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 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.

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.[1]

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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

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Commentary by **David M. Lang, JD, PA-C,** an experienced PA and a former medical malpractice defense attorney who practices law in Granite Bay, California. Cases reprinted with permission from *Medical Malpractice Verdicts, Settlements and Experts*, Lewis Laska, Editor, (800) 298-6288.

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 statements 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.