fatty liver, breast and uterine cancer, high blood pressure, type 2 diabetes, chronic obstructive pulmonary disease, asthma, cholecystitis, Barrett's esophagus, and importantly, a history of Nissen fundoplication. She also smoked more than a pack of cigarettes a day.

She was admitted to the hospital for surgical repair of her now-herniated previous Nissen fundoplication. Dr. G, a MedPro-insured general surgeon, was scheduled to do the repair. She signed an appropriate informed consent form for this open procedure.

The surgical procedure was commenced and numerous old operative adhesions were noted. Dr. G proceeded to repair the previous Nissen fundoplication without apparent complications. As the abdominal incision was being closed, the certified registered nurse anesthetist attempted to pass a nasogastric (NG) tube; however, she was not able to

5814 REED ROAD | FORT WAYNE, IN 46835 | 800-4MEDPRO | MEDPRO.COM

HOSPITALS | FACILITIES | SENIOR CARE | DOCTORS | OTHER HEALTHCARE PROFESSIONALS

advance it more than 30 cm. The anesthesiologist also attempted to pass the NG tube without success, and a gastroenterologist was ultimately summoned. The gastroenterologist passed the NG tube on her second attempt.

The rest of the surgical day was unremarkable, with the patient having stable vital signs and her pain (10/10) controlled with medication. The NG tube was intermittently draining green fluid. The patient alternated between sleeping and visiting with family in her room.

However, things began to change the following morning. On postoperative Day 1, the patient reported abdominal pain at a 10/10 level at 9:00 a.m. Dr. G was called, and he ordered repositioning of the patient and administration of 2 mg of morphine. Because of no improvement, the patient received 1 mg of hydromorphone at 10:22 a.m. as well as an albuterol treatment at 10:43 a.m. and intravenous (IV) albumin at 10:47 a.m. An additional 1 mg of hydromorphone was administered at 11:30 a.m., and 1,000 mg of acetaminophen were administered at 11:55 a.m. Dr. G ordered all of this treatment remotely and did not come in to see the patient in person.

At 3:00 p.m., Dr. G was present at the patient's bedside. The patient had received an aerosol breathing treatment at approximately 2:30 p.m.; however, she displayed confusion and poor respiratory effort, causing Dr. G to be concerned regarding her respiratory status. He ordered her transfer to the intensive care unit (ICU), a STAT thoracic X-ray, arterial blood gases (ABGs), and various other lab tests. Dr. G personally phoned the critical care unit/pulmonary consultant on call, Dr. T, requesting a STAT consult.

The first set of ABGs came back at 3:32 p.m., indicating respiratory and metabolic acidosis. These results were communicated to Dr. T (who did not come in to the hospital), and she ordered BiPap. Dr. G also ordered a STAT cardiac panel and consultation with a cardiologist.

At 6:00 p.m., another set of ABGs demonstrated continued acidosis, and by 7:00 p.m. the cardiologist had ruled out a cardiac etiology. Dr. G then ordered antibiotics, a thoracic computed tomography (CT), and placement of a central line. By 8:00 p.m., Dr. G had summoned anesthesiology, the patient was intubated, and an arterial line was placed.

Another set of ABGs at 8:25 p.m. indicated continued acidosis so norepinephrine was commenced at 1 mcg per minute. Oxygen

saturation remained poor (86 percent), and pleural effusions were present bilaterally. Because the patient's hemoglobin and hematocrit were stable, Dr. G concluded that she was septic. In a conversation with the family, at their request, Dr. G arranged a Life Flight transfer to a tertiary care center.

The patient came under the care of the tertiary care center at 1:00 a.m. on postoperative Day 2. She was emergently transferred to the operating room, where a right-side chest tube drained 700 ml of bilious fluid. A left-side tube drained another 1,500 ml. The surgeon then performed an esophagoscopy and identified a 2 cm perforation located 37 cm from the incisors. The surgeon established further drainage, but because of the patient's instability, she could not finish the procedure and temporarily closed the patient.

The operating surgeon met with the family and explained that multiple surgeries would be needed going forward and that it was unlikely that the patient could ever be weaned from the ventilator.

The family opted for comfort care measures only, and the patient died 1 week later. A subsequent autopsy established sepsis as the cause of death.

A malpractice lawsuit was commenced against Dr. G, Dr. T, and the hospital. At their request, the case against the two physicians was settled before trial with a combined payment in the high range and defense costs also in the high range. The hospital also made an undisclosed payment, which likely pushed the total paid to the family into the very high range.

Discussion

When analyzing a case like this from a risk management perspective, several approaches can be used. In this case, we will look at it from the standpoint of the plaintiffs' allegations; that is, how they say this poor outcome happened. This approach should provide a well-organized and chronological approach.

