

Legal Considerations

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INTRODUCTION

As trial lawyers with over 50 years of combined experience we urge you to invest the time it takes to read this chapter. Then, make a commitment to change your practice to consent patients correctly. Top surgeons understand that effective communication with their patients is a skill that needs to be updated and refined over time just like surgical technique. Proper consent does not require more time when you understand the true nature of an adequate consent.

LEGAL PITFALLS IN SURGICAL CARE BEFORE ENTERING THE OPERATING ROOM

Let us start by emphasizing the key point of this chapter—**informed consent is a process.** It is not a hospital-generated form. Surgeons make a critical error when they assume that getting a patient to sign the hospital's consent forms means that they have complied with the requirements of informed consent. This error can be quite costly to your practice and to your reputation.

Consent is a process that requires communication between the surgeon and the patient. Usually, it is a two-step process that starts during the office visit and continues at the hospital before surgery. The office visit is your opportunity to take the time to explain the proposed surgery, the risks and alternatives, and the consequences of not proceeding. Thus, patients have time to reflect on all the information you have given them and can really make an informed decision to proceed with the surgery you suggest.

The time for having that discussion is not in the hallway of the same-day surgery unit while you are trying to get in the first case of the day. That is not fair to you or to the patient and is certainly not the best use of your time. Patients can feel pressured to agree and will often say they were so worried about the surgery that they did not even listen or that they signed the forms just to get things moving without having time to ask questions or to reflect on the complex decision they were asked to make.

In most hospitals, the surgical consent form is executed right before surgery. This is a good practice because it

provides some evidence that the patient consented to surgery. However, in most states, that form alone is not sufficient to establish that you met your duty to your patient.

We have both seen surgeons mismanage their relationship with their patient and their family in ways that have led to medical errors, an omission through miscommunication, or claims from patients that the surgeon failed to provide them with sufficient information to make an informed decision about surgery: Here are three ways we have observed: (1) the surgeon acted as an all-knowing being; (2) no office notes were kept about the consent discussion or the refusal of care; (3) the surgeon did not tell the patients about who would assist with their surgery.

Surgeon as All-Knowing Being

If you have this aura and express it to your patients, then this is what they will expect. *If you tell the patients what surgery they need and just assure them that “everything will be fine,” then you have taken complete responsibility for the decision making as well as the outcome. No wonder the patient (and the jury) will want to hold you 100% responsible for any negative outcome.*

Practice Pointer. Communication and decision making are a two-way street. Patients have responsibilities along with their rights. Share these responsibilities with the patient. Make the patient part of your health care team. Here are some ways to do that:

- Have brochures in your office that explain office hours, after-hours call procedures, what to do in an emergency, and who to call in your office if they are having problems **after** surgery. Tell them whether they are responsible for bringing their films to the hospital. Also, the brochure can outline their role in follow-up after getting laboratory tests, diagnostic tests, **especially from outside providers.** Make sure they understand how to get to you if they think they are having a complication and need to be seen. If others will take calls for you, explain how that works.
- *Use American College of Surgeons or other specialized brochures, videos, and computer-*

generated educational materials to supplement your discussion with patients regarding the alternatives, risks, and benefits of the surgery you propose. Also direct them to websites that you think are accurate for basic information, if appropriate. You can provide a fact sheet that explains in detail why the surgery is performed, the alternatives, the risks, and what to expect after surgery. This can be handed out, not as a substitute for discussion, but as a supplement. Your staff can use a checklist to confirm that the patient received the materials. Whereas this is not a substitute for discussion, it certainly helps support your argument that the patient was thoroughly informed about the surgery before the big day!

- If you send a patient for a magnetic resonance imaging (MRI) scan at an outside facility and they need to come back to discuss results, the order for the MRI should include a section that reminds them that it is their responsibility to obtain the film **and** obtain a follow-up appointment. Many surgeons have the patient sign this acknowledgment. That is a good way to communicate that the patient is sharing responsibility for the implementation of the plan of care.

No Office Notes about the Consent Discussion or the Refusal of Care

A surgeon's note, timed and dated contemporaneously with the event, is the best way to avoid subsequent allegations regarding lack of informed consent. Surgeons often fail to document the most important part of a discussion when a patient refuses care. The key part to document is that you told them the potential consequences of their refusal. A patient cannot make an informed decision about whether to have a surgery or a major diagnostic test without weighing what might happen if they do not have it.

Example: "Told the patient that the lump was probably just a cyst but told her to go and have a mammogram."

