Clinician Reviews®

Today's Care Must Extend Beyond the Exam Room

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In May 2014, a 70-year-old retiree underwent repair of a fracture of her left ankle. The procedure was performed at a local hospital. A splint was applied to the ankle, and a nurse provided crutches.

Following discharge from the hospital, the patient hailed a taxi to take her home. As she was exiting the taxi at her residence, the patient fell and sustained comminuted fractures to the distal radius and distal ulna of her right (dominant) wrist and a trimalleolar fracture to her repaired left ankle.

The plaintiff was transported back to the hospital via ambulance. She underwent closed reduction of her wrist fractures and 11 days later was transferred to another facility for open reduction and internal fixation of her left ankle fracture. Her hospitalizations totaled 13 days and were followed by a course of inpatient rehabilitative therapy; the latter lasted until late August 2014, with a brief interruption in June when she underwent open reduction and internal fixation of her wrist fractures. When she returned home in August, the patient required the assistance of visiting aides and 3 additional months of rehabilitative therapy.

At trial, the plaintiff claimed that her left ankle and her right wrist remained painful, that she sustained a mild residual diminution of each area's range of motion, and that these residual effects hindered her performance of basic physical activities (eg, cleaning and cooking).

The plaintiff alleged that her fall while exiting the taxi resulted from unsteadiness, which was a lingering effect of morphine that was administered during the repair of her fracture. She sought recovery of damages for past and future pain and suffering from the hospital's operator. The lawsuit alleged that the nurse had failed to provide instructions on the proper use of crutches, that the nurse had failed to undertake measures that would have diminished the plaintiff's likelihood of falling, that the nurse's failures constituted malpractice and negligence, and that the hospital operator was vicariously liable for the nurse's actions.

The plaintiff claimed that she repeatedly warned that she did not believe that she could safely use the crutches provided by the nurse. She claimed that she was unsteady and lightheaded, and that when she requested a wheelchair, an escort, or an ambulance, the nurse rejected the request. The nursing standards expert for the plaintiff opined that the request should have been satisfied or alternatively, that the nurse should have explained the manner in which a crutch-dependent person could safely enter and exit a vehicle.

Defense counsel claimed that the nurse explained proper use of the crutches, the plaintiff indicated that she understood the explanation, and the plaintiff demonstrated proper use and did not express concern. The defense's expert contended that the nurse did not have to explain how a crutch-dependent person could safely enter and exit a vehicle and that the plaintiff's fall resulted from her own failure to exercise appropriate caution. The defense further contended that the plaintiff achieved an excellent recovery.

After a 7-day trial and 3 hours and 45 minutes' deliberation, the jury found in favor of the plaintiff. It found that the nurse was negligent in her provision of crutches and that the act was a substantial cause of the plaintiff's injuries. The jury also found that the nurse did not properly explain the use of crutches but determined that the error was not a substantial cause of the plaintiff's injuries.

VERDICT

The jury awarded the plaintiff a total of $850,000 in damages. The plaintiff also recovered stipulated medical expenses.

COMMENTARY

Medical malpractice litigation involves recovery for acts or omissions that constitute a departure from the standard of care. We all recognize injurious acts—improper esophageal intubation in the emergency department, transection of a nerve in the operating room, or prescription of a contraindicated medication to an allergic patient—and acknowledge damaging omissions, such as failure to screen for colon cancer or recognize treatable diabetes.

However, some cases are disposition related; they arise from how patients are discharged, what instructions they are given, where they go, and what they do after discharge. These cases involve the patient's medical issues engrafted on his or her transportation, job, and more generally, living environment.

The lay public expects patients to have a right of self-determination, to control the nature and course of their medical care. Yet, the modern lay public also expects the medical profession to act as an authority figure—exercising a degree of paternalism to safeguard patients from harm. This expectation is commonly articulated in retrospect, after something has gone wrong. Consequently, clinicians must be aware of what will happen to the patient after discharge.

With all interventions, weigh the postdischarge consequences. If you give an injection of hydromorphone, you cannot discharge the patient to drive home 45 minutes later. If you have diagnosed vertigo in a patient, you cannot prescribe meclizine and return that patient to her job working on scaffolding 50 ft above ground. If a frail patient lives alone and cannot safely walk, and you've started him on furosemide, you cannot discharge him without considering how he will get to the bathroom. Other concerns are even more difficult—for example, the homeless patient who does not have the environment or resources to follow your instructions.

It is tempting to view these concerns as not our responsibility or dismiss them as "not medicine." Clinicians can feel frustrated at being pulled into the realm of social work, where we are ill equipped to deal with and sort out the patient's "life problems." For one thing, we don't often have the resources to deal with these issues. And for another, addressing the patient's postdischarge living situation takes *time*—something in short supply and intangible to the other patients in the waiting room, who are expecting your attention and wondering, "What's the holdup?"

In the case presented, the plaintiff was a 70-year-old retiree. She was discharged from the hospital with crutches. Crutches are age-old and familiar devices. Nevertheless, crutches are for people who are able to use their arms for weight bearing and propulsion and require a fair amount of physical strength, timing, and dexterity. While a potentially debatable point, an assumption that a 70-year-old patient has the arm strength and dexterity to properly propel herself with crutches may be faulty. There was disagreement between the patient, who claimed she could not safely use the crutches, and the nurse, who said the patient accepted the crutches without concern. The safest course of action would be for discharge personnel to demonstrate the use of crutches, observe the patient using the crutches, and document that in the record.

In this case, it is unclear if the nurse demonstrated how to use the crutches or witnessed the plaintiff demonstrating she could safely use them. The jury found the nurse was negligent "in her provision" of crutches—an act they deemed a substantial cause of the plaintiff's injuries. Interestingly, the jury did not consider the lack of explanation on the crutches' use to be a substantial cause of injury. But the bottom line is, they faulted the nurse for the act of giving this patient crutches and awarded $850,000 in damages.

Society is changing. Fifty years ago, jurors would expect people to be familiar with crutches, and if you fell while using them, that was your own fault. Modern jurors expect hospitals and providers to get more involved in what happens to a patient after discharge. The news media has heavily publicized cases of alleged "patient dumping."

As a result, we see legislative changes, such as the recently passed California Senate Bill 1152, which requires that homeless patients be fed; provided weather-appropriate clothing, filled prescriptions, and vaccinations; given medical screening, examination, and evaluation that requires the "treating physician" to arrange behavioral health care; and enrolled in "any affordable health insurance coverage for which he or she is eligible."

Whether it is appropriate to ask hospitals and clinicians to get this involved is beyond the scope of this column. What is clear is that society increasingly expects clinicians and hospitals to take responsibility for patients. This societal change has an impact on the lay public's perception of what is expected of health care providers. Tomorrow's juror comes to court with a belief that hospitals and clinicians owe a duty of care that extends beyond the walls of the exam room.

IN SUMMARY

Reality test your post-treatment instructions to be sure they will work for the patient and are not grossly incompatible with his or her known postdischarge environment. To the extent possible, involve discharge planning personnel in your practice. Let your record reflect that you are acting in the patient's best interest, and evade the temptation to squint narrowly to avoid seeing circumstances in the patient's life that prevent safe implementation of your plan. **CR**