

Failure to Closely Monitor Patient's Condition Leads to Death From Septicemia

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Introduction

The last issue of *Risk Management Review* discussed how poor communication and documentation led to a suboptimal patient outcome and a subsequent malpractice case that was difficult to defend. This case from the upper Midwest shows how poor communication and documentation about a surgical inpatient can have fatal consequences.

Facts

The patient, a 39-year-old female, consulted Dr. Y, a gynecologist, for the first time in September of Year 1 for a general gynecological exam and discussion of recurrent pelvic pain. The patient had a significant gynecological history, including an ectopic pregnancy requiring salpingectomy and later a successful pregnancy resulting in the cesarean delivery of a healthy child. After that delivery, she had another ectopic pregnancy requiring a second salpingectomy. During that procedure, a bowel perforation occurred, but it was successfully detected and repaired. Dr. Y knew

about the patient's previous gynecological complications, but did not review any health records from the patient's previous gynecologists or surgeons.

After an examination, Dr. Y determined that the patient's uterus was tender and prescribed oral antibiotics for suspected pelvic inflammation. Two months later, the patient complained of continuing pain on the left side, and an examination indicated that the cervix was also painful. Dr. Y prescribed oral antibiotics again. The medication was apparently successful because the patient did not return to Dr. Y's office until April of Year 2.

When the patient returned in April of Year 2, she complained again about pelvic pain. Vaginal ultrasound results indicated no issues except for a small amount of free fluid in the pelvis (possibly consistent with pelvic inflammatory disease). Dr. Y prescribed oral antibiotics again and also discussed possible exploratory laparoscopy if the pain did not resolve. The pain persisted, so the patient had a laparoscopy performed on April 30 of Year 2.

During the laparoscopy, Dr. Y found extensive adhesions throughout the patient's pelvis that were consistent with her prior surgeries. These adhesions, which extended from the omentum to the anterior left side of the pelvis as well as the lateral right side, likely caused the patient's pelvic pain. Dr. Y released the adhesions surrounding the uterus and its ligaments and placed dissolving mesh around the area to prevent further adhesion formation. No evidence of bowel injury or leakage was found in the abdomen at that time, so the patient was discharged later that same day.

Later that evening, the patient's mother called Dr. Y because her daughter could not void. Dr. Y requested that the patient return to the hospital. The patient was directly admitted to the hospital, and a Foley catheter was placed. Dr. Y did not go to the hospital at that time, but she did receive a call at 10:20 p.m. indicating that the patient was hungry. According to Dr. Y's memory, the patient's vital signs were normal and she was in no distress. However, Dr. Y did not document this conversation with the floor nurse, and the nursing notes indicated that the patient was mildly tachycardic and febrile as of 9 p.m.

The following morning (May 1), the Foley catheter was removed, but the patient continued to be unable to void. At 7:30 a.m., nurses documented that she was tachycardic and hypotensive. Dr. Y said she saw the patient that morning, and the patient indicated that she was passing gas and feeling better. However, no documentation of Dr. Y's visit to the patient's room exists. At 11:30 a.m., Dr. Y ordered bethanechol to promote urination.

At 1 p.m., the nursing staff contacted Dr. Y again and indicated that the patient still had not voided. At 4 p.m., the nursing staff contacted Dr. Y because the patient was more lethargic and her abdomen was distended. Her vital signs indicated the following: temperature 97.7, pulse 130, respirations 26, and blood pressure 81/62. In response to the 4 p.m. call, Dr. Y ordered an increase in the bethanechol. At 5:30 p.m., the nursing staff contacted Dr. Y to report the patient's continuing abnormal vital signs, increased abdominal pain, and paleness. Dr. Y ordered a CBC, BUN, and creatinine blood test.

At 6:30 p.m., Dr. Y examined the patient in the hospital and immediately took her to surgery for an exploratory laparotomy, accompanied by Dr. M, a general surgeon. The surgeon found brown fluid in the abdomen and a 20 to 25 mm opening in the sigmoid colon. Dr. M resected the damaged portion of the colon and created a colostomy. At the end of this procedure, the patient's blood pressure dropped, which required vasopressors and fluids, and she was admitted to the intensive care unit.