It is easy to understand if the patient later says, "I trusted Dr. Smith when she said it was just a cyst, so it didn't seem necessary to have the mammogram."

Practice Pointers. Make sure that you document not only the fact that you had a discussion about the surgery but also that you reviewed the risks, alternatives, and likely outcome if nothing was done. The note should state that the patient understood your explanations and that all questions were answered.

- If the patient has any additional risks or conditions that make the surgery more risky, you need to document that portion of the discussion more extensively.
- When the patient refuses or seems like she or he is not going to have the surgery, you need to add details about your explanations of the risks of delay and the consequences of no treatment. This is often a good

time for a follow-up letter to the patient, sent by certified mail.

Not Telling Patients about Who Will Assist You with Their Surgery

In general, patients will appreciate and understand that you cannot perform the surgery by yourself, but in most circumstances, you have a duty to explain who will be involved and what the assistants will be doing.

Patients will also understand that sometimes others, including vendors and technical people, need to be present to assist with device placement. It is your job to make sure the patient agrees to that.

Failing to explain these facts can result in claims for fraud or battery. You may also get testimony in a malpractice case that the patient never consented to having a resident do certain portions of the surgery.

Practice Pointers

- If you are in a teaching hospital, you must explain what the resident's role will be and document that you had this discussion with the patient.
- If you are in a community hospital, you must explain who will be assisting you with surgery and what they will be doing. Document that discussion.
- If vendors or others will be present, the patient has a right to know and needs to consent.
- Some hospital consent forms include general language regarding assistants and others in the operating room, but you are the person that the patient agreed could perform the surgery, not others, so make sure the patient is clear about the role of others.

These are fairly simple, straightforward concepts that need to be incorporated into your practice to make certain the patient is provided with all the facts before he or she consents to surgery.

LEGAL PITFALLS IN SURGICAL CARE AFTER THE OPERATING ROOM

Murphy's Law: If anything can go wrong, it will. When Murphy developed his law, he must have been partially thinking about health care providers. What else could explain why doctors and other health care personnel spend countless hours talking with patients about things that might go wrong during treatments and procedures? Why else are entire books like this written about surgical pitfalls if adverse outcomes do not actually occur? Whether a doctor is just finishing a residency program or is getting ready to retire, every doctor should know that you do not need to commit medical malpractice to get sued, you just have to have an unhappy patient—and nothing, we repeat, nothing, can make a patient or family more unhappy than an unexpected surgical complication.

Part of the problem and shock can be ameliorated with a good, complete, preprocedure informed-consent discussion. That topic has already been dealt with in this chapter. Unfortunately, even the best informed-consent conversation or document, by itself, may not be enough to prevent a malpractice suit from being filed. You are lucky, however, because when an adverse outcome occurs, you have a second chance to prevent a lawsuit from being filed or, if it is destined to be filed, to improve your chances of prevailing. Although most of these are common sense suggestions, in 30 years of litigating hundreds of medical negligence cases, we have both come to appreciate that common sense does not always rule when a serious injury or death occurs. Thus, a bit of repetition may prove helpful.

