

# Patient Suffers Complication Following Procedure Resulting in Brain Damage; Malpractice Lawsuit Follows

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

## Introduction

Almost all human relationships — medical and nonmedical alike — thrive when efficacious communication occurs between the parties. In the medical context, this is even more important because of the complexity involved in rendering medical care, and the likelihood that many parties may be involved in these conversations. This case from the Midwest illustrates how poor communication (combined with some unusual extrinsic factors) can result in a suboptimal outcome and a difficult malpractice case to defend.

## Facts

The patient was a 44-year-old female with no significant medical history except a 20-year history of smoking (1.5 packs per day). Both of her parents had died of heart disease. While the patient had been criminally convicted for

the manufacture and distribution of illegal drugs, she denied any personal drug use.

When she developed an acute onset of chest and jaw pain, the patient presented to her primary care physician who administered sublingual nitroglycerine, providing some abatement of her symptoms. He also ordered an ECG and cardiac enzyme marker test to be performed at the local hospital, and the results were normal. Because of continuing discomfort, however, she was transferred to a tertiary care center.

At the tertiary care center, Dr. D, a cardiologist, assumed her care. Dr. D performed a cardiac catheterization, and the results were normal. Dr. D then attempted to perform a pulmonary angiogram by accessing through a femoral vein. In the process of this procedure, Dr. D

apparently damaged the femoral artery, causing a retroperitoneal bleed. Nevertheless, Dr. D documented in her procedure report that everything had gone well (without complication).

Why Dr. D wrote this in her report is unknown (this will be explained subsequently). Dr. D went off duty shortly thereafter, and Dr. W, a MedPro-insured cardiologist, assumed coverage. Dr. W had no knowledge of the retroperitoneal bleed.

Later that evening, the patient's blood pressure began to drop and the nursing staff contacted Dr. W, who arrived at approximately 8:00 p.m. Dr. W ordered vasopressors, volume support, and the patient's transfer to the intensive care unit (ICU). Initially, the patient responded well, and by 11:30 p.m., she was stable. However, this was temporary, and Dr. W was contacted again at midnight because the patient's body temperature was dropping, her back and flank were tender, and her abdomen was becoming firm and distended.

By 12:30 a.m., Dr. W had identified the retroperitoneal bleed and called in Dr. G, a cardiothoracic surgeon. Dr. G chose a conservative approach instead of surgery (oftentimes in these cases, surgery is not helpful and the bleed seals itself). Dr. G established a central line through the left subclavian artery; however,

in the process, the patient's heart rate dropped from 140 to 40. With the administration of atropine, her heart rate raised to the 70s; however, she soon went into respiratory arrest. She was intubated and received three units of packed blood cells.

Dr. G then left the hospital at about 2:00 a.m., after having talked to Dr. W. At 5:30 a.m., Dr. G (who was now out of town) checked in with the hospital and was told that the patient's arterial blood gases indicated acidosis (Dr. W had not been contacted at any time by the hospital after midnight). Dr. G ordered intravenous bicarbonate, and also said the patient should be seen by another member of his practice.

Fortunately, Dr. T, another cardiothoracic surgeon in the group, was beginning his rounds. He evaluated the patient and immediately took her to the operating room. In surgery, he identified a large hematoma caused by a 2 mm tear in the femoral artery. The hematoma was evacuated, the tear repaired, and the patient was stabilized.

The patient spent 1 month in the ICU, followed by another week on a medical floor. During this entire time, she was on dialysis. Her time at the hospital was described as "stormy," including another event of respiratory arrest (requiring

intubation) and various infections requiring vancomycin.

The patient was then transferred to a rehabilitation facility for an extended period, mainly because of behavioral medical issues including hallucinations and paranoia. Although anoxic brain injury was diagnosed at the time of her transfer, by the time of her discharge from the rehabilitation facility, it was noted that her anoxic brain injury was “remarkably improved” and that her renal failure was “completely resolved.” After her discharge, she was seen for panic attacks and mental confusion.

A medical malpractice lawsuit was filed against Dr. W, Dr. G, and the hospital — and later Dr. D. Evaluation of the case resulted in agreement between Dr. W, his defense counsel, and MedPro that the case should be vigorously defended. This was done, and settlement negotiations resulted in no payment on behalf of Dr. W, but the defense costs were in the very high range. The hospital, Dr. G, and Dr. D’s insurer all paid amounts in the mid-range.

