

I Just Had a Significant Complication – Now What Do I Do?

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OBJECTIVES

1. To develop a working definition of what a significant complication is
2. To be able to differentiate between a complication and medical negligence
3. To initially evaluate the liability risk in order to locally manage a significant complication where liability may exist.
4. To understand when it is necessary to speak in a legal forum
5. To understand what is required to speak in a legal forum

STEM CASE - KEY QUESTIONS

Key Questions

1. What is a significant complication?
2. How do I evaluate a significant complication?
3. How do I properly and responsibly respond to a significant complication?
4. What should I avoid doing if I have a significant complication?
5. If I am deposed what do I do?

Case #1

63 yo male with known cardiac disease enters hospital with a tachyarrhythmia. Patient is fed on admission to ICU whereupon his cardiologist exams him and determines that emergency cardioversion is indicated. The patient is temporarized for 4 hours at which time the cardiologist insists he must proceed. The anesthesia provider is present as the cardiologist proceeds to cardiovert. Propofol is used in the 30-50 mg range. The patient is shocked for atrial conversion but goes into a pulseless ventricular tachyarrhythmia. The patient vomits and is intubated and shocked out of his tachyarrhythmia. He is unresponsive for 4 hours but becomes arousable. His chest x-ray shows a small area of atelectasis at the right hilum. He is extubated and talking. 6 hours later, the patient has a cardiac arrest and is not resuscitatable.

Was there an anesthetic complication?

Was there a deviation from the standard of care in anesthesia care? In cardiology care? Both?

If yes, did it result in injury?

Did the injury result from the anesthetic management, the cardiac management or from both?

Case #2

58 yo wm physician with history of CAD now presents for a redo repair of a prior incisional hernia repair with possible intermittent entrapment of bowel. He is moderately obese, type II diabetic and has a class 2/3 airway. ECG shows non-specific changes in the lateral leads, with frequent pacs, CXR show a heart at the upper limits of normal. He smoked for 30 years but has

recently given it up. Medications include a diuretic, ace inhibitor and beta-blocker used for controlling palpitations. An a-line was started in his left radial artery just above the wrist after patient was induced. The case goes well but was prolonged and patient is taken to PAC. Patient complains of tingling in his left hand and arm in the PACU and it continues past discharge. At one month, the patient has some tingling like discomfort in his hand that compromises the use of his hand. Luckily patient is a right-handed psychiatrist.

What factors present or omitted from this description makes the filing of a lawsuit more or less likely?

What factors, if they were true concerning the management of this patient would make this case more likely to result in a successful defense of a lawsuit?

Would documentation of positioning make a difference in the liability of the providers involved in this case?

Would the quality of management of the post-operative condition alter liability in this case? Are other issues to consider?

PROBLEM BASED LEARNING DISCUSSION

I. Complications – A Definition

The mere mention of the word “complication” sends chills down any medical practitioner’s spine. Yet, we know that complications are part of medicine and indeed part of life. We have to know how to manage them. But first we need a definition that helps us understand the problem. A suggested working definition for this presentation is “A **complication** is an outcome or result of a medical intervention that A.) Was not expected because it was not the usual outcome” and B.) The complication becomes a **significant complication** when the unexpected effect is a long lasting or permanent adverse outcome.

Unexpected results can be both qualitative and quantitative, the presence or absence of something or some condition and too much or too little of a condition. A long lasting or permanent effect is a fairly clear concept. In medical circles almost all complications are evaluated in this way as well. The patient who has a transient “adverse outcome” will be less of a problem because of the expectation of the patient returning to his previous state tends to cause fewer problems than the complication that will not go away.

Clearly, it is the analysis of what the complication is in terms of its cause, if it can be determined, and the status of the patient that has great bearing on what the consequences will be for the providers involved. Anyone who provides anesthesia care knows that even under the best of circumstances, the nature of what we are doing, giving a controlled overdose, in the case of general anesthetics, is an unpredictable business. We often cannot predict a patient’s precise response to a given intervention. Under our definition of significant complication, transient unexpected results or responses will be not considered here.

What kind of complications are we talking about? Fredrick Orkin in his book, *Complications in Anesthesiology*, 1983 divides the assessment of complications this way. 1.) Complications, which are not the result of error and 2.) Complications, which are the result of error. Cooper who

asked trainees and attendings at Mass General Hospital to discuss near misses or non-death causing incidents further evaluated this second category. Cooper found that complications could be divided into human error 82% and 14% equipment error. Human errors are considered to both omission and commission. The IOM Committee on Quality Healthcare in America defines error as “ the failure of a planned action to be completed as intended (omission) or the use of wrong plan to achieve an aim (commission)”. Dr. Cooper’s list of human errors includes: failure to monitor, syringe swaps, inadequate training or knowledge of equipment or procedure. Giving the wrong drug or the wrong dosage of the appropriate drug, giving a drug inappropriately, etc

Vigilance has been the watchword of the anesthesia practitioner and the need to be ever attentive has become the focal point of anesthesia care. To aid in that vigilance, the ability to monitor the vital signs and anesthesia parameters have become increasingly important to the management of patients within the standard of care. Indeed, the ASA was the first specialty society to list comprehensive practice parameters. This was done in recognition of the data gathered that indicated that some problems were indigenous to the practice of anesthesia. As every practitioner knows, airway management and ventilation is the most continuously pressing problem. But airway and ventilation problems are by no means the end of the problems. These other areas are discussed below.

