

# Keep Calm & Provide Good Care

In July 2010, a 67-year-old woman underwent a laparoscopic cholecystectomy performed by Dr. P at a Georgia hospital. When extensive scar tissue was found, the procedure was converted to an open surgery.

In the process, Dr. P encountered excessive bleeding and discovered a tear in the portal vein (which carries blood from the spleen, pancreas, and gallbladder to the liver). Dr. P called in a vascular surgeon, Dr. L, to repair the vein. But the woman had already experienced catastrophic blood loss, and she died in the ICU shortly after surgery.

The plaintiffs argued that Dr. P

“*Never give patients the perception that you are too busy. It’s an admission that you’re shortchanging them.*”

was behind schedule and rushed through the surgery, inserting a trocar tube without proper visualization and causing the portal vein injury. Dr. P claimed that the scar tissue had caused complications but admitted that he had not inserted a Veress needle into the abdominal cavity to create space around the organs before inserting the trocar tube. Dr. P claimed that this was not negligence, just a departure from his own usual practice.

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## OUTCOME

A \$1,050,000 settlement was reached during jury deliberations. This included \$1 million from the insurer and \$50,000 from Dr. P personally.

## COMMENT

Here, the surgeon injured the portal vein during insertion of a trocar. Often, a Veress needle is first inserted and carbon dioxide insufflated into the peritoneum to establish a pneumoperitoneum that provides space between injury-prone structures. However, trocars can also be inserted directly, without a pneumoperitoneum (this is known as *direct*

*trocar insertion*). It has been estimated that 40% of surgeons use Veress needle insufflation prior to primary trocar insertion, 30% use direct trocar insertion, and another 30% use the Hasson (direct visualization) technique.<sup>1</sup>

The plaintiff’s expert witness attempted to convince the jury that the standard of care required a pneumoperitoneum and proper visualization. The defense expert likely offered a compelling defense that the direct trocar insertion technique was an acceptable alternative. But did this case ultimately hinge on two competing methods of trocar placement, or something else? I would suggest the latter.

First, be cautious about letting scheduling drive any aspect

of patient care. In this case, the plaintiffs were able to show that the surgeon was behind schedule and that he departed from his usual practices by foregoing the pneumoperitoneum. This was aided by the defendant’s own admission. While lay jurors may have difficulty understanding complication rate data on the Veress needle insufflation technique versus direct trocar insertion technique or the location of the portal vein, they can easily understand rushing through a job and will use the physician’s own haste-based departure from usual practice against him. In sum, do not depart from usual practices because of scheduling matters or patient backlogs.

Furthermore, while it is tempting to let patients know the emergency department is busy, or that you are swamped or backlogged in the clinic—don’t. Just don’t. Never give patients the perception that you are too busy. At best, it will be interpreted as an admission that you are overtaxed; at worst, an admission that you are shortchanging the patient.

I have seen the bursting waiting room; the inbox overflowing with charts; patients and family members wandering in and out of treatment areas asking “How long?”; the single patient who requires nearly all resources; and of course, the wait for a callback from the on-call consultant who never responds. As clinicians, we can only do our best on these shifts, despite being tired, overwhelmed, and besieged.

But I have also seen the other side, where the plaintiff’s attorney’s theory of the case centers

#### 8.4 Pediatric Use

Safety and efficacy of Skyla have been established in women of reproductive age. Efficacy is expected to be the same for postpubertal females under the age of 18 as for users 18 years and older. Use of this product before menarche is not indicated.

#### 8.5 Geriatric Use

Skyla has not been studied in women over age 65 and is not approved for use in this population.

#### 8.6 Hepatic Impairment

No studies were conducted to evaluate the effect of hepatic disease on the disposition of LNG released from Skyla [see *Contraindications* (4)].

#### 8.7 Renal Impairment

No studies were conducted to evaluate the effect of renal disease on the disposition of LNG released from Skyla.

