

What to do when things go bad: a perspective from defense counsel

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Fact situation #1: A 63-year-old male patient suddenly arrests during sinus surgery at a free standing surgery center. After the patient was resuscitated and taken to the postanesthesia care unit, it was discovered that epinephrine rather than dexamethasone was administered inadvertently. The anesthesiologist suffers profound emotional distress, the patient is transferred to another facility for additional care, and the handwritten anesthesia record transferred with the patient is essentially blank.

Fact situation #2: A 76-year-old male patient suddenly arrests during monitored anesthesia care for surgical removal of a cyst on the back of his head. The young anesthesiologist, a month out of residency, is not fully familiar with the electronic anesthesia record and fails to trigger the system to record all of the patient's vital signs. As a result, the intraoperative blood pressures and pulse rates are missing.

Fact situation #3: An anesthesiologist is called to provide epidural analgesia for a 23-year-old pregnant patient who is in labor. Upon arrival, the patient is in respiratory distress and suddenly decompensates and arrests, requiring emergent intubation and a crash cesarean section in the patient's labor and delivery room and without access to an anesthesia machine. A traditional anesthesia record and a code record are not created because of the chaotic nature of the situation and the relative inexperience of the provider in handling such an unusual emergency.

Introduction

No health care provider walks into work, whether it is into an examining room or an operating room (OR), thinking that some catastrophe is going to befall one of their patients that day. In fact, for most people, that is the last thing on one's mind. And for anesthesiologists, when that event occurs, it is not only devastating to the patient and the patient's family, but it is usually a total surprise and a terrible emotional shock to the system for that physician. That emotional response, coupled with the need to care for the patient, the need to speak with family members, the pressure to "keep the line moving," and other systems issues, creates hurdles that can make it exceedingly difficult to do what is necessary from a legal standpoint to protect oneself. This article is an effort to outline, from a medical legal standpoint, common

mistakes and assumptions as to how these situations occur and to provide a roadmap for navigating these challenges.

The statute of limitations for filing a medical malpractice lawsuit varies state by state and may also depend on the age of the patient and other factors such as fraudulent concealment. For example, in California, the statute of limitations for adults is 1 year from the date of discovery or 3 years from the date of injury, whichever date is the soonest. If the patient is a minor, the statute of limitations in California expires 3 years from the date of the alleged wrongful act, except that actions by a minor under the full age of 6 shall be commenced within 3 years or before the minor's eighth birthday, whichever provides a longer period. (California Code of Civil Procedure section 350.5.) As a result, a physician may not know that he or she is going to have to defend the care provided in a medical malpractice action sometimes for upwards of 8 years or even longer. However, even in instances where the lawsuit is filed within a year, it is not unusual, in fact it is common, for memories to fade, for witnesses to die, move out of state or to become otherwise unavailable, and for critical evidence to be lost because of a failure to capture that information in the first place, inadvertent destruction, or because of insufficient documentation.

In a medical malpractice lawsuit, generally speaking the burden of proof is on the plaintiff. The plaintiff must prove: (1) that the health care provider was negligent—specifically that the provider did not act as a reasonable and prudent practitioner would act under similar circumstances; (2) that an unreasonable and imprudent act or omission caused injury; and (3) the nature and extent of the damages flowing therefrom. In California, for example, the plaintiff has the burden of proof to convince the jury by a preponderance of the evidence that it is more likely than not that a defendant anesthesiologist did not act in accordance with how other reasonable and prudent anesthesiologists would act under similar circumstances.

Surprised, angry, or suspicious patients and family members are more likely to seek assistance from attorneys to "get answers." The records are obtained and sent to an "expert," typically another anesthesiologist for review. Poor or absent documentation can lead to the filing of a lawsuit because the plaintiff's expert assumes that certain acts did not occur or the documentation is unclear or contradictory as to what occurred. Ultimately, this can make it extremely challenging for a provider to provide a reasonable explanation for what he or she did and can also lead to defendants taking inconsistent positions in a case.

How does this happen

As alluded to above, a significant hurdle to defending oneself in a medical malpractice lawsuit comes about as a result of poor or

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absent documentation. Although electronic anesthesia records are more commonly used these days, they are hardly a panacea in this setting. While electronic records can be of assistance in capturing some data “real time,” specifically vital signs, other important information still must be entered by hand. If a paper chart is being utilized, obviously it goes without saying that significant information must be written in the chart. No matter what record keeping system is being used, the anesthesia machine can be a helpful resource as it captures a lot of data during the course of the operation, but it is often a forgotten source of information and unthinkingly is changed over to the next case or turned off, resulting in the loss of important data.