II. Areas of Complications in Anesthesia Care

A non exhaustive list of some of the more common areas where complications (transient and significant) can occur include:

1. Untoward Drug Reactions including induction of abnormal hemoglobinemias and inducible porphyrias
2. Prior Drug Therapy interactions with anesthetic agents and/or surgical interventions
3. Reactions to local anesthetic and regional anesthesia
4. Airway management trauma and complications of the managing a difficult airway
5. Peri-operative Ventilation and Oxygenation problems
6. Cardiac related problems from pre-existing or new onset disease including problems with open-heart surgery
7. Temperature control issues of both hypo and hyperthermia
8. Awareness during anesthesia
9. Reactions to Anesthetic or related agents
 - A. Narcotics
 - B. Muscle Relaxants
 - C. Local Anesthetics
 - D. Others
10. Equipment Malfunction
11. Positioning problems
12. Burns and Electrocutions

III Analysis What to consider - the law, the medicine and their application to the particular case.

In past years, before the present capability of monitoring as many parameters as we now do, the discovery and often the diagnosis of a complication was delayed until the patient showed

definitive signs of compromise. Late discovery of human error is much less likely today. In fact most of the recurrent problems of anesthesia practice have been identified. For example, closed claim projects of the late 1980s and early 1990s identified the areas where most of the injuries occurred. Ventilation and other airway management problems were first on the list, in terms of severity of injury, followed by peripheral nerve injuries, mismanagement of sympatheolytic blocks and eye injuries. Perhaps it needs to be stated that such late diagnosis is still possible and prevalent in situations where the purpose and spirit of alarms and monitors are defeated by inattention and alarm settings set inappropriately or simply turned off.

A. Legal Issues -The Law: Theories under which litigation may proceed

In order to assess the status of any significant complication it is necessary to evaluate the complication medically as described above. What is your honest opinion of what happened? What do your working peers think? What is in the literature concerning the complication? The Closed Claim studies have shown definite patterns and trends in complications. Does this one fit a pattern and if so what has been written about it? If in fact the complication is due to human error or it cannot be ruled out then the application of legal principles described below apply. Below is a list of types of liability created by practicing medicine and having a complication.

1. Tort

Medical Malpractice is a tort and requires the elements of tort law; duty, breach, injury, damages and most importantly, the proximate cause, a legal established relationship between the breach, the injury and the damages.

2. Contract

When a doctor-patient relationship is created, a contract may be created between the patient and the physician where the physician agrees to provide professional medical services at the standard of care. When the services do not meet the agreed standard then there is a breach of the contract and damages arising out of the breach of the contract, which must be proven in court. The difference is that the ability to prove damages is far less difficult but the damages are limited by what is the difference between what was promised and what was delivered. Alternatively, the patient may attempt to get the court to put them in the same position they were (economically) before the service was performed. Contract actions for patient dissatisfaction and injury are relatively rare.

3. Consent:

Failure to obtain consent is considered to be a tort in modern era and not a precursor for battery. The thinking is that obtaining consent, e.g., providing disclosure is a duty, which is breached if not provided.

B. Medical Negligence

Clearly Tort law and its application in medicine, medical negligence is the law used most often to prosecute claims against physicians. However, medical negligence and significant complications are not synonymous terms. We have defined a significant complication above as an unexpected outcome that is either long lasting or permanent. Medical negligence occurs when a provider renders care below the prevailing standard of care and there is an injury, which can be directly attributable to the rendered care.

1. Standard of Care

The key issue is whether the standard of care had been met and maintained involving the care rendered during the complication. In the United States, the standard of care is defined as “ What a reasonably well qualified individual would have done in the same or similar situation.

A. What does reasonably well qualified mean?

It means average qualification, not the best, not the worst

B. What does same or similar situation mean?

What is required of the practitioner varies with the situation – like situations must be compared.

C. Important concerns and questions included in evaluating what the standard of care requires in your situation:

1. The circumstances of the care; was it elective? Emergent? Urgent?
2. Was the documentation appropriate?
3. Was consent obtained for what was done including a reasonable recitation of the risks?
4. Was care rendered consistent with known parameters?

IV. What to do when you have a complication -

- A. Evaluate the situation as described above
- B. Document what you know about the clinical situation,
- C. Discuss with the patient what happened,
- D. Notify your insurer if appropriate

First, review, familiarize yourself or learn as much about the problems associated with the complication. Evaluate your situation legally by being honest with yourself about what happened, your role in the mishap and what you believe other practitioners would think about your complication. If you can put yourself in the position of an unbiased observer, what would you think happened? Did you meet the standard of care at all times or was there some aspect to your care that was substandard? At this point it is important to apply the appropriate test of what the applicable standard that applies to your situation. This standard might be a consensus statement written and promulgated by a national organization or the common practice of a majority of qualified practitioners providing that practice as described in review articles or text.

Next, make sure that your documentation is complete both on the anesthesia record and in the medical record concerning your understanding of what took place including the circumstances surrounding the complication, what you did about it (medically) and what the (clinical) response was.

Next, inform the patient and family, when appropriate about the situation, what the complication was and what can be expected. This may not be easy to do, particularly if the complication is catastrophic or potentially catastrophic. Then follow along and make yourself available and offer to answer questions and coordinate and facilitate information delivery to the patient and the family.

While showing concern and empathy, the physician should avoid any type of “mea culpa” statements. It is better to limit contact if the urge to incriminate oneself is strong. This is important, particularly early when the full clinical situation cannot be known and the responsible physician fears the worst. Before speaking to anyone about a complication, make sure that your

information is accurate. Check references first and learn or refresh your knowledge if you are unsure about any aspect of the information you are going to give the patient or the family.

Notify your insurer directly, not just your department, as soon as possible if you conclude that you have liability in your situation. In general you should have a low threshold for reporting situations. Err on the side of reporting in situations when you are involved even if it does not appear that you have liability.

V. What not to do

1. “Confess” to staff or family members.
2. Become defensive or offensive with staff or family members.
3. Write self-incriminating entries into the medical record or other official documents.
4. Attempt to garner support from those present at the time of the incident.
5. Discuss your opinion of what happened in informal settings.
6. Compromise the care of the patient in question or subsequent patients.
7. Delay in contacting the Hospital and insurance company, informing them of the occurrence.
8. Omit any important facts or circumstances when reporting incident to your insurer.
9. Become unavailable to patient’s family or official inquiries at the departmental, hospital or university level.
10. Continue to work providing care if you are unable concentrate on what is happening right now.

V. What to do when being deposed as a medical provider involved in the case (as opposed to an expert)

Medical providers may have to give testimony or depositions in matters where an action has been filed. Depending on the individual’s status in the case, the court may have jurisdiction over an individual, if they are a party or have important information for the court. However, each case is individual and the individuals involved must check with counsel to understand their rights and responsibilities when dealing with a subpoena to give testimony or a deposition. In general, a non-party provider will have much more leeway in dealing with the court.

In a malpractice action, a medical provider may be deposed for 3 different reasons:

1. The provider is a defendant
2. The provider is a subsequent or concurrent treater and may just be
3. The provider is an expert witness who has reviewed the case and is being asked to render an opinion as to what the standard of care was based on review of the record

Non-expert witnesses, called occurrence witnesses, are asked to give testimony or a deposition to present the facts and other information to the court. Expert witnesses are also called “opinion witnesses” Generally provider occurrence witnesses are also experts but may not testify as an expert unless qualified to do so. However, in general, most physicians are considered to be experts especially if they are board certified. The subtle difference, in the instance of testimony from medical providers, between an occurrence witness and the opinion witness is that the occurrence witness need not offer any opinion about the so called “ultimate questions” which are: 1.) Whether or not there was a deviation from the standard of care and 2.) If that deviation

was the cause of the injury for which the action was filed. The occurrence witness need only testify as to what was done for a patient and why and even if asked if they have an opinion, they may decline to give one by simply saying they have no opinion. An expert witness on the other hand is there for the express purpose of rendering an opinion.

VI. What is required of a medical provider in a deposition?

In a deposition (and later testimony) the provider is expect to be intimately familiar with the record of the patient in question regardless of his status in this particular action. In general the expert witness has a slightly different role but these same rules apply.

1. Know the records intimately
2. The doctor must listen to the question carefully
3. The doctor should respond thoroughly, but directly and to the point
4. The doctor should use the medical record
5. The theatrics of the plaintiff's attorney should be disregarded.
6. The doctor should be consistent.
7. The doctor should wait for the next question after finishing a response.
8. The doctor should be extremely cautious in responding to leading questions, such as "Is it a fair statement . . ."; "Let me summarize your testimony as follows. . ."; "Doctor, just so I understand what you are saying. . ."
9. The doctor should be careful of conversation during breaks.
10. The doctor should be courteous, professional firm, and credible.

And finally a word of hope – Most medical negligence trials result in a not guilty verdict for the provider.

REFERENCES

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