### 17 PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Patient Information)

- Counsel the patient that this product does not protect against HIV infection (AIDS) and other sexually transmitted diseases (STDs).
- Counsel the patient on the benefits, risks, and side effects of Skyla prior to insertion. Provide the Patient Information Booklet and give her the opportunity to read the information and discuss fully any questions she may have concerning Skyla as well as other methods of contraception. Advise the patient that the Full Prescribing Information is available to her upon request.
- Inform the patient about the risks of ectopic pregnancy, including the loss of fertility. Teach her to recognize and report to her healthcare provider promptly any symptoms of ectopic pregnancy.
- Inform the patient about the possibility of PID and that PID can cause tubal damage leading to ectopic pregnancy or infertility, or infrequently can necessitate hysterectomy, or cause death. Teach patients to recognize and report to their physician promptly any symptoms of pelvic inflammatory disease. These symptoms include development of menstrual disorders (prolonged or heavy bleeding), unusual vaginal discharge, abdominal or pelvic pain or tenderness, dyspareunia, chills, and fever.
- Counsel the patient that irregular or prolonged bleeding and spotting, and/or cramps may occur during the first few weeks after insertion. If her symptoms continue or are severe she should report them to her healthcare provider.

- Counsel the patient on how she can check that the threads still protrude from the cervix and caution her not to pull on the threads and displace Skyla. Inform her that there is no contraceptive protection if Skyla is displaced or expelled. [See *Warnings and Precautions* (5.6, 5.7).]
- Instruct the patient to contact her healthcare provider if she experiences any of the following:
  - A stroke or heart attack
  - Very severe or migraine headaches
  - Unexplained fever
  - Yellowing of the skin or whites of the eyes, as these may be signs of serious liver problems
  - Pregnancy or suspected pregnancy
  - Pelvic pain or pain during sex
  - HIV positive seroconversion in herself or her partner
  - Possible exposure to sexually transmitted infections (STIs)
  - Unusual vaginal discharge or genital sores
  - Severe vaginal bleeding or bleeding that lasts a long time, or if she misses a menstrual period
  - Inability to feel Skyla's threads
- Inform the patient that Skyla can be safely scanned with MRI only under specific conditions [see *Warnings and Precautions* (5.11)]. Instruct patients who will have an MRI to tell their doctor that they have Skyla. This information is included on the Follow-Up Reminder Card.
- Complete the Follow-up Reminder Card and give to the patient.

Manufactured for:



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## MALPRACTICE CHRONICLE

around the idea that his client received substandard treatment because of taxed system resources—with you taking the fall. What would they like to prove? That you were tired, overwhelmed, and besieged.

Don't hang yourself with your own words. Nothing furthers the plaintiff's case like statements from the clinician such as "Things are crazy here tonight," "We are just trying to get by," "We are two people short," etc. While such statements are fine for KFC or the DMV, they have no place in clinical practice. Even when invited—perhaps the patient says, "You guys are hopping tonight"—the best response is, "We just want to provide the best care for everyone here."

Why this paranoia about the spoken word? It's simple: Should any outcome be unfavorable, patients will have the perception that they were "rushed through." Under evidence law, your state-

ments to the patient and family about the "crazy shift" may be directly admissible as evidence against you, being classified either as nonhearsay or as an exception to the hearsay rule.

You want the jurors to judge you on the merits of the care provided, not on collateral matters out of your control. In a close case, a "rushed out the door" narrative may tip the balance in the plaintiff's favor. Avoid setting this table for the plaintiff.

If you become dangerously busy, your system is broken and must be fixed. It must be fixed for burnout reasons, for patient satisfaction reasons, and most importantly, for patient *safety* reasons. Have this discussion, but have it with the right people in your practice—not the patient or patient's family at bedside.

This surgeon paid part of the settlement out of his own pocket. His malpractice insurance policy was likely capped at \$1 million.

After the close of final arguments, the parties, believing the case could go either way, reached a settlement of \$1 million plus a sizable contribution of \$50,000 from the surgeon's personal assets. This may have been preferable to the prospect of a runaway verdict with the potential to bankrupt the surgeon and his family.

What about your malpractice policy? It's no romance novel or bestseller, but you should be familiar with the general terms: the policy limits, who has settlement authority (the clinician or insurance company), and any important exclusions/limitations. Furthermore, NPs and PAs should know whether they are covered as an insured party in their own right or if coverage is shared with a physician. The difference could be an important one. —DML CR

### REFERENCE

1. Emergency Care Research Institute. Trocars: safety and selection. *Health Devices*. 1998;27(11):376-399.