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Risk Management Review

Perioperative Lapses Result in Permanent Injuries to Patient

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Introduction

Modern surgery is a complicated process, commencing long before the patient's arrival in the surgical suite and continuing after the actual surgery. When steps in this process are performed improperly (or skipped altogether), the likelihood of a suboptimal outcome significantly increases, as illustrated in this plastic surgery case.

Facts

The patient was an African-American female in her early thirties who was 5'5" tall and weighed 199 pounds. She had a history of abdominoplasty (2 years prior). That procedure had been problematic, resulting in infection, sepsis, and necrotic tissue that required debriding. For that reason, she was apprehensive about having further plastic surgery. Nevertheless, she consulted Dr. W (a MedPro-insured, board-certified plastic surgeon) regarding additional treatment.

She met with Dr. W's surgical coordinator, and a laser-assisted liposuction (LAL) procedure was recommended (a procedure that uses a laser to liquefy fat cells, which are then suctioned out). The patient agreed to this procedure, and it was scheduled. No evidence suggests that Dr. W (or anyone else) met with the patient prior to surgery to acquire a medical history or do a presurgical assessment.

On the day of surgery, the patient gave informed consent for the LAL procedure; however, Dr. W performed a tumescent liposuction (a different procedure from LAL). Additionally, Dr. W brought a surgical assistant to help her with the procedure; the assistant was properly licensed but not credentialed by the hospital where the procedure was performed. Documentation of the procedure was minimal, but it is known that Dr. W removed about 5,300 cc of fat tissue. The patient was discharged following her recovery from the anesthesia.

The following day (Postsurgical Day 1), the patient exchanged text messages with Dr. W's "clinical nurse manager" (a person who had attended nursing school, but did not graduate and was not licensed in any medical capacity). The patient expressed concern regarding "deep red blood pouring down her leg, with thin layers of clots." The nurse manager advised her that postsurgical drainage was normal for up to 48 hours, and to maintain the compression that had been applied after surgery.

On Postsurgical Day 2, the patient texted the nurse manager photos of the bruising around her midsection and asked if it was normal. She was advised to loosen the compression garment, and the nurse manager called in a prescription for nitroglycerin ointment (without consulting Dr. W). When the patient indicated that she had taken some ibuprofen for the discomfort, the nurse manager instructed her to switch to acetaminophen.

On the evening of Postsurgical Day 3, the patient became much worse and passed out, resulting in her husband taking her to the local emergency department. She was admitted and placed on antibiotics. No systemic infection was identified, and the patient was discharged on Postsurgical Day 5, with instructions to follow up with Dr. W as soon as possible.

The patient did not return to Dr. W. Instead, she saw Dr. P, another plastic surgeon, who immediately discontinued the nitroglycerin ointment and began silver sulfadiazine cream to treat what he ultimately diagnosed as a third-degree surgical wound infection with deep necrosis. Eventually, the patient's wounds did heal, but she continues to suffer from hypopigmentation and burning abdominal pain. She also continues to experience neuralgia, neuritis, and severe dysthesia.

A medical malpractice lawsuit was commenced against Dr. W. No expert witnesses could support Dr. W's care, so the case was settled with a payment in the high range. Because this case was so quickly determined to be indefensible, defense costs were in the midrange.

Discussion

As stated above, no qualified experts would support Dr. W's care of this patient. However, the experts who were consulted explained the reasons they felt Dr. W's care fell below the standard of care.

The experts' criticisms began with the lack of presurgical assessment of this patient. Although Dr. W maintained that she had met with the patient (which the patient denied), the absence of even a cursory entry in the patient's

record undercut Dr. W's contention. In any case, it is clear that Dr. W went into this surgery without the benefit of a thorough understanding of the patient's physical (and emotional) condition.

Although the patient signed an informed consent form prior to treatment, it was for a procedure other than the one that Dr. W performed. This fact largely neutralized the legal effect of the consent process, meaning that the procedure was performed without proper consent. Treatment without proper consent (even if it is beneficial treatment) legally constitutes a battery, a different cause of action than malpractice. An exception to the need for formal consent exists in the case of emergencies, but this treatment was strictly elective and not time sensitive.

Because surgery often is unpredictable and may require a change in strategy during the procedure, well-constructed informed consent forms should include language stating that the surgeon may need to deviate from the original plan once surgery is under way. In this case, the form that the patient signed did not include any such language. For whatever reason, Dr. W performed a different procedure than the one for which the patient consented, without consulting the patient.

Most of what occurred in the operating room is unknown because the documentation was very minimal. It seems unlikely that a surgical timeout occurred prior to the commencement of the procedure; if one had occurred, someone probably would have identified the incorrect procedure.

It is known that Dr. W's medical assistant (different from the aforementioned surgical assistant) injected the premixed tumescent anesthesia solution into this patient — an activity that medical assistants are specifically prohibited from performing in the state in which this case occurred. Further, given the sparse documentation, it is unknown how skillfully Dr. W performed the tumescent procedure.

Aftercare was also an issue. First, Dr. W's clinical nurse manager was not licensed as any level of nurse. Her title was a blatant misrepresentation of her qualifications, and her lack of credentials called into question her competency to deal with the patient's postsurgical complications.

Another issue was the nurse manager calling in a prescription for nitroglycerin ointment, rather than contacting Dr. W for guidance. This action was likely a violation of Dr. W's prescribing authority. In addition, the experts were in

agreement with Dr. P (the subsequently treating plastic surgeon) that nitroglycerin ointment was not an appropriate treatment for the patient's symptoms.

Dr. W opined that the patient's postsurgical complications were the result of her taking ibuprofen. The experts were unanimous in rejecting this explanation; even if it was true, the patient would not know taking ibuprofen was contraindicated unless she was told. This speaks to the importance of written postsurgical instructions, which the patient did not receive.

Summary Suggestions

The following suggestions may be helpful when providing surgical care:

- Perform adequate presurgical assessments for each patient, including taking a thorough medical history, conducting an appropriate physical examination, considering patient selection criteria for the procedure, reconciling the patient's medications, verifying that all relevant health information is documented in the patient's record, and discussing any special circumstances that may exist.
- Conduct thorough informed consent discussions with patients, including a review of risks, benefits, and alternative treatments. Use a technique such as teach-back to gauge patients' comprehension of information.
- Document informed consent discussions, including the provision of verbal and written patient education, and make sure any signed informed consent forms are included in patients' records.
- Document complete, concise, and accurate operative reports that discuss each stage of the surgical process.
- Participate in surgical timeouts prior to the commencement of surgical procedures. Timeouts have proven their value in ensuring (among other things) that the surgical team is performing the correct procedure on the correct patient.
- Make sure all members of the healthcare team are properly licensed and credentialed to perform their respective functions. Also ensure that all of their activities are permissible within their scopes of practice.

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- Ensure that accountability for writing prescriptions is designated to healthcare professionals who are (a) legally permitted by state law to perform these activities, and (b) are properly trained and credentialed. Any “blanket” permission for another person to prescribe under a practitioner’s license should not occur. Providers with prescribing authority also should routinely monitor their state’s prescription drug monitoring program to ensure that their records are accurate.
- Provide postsurgical patients with written aftercare instructions as well as a way to reach the surgeon (or their designate) with any questions or concerns.

Conclusion

One of the blessings of our modern age is that surgery is more efficacious and safer than it ever has been. When adhered to, well-defined protocols and processes can greatly enhance the safety of surgical procedures and the quality of the patient experience.