## Discussion

The obvious starting point in a discussion of this case is the failure of Dr. D to document the retroperitoneal bleed in the patient’s health record and advise the physician who was

assuming care of this condition. Although the actual occurrence of the tear is not necessarily indicative of a deviation from the standard of care (this is a recognized risk of the procedure), the failure to document it cannot be justified.

As stated above, it is not known why Dr. D documented what she did. The reason we do not know is that the plaintiff’s attorney did not name Dr. D as a defendant at the origination of the lawsuit (this was presumably an error on their part). Unfortunately, shortly after she was named, Dr. D tragically died. Because of Dr. D’s untimely death, the litigants had no explanation for why she never documented the bleed in the patient health record or communicated it to Dr. W directly (an obvious and important question).

Dr. D’s death had other significant implications for the remaining defendants. First, although the damage to the femoral artery did not necessarily directly result in the patient’s injuries, the failure to record it likely delayed a correct diagnosis and more prompt treatment, contributing to the final outcome. This allowed the other defendants to “deflect” some of the criticism toward Dr. D, in what is commonly known as the “empty chair” defense.

Second, Dr. D had what is known as a “death, disability, and retirement” (DDR) provision in her professional liability insurance policy, which provided indemnity even after her death (for her practice before her death). This provision provided another set of insurance limits with which to resolve the case.

MedPro’s defense experts fully supported Dr. W’s care. Although they speculated that, if he had been contacted during the night, Dr. W would have taken steps to prevent the patient’s deterioration into an acidotic state, the failure of the nursing staff to notify him deprived him of that opportunity. Again, this contributed to the decision to vigorously defend Dr. W.

The defense experts felt that Dr. G’s care did not meet the standard of care. Although the decision to not operate immediately was defensible, his travel out of the area without making adequate provision for the patient’s continued care was not defensible. Dr. T (the surgeon who assumed her care) knew nothing about the patient until he was contacted while on his rounds in the hospital the following morning.

The defense experts also could not support the nursing care. They noted a several-hours period during the night when the patient deteriorated into an acidotic state without either treating physician being advised.

Finally, the MedPro neuro-psychiatric expert opined that some of the patient’s lingering cognitive issues could be attributed to her exposure to chemicals during her previous illegal drug manufacturing activity.

This raised the question of how much of the patient’s injuries were actually the result of the alleged malpractice. Under the specific facts of this case, the court ruled that evidence of the patient’s prior exposure to harmful chemicals was “more probative than prejudicial” (a legal term) and could therefore be presented at trial. This was the correct ruling, and it was beneficial to the defense of the case.

## Summary Recommendations

The following recommendations may assist caregivers and entities when multiple providers are involved in the care of critically ill patients:

- A structured communication process of handoffs and signouts should be implemented to ensure critical patient information is consistently communicated. Handoffs or transitions of care are a critical time when communication gaps can and do occur and often contribute to medical errors. Examples of transfers and handoffs include transfer of a patient between primary and acute

settings, transfer of a patient between departments, transfer of patient care during a shift change, and transfer of patient care between providers. A number of techniques and communication tools have been developed to provide a reliable structure including Situation-Background-Assessment-Recommendation and Request (**SBAR**), **I PASS THE BATON**, **I-PASS** and **Safer Sign Out**.

- Whenever care is transitioned from one provider to another, a handoff should be conducted with the oncoming physician. A handoff to a different provider is a vulnerable time for the patient as this introduces the possibility of miscommunication. Standardized sign-out checklists can remind healthcare providers about important patient information to communicate to the next provider, such as the patient's diagnosis, medical history, lab/test results, recent changes in condition, current stage of treatment, and potential complications.
- When a physician has been caring for a patient, but then anticipates being out of

the area, arrangements for same-specialty coverage should be made in advance. A report should be provided to the covering physician with an opportunity to ask questions.

- Facilities should have up-to-date policies regarding response times for those physicians who have hospitalized a patient and have not made formal coverage arrangements.
- Facilities should also have comprehensive chain of command protocols in place to address situations when a patient's safety is in jeopardy. All bedside staff should be trained regarding their authority and responsibility to use these protocols when appropriate.

## Conclusion

Given the complexity of modern healthcare delivery, favorable patient outcomes are not likely to occur in the absence of comprehensive institutional protocols and excellent communication at all levels. When these things do occur, the likelihood of a favorable outcome is greatly increased, and professional liability exposure is substantially diminished.

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