DEFENSE VERDICT AFTER PATIENT CHALLENGED SURGICAL OUTCOME

By Jennifer Vuu Sanchez, *Program Director*

DESCRIPTION

A 42-year-old female dissatisfied with post-surgical outcomes for chronic pelvic pain sued her gynecologist.

KEY LESSONS

- Patients will sue even if there is no malpractice because of unexpected outcomes, anger, dissatisfaction, or lack of understanding of what occurred.
- Appropriate provider-patient communication helps manage expectations and complications.
- Provide emotional support for clinicians named in a malpractice lawsuit or claim.

CLINICAL SEQUENCE

April 3: A 42-year-old female with a history of chronic pelvic pain (CPP) presented to her gynecologist with complaints of pelvic pain and uterine fibroids seen on an ultrasound. Upon examination, the gynecologist noted a tender uterus and a small submucosal fibroid. A plan was made for a hysteroscopy with fibroid removal and a diagnostic laparoscopy to rule out endometriosis.

May 4: A hysteroscopy, dilation and curettage, laparoscopy, and lysis of adhesions was completed. A small posterior fibroid was removed; no endometriosis or submucosal fibroid was visualized. The gynecologist stated that they notified the patient of the findings, however, the patient denies this.

August 10: The patient returned to the gynecologist with complaints of increased urination and bilateral pelvic/hip pain. The patient's bladder was noted to be tender on examination. Urine cultures, antibiotics, and an ultrasound were ordered.

September–October: The ultrasound results showed a posterior fibroid pressing the endometrial cavity and a submucosal fibroid projecting posteriorly. An MRI showed a fibroid with submucosal extension, and small submucosal fibroid. A cystoscopy was completed showing bladder indents likely from the fibroid.

October 30: The gynecologist performed a cautery of the endometrium/uterosacral tissue, a right ovarian cystectomy, and a lap myomectomy. In addition, the posterior fibroid and another (1–2 cm) fibroid were removed.

November 14: The patient continued to complain of CPP, although healing was noted.

November–November: Over the next year, patient presented to the Gynecology office multiple times with complaints of bleeding, nausea/vomiting, abdominal pain, and painful menses. Exams and labs were within normal limits. Painful menses was resolved with NSAIDs and birth control pills. An ultrasound showed new small submucosal, intramural fibroid. Adenomyosis was also noted. A total abdominal hysterectomy (TAH) was advised; the patient declined. The plan was to continue on NSAIDs and birth control pills for symptom management.

December–December: The following year, the patient sought care from three other gynecologists for complaints of pelvic pain, fibroids, and urinary signs and symptoms. Again, a TAH was recommended and declined by the patient. Antihormonal medications were prescribed, and a one-time Lupron injection was administered.

ALLEGATION

The patient filed a medical professional liability (MPL) lawsuit alleging that there was improper performance of surgery from the initial procedure.

DISPOSITION

The expert gynecologist was fully supportive of the indications and performances of the initial surgery. The case went to trial and concluded in a defense verdict in favor of the gynecologist. The expenses to defend the case exceeded $100,000.

ANALYSIS

When there is no indication of malpractice, patients pursue an MPL case for a variety of reasons, including:

- Unmet or unrealistic expectations
- A perceived "bad" outcome
- Lack of clarity about what happened or why

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ANALYSIS

- Anger
- Accountability
- Punishment

In this case, the patient expected the surgery to resolve her CPP symptoms. When it did not, she sought alternative treatment from other gynecologists who, ultimately, came to the same conclusion and recommended the same treatment options. As a result, the patient sued the first gynecologist for improper performance of surgery from the initial procedure.

Communication

For surgery cases, provider-patient communication errors can often be attributed to inadequate informed consent, miscommunication among providers re: patient's condition, and unsympathetic response to a patient complaint. CRICO-Candello's 2015 benchmarking report analyzing more than 7,500 surgery-related malpractice cases found that, in more than half of these cases, "the surgical technique was not questioned, but the patient's care was impacted by miscommunication within the surgical team and—more commonly—by inadequate communication with the patient."

Adverse outcomes (real or perceived) will likely cause patient dissatisfaction. However, good communication throughout the surgical process assists in managing expectations and complications for both patients and providers. For instance, ensuring during the pre-surgery consent process that the patient understands the overall risks, benefits, and expected outcomes can be helpful when addressing post-op complications and patient expectations.

Candello 2015 Benchmarking Report: Malpractice Risks in Communication Failures

CRICO Informed Consent FAQs

CRICO Informed Consent Guidelines Overview

When Things Go Wrong (video)

ANALYSIS

Defendant Support

Even when the standard of care was met, patients may allege otherwise, imposing a significant impact on providers who are named in a lawsuit or claim. Emotional support for named providers recognizes that their coping skills can significantly burden their day-to-day practice and how effective they are as a defendant.

Clinicians are Far from Alone During a Lawsuit (Podcast)

Getting Clinicians in Lawsuits to Care for Selves is Hard (Podcast)

Healing the Healer Video (Video)

Understanding "Standard of Care" A Doctor and A Lawyer Share from the Medmal Front Lines (Podcast)