ORs are very busy places. Typically, multiple patients are scheduled for surgery in a single OR, with 1 anesthesiologist being assigned to that room and those patients. There is pressure on everyone, the surgeon, the OR staff, and the anesthesiologist, to stay on schedule, in essence “keep the line moving.” This pressure does not dissipate in the face of an emergency; rather, in many cases, it is exacerbated as a patient who experiences an unexpected event or complication must be cared for as precious minutes tick by and other patients and surgeons are impatiently waiting their turn.

In this high-pressure, fast-paced setting, it is difficult not to succumb to the pressure to defer the critical tasks of communicating with the surgical team regarding the event, securing possibly important evidence, and completing necessary documentation. The providers move on to the next case (and the next case after that), thinking that these tasks can be completed during a later break or at the end of the day. This is a mistake for several reasons. The surgeon will speak with the family and/or patient shortly after surgery. In some instances, participating in that conversation can be important in providing consistent and accurate information to the family in an upsetting moment in time. Assuming that the OR where the event occurred is going to be used for additional cases, in many instances, once the anesthesia machine is placed into use for the next patient, all of the data stored in that anesthesia machine will be lost and irretrievable including all of the vital sign measurements, anesthesia gas dosages, and electrocardiogram tracings. In the case of an event where there is an equipment failure or malfunction, when the room is turned over for the next patient, valuable evidence may be inadvertently discarded or destroyed. Staff involved in the event may go off shift and be unavailable to debrief on the event so that all available information is gathered and properly documented. One also cannot minimize the effect that trauma, shock, and emotional distress have on the memory of the providers in this circumstance, even in the short term.

Important considerations to keep in mind when an unexpected event occurs

The patient

It goes without saying that the first essential task is to take care of the patient. Do what is necessary to stabilize and treat the patient to the best of your ability. It is important to remember to call for additional assistance from other anesthesiologists or specialists as needed depending on the clinical situation.

Documentation

Most charts, in retrospect, can be improved. In the setting of an unexpected complication, taking the necessary time to complete one’s documentation is essential. It is also important to recognize that properly completing the documentation does not have to be a one-person job. The circulating nurse and OR personnel, and other members of the anesthesia team can and should be enlisted, when appropriate, to help capture necessary data. The manager of the OR should be notified that there will be a delay in the surgical schedule, and it may be helpful for risk management to be informed to provide another trained professional to assist in the immediacy of the situation.

The anesthesia machine should be interrogated to obtain all of the essential information regarding vital signs, electrocardiogram strips, and other available data. If the preprinted anesthesia record does not have enough room to accurately and clearly contain all information, use an addendum. Enlist the assistance of a trusted member of the surgical team to complete this task with you, whether it be to act as a scribe or to collect and save the necessary information. If the anesthesia record has been generated electronically, double check to make sure that the data were properly uploaded into the patient’s chart and that all of this information is there. If it is not, do not turn off the computer and immediately request assistance from the facility computer technicians.

Whether the anesthesia record is handwritten or computer generated, consider authoring a narrative summary as to the event. Even though one is inclined to think “I am never going to forget this,” the truth is that memories fade or change because of time, emotions, and other human factors. A well-thought-out narrative that provides information as to what transpired and what steps were taken—and why—can be invaluable when looking back to provide insight into the provider’s clinical judgment. In all instances, the narrative should be objective and factual. The medical record is not the forum for blame, personal attacks, or finger pointing.

Providers should refrain from documenting outside the record. Generally, if information about what occurred is important enough to be written down, it is best to include this documentation in the patient chart. On occasion, upon further review, a provider may discover that information was inadvertently omitted from the chart. Depending on the timing of the discovery, the provider may place a “late entry” in the chart. In all such instances, it is essential that the entry be clearly designated as a “late entry” to preclude any potential allegations that the record was tampered with. In the event excessive time has passed, the provider should strongly consider contacting one’s professional liability carrier for advice as to whether a narrative outside the chart should be prepared and maintained. If counsel is assigned, such documentation can be privileged as an attorney client communication.