Over the next several days, the patient appeared to be stable and the colostomy seemed to be functioning properly. However, on May 5, she developed a temperature of 104 and became tachycardic. In another surgery, Dr. M drained an intra-abdominal abscess in the right upper quadrant and a second one around the spleen. Dr. M also ran the entire bowel and explored the pelvis, noting no evidence of injury or leakage. The

fluid extracted from the abscesses grew *E. coli* and other colonic organisms.

On the evening of May 5, the patient's condition worsened, ultimately deteriorating into cardiac arrest and death. An autopsy indicated multisystem organ failure secondary to sepsis, secondary to injury to the sigmoid colon, as the cause of death.

A malpractice suit was initiated against Dr. Y. Because the case was unlikely to be successfully defended, it was settled in the very high range with Dr. Y's agreement. Defense costs were also in the very high range.

Discussion

This case had an unfortunate outcome in several respects. First, and most tragically, a young, generally healthy woman died under possibly avoidable circumstances. Second, although a payment was made to resolve this case, there were some questions about whether malpractice actually occurred. The defense experts in this case thought they could support the care, but that was based on assumptions that could not be proven with certainty.

The first point of possible miscommunication between Dr. Y and the nursing staff occurred on the night of April 30. Dr. Y and the attending nurse did discuss the patient, but Dr. Y did not see the patient at the hospital that evening. Although Dr. Y's memory of her conversation with the nurse was that the vital

signs were normal, she did not document it, and the nurse's notes indicated that the patient was mildly tachycardic and febrile at that time. Whether those symptoms, if true, indicated that Dr. Y should have seen the patient in the hospital was a concern in this case's defense.

Dr. Y's care rendered during the day on May 1 was the defense's greatest concern. Dr. Y contended that she remembered seeing the patient that morning, but she did not document the visit in the patient's health record. Based on nursing documentation, Dr. Y ordered the administration of bethanechol late that morning, which supports her contention that she saw the patient in the hospital. However, nursing notes as early as 7:30 a.m. indicated that the patient was tachycardic and hypotensive. Because it appears that Dr. Y did nothing about these abnormal vital signs, it is questionable as to whether the physician saw the patient that morning. Additionally, because of a legal rule in this jurisdiction called the "Dead Man's Statute," it is unlikely that the physician would have been able to testify that she saw the patient in the hospital because no supporting documentation exists.¹

According to nursing documentation, the nursing staff contacted Dr. Y at 1 p.m. and again at 4 p.m. (this call indicated that the vital signs were significantly abnormal). As the patient continued to worsen, the nursing staff called Dr. Y again at 5:30 p.m. At that time, nursing records showed that the nurse called her supervisor because she did not feel Dr. Y

¹ The "Dead Man's Statute" takes slightly different forms in different states. In the jurisdiction for this case, the rule prevents the physician testifying from memory that she went to the hospital to see the patient when the patient (i.e., the opposing party) cannot testify to refute the physician's contention. However, if the physician had supported her testimony by documenting it in the health record (or by some other means), she could have testified to this disputed fact.

was adequately responding to the patient's worsening condition. It remains questionable whether the nursing supervisor's involvement was the reason Dr. Y went to the hospital at 6:30 p.m. when the patient's condition was very serious.

It appears likely that the patient did not recover from the events of May 1, even with appropriate care after that time. Because of these factors, defense counsel concluded that successful defense of this case was unlikely.

Summary Suggestions

The following suggestions might help physicians better communicate with hospital staff and document the care that they render to patients:

- When communicating with hospital nursing staff, clarity in the content of the communication is essential. It might be beneficial to repeat back critical information so that the caller can confirm it.
- The physician should have a method to document calls received from hospital nursing staff. Without such documentation, the physician is dependent on whatever the caller has documented. The physician may be in a very

vulnerable position if a disagreement about documentation occurs.

- When a physician sees a hospitalized patient, two things should occur. First, the physician should review any recent notes or findings contained in the health record. Second, the physician should document all impressions of the patient and any orders being made or changed at that time.
- A physician should carefully acknowledge a hospitalized patient's significantly abnormal vital signs (such as what occurred at 4 p.m. on May 1 in this case). This acknowledgment will show that the decision to not go to the hospital to see the patient was a clinical judgment, not an oversight or miscommunication.

Conclusion

Although a physician's decision to go to the hospital to examine a patient often is based on clinical judgment, careful communication and documentation are critical in minimizing treatment errors. If litigation does occur, subsequent reviewers of a case may be more likely to understand the circumstances at the time the treatment decision was made if thorough documentation exists.

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