The plaintiffs did not criticize the events on the day of surgery; their focus was on the postoperative care. They contended that there was adequate opportunity to intervene when the patient began to decompensate at approximately 9:00 a.m. the next day. According to the plaintiffs, here is the cascade of events leading to the patient's death:

- 9:00 a.m. — Patient is complaining of increasing pain that is not being relieved by pain medication. The

nursing staff is quite concerned. Dr. G is contacted and advised of her destabilizing condition. Rather than coming in to see the patient in person, Dr. G orders repositioning and the administration of morphine.

- 10:00 a.m. — Because of no improvement, Dr. G (again, remotely) orders hydromorphone, acetaminophen, albumin, and albuterol. The patient continues to deteriorate.
- 3:00 p.m. — Dr. G is at the bedside and assesses the patient to be very ill. He orders transfer to the ICU and appropriate testing, and he personally calls Dr. T and requests her to come in, as he feels intubation is necessary so that the patient can be moved to the CT suite (several floors down). Because of a communication breakdown between Drs. G and T, Dr. T never comes in and the patient remains on BiPap.
- 6:00 p.m. — Vital signs and lab tests are very concerning. After cardiology rules out a cardiac etiology, a central line is placed in preparation for a thoracic and abdominal CT.
- 8:00 p.m. — Anesthesiology has intubated the patient; however, she is now judged to be too unstable to tolerate movement to the CT suite.
- 8:30 p.m. — Because it appears that the patient is now septic, the decision is made to transfer her to the tertiary care center, and she comes under its care at 1:00 a.m. on postoperative Day 2. The plaintiffs had no criticism of the patient's care at the tertiary care facility.

The plaintiffs' criticism of Dr. G did not relate to the surgery or the care he rendered at her bedside after he arrived at 3:00 p.m. on postoperative Day 1; it was directed at his failure to come in between 9:00 a.m. and 3:00 p.m., which were likely her "golden hours." Although the defense located expert support for Dr. G, it was only after several attempts, and the retained expert was not strong in his support of this 6-hour period.

As to Dr. T, the plaintiffs contended that she deviated from the standard of care by not being present in the hospital when a STAT consultation was requested by Dr. G, thereby delaying the patient's intubation and transfer to the CT suite (where the fissure would have

been diagnosed) and her order for BiPap (which was inadequate for the patient's condition). Expert support for Dr. T was located; however, it was based on the assumption that she had been given inadequate information by Dr. G (thus pitting Dr. T against Dr. G).

In regards to the hospital, the plaintiffs contended that the bedside nurse's communication with Dr. G was inadequate at 9:00 a.m. and 10:00 a.m. (causing him to not come in sooner); and when he did not come in, staff failed to use the hospital's chain of command protocol to have another physician assess the patient.

The plaintiffs also contended that the hospital's STAT consult response protocol, which stated in relevant part "Urgent: Within 12-24 hours, or sooner if the admitting/attending physician personally calls the consultant asking the consultant to see the patient as soon as possible," was vague, possibly contributing to the miscommunication between Dr. G and Dr. T.

Finally, the plaintiffs had testimony from a hospital social worker involved in the case who stated that, in her opinion, the patient was neglected for a critical period.

Given the weak expert support and the doctors' desire to resolve the case, it was decided to settle the case within the doctors' policy limits.

Summary Suggestions

The following suggestions may be helpful when multiple providers are caring for a single patient:

- As always, clear, concise communication is vital, and this communication should be thoroughly documented. The Situation-Background-Assessment-Recommendation (SBAR) technique may have been beneficial in the nurses' communication with both physicians, and the communication between Dr. G and Dr. T appears to have been neither adequate nor well documented.
- Failure to rescue a patient with a deteriorating condition has been recognized as a contributing factor in the cause of patient harm. Nursing staff should have a process that includes clinical parameters to directly request additional assistance from specially trained individuals when the patient's condition appears to be worsening.

- When consultants receive a STAT request, they should concisely question whether their physical presence is required. If they cannot determine a clear answer, then they should be present.
- Bedside nursing staff should be thoroughly familiar with the facility's chain of command protocol, including when and how to activate it, to address situations in which patient safety may be in jeopardy.

Conclusion

Unfortunately, errors in both judgment and performance are — and always will be — a part of healthcare. These errors can often be identified and corrected when clear, precise communication exists between healthcare providers and robust patient safety protocols are followed. The result is safer care for patients and reduced professional liability exposure for providers.

5814 REED ROAD | FORT WAYNE, IN 46835 | 800-4MEDPRO | MEDPRO.COM

HOSPITALS | FACILITIES | SENIOR CARE | DOCTORS | OTHER HEALTHCARE PROFESSIONALS