

Unexpected Outcomes: Investigate, Communicate, Document

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Unexpected treatment outcomes can cause feelings of self-doubt, remorse, failure, and fear of litigation in physicians and healthcare providers.¹ Patients and families may feel mistrust, anger, and confusion especially if communication from the physician and healthcare team is delayed. This article discusses techniques for properly disclosing an unexpected outcome and documenting a patient's healthcare encounter in a manner that can facilitate the defense of a malpractice lawsuit.

Case One: Disclosure Following an Unexpected Death

A morbidly obese woman with multiple comorbidities presented to an emergency department (ED) after a fall. X-rays revealed a right tibial plateau fracture. She was referred to an orthopedic surgeon who recommended an open reduction and internal fixation. Preoperatively the patient's spouse offered the patient's CPAP to the operating room (OR) team, explaining the patient could not lie flat without it. His offer was not accepted. Intraoperatively the patient had a bradycardic event and hypotension. A code blue was called. Although initially stabilized, the patient died on postoperative day 12.

The patient's spouse sued various members of the patient's healthcare team and the hospital for malpractice.

Discussion

In this case, the healthcare team had multiple opportunities to reduce the risk of potential liability before, during, and after the patient's surgery. These included addressing comorbidities, being aware of the patient's medical history, adequately documenting, and engaging in an appropriate disclosure process. In fact, during his deposition, the patient's spouse claimed no one told him what happened to his wife. He suspected his wife's death was related to the surgical team's failure to use the CPAP.

Risk Reduction Strategies

Consider the following strategies when providing disclosure:

- Plan what you intend to say before you start the disclosure discussion.
- Have a fact witness present.
- Allow adequate time to listen and respond to questions.
- Focus on the patient and family, not yourself.
- Be empathetic. Acknowledge patient and family suffering.
- Do not blame others.
- Apologize for the occurrence of the incident: "I'm sorry this has happened to you."²
- Don't speculate. Let the family know that investigation is ongoing.³
- Know that disclosure is a process, not a one-time meeting, especially after serious events.⁴

Case Two: Documentation's Impact in Malpractice Litigation

A 42-year-old patient with a history of diabetes, hypertension, hyperlipidemia, and morbid obesity (BMI 43) presented to her PCP. She complained of left knee pain. Her PCP referred her to an orthopedic surgeon, who completed a thorough history and physical examination (H&P) and ordered an MRI. Based on the results the surgeon proposed three options: “watch and wait,” meniscus tear repair, and meniscus tear and anterior cruciate ligament repair. He reviewed the risks and benefits of each option. The patient chose the third option. In addition to using a consent form, which included risks specific to the patient, the surgeon documented the discussion. He included the patient’s responses, which provided further evidence of the patient’s informed consent. When the patient arrived for surgery, a reassessment was done. The surgeon documented no changes from the initial findings. The surgery was uneventful, and the patient was discharged home later that day.

The next day, the patient presented to the ED for swelling and pain in her surgical leg. Exams were benign. After her pain was relieved, she was discharged home. Later the surgeon examined her for swelling and pain in his office. He found nothing unusual and treated her pain. The patient called the surgeon two additional times complaining of swelling and pain. She was advised to elevate and ice her leg and go to the ED if she was not able to touch her leg due to pain. At 6:30 p.m. the patient returned to the ED reporting 10/10 pain in her leg and back. She could not move her leg, which appeared swollen. IV pain medication was administered. The ED physician aspirated the knee. Because the specimen showed Gram-positive rods, he started antibiotics. He asked the orthopedic surgeon to come in for an examination.

The orthopedic surgeon noted edema from thigh to calf. Two additional aspirations of the knee were attempted, but only air was attained. The surgeon ordered a CT scan, suspecting gas gangrene. With confirmation on the CT scan, arrangements were made for the patient to be airlifted to a tertiary hospital that had an ICU and would be able to do additional surgery. At the tertiary hospital, the patient was diagnosed with clostridial necrotizing fasciitis, which required amputation of her entire left leg. Shortly after the amputation, the patient went into cardiac arrest and died.

The patient’s family sued various members of the patient’s healthcare team and the hospital for negligence.

Discussion

Healthcare providers may wonder to what extent their documentation would matter in a malpractice lawsuit. This case was successfully defended in large part due to the documentation before, during, and after the patient’s surgery. The documentation was clear, thorough, and contemporaneous. It included specific details and exact instructions communicated to the patient and family. The defense team was able to use the documentation to show the standard of care was met and the care did not cause the patient’s outcome. Ultimately, the patient’s death was determined to be an unfortunate and unexpected event that was not preventable.

Risk Reduction Strategies

Consider the following documentation strategies:

- Document which risks, benefits, and alternatives you discussed, and indicate what you did to determine that the patient understood you.

- Create a record that shows patient education about the signs and symptoms of postoperative complications, and how and when to follow up.
- Show your compliance with the standard of care. Include your plan, your differential diagnosis, and your thresholds to move forward and to stop. Be timely, clear, and factual.
- Include examination observations that will remind you and educate others about what you saw and when.

Conclusion

Maintaining open and honest communications with patients and families is a powerful risk management strategy, in general, and particularly following an unexpected outcome. Listen with intent to understand, not to answer. Respond to questions with facts and compassion. Involve the patient and family in decision-making. This builds trust. Because memories fade, take time during a patient visit or immediately afterwards to complete documentation. Your notes provide a way to review your prior decisions and the way in which you communicated your plan and reasoning. As the case studies in this article indicate, documentation is a key aspect of defending medical malpractice claims following unexpected outcomes.

Endnotes:

1. "Clinical Outcomes, Disclosing Unanticipated (Position Paper)," American Academy of Family Physicians, October 2023, <https://www.aafp.org/about/policies/all/clinical-outcomes-disclosing-unanticipated.html>.
2. Lauren Fagadau Bender, "'I'm Sorry' Laws and Medical Liability," *Virtual Mentor* 9, no.4 (2007): 300-304, <https://doi.org/10.1001/virtualmentor.2007.9.4.hlaw1-0704>.
3. Committee on Patient Safety and Quality Improvement of the American College of Obstetricians and Gynecologists, "Disclosure and Discussion of Adverse Events," Number 681, reaffirmed 2019, <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/12/disclosure-and-discussion-of-adverse-events>.
4. Ryan Murphy et al., "How to Disclose Medical Errors and Unanticipated Outcomes," Accelerate Learning Community, University of Utah, March 18, 2021, <https://accelerate.uofuhealth.utah.edu/improvement/how-to-disclose-medical-errors-and-unanticipated-outcomes>.

The information provided in this article offers risk management strategies and resource links. Guidance and recommendations contained in this article are not intended to determine the standard of care but are provided as risk management advice only. The ultimate judgment regarding the propriety of any method of care must be made by the healthcare professional. The information does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about this topic should be directed to an attorney.

<https://proassurance.com/knowledge-center/unexpected-outcomes-investigate-communicate-document>