The family

Although it may appear clear initially to a provider what caused the problem, as further facts become known, the initial conclusion may in retrospect be erroneous. Receiving news that a family member has had a complication during surgery is upsetting. Although well meaning, providing family members, or a patient for that matter, with an explanation for what caused a complication, which in retrospect is incorrect or incomplete, can

compound a family member's concerns. When disparate information on an event is received, this can lead to suspicion and a breakdown in trust.

Where possible, it is helpful to participate in the initial post-procedure conversation with available family with the surgeon so that accurate and consistent information is provided to the family from the surgical team. Tell the surgeon you want to be a part of that discussion and discuss the parameters of what is currently known and what should be disclosed at that time. It is important to be truthful. It is also important to recognize what is and is not truly known about what occurred and to avoid providing confusing or conflicting information. Be prepared to discuss in basic terms that a complication arose and what has been done to stabilize and care for the patient. Avoid the temptation to jump to conclusions as to why or how the complication occurred. Do not guess or speculate in these initial conversations with family members, or the patient for that matter, as to what happened. Rather, err on the side of caution; inform the family about what is being done to care for the patient. It is perfectly appropriate to indicate that the matter will be investigated and focus the conversation on what is being done to treat the patient.

The importance of follow-up with the patient and the family cannot be overstated. Often-overlooked resources for dealing with post-complication conversations include hospital risk managers and social workers, the provider's malpractice carrier risk management department, and the provider's group or department leadership. There may be a temptation to handle the situation oneself either because of lack of experience in handling this type of situation or because of emotional upset or embarrassment. Garnering support and counsel from knowledgeable, experienced resources as to how to handle conversations with family and the patient and other members of the surgical team can be extremely helpful. Do not hesitate to contact these resources for assistance from the outset.

If the patient is being admitted to the hospital for further care, be prepared to and do visit the patient. Be prepared to be asked questions. Be prepared to have a discussion, where appropriate, about what occurred if in fact a conclusion has been reached after a thorough investigation. These visits are not "fact finding" missions; rather, they are a time to provide support and to demonstrate to the patient and the family that you are engaged and that you care. Again, do not guess or speculate about what occurred. If you identify a certain need or point of frustration, be proactive in attempting to provide further support by communicating with other resources in the hospital such as risk management or discharge planning to inform them about these issues. Be compassionate and caring. Document your visits, even if they are brief or social in nature.

Follow-up in these situations is crucial. If you tell a patient or a family member that you will follow-up to provide additional information, it is important to in fact do this. Provide contact

information so that the patient or family member can reach you. Document those contacts when appropriate.

Texting with patients or family members, however, is not advised. Text messages cannot be preserved and using one's personal cell phone may violate federal or state privacy laws as the information is not appropriately secured. In addition, communicating with patients or family members through social media sites, such as Facebook, should be avoided for obvious reasons.

Do not underestimate the value of emotional support

When something bad happens to a patient, the emotional impact can be both immediate and long lasting. In the immediate time frame, providers need to assess whether, in the face of an unexpected complication, they actually are emotionally and physically capable of continuing to provide appropriate patient care. This is a difficult question; however, it should be recognized that "toughing it out" to finish a shift or a list of cases may not be in anyone's best interest, including that of the patients in line for surgery. Providers should not be afraid to communicate with their group's leadership in the immediacy of this type of situation to problem solve whether appropriate backup is necessary or a "pause" of some length is in order to prepare for other patient care responsibilities.

The emotional consequences of a complication can be long lasting and can effect a provider's ability to provide care to other patients. At a minimum, providers should consider contacting their professional liability carrier to inform the carrier of the event and to secure assistance from the carrier's risk department. Some carriers will assign counsel proactively to assist with questions and provide guidance. In addition, many carriers now provide resource referrals for mental health professionals who specialize in assisting health care providers who have experienced these traumatic events.

Conclusions

Unexpected events happen, despite careful planning, to the best and most well-trained providers. Having a basic plan in mind is essential to negotiating through these events while still providing the best care possible. Pause, think, and do not be afraid to get help. Document accurately and factually as soon as possible after an event. These few tips will hopefully minimize the likelihood of being drawn into litigation, but if litigation ensues, will help support providers in the process.

Conflict of interest disclosure

The author declares that there is nothing to disclose.