DOS AND DON'TS

- **Don't** stop seeing or decrease the frequency of visits with your patient or your patient's family. When problems occur, this is the time for you to be the most visible. *We cannot begin to tell you the number of depositions we have taken in which the patient or the family complains that Dr. X "never seemed to be around to answer our questions after the surgery" or "I never saw Dr. X for the several days between the surgery and the death of my husband."* Rather than making the heart grow fonder, absence will make the patient or the family think that you do not want to face them and explain what occurred. We have known doctors who have called subsequent treating physicians to simply inquire about how the patient is doing and made note of those conversations in their office charts.
 - **Do** make sure that the family of the patient knows of your concern over what occurred. It is not an admission of liability to express condolences over death or to let a patient know that you are sorry they have suffered a complication. We have even known of surgeons who attended funerals of patients who died after a surgery. To ignore a problem leads the patient or the family to think you do not care. If a patient thinks you do not care about her or his welfare, you are much more likely to be included in any litigation. Remember, the general rule is that people do not sue people they like. The authors are frequently amazed at the number of times potential defendants in malpractice litigation are not sued even though a real question exists about whether their actions were a deviation from the standard of care. This topic is usually explored at deposition only to learn that the patient simply did not want to sue Dr. X because the patient liked him or her.
 - *Don't try to explain what occurred until you are sure of your facts and until your conclusion can be corroborated.* Obviously, you are going to be ques-
- tioned immediately by the patient or the family about what occurred. You will need to describe to them, from a factual standpoint, what you know up to that point. Just refrain from making conclusions as to the cause of problems. In most instances, you would not try to make a diagnosis without adequate data. Why do it now? The admonition not only applies to direct conversations with patients but also to documentation. In a recent obstetric case, a baby was transferred to the neonatal intensive care unit (NICU) for a brachial plexus injury postdelivery. The neonatologist, who should have known better, reported that he was dealing with a newborn with an obvious brachial plexus injury **caused by excessive traction**. Not only was that conclusion shared with the parents in the following days, it was repeated during the pendency of the litigation. In fact, the defendant doctor vigorously denied that excessive traction was used, and had evidence to support that defense. The family and their attorney kept arguing that even the neonatologist concurred that negligence had caused the injuries at birth. It would have been a simple matter for the neonatologist to write "obvious brachial plexus injury, cause unknown at this time." Similarly, in a recent laparoscopic appendectomy case on a 20-weeks' pregnant patient, a general surgeon wrote, in a *nonperforated* appendix procedure, "that upon entering the abdomen, I saw purulent fluid around the appendix." What he really saw was a whitish exudate and not purulent fluid because there was no source for the purulence in this nonperforated appendix simulation. Weeks later, the patient developed an infection after a spontaneous abortion, and the surgeon was sued for not starting antibiotics in the presence of purulence. The entire lawsuit, over 7 trial days, could possibly have been averted had he simply written that he visualized a white substance around the appendix rather than calling it purulence, especially because he had no information that it was.
- **Do** make complete records whenever an adverse outcome occurs including as much factual information as you can recall. The plaintiff's attorney may argue that you are attempting to create a defense, your attorney will counter by arguing that you were attempting to facilitate the investigation or understanding of what occurred by providing the most detail possible. Any entry along these lines should be correctly dated and timed, so that there is no argument that someone was attempting to "alter" their records.
 - **Don't** ever, **ever**, alter your records. Even if your alteration, deletion, or addition is perfectly innocent, it will never appear that way. If, after an adverse outcome, you are found to have made a change to an existing record, that patient, their family, and most important, the jury will automatically assume you were attempting to delete a harmful notation and will not believe a word you say. *Statistics tell us that approximately 70% of all medical malpractice cases that go to trial*

end up favorably for the health care provider.

Clearly, that means that cases are won even in cases in which significant injuries or death occurs. You can talk your way out of a bad outcome. You can never talk your way out of a lie.

- **Do** carefully read chart entries after an adverse outcome occurs and be sure to properly and timely note any disagreements you might have with the charted information. We know what you are thinking right now. You simply do not have time to read entries that should have been accurately charted by residents, colleagues, or consultants. Take the time. If you make your disagreement known contemporaneously with your review of the note, you can argue that there was a legitimate disagreement. Many of you sign off on notes written by others. A smart plaintiff's attorney will start by getting you to agree that your countersignature on a note is your statement that you agreed with what was written. As you can see, making your disagreement known 2 years later, when you are in the midst of a malpractice case, will cause you to look like you are manufacturing a defense because you have already agreed that your signature is your statement that you agreed with the note. It will be further argued by your opponent that you now recognize how harmful that fact or comment is to your defense and that any reasonable doctor would have corrected that mistake earlier if, in fact, a disagreement really existed.
- **Don't** ignore legitimate requests for medical records by a patient, a family member, or an attorney representing the patient. In many states, the time to respond to

these requests and the amount that can be charged are governed by statute. To ignore this type of request or to take too long to respond will cause the person making the request to question why the records were not sent and will again raise the specter that you are attempting to hide something. The records, in their entirety, should be timely copied and mailed, along with an appropriate letter, inquiring as to whether there is any other way you might be of assistance and again inquiring into the health of the patient or to pass along your sympathies. In another recent general surgery matter involving a failure to timely diagnose and treat a breast mass, the surgeon was accused of withholding information and falsifying his records when his office took months to send out records, did so in a piecemeal fashion, and never sent out all the records. The case, ultimately won by the surgeon, could have been tried in a few days with the central issue being standard of care. Instead, the surgeon's credibility became the central issue, and days were wasted calling present and past employees about record keeping and responding to record requests.

The lists of **Dos** and **Don'ts** goes on forever and is far too numerous to cite, in its entirety, here. When you are faced with that inevitable, adverse outcome and you are questioning how you should be handling a particular situation, always ask yourself this question: How would my patient or a jury view my actions? Your choice might just be the thing to keep you from being sued or the exact thing